Filing at a Glance

Company:	Freelancers Health Service Corporation
Product Name:	FHSC Sm Group Off Exchange
State:	New York
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.003G Small Group Only - Other
Filing Type:	Off Exchange NG Forms & Rates
Date Submitted:	05/15/2013
SERFF Tr Num:	HNMN-129030721
SERFF Status:	Closed-APPR Approved
State Tr Num:	2013050119
State Status:	APPR Approved
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	09/26/2013
Disposition Status:	APPR Approved
Implementation Date:	09/26/2013

State Filing Description:

[redacted]

State: *New York* **Filing Company:** *Freelancers Health Service Corporation*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *FHSC Sm Group Off Exchange*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Non Employer Group
Filing Status Changed: 09/26/2013
State Status Changed: 09/26/2013
Created By: [redacted]
Corresponding Filing Tracking Number:

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

Deemer Date:
Submitted By: [redacted]

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

This filing contains small group 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: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *FHSC Sm Group Off Exchange*
Project Name/Number: */*

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

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 filed by a new company.

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:			33,148					
Policy Holders:			33,148					

Rate Review Detail

COMPANY:

Company Name: Freelancers Health Service Corporation
HHS Issuer Id: 71644
Product Names: Small Group Off Exchange Products
Trend Factors:

FORMS:

New Policy Forms: FHSC-WMBT003, FHSC-SHOP002, FHSC-GPCON001, FHSC-SHOP001, FHSC-WMBT002, 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: 13,394,174.00
Projected Incurred Claims: 11,150,006.00
Annual $: Min: 202.36 Max: 570.13 Avg: 404.07

State: New York **Filing Company:** Freelancers Health Service Corporation
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: FHSC Sm Group Off Exchange
Project Name/Number: /

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 SG (6-10-2013).xlsx, FHSC Rate Manual SG (6-10-2013).pdf,

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Table of Contents

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

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Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rate Setting Parameters

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Index Rate (Adult)	192.586035
Conversion Factor	1.212121

HIOS ID	Product	Market	Metal	Rate Factor
71644NY0050004	EssentialCare Platinum Plan	On and Off Exchange	Platinum	1.679497
71644NY0050003	EssentialCare Gold Plan	On and Off Exchange	Gold	1.428384
71644NY0050002	EssentialCare Silver Plan	On and Off Exchange	Silver	1.222445
71644NY0050001	EssentialCare Bronze Plan	On and Off Exchange	Bronze	1.000000
71644NY0230004	EssentialCare Platinum Plan Restricted-D	On and Off Exchange	Platinum	1.679497
71644NY0230003	EssentialCare Gold Plan Restricted-D	On and Off Exchange	Gold	1.428384
71644NY0230002	EssentialCare Silver Plan Restricted-D	On and Off Exchange	Silver	1.222445
71644NY0230001	EssentialCare Bronze Plan Restricted-D	On and Off Exchange	Bronze	1.000000
71644NY0240004	EssentialCare Platinum Plan Restricted-F	On and Off Exchange	Platinum	1.679497
71644NY0240003	EssentialCare Gold Plan Restricted-F	On and Off Exchange	Gold	1.428384
71644NY0240002	EssentialCare Silver Plan Restricted-F	On and Off Exchange	Silver	1.222445
71644NY0240001	EssentialCare Bronze Plan Restricted-F	On and Off Exchange	Bronze	1.000000
71644NY0250004	EssentialCare Platinum Plan Restricted-DF	On and Off Exchange	Platinum	1.679497
71644NY0250003	EssentialCare Gold Plan Restricted-DF	On and Off Exchange	Gold	1.428384
71644NY0250002	EssentialCare Silver Plan Restricted-DF	On and Off Exchange	Silver	1.222445
71644NY0250001	EssentialCare Bronze Plan Restricted-DF	On and Off Exchange	Bronze	1.000000
71644NY0620004	Essential Care Platinum Plan	On and Off Exchange	Platinum	1.706409
71644NY0620003	Essential Care Gold Plan	On and Off Exchange	Gold	1.454640
71644NY0620002	Essential Care Silver Plan	On and Off Exchange	Silver	1.248383
71644NY0620001	Essential Care Bronze Plan	On and Off Exchange	Bronze	1.016855
71644NY0290004	Essential Care Platinum Plan Restricted-D	On and Off Exchange	Platinum	1.706409
71644NY0290003	Essential Care Gold Plan Restricted-D	On and Off Exchange	Gold	1.454640
71644NY0290002	Essential Care Silver Plan Restricted-D	On and Off Exchange	Silver	1.248383
71644NY0290001	Essential Care Bronze Plan Restricted-D	On and Off Exchange	Bronze	1.016855
71644NY0300004	Essential Care Platinum Plan Restricted-F	On and Off Exchange	Platinum	1.706409
71644NY0300003	Essential Care Gold Plan Restricted-F	On and Off Exchange	Gold	1.454640
71644NY0300002	Essential Care Silver Plan Restricted-F	On and Off Exchange	Silver	1.248383
71644NY0300001	Essential Care Bronze Plan Restricted-F	On and Off Exchange	Bronze	1.016855
71644NY0310004	Essential Care Platinum Plan Restricted-DF	On and Off Exchange	Platinum	1.706409
71644NY0310003	Essential Care Gold Plan Restricted-DF	On and Off Exchange	Gold	1.454640
71644NY0310002	Essential Care Silver Plan Restricted-DF	On and Off Exchange	Silver	1.248383
71644NY0310001	Essential Care Bronze Plan Restricted-DF	On and Off Exchange	Bronze	1.016855
71644NY0170004	EssentialCare Platinum Plan 29	On and Off Exchange	Platinum	1.679497
71644NY0170003	EssentialCare Gold Plan 29	On and Off Exchange	Gold	1.428384
71644NY0170002	EssentialCare Silver Plan 29	On and Off Exchange	Silver	1.222445
71644NY0170001	EssentialCare Bronze Plan 29	On and Off Exchange	Bronze	1.000000
71644NY0260004	EssentialCare Platinum Plan 29 Restricted-D	On and Off Exchange	Platinum	1.679497
71644NY0260003	EssentialCare Gold Plan 29 Restricted-D	On and Off Exchange	Gold	1.428384
71644NY0260002	EssentialCare Silver Plan 29 Restricted-D	On and Off Exchange	Silver	1.222445
71644NY0260001	EssentialCare Bronze Plan 29 Restricted-D	On and Off Exchange	Bronze	1.000000
71644NY0270004	EssentialCare Platinum Plan 29 Restricted-F	On and Off Exchange	Platinum	1.679497
71644NY0270003	EssentialCare Gold Plan 29 Restricted-F	On and Off Exchange	Gold	1.428384
71644NY0270002	EssentialCare Silver Plan 29 Restricted-F	On and Off Exchange	Silver	1.222445
71644NY0270001	EssentialCare Bronze Plan 29 Restricted-F	On and Off Exchange	Bronze	1.000000
71644NY0280004	EssentialCare Platinum Plan 29 Restricted-DF	On and Off Exchange	Platinum	1.679497
71644NY0280003	EssentialCare Gold Plan 29 Restricted-DF	On and Off Exchange	Gold	1.428384
71644NY0280002	EssentialCare Silver Plan 29 Restricted-DF	On and Off Exchange	Silver	1.222445
71644NY0280001	EssentialCare Bronze Plan 29 Restricted-DF	On and Off Exchange	Bronze	1.000000
71644NY0180004	Essential Care Platinum Plan 29	On and Off Exchange	Platinum	1.706409
71644NY0180003	Essential Care Gold Plan 29	On and Off Exchange	Gold	1.454640
71644NY0180002	Essential Care Silver Plan 29	On and Off Exchange	Silver	1.248383
71644NY0180001	Essential Care Bronze Plan 29	On and Off Exchange	Bronze	1.016855
71644NY0320004	Essential Care Platinum Plan 29 Restricted-D	On and Off Exchange	Platinum	1.706409
71644NY0320003	Essential Care Gold Plan 29 Restricted-D	On and Off Exchange	Gold	1.454640
71644NY0320002	Essential Care Silver Plan 29 Restricted-D	On and Off Exchange	Silver	1.248383
71644NY0320001	Essential Care Bronze Plan 29 Restricted-D	On and Off Exchange	Bronze	1.016855
71644NY0330004	Essential Care Platinum Plan 29 Restricted-F	On and Off Exchange	Platinum	1.706409
71644NY0330003	Essential Care Gold Plan 29 Restricted-F	On and Off Exchange	Gold	1.454640
71644NY0330002	Essential Care Silver Plan 29 Restricted-F	On and Off Exchange	Silver	1.248383
71644NY0330001	Essential Care Bronze Plan 29 Restricted-F	On and Off Exchange	Bronze	1.016855
71644NY0340004	Essential Care Platinum Plan 29 Restricted-DF	On and Off Exchange	Platinum	1.706409
71644NY0340003	Essential Care Gold Plan 29 Restricted-DF	On and Off Exchange	Gold	1.454640
71644NY0340002	Essential Care Silver Plan 29 Restricted-DF	On and Off Exchange	Silver	1.248383
71644NY0340001	Essential Care Bronze Plan 29 Restricted-DF	On and Off Exchange	Bronze	1.016855
71644NY0070004	PrimarySelect Platinum Plan	On and Off Exchange	Platinum	1.610092
71644NY0070003	PrimarySelect Gold Plan	On and Off Exchange	Gold	1.427252
71644NY0070002	PrimarySelect Silver Plan	On and Off Exchange	Silver	1.221564
71644NY0070001	PrimarySelect Bronze Plan	On and Off Exchange	Bronze	0.866851
71644NY0350004	PrimarySelect Platinum Plan Restricted-D	On and Off Exchange	Platinum	1.610092
71644NY0350003	PrimarySelect Gold Plan Restricted-D	On and Off Exchange	Gold	1.427252
71644NY0350002	PrimarySelect Silver Plan Restricted-D	On and Off Exchange	Silver	1.221564
71644NY0350001	PrimarySelect Bronze Plan Restricted-D	On and Off Exchange	Bronze	0.866851

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

Semi-Annual Trend Factors:

Period 1 2014	1.000
Period 2 2014	1.025

Sample Rate Calculation:
Platinum Select in Region 2 for a Couple with Two Dependents =
Base Rate x Conversion Factor x Platinum Select Factor x Region 2 Factor x Couple and Two Dependents Factor =
$192.59 x 1.212121 x 1.610092 x 1.017235 x 2.85 = **$1,089.65**

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rate Setting Parameters

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

71644NY0360004	PrimarySelect Platinum Plan Restricted-F	On and Off Exchange	Platinum	1.610092
71644NY0360003	PrimarySelect Gold Plan Restricted-F	On and Off Exchange	Gold	1.427252
71644NY0360002	PrimarySelect Silver Plan Restricted-F	On and Off Exchange	Silver	1.221564
71644NY0360001	PrimarySelect Bronze Plan Restricted-F	On and Off Exchange	Bronze	0.866851
71644NY0370004	PrimarySelect Platinum Plan Restricted-DF	On and Off Exchange	Platinum	1.610092
71644NY0370003	PrimarySelect Gold Plan Restricted-DF	On and Off Exchange	Gold	1.427252
71644NY0370002	PrimarySelect Silver Plan Restricted-DF	On and Off Exchange	Silver	1.221564
71644NY0370001	PrimarySelect Bronze Plan Restricted-DF	On and Off Exchange	Bronze	0.866851
71644NY0640004	Primary Select Platinum Plan	On and Off Exchange	Platinum	1.637004
71644NY0640003	Primary Select Gold Plan	On and Off Exchange	Gold	1.453509
71644NY0640002	Primary Select Silver Plan	On and Off Exchange	Silver	1.247502
71644NY0640001	Primary Select Bronze Plan	On and Off Exchange	Bronze	0.883706
71644NY0410004	Primary Select Platinum Plan Restricted-D	On and Off Exchange	Platinum	1.637004
71644NY0410003	Primary Select Gold Plan Restricted-D	On and Off Exchange	Gold	1.453509
71644NY0410002	Primary Select Silver Plan Restricted-D	On and Off Exchange	Silver	1.247502
71644NY0410001	Primary Select Bronze Plan Restricted-D	On and Off Exchange	Bronze	0.883706
71644NY0420004	Primary Select Platinum Plan Restricted-F	On and Off Exchange	Platinum	1.637004
71644NY0420003	Primary Select Gold Plan Restricted-F	On and Off Exchange	Gold	1.453509
71644NY0420002	Primary Select Silver Plan Restricted-F	On and Off Exchange	Silver	1.247502
71644NY0420001	Primary Select Bronze Plan Restricted-F	On and Off Exchange	Bronze	0.883706
71644NY0430004	Primary Select Platinum Plan Restricted-DF	On and Off Exchange	Platinum	1.637004
71644NY0430003	Primary Select Gold Plan Restricted-DF	On and Off Exchange	Gold	1.453509
71644NY0430002	Primary Select Silver Plan Restricted-DF	On and Off Exchange	Silver	1.247502
71644NY0430001	Primary Select Bronze Plan Restricted-DF	On and Off Exchange	Bronze	0.883706
71644NY0190004	PrimarySelect Platinum Plan 29	On and Off Exchange	Platinum	1.610092
71644NY0190003	PrimarySelect Gold Plan 29	On and Off Exchange	Gold	1.427252
71644NY0190002	PrimarySelect Silver Plan 29	On and Off Exchange	Silver	1.221564
71644NY0190001	PrimarySelect Bronze Plan 29	On and Off Exchange	Bronze	0.866851
71644NY0380004	PrimarySelect Platinum Plan 29 Restricted-D	On and Off Exchange	Platinum	1.610092
71644NY0380003	PrimarySelect Gold Plan 29 Restricted-D	On and Off Exchange	Gold	1.427252
71644NY0380002	PrimarySelect Silver Plan 29 Restricted-D	On and Off Exchange	Silver	1.221564
71644NY0380001	PrimarySelect Bronze Plan 29 Restricted-D	On and Off Exchange	Bronze	0.866851
71644NY0390004	PrimarySelect Platinum Plan 29 Restricted-F	On and Off Exchange	Platinum	1.610092
71644NY0390003	PrimarySelect Gold Plan 29 Restricted-F	On and Off Exchange	Gold	1.427252
71644NY0390002	PrimarySelect Silver Plan 29 Restricted-F	On and Off Exchange	Silver	1.221564
71644NY0390001	PrimarySelect Bronze Plan 29 Restricted-F	On and Off Exchange	Bronze	0.866851
71644NY0400004	PrimarySelect Platinum Plan 29 Restricted-DF	On and Off Exchange	Platinum	1.610092
71644NY0400003	PrimarySelect Gold Plan 29 Restricted-DF	On and Off Exchange	Gold	1.427252
71644NY0400002	PrimarySelect Silver Plan 29 Restricted-DF	On and Off Exchange	Silver	1.221564
71644NY0400001	PrimarySelect Bronze Plan 29 Restricted-DF	On and Off Exchange	Bronze	0.866851
71644NY0200004	Primary Select Platinum Plan 29	On and Off Exchange	Platinum	1.637004
71644NY0200003	Primary Select Gold Plan 29	On and Off Exchange	Gold	1.453509
71644NY0200002	Primary Select Silver Plan 29	On and Off Exchange	Silver	1.247502
71644NY0200001	Primary Select Bronze Plan 29	On and Off Exchange	Bronze	0.883706
71644NY0440004	Primary Select Platinum Plan 29 Restricted-D	On and Off Exchange	Platinum	1.637004
71644NY0440003	Primary Select Gold Plan 29 Restricted-D	On and Off Exchange	Gold	1.453509
71644NY0440002	Primary Select Silver Plan 29 Restricted-D	On and Off Exchange	Silver	1.247502
71644NY0440001	Primary Select Bronze Plan 29 Restricted-D	On and Off Exchange	Bronze	0.883706
71644NY0450004	Primary Select Platinum Plan 29 Restricted-F	On and Off Exchange	Platinum	1.637004
71644NY0450003	Primary Select Gold Plan 29 Restricted-F	On and Off Exchange	Gold	1.453509
71644NY0450002	Primary Select Silver Plan 29 Restricted-F	On and Off Exchange	Silver	1.247502
71644NY0450001	Primary Select Bronze Plan 29 Restricted-F	On and Off Exchange	Bronze	0.883706
71644NY0460004	Primary Select Platinum Plan 29 Restricted-DF	On and Off Exchange	Platinum	1.637004
71644NY0460003	Primary Select Gold Plan 29 Restricted-DF	On and Off Exchange	Gold	1.453509
71644NY0460002	Primary Select Silver Plan 29 Restricted-DF	On and Off Exchange	Silver	1.247502
71644NY0460001	Primary Select Bronze Plan 29 Restricted-DF	On and Off Exchange	Bronze	0.883706
71644NY0080002	PrimarySelect EPO Silver Plan	On and Off Exchange	Silver	1.152587
71644NY0470002	PrimarySelect EPO Silver Plan Restricted-D	On and Off Exchange	Silver	1.152587
71644NY0480002	PrimarySelect EPO Silver Plan Restricted-F	On and Off Exchange	Silver	1.152587
71644NY0490002	PrimarySelect EPO Silver Plan Restricted-DF	On and Off Exchange	Silver	1.152587
71644NY0650002	Primary Select EPO Silver Plan	On and Off Exchange	Silver	1.178525
71644NY0500002	Primary Select EPO Silver Plan Restricted-D	On and Off Exchange	Silver	1.178525
71644NY0510002	Primary Select EPO Silver Plan Restricted-F	On and Off Exchange	Silver	1.178525
71644NY0520002	Primary Select EPO Silver Plan Restricted-DF	On and Off Exchange	Silver	1.178525
71644NY0210002	PrimarySelect EPO Silver Plan 29	On and Off Exchange	Silver	1.152587
71644NY0530002	PrimarySelect EPO Silver Plan 29 Restricted-D	On and Off Exchange	Silver	1.152587
71644NY0540002	PrimarySelect EPO Silver Plan 29 Restricted-F	On and Off Exchange	Silver	1.152587
71644NY0550002	PrimarySelect EPO Silver Plan 29 Restricted-DF	On and Off Exchange	Silver	1.152587
71644NY0220002	Primary Select EPO Silver Plan 29	On and Off Exchange	Silver	1.178525
71644NY0560002	Primary Select EPO Silver Plan 29 Restricted-D	On and Off Exchange	Silver	1.178525
71644NY0570002	Primary Select EPO Silver Plan 29 Restricted-F	On and Off Exchange	Silver	1.178525
71644NY0660002	Primary Select EPO Silver Plan 29 Restricted-DF	On and Off Exchange	Silver	1.178525

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
EssentialCare Platinum	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
EssentialCare Platinum Restricted-D	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Restricted-D	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Restricted-D	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Restricted-D	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
EssentialCare Platinum Restricted-F	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Restricted-F	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Restricted-F	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Restricted-F	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
EssentialCare Platinum Restricted-DF	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Restricted-DF	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Restricted-DF	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Restricted-DF	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Dental	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
Essential Care Platinum Dental Restricted-D	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Restricted-D	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Restricted-D	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Restricted-D	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
Essential Care Platinum Dental Restricted-F	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Restricted-F	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Restricted-F	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Restricted-F	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
Essential Care Platinum Dental Restricted-DF	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Restricted-DF	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Restricted-DF	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Restricted-DF	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
EssentialCare Platinum Age 29 Option	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Age 29 Option	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Age 29 Option	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Age 29 Option	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
EssentialCare Platinum Age 29 Option Restricted-D	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Age 29 Option Restricted-D	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Age 29 Option Restricted-D	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Age 29 Option Restricted-D	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
EssentialCare Platinum Age 29 Option Restricted-F	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Age 29 Option Restricted-F	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Age 29 Option Restricted-F	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Age 29 Option Restricted-F	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
EssentialCare Platinum Age 29 Option Restricted-DF	Region 1	$426.04	$852.07	$724.26	$724.26	$724.26	$1,214.20	$1,214.20	$1,214.20
	Region 2	$398.81	$797.63	$677.99	$677.99	$677.99	$1,136.62	$1,136.62	$1,136.62
	Region 3	$478.57	$957.13	$813.56	$813.56	$813.56	$1,363.91	$1,363.91	$1,363.91
	Region 4	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
	Region 5	$392.06	$784.12	$666.50	$666.50	$666.50	$1,117.36	$1,117.36	$1,117.36
	Region 6	$414.04	$828.07	$703.86	$703.86	$703.86	$1,180.00	$1,180.00	$1,180.00
	Region 7	$402.87	$805.74	$684.88	$684.88	$684.88	$1,148.18	$1,148.18	$1,148.18
	Region 8	$561.14	$1,122.29	$953.94	$953.94	$953.94	$1,599.26	$1,599.26	$1,599.26
EssentialCare Gold Age 29 Option Restricted-DF	Region 1	$362.34	$724.67	$615.97	$615.97	$615.97	$1,032.66	$1,032.66	$1,032.66
	Region 2	$339.19	$678.37	$576.61	$576.61	$576.61	$966.68	$966.68	$966.68
	Region 3	$407.01	$814.02	$691.92	$691.92	$691.92	$1,159.98	$1,159.98	$1,159.98
	Region 4	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
	Region 5	$333.44	$666.88	$566.85	$566.85	$566.85	$950.30	$950.30	$950.30
	Region 6	$352.13	$704.26	$598.62	$598.62	$598.62	$1,003.57	$1,003.57	$1,003.57
	Region 7	$342.64	$685.27	$582.48	$582.48	$582.48	$976.51	$976.51	$976.51
	Region 8	$477.24	$954.48	$811.31	$811.31	$811.31	$1,360.14	$1,360.14	$1,360.14
EssentialCare Silver Age 29 Option Restricted-DF	Region 1	$310.10	$620.19	$527.16	$527.16	$527.16	$883.77	$883.77	$883.77
	Region 2	$290.28	$580.57	$493.48	$493.48	$493.48	$827.31	$827.31	$827.31
	Region 3	$348.33	$696.66	$592.16	$592.16	$592.16	$992.74	$992.74	$992.74
	Region 4	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
	Region 5	$285.36	$570.73	$485.12	$485.12	$485.12	$813.29	$813.29	$813.29
	Region 6	$301.36	$602.72	$512.31	$512.31	$512.31	$858.88	$858.88	$858.88
	Region 7	$293.24	$586.47	$498.50	$498.50	$498.50	$835.72	$835.72	$835.72
	Region 8	$408.44	$816.87	$694.34	$694.34	$694.34	$1,164.04	$1,164.04	$1,164.04
EssentialCare Bronze Age 29 Option Restricted-DF	Region 1	$253.67	$507.34	$431.24	$431.24	$431.24	$722.95	$722.95	$722.95
	Region 2	$237.46	$474.92	$403.68	$403.68	$403.68	$676.76	$676.76	$676.76
	Region 3	$284.95	$569.89	$484.41	$484.41	$484.41	$812.10	$812.10	$812.10
	Region 4	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22
	Region 5	$233.44	$466.88	$396.84	$396.84	$396.84	$665.30	$665.30	$665.30
	Region 6	$246.52	$493.05	$419.09	$419.09	$419.09	$702.59	$702.59	$702.59
	Region 7	$239.88	$479.75	$407.79	$407.79	$407.79	$683.65	$683.65	$683.65
	Region 8	$334.11	$668.23	$567.99	$567.99	$567.99	$952.22	$952.22	$952.22

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Dental Age 29 Option	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Age 29 Option	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Age 29 Option	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Age 29 Option	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
Essential Care Platinum Dental Age 29 Option Restricted-D	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Age 29 Option Restricted-D	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Age 29 Option Restricted-D	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Age 29 Option Restricted-D	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
Essential Care Platinum Dental Age 29 Option Restricted-F	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Age 29 Option Restricted-F	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Age 29 Option Restricted-F	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Age 29 Option Restricted-F	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
Essential Care Platinum Dental Age 29 Option Restricted-DF	Region 1	$432.86	$865.72	$735.87	$735.87	$735.87	$1,233.66	$1,233.66	$1,233.66
	Region 2	$405.21	$810.41	$688.85	$688.85	$688.85	$1,154.84	$1,154.84	$1,154.84
	Region 3	$486.23	$972.47	$826.60	$826.60	$826.60	$1,385.77	$1,385.77	$1,385.77
	Region 4	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
	Region 5	$398.34	$796.68	$677.18	$677.18	$677.18	$1,135.27	$1,135.27	$1,135.27
	Region 6	$420.67	$841.34	$715.14	$715.14	$715.14	$1,198.91	$1,198.91	$1,198.91
	Region 7	$409.33	$818.65	$695.86	$695.86	$695.86	$1,166.58	$1,166.58	$1,166.58
	Region 8	$570.13	$1,140.27	$969.23	$969.23	$969.23	$1,624.88	$1,624.88	$1,624.88
Essential Care Gold Dental Age 29 Option Restricted-DF	Region 1	$369.00	$737.99	$627.29	$627.29	$627.29	$1,051.64	$1,051.64	$1,051.64
	Region 2	$345.42	$690.84	$587.21	$587.21	$587.21	$984.45	$984.45	$984.45
	Region 3	$414.49	$828.99	$704.64	$704.64	$704.64	$1,181.31	$1,181.31	$1,181.31
	Region 4	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
	Region 5	$339.57	$679.14	$577.27	$577.27	$577.27	$967.77	$967.77	$967.77
	Region 6	$358.60	$717.21	$609.63	$609.63	$609.63	$1,022.02	$1,022.02	$1,022.02
	Region 7	$348.93	$697.87	$593.19	$593.19	$593.19	$994.46	$994.46	$994.46
	Region 8	$486.02	$972.03	$826.23	$826.23	$826.23	$1,385.14	$1,385.14	$1,385.14
Essential Care Silver Dental Age 29 Option Restricted-DF	Region 1	$316.68	$633.35	$538.35	$538.35	$538.35	$902.52	$902.52	$902.52
	Region 2	$296.44	$592.88	$503.95	$503.95	$503.95	$844.86	$844.86	$844.86
	Region 3	$355.72	$711.44	$604.73	$604.73	$604.73	$1,013.81	$1,013.81	$1,013.81
	Region 4	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
	Region 5	$291.42	$582.84	$495.41	$495.41	$495.41	$830.55	$830.55	$830.55
	Region 6	$307.76	$615.51	$523.19	$523.19	$523.19	$877.10	$877.10	$877.10
	Region 7	$299.46	$598.92	$509.08	$509.08	$509.08	$853.45	$853.45	$853.45
	Region 8	$417.10	$834.20	$709.07	$709.07	$709.07	$1,188.74	$1,188.74	$1,188.74
Essential Care Bronze Dental Age 29 Option Restricted-DF	Region 1	$257.94	$515.89	$438.50	$438.50	$438.50	$735.14	$735.14	$735.14
	Region 2	$241.46	$482.93	$410.49	$410.49	$410.49	$688.17	$688.17	$688.17
	Region 3	$289.75	$579.50	$492.57	$492.57	$492.57	$825.78	$825.78	$825.78
	Region 4	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27
	Region 5	$237.37	$474.74	$403.53	$403.53	$403.53	$676.51	$676.51	$676.51
	Region 6	$250.68	$501.36	$426.15	$426.15	$426.15	$714.44	$714.44	$714.44
	Region 7	$243.92	$487.84	$414.66	$414.66	$414.66	$695.17	$695.17	$695.17
	Region 8	$339.75	$679.49	$577.57	$577.57	$577.57	$968.27	$968.27	$968.27

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
PrimarySelect Platinum Restricted-D	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold Restricted-D	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver Restricted-D	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze Restricted-D	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
PrimarySelect Platinum Restricted-F	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold Restricted-F	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver Restricted-F	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze Restricted-F	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
PrimarySelect Platinum Restricted-DF	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold Restricted-DF	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver Restricted-DF	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze Restricted-DF	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
Primary Select Platinum Dental	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
Primary Select Platinum Dental Restricted-D	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Restricted-D	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Restricted-D	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Restricted-D	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
Primary Select Platinum Dental Restricted-F	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Restricted-F	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Restricted-F	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Restricted-F	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
Primary Select Platinum Dental Restricted-DF	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Restricted-DF	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Restricted-DF	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Restricted-DF	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
Age 29 Option	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
Age 29 Option	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
Age 29 Option	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
Age 29 Option	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
PrimarySelect Platinum	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
Age 29 Option	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
Restricted-D	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
Age 29 Option	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
Restricted-D	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
Age 29 Option	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
Restricted-D	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
Age 29 Option	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
Restricted-D	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
PrimarySelect Platinum	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
Age 29 Option	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
Restricted-F	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
Age 29 Option	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
Restricted-F	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
Age 29 Option	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
Restricted-F	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
Age 29 Option	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
Restricted-F	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
PrimarySelect Platinum	Region 1	$408.43	$816.86	$694.33	$694.33	$694.33	$1,164.02	$1,164.02	$1,164.02
Age 29 Option	Region 2	$382.33	$764.67	$649.97	$649.97	$649.97	$1,089.65	$1,089.65	$1,089.65
Restricted-DF	Region 3	$458.79	$917.58	$779.94	$779.94	$779.94	$1,307.55	$1,307.55	$1,307.55
	Region 4	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
	Region 5	$375.86	$751.71	$638.96	$638.96	$638.96	$1,071.19	$1,071.19	$1,071.19
	Region 6	$396.93	$793.85	$674.77	$674.77	$674.77	$1,131.24	$1,131.24	$1,131.24
	Region 7	$386.22	$772.45	$656.58	$656.58	$656.58	$1,100.74	$1,100.74	$1,100.74
	Region 8	$537.95	$1,075.91	$914.52	$914.52	$914.52	$1,533.17	$1,533.17	$1,533.17
PrimarySelect Gold	Region 1	$362.05	$724.10	$615.48	$615.48	$615.48	$1,031.84	$1,031.84	$1,031.84
Age 29 Option	Region 2	$338.92	$677.83	$576.16	$576.16	$576.16	$965.91	$965.91	$965.91
Restricted-DF	Region 3	$406.69	$813.38	$691.37	$691.37	$691.37	$1,159.06	$1,159.06	$1,159.06
	Region 4	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
	Region 5	$333.17	$666.35	$566.40	$566.40	$566.40	$949.55	$949.55	$949.55
	Region 6	$351.85	$703.70	$598.15	$598.15	$598.15	$1,002.78	$1,002.78	$1,002.78
	Region 7	$342.36	$684.73	$582.02	$582.02	$582.02	$975.74	$975.74	$975.74
	Region 8	$476.86	$953.73	$810.67	$810.67	$810.67	$1,359.06	$1,359.06	$1,359.06
PrimarySelect Silver	Region 1	$309.87	$619.74	$526.78	$526.78	$526.78	$883.14	$883.14	$883.14
Age 29 Option	Region 2	$290.07	$580.15	$493.13	$493.13	$493.13	$826.71	$826.71	$826.71
Restricted-DF	Region 3	$348.08	$696.16	$591.73	$591.73	$591.73	$992.03	$992.03	$992.03
	Region 4	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
	Region 5	$285.16	$570.32	$484.77	$484.77	$484.77	$812.70	$812.70	$812.70
	Region 6	$301.14	$602.29	$511.95	$511.95	$511.95	$858.26	$858.26	$858.26
	Region 7	$293.02	$586.05	$498.14	$498.14	$498.14	$835.12	$835.12	$835.12
	Region 8	$408.14	$816.28	$693.84	$693.84	$693.84	$1,163.20	$1,163.20	$1,163.20
PrimarySelect Bronze	Region 1	$219.89	$439.79	$373.82	$373.82	$373.82	$626.69	$626.69	$626.69
Age 29 Option	Region 2	$205.84	$411.69	$349.93	$349.93	$349.93	$586.65	$586.65	$586.65
Restricted-DF	Region 3	$247.01	$494.01	$419.91	$419.91	$419.91	$703.97	$703.97	$703.97
	Region 4	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44
	Region 5	$202.36	$404.71	$344.00	$344.00	$344.00	$576.71	$576.71	$576.71
	Region 6	$213.70	$427.40	$363.29	$363.29	$363.29	$609.04	$609.04	$609.04
	Region 7	$207.94	$415.87	$353.49	$353.49	$353.49	$592.62	$592.62	$592.62
	Region 8	$289.63	$579.25	$492.37	$492.37	$492.37	$825.44	$825.44	$825.44

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
Primary Select Platinum Dental Age 29 Option	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Age 29 Option	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Age 29 Option	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Age 29 Option	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
Primary Select Platinum Dental Age 29 Option Restricted-D	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Age 29 Option Restricted-D	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Age 29 Option Restricted-D	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Age 29 Option Restricted-D	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
Primary Select Platinum Dental Age 29 Option Restricted-F	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Age 29 Option Restricted-F	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Age 29 Option Restricted-F	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Age 29 Option Restricted-F	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
Primary Select Platinum Dental Age 29 Option Restricted-DF	Region 1	$415.26	$830.51	$705.93	$705.93	$705.93	$1,183.48	$1,183.48	$1,183.48
	Region 2	$388.72	$777.45	$660.83	$660.83	$660.83	$1,107.86	$1,107.86	$1,107.86
	Region 3	$466.46	$932.91	$792.98	$792.98	$792.98	$1,329.40	$1,329.40	$1,329.40
	Region 4	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
	Region 5	$382.14	$764.28	$649.63	$649.63	$649.63	$1,089.09	$1,089.09	$1,089.09
	Region 6	$403.56	$807.12	$686.05	$686.05	$686.05	$1,150.15	$1,150.15	$1,150.15
	Region 7	$392.68	$785.36	$667.55	$667.55	$667.55	$1,119.13	$1,119.13	$1,119.13
	Region 8	$546.95	$1,093.89	$929.81	$929.81	$929.81	$1,558.79	$1,558.79	$1,558.79
Primary Select Gold Dental Age 29 Option Restricted-DF	Region 1	$368.71	$737.42	$626.81	$626.81	$626.81	$1,050.82	$1,050.82	$1,050.82
	Region 2	$345.15	$690.30	$586.76	$586.76	$586.76	$983.68	$983.68	$983.68
	Region 3	$414.17	$828.34	$704.09	$704.09	$704.09	$1,180.39	$1,180.39	$1,180.39
	Region 4	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
	Region 5	$339.30	$678.61	$576.82	$576.82	$576.82	$967.02	$967.02	$967.02
	Region 6	$358.32	$716.65	$609.15	$609.15	$609.15	$1,021.22	$1,021.22	$1,021.22
	Region 7	$348.66	$697.32	$592.73	$592.73	$592.73	$993.69	$993.69	$993.69
	Region 8	$485.64	$971.27	$825.58	$825.58	$825.58	$1,384.07	$1,384.07	$1,384.07
Primary Select Silver Dental Age 29 Option Restricted-DF	Region 1	$316.45	$632.90	$537.97	$537.97	$537.97	$901.89	$901.89	$901.89
	Region 2	$296.23	$592.47	$503.60	$503.60	$503.60	$844.26	$844.26	$844.26
	Region 3	$355.47	$710.94	$604.30	$604.30	$604.30	$1,013.09	$1,013.09	$1,013.09
	Region 4	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
	Region 5	$291.21	$582.43	$495.06	$495.06	$495.06	$829.96	$829.96	$829.96
	Region 6	$307.54	$615.08	$522.82	$522.82	$522.82	$876.49	$876.49	$876.49
	Region 7	$299.25	$598.49	$508.72	$508.72	$508.72	$852.85	$852.85	$852.85
	Region 8	$416.81	$833.62	$708.57	$708.57	$708.57	$1,187.90	$1,187.90	$1,187.90
Primary Select Bronze Dental Age 29 Option Restricted-DF	Region 1	$224.17	$448.34	$381.09	$381.09	$381.09	$638.88	$638.88	$638.88
	Region 2	$209.85	$419.69	$356.74	$356.74	$356.74	$598.06	$598.06	$598.06
	Region 3	$251.81	$503.62	$428.07	$428.07	$428.07	$717.65	$717.65	$717.65
	Region 4	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49
	Region 5	$206.29	$412.58	$350.69	$350.69	$350.69	$587.93	$587.93	$587.93
	Region 6	$217.85	$435.71	$370.35	$370.35	$370.35	$620.89	$620.89	$620.89
	Region 7	$211.98	$423.96	$360.37	$360.37	$360.37	$604.14	$604.14	$604.14
	Region 8	$295.26	$590.52	$501.94	$501.94	$501.94	$841.49	$841.49	$841.49

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 1 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Silver EPO	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
PrimarySelect Silver EPO Restricted-D	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
PrimarySelect Silver EPO Restricted-F	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
PrimarySelect Silver EPO Restricted-DF	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
Primary Select Silver EPO Dental	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
Primary Select Silver EPO Dental Restricted-D	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
Primary Select Silver EPO Dental Restricted-F	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
Primary Select Silver EPO Dental Restricted-DF	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
PrimarySelect Silver EPO Age 29 Option	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
PrimarySelect Silver EPO Age 29 Option Restricted-D	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
PrimarySelect Silver EPO Age 29 Option Restricted-F	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
PrimarySelect Silver EPO Age 29 Option Restricted-DF	Region 1	$292.37	$584.75	$497.04	$497.04	$497.04	$833.27	$833.27	$833.27
	Region 2	$273.69	$547.39	$465.28	$465.28	$465.28	$780.03	$780.03	$780.03
	Region 3	$328.42	$656.85	$558.32	$558.32	$558.32	$936.01	$936.01	$936.01
	Region 4	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
	Region 5	$269.06	$538.11	$457.40	$457.40	$457.40	$766.81	$766.81	$766.81
	Region 6	$284.14	$568.28	$483.04	$483.04	$483.04	$809.80	$809.80	$809.80
	Region 7	$276.48	$552.96	$470.01	$470.01	$470.01	$787.96	$787.96	$787.96
	Region 8	$385.10	$770.19	$654.66	$654.66	$654.66	$1,097.52	$1,097.52	$1,097.52
Primary Select Silver EPO Dental Age 29 Option	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
Primary Select Silver EPO Dental Age 29 Option Restricted-D	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
Primary Select Silver EPO Dental Age 29 Option Restricted-F	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
Primary Select Silver EPO Dental Age 29 Option Restricted-DF	Region 1	$298.95	$597.91	$508.22	$508.22	$508.22	$852.02	$852.02	$852.02
	Region 2	$279.85	$559.71	$475.75	$475.75	$475.75	$797.58	$797.58	$797.58
	Region 3	$335.82	$671.63	$570.89	$570.89	$570.89	$957.07	$957.07	$957.07
	Region 4	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22
	Region 5	$275.11	$550.22	$467.69	$467.69	$467.69	$784.07	$784.07	$784.07
	Region 6	$290.53	$581.07	$493.91	$493.91	$493.91	$828.02	$828.02	$828.02
	Region 7	$282.70	$565.40	$480.59	$480.59	$480.59	$805.70	$805.70	$805.70
	Region 8	$393.76	$787.52	$669.39	$669.39	$669.39	$1,122.22	$1,122.22	$1,122.22

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
EssentialCare Platinum	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
EssentialCare Platinum Restricted-D	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Restricted-D	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Restricted-D	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Restricted-D	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
EssentialCare Platinum Restricted-F	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Restricted-F	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Restricted-F	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Restricted-F	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
EssentialCare Platinum Restricted-DF	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Restricted-DF	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Restricted-DF	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Restricted-DF	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Dental	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
Essential Care Platinum Dental Restricted-D	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Restricted-D	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Restricted-D	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Restricted-D	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
Essential Care Platinum Dental Restricted-F	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Restricted-F	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Restricted-F	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Restricted-F	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
Essential Care Platinum Dental Restricted-DF	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Restricted-DF	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Restricted-DF	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Restricted-DF	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
EssentialCare Platinum Age 29 Option	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Age 29 Option	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Age 29 Option	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Age 29 Option	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
EssentialCare Platinum Age 29 Option Restricted-D	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Age 29 Option Restricted-D	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Age 29 Option Restricted-D	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Age 29 Option Restricted-D	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
EssentialCare Platinum Age 29 Option Restricted-F	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Age 29 Option Restricted-F	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Age 29 Option Restricted-F	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Age 29 Option Restricted-F	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
EssentialCare Platinum Age 29 Option Restricted-DF	Region 1	$436.69	$873.37	$742.37	$742.37	$742.37	$1,244.56	$1,244.56	$1,244.56
	Region 2	$408.78	$817.57	$694.94	$694.94	$694.94	$1,165.04	$1,165.04	$1,165.04
	Region 3	$490.53	$981.06	$833.90	$833.90	$833.90	$1,398.01	$1,398.01	$1,398.01
	Region 4	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
	Region 5	$401.86	$803.72	$683.16	$683.16	$683.16	$1,145.29	$1,145.29	$1,145.29
	Region 6	$424.39	$848.77	$721.46	$721.46	$721.46	$1,209.50	$1,209.50	$1,209.50
	Region 7	$412.94	$825.88	$702.00	$702.00	$702.00	$1,176.88	$1,176.88	$1,176.88
	Region 8	$575.17	$1,150.35	$977.79	$977.79	$977.79	$1,639.24	$1,639.24	$1,639.24
EssentialCare Gold Age 29 Option Restricted-DF	Region 1	$371.40	$742.79	$631.37	$631.37	$631.37	$1,058.48	$1,058.48	$1,058.48
	Region 2	$347.67	$695.33	$591.03	$591.03	$591.03	$990.85	$990.85	$990.85
	Region 3	$417.19	$834.37	$709.22	$709.22	$709.22	$1,188.98	$1,188.98	$1,188.98
	Region 4	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
	Region 5	$341.78	$683.55	$581.02	$581.02	$581.02	$974.06	$974.06	$974.06
	Region 6	$360.93	$721.87	$613.59	$613.59	$613.59	$1,028.66	$1,028.66	$1,028.66
	Region 7	$351.21	$702.40	$597.04	$597.04	$597.04	$1,000.92	$1,000.92	$1,000.92
	Region 8	$489.17	$978.34	$831.59	$831.59	$831.59	$1,394.14	$1,394.14	$1,394.14
EssentialCare Silver Age 29 Option Restricted-DF	Region 1	$317.85	$635.69	$540.34	$540.34	$540.34	$905.86	$905.86	$905.86
	Region 2	$297.54	$595.08	$505.82	$505.82	$505.82	$847.99	$847.99	$847.99
	Region 3	$357.04	$714.08	$606.96	$606.96	$606.96	$1,017.56	$1,017.56	$1,017.56
	Region 4	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
	Region 5	$292.49	$585.00	$497.25	$497.25	$497.25	$833.62	$833.62	$833.62
	Region 6	$308.89	$617.79	$525.12	$525.12	$525.12	$880.35	$880.35	$880.35
	Region 7	$300.57	$601.13	$510.96	$510.96	$510.96	$856.61	$856.61	$856.61
	Region 8	$418.65	$837.29	$711.70	$711.70	$711.70	$1,193.14	$1,193.14	$1,193.14
EssentialCare Bronze Age 29 Option Restricted-DF	Region 1	$260.01	$520.02	$442.02	$442.02	$442.02	$741.02	$741.02	$741.02
	Region 2	$243.40	$486.79	$413.77	$413.77	$413.77	$693.68	$693.68	$693.68
	Region 3	$292.07	$584.14	$496.52	$496.52	$496.52	$832.40	$832.40	$832.40
	Region 4	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03
	Region 5	$239.28	$478.55	$406.76	$406.76	$406.76	$681.93	$681.93	$681.93
	Region 6	$252.68	$505.38	$429.57	$429.57	$429.57	$720.15	$720.15	$720.15
	Region 7	$245.88	$491.74	$417.98	$417.98	$417.98	$700.74	$700.74	$700.74
	Region 8	$342.46	$684.94	$582.19	$582.19	$582.19	$976.03	$976.03	$976.03

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Dental Age 29 Option	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Age 29 Option	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Age 29 Option	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Age 29 Option	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
Essential Care Platinum Dental Age 29 Option Restricted-D	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Age 29 Option Restricted-D	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Age 29 Option Restricted-D	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Age 29 Option Restricted-D	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
Essential Care Platinum Dental Age 29 Option Restricted-F	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Age 29 Option Restricted-F	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Age 29 Option Restricted-F	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Age 29 Option Restricted-F	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
Essential Care Platinum Dental Age 29 Option Restricted-DF	Region 1	$443.68	$887.36	$754.27	$754.27	$754.27	$1,264.50	$1,264.50	$1,264.50
	Region 2	$415.34	$830.67	$706.07	$706.07	$706.07	$1,183.71	$1,183.71	$1,183.71
	Region 3	$498.39	$996.78	$847.27	$847.27	$847.27	$1,420.41	$1,420.41	$1,420.41
	Region 4	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
	Region 5	$408.30	$816.60	$694.11	$694.11	$694.11	$1,163.65	$1,163.65	$1,163.65
	Region 6	$431.19	$862.37	$733.02	$733.02	$733.02	$1,228.88	$1,228.88	$1,228.88
	Region 7	$419.56	$839.12	$713.26	$713.26	$713.26	$1,195.74	$1,195.74	$1,195.74
	Region 8	$584.38	$1,168.78	$993.46	$993.46	$993.46	$1,665.50	$1,665.50	$1,665.50
Essential Care Gold Dental Age 29 Option Restricted-DF	Region 1	$378.23	$756.44	$642.97	$642.97	$642.97	$1,077.93	$1,077.93	$1,077.93
	Region 2	$354.06	$708.11	$601.89	$601.89	$601.89	$1,009.06	$1,009.06	$1,009.06
	Region 3	$424.85	$849.71	$722.26	$722.26	$722.26	$1,210.84	$1,210.84	$1,210.84
	Region 4	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
	Region 5	$348.06	$696.12	$591.70	$591.70	$591.70	$991.96	$991.96	$991.96
	Region 6	$367.57	$735.14	$624.87	$624.87	$624.87	$1,047.57	$1,047.57	$1,047.57
	Region 7	$357.65	$715.32	$608.02	$608.02	$608.02	$1,019.32	$1,019.32	$1,019.32
	Region 8	$498.17	$996.33	$846.89	$846.89	$846.89	$1,419.77	$1,419.77	$1,419.77
Essential Care Silver Dental Age 29 Option Restricted-DF	Region 1	$324.60	$649.18	$551.81	$551.81	$551.81	$925.08	$925.08	$925.08
	Region 2	$303.85	$607.70	$516.55	$516.55	$516.55	$865.98	$865.98	$865.98
	Region 3	$364.61	$729.23	$619.85	$619.85	$619.85	$1,039.16	$1,039.16	$1,039.16
	Region 4	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
	Region 5	$298.71	$597.41	$507.80	$507.80	$507.80	$851.31	$851.31	$851.31
	Region 6	$315.45	$630.90	$536.27	$536.27	$536.27	$899.03	$899.03	$899.03
	Region 7	$306.95	$613.89	$521.81	$521.81	$521.81	$874.79	$874.79	$874.79
	Region 8	$427.53	$855.06	$726.80	$726.80	$726.80	$1,218.46	$1,218.46	$1,218.46
Essential Care Bronze Dental Age 29 Option Restricted-DF	Region 1	$264.39	$528.79	$449.46	$449.46	$449.46	$753.52	$753.52	$753.52
	Region 2	$247.50	$495.00	$420.75	$420.75	$420.75	$705.37	$705.37	$705.37
	Region 3	$296.99	$593.99	$504.88	$504.88	$504.88	$846.42	$846.42	$846.42
	Region 4	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48
	Region 5	$243.30	$486.61	$413.62	$413.62	$413.62	$693.42	$693.42	$693.42
	Region 6	$256.95	$513.89	$436.80	$436.80	$436.80	$732.30	$732.30	$732.30
	Region 7	$250.02	$500.04	$425.03	$425.03	$425.03	$712.55	$712.55	$712.55
	Region 8	$348.24	$696.48	$592.01	$592.01	$592.01	$992.48	$992.48	$992.48

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
PrimarySelect Platinum Restricted-D	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Restricted-D	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Restricted-D	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Restricted-D	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
PrimarySelect Platinum Restricted-F	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Restricted-F	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Restricted-F	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Restricted-F	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
PrimarySelect Platinum Restricted-DF	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Restricted-DF	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Restricted-DF	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Restricted-DF	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
Primary Select Platinum Dental	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
Primary Select Platinum Dental Restricted-D	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Restricted-D	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Restricted-D	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Restricted-D	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
Primary Select Platinum Dental Restricted-F	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Restricted-F	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Restricted-F	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Restricted-F	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
Primary Select Platinum Dental Restricted-DF	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Restricted-DF	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Restricted-DF	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Restricted-DF	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Age 29 Option	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Age 29 Option	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Age 29 Option	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Age 29 Option	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
PrimarySelect Platinum Age 29 Option Restricted-D	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Age 29 Option Restricted-D	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Age 29 Option Restricted-D	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Age 29 Option Restricted-D	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
PrimarySelect Platinum Age 29 Option Restricted-F	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Age 29 Option Restricted-F	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Age 29 Option Restricted-F	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Age 29 Option Restricted-F	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
PrimarySelect Platinum Age 29 Option Restricted-DF	Region 1	$418.64	$837.28	$711.69	$711.69	$711.69	$1,193.12	$1,193.12	$1,193.12
	Region 2	$391.89	$783.79	$666.22	$666.22	$666.22	$1,116.89	$1,116.89	$1,116.89
	Region 3	$470.26	$940.52	$799.44	$799.44	$799.44	$1,340.24	$1,340.24	$1,340.24
	Region 4	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
	Region 5	$385.26	$770.50	$654.93	$654.93	$654.93	$1,097.97	$1,097.97	$1,097.97
	Region 6	$406.85	$813.70	$691.64	$691.64	$691.64	$1,159.52	$1,159.52	$1,159.52
	Region 7	$395.88	$791.76	$672.99	$672.99	$672.99	$1,128.26	$1,128.26	$1,128.26
	Region 8	$551.40	$1,102.81	$937.38	$937.38	$937.38	$1,571.50	$1,571.50	$1,571.50
PrimarySelect Gold Age 29 Option Restricted-DF	Region 1	$371.10	$742.20	$630.87	$630.87	$630.87	$1,057.64	$1,057.64	$1,057.64
	Region 2	$347.39	$694.78	$590.56	$590.56	$590.56	$990.06	$990.06	$990.06
	Region 3	$416.86	$833.71	$708.65	$708.65	$708.65	$1,188.04	$1,188.04	$1,188.04
	Region 4	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
	Region 5	$341.50	$683.01	$580.56	$580.56	$580.56	$973.29	$973.29	$973.29
	Region 6	$360.65	$721.29	$613.10	$613.10	$613.10	$1,027.85	$1,027.85	$1,027.85
	Region 7	$350.92	$701.85	$596.57	$596.57	$596.57	$1,000.13	$1,000.13	$1,000.13
	Region 8	$488.78	$977.57	$830.94	$830.94	$830.94	$1,393.04	$1,393.04	$1,393.04
PrimarySelect Silver Age 29 Option Restricted-DF	Region 1	$317.62	$635.23	$539.95	$539.95	$539.95	$905.22	$905.22	$905.22
	Region 2	$297.32	$594.65	$505.46	$505.46	$505.46	$847.38	$847.38	$847.38
	Region 3	$356.78	$713.56	$606.52	$606.52	$606.52	$1,016.83	$1,016.83	$1,016.83
	Region 4	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
	Region 5	$292.29	$584.58	$496.89	$496.89	$496.89	$833.02	$833.02	$833.02
	Region 6	$308.67	$617.35	$524.75	$524.75	$524.75	$879.72	$879.72	$879.72
	Region 7	$300.35	$600.70	$510.59	$510.59	$510.59	$856.00	$856.00	$856.00
	Region 8	$418.34	$836.69	$711.19	$711.19	$711.19	$1,192.28	$1,192.28	$1,192.28
PrimarySelect Bronze Age 29 Option Restricted-DF	Region 1	$225.39	$450.78	$383.17	$383.17	$383.17	$642.36	$642.36	$642.36
	Region 2	$210.99	$421.98	$358.68	$358.68	$358.68	$601.32	$601.32	$601.32
	Region 3	$253.19	$506.36	$430.41	$430.41	$430.41	$721.57	$721.57	$721.57
	Region 4	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08
	Region 5	$207.42	$414.83	$352.60	$352.60	$352.60	$591.13	$591.13	$591.13
	Region 6	$219.04	$438.09	$372.37	$372.37	$372.37	$624.27	$624.27	$624.27
	Region 7	$213.14	$426.27	$362.33	$362.33	$362.33	$607.44	$607.44	$607.44
	Region 8	$296.87	$593.73	$504.68	$504.68	$504.68	$846.08	$846.08	$846.08

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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
Primary Select Platinum Dental Age 29 Option	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Age 29 Option	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Age 29 Option	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Age 29 Option	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
Primary Select Platinum Dental Age 29 Option Restricted-D	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Age 29 Option Restricted-D	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Age 29 Option Restricted-D	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Age 29 Option Restricted-D	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
Primary Select Platinum Dental Age 29 Option Restricted-F	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Age 29 Option Restricted-F	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Age 29 Option Restricted-F	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Age 29 Option Restricted-F	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
Primary Select Platinum Dental Age 29 Option Restricted-DF	Region 1	$425.64	$851.27	$723.58	$723.58	$723.58	$1,213.07	$1,213.07	$1,213.07
	Region 2	$398.44	$796.89	$677.35	$677.35	$677.35	$1,135.56	$1,135.56	$1,135.56
	Region 3	$478.12	$956.23	$812.80	$812.80	$812.80	$1,362.64	$1,362.64	$1,362.64
	Region 4	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
	Region 5	$391.69	$783.39	$665.87	$665.87	$665.87	$1,116.32	$1,116.32	$1,116.32
	Region 6	$413.65	$827.30	$703.20	$703.20	$703.20	$1,178.90	$1,178.90	$1,178.90
	Region 7	$402.50	$804.99	$684.24	$684.24	$684.24	$1,147.11	$1,147.11	$1,147.11
	Region 8	$560.62	$1,121.24	$953.06	$953.06	$953.06	$1,597.76	$1,597.76	$1,597.76
Primary Select Gold Dental Age 29 Option Restricted-DF	Region 1	$377.93	$755.86	$642.48	$642.48	$642.48	$1,077.09	$1,077.09	$1,077.09
	Region 2	$353.78	$707.56	$601.43	$601.43	$601.43	$1,008.27	$1,008.27	$1,008.27
	Region 3	$424.52	$849.05	$721.69	$721.69	$721.69	$1,209.90	$1,209.90	$1,209.90
	Region 4	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
	Region 5	$347.78	$695.58	$591.24	$591.24	$591.24	$991.20	$991.20	$991.20
	Region 6	$367.28	$734.57	$624.38	$624.38	$624.38	$1,046.75	$1,046.75	$1,046.75
	Region 7	$357.38	$714.75	$607.55	$607.55	$607.55	$1,018.53	$1,018.53	$1,018.53
	Region 8	$497.78	$995.55	$846.22	$846.22	$846.22	$1,418.67	$1,418.67	$1,418.67
Primary Select Silver Dental Age 29 Option Restricted-DF	Region 1	$324.36	$648.72	$551.42	$551.42	$551.42	$924.44	$924.44	$924.44
	Region 2	$303.64	$607.28	$516.19	$516.19	$516.19	$865.37	$865.37	$865.37
	Region 3	$364.36	$728.71	$619.41	$619.41	$619.41	$1,038.42	$1,038.42	$1,038.42
	Region 4	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
	Region 5	$298.49	$596.99	$507.44	$507.44	$507.44	$850.71	$850.71	$850.71
	Region 6	$315.23	$630.46	$535.89	$535.89	$535.89	$898.40	$898.40	$898.40
	Region 7	$306.73	$613.45	$521.44	$521.44	$521.44	$874.17	$874.17	$874.17
	Region 8	$427.23	$854.46	$726.28	$726.28	$726.28	$1,217.60	$1,217.60	$1,217.60
Primary Select Bronze Dental Age 29 Option Restricted-DF	Region 1	$229.77	$459.55	$390.62	$390.62	$390.62	$654.85	$654.85	$654.85
	Region 2	$215.10	$430.18	$365.66	$365.66	$365.66	$613.01	$613.01	$613.01
	Region 3	$258.11	$516.21	$438.77	$438.77	$438.77	$735.59	$735.59	$735.59
	Region 4	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53
	Region 5	$211.45	$422.89	$359.46	$359.46	$359.46	$602.63	$602.63	$602.63
	Region 6	$223.30	$446.60	$379.61	$379.61	$379.61	$636.41	$636.41	$636.41
	Region 7	$217.28	$434.56	$369.38	$369.38	$369.38	$619.24	$619.24	$619.24
	Region 8	$302.64	$605.28	$514.49	$514.49	$514.49	$862.53	$862.53	$862.53

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rates - Period 2 2014

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Silver EPO	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
PrimarySelect Silver EPO Restricted-D	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
PrimarySelect Silver EPO Restricted-F	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
PrimarySelect Silver EPO Restricted-DF	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
Primary Select Silver EPO Dental	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
Primary Select Silver EPO Dental Restricted-D	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
Primary Select Silver EPO Dental Restricted-F	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
Primary Select Silver EPO Dental Restricted-DF	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
PrimarySelect Silver EPO Age 29 Option	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
PrimarySelect Silver EPO Age 29 Option Restricted-D	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
PrimarySelect Silver EPO Age 29 Option Restricted-F	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
PrimarySelect Silver EPO Age 29 Option Restricted-DF	Region 1	$299.68	$599.37	$509.47	$509.47	$509.47	$854.10	$854.10	$854.10
	Region 2	$280.53	$561.07	$476.91	$476.91	$476.91	$799.53	$799.53	$799.53
	Region 3	$336.63	$673.27	$572.28	$572.28	$572.28	$959.41	$959.41	$959.41
	Region 4	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
	Region 5	$275.79	$551.56	$468.84	$468.84	$468.84	$785.98	$785.98	$785.98
	Region 6	$291.24	$582.49	$495.12	$495.12	$495.12	$830.05	$830.05	$830.05
	Region 7	$283.39	$566.78	$481.76	$481.76	$481.76	$807.66	$807.66	$807.66
	Region 8	$394.73	$789.44	$671.03	$671.03	$671.03	$1,124.96	$1,124.96	$1,124.96
Primary Select Silver EPO Dental Age 29 Option	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
Primary Select Silver EPO Dental Age 29 Option Restricted-D	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
Primary Select Silver EPO Dental Age 29 Option Restricted-F	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
Primary Select Silver EPO Dental Age 29 Option Restricted-DF	Region 1	$306.42	$612.86	$520.93	$520.93	$520.93	$873.32	$873.32	$873.32
	Region 2	$286.85	$573.70	$487.64	$487.64	$487.64	$817.52	$817.52	$817.52
	Region 3	$344.22	$688.42	$585.16	$585.16	$585.16	$981.00	$981.00	$981.00
	Region 4	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28
	Region 5	$281.99	$563.98	$479.38	$479.38	$479.38	$803.67	$803.67	$803.67
	Region 6	$297.79	$595.60	$506.26	$506.26	$506.26	$848.72	$848.72	$848.72
	Region 7	$289.77	$579.54	$492.60	$492.60	$492.60	$825.84	$825.84	$825.84
	Region 8	$403.60	$807.21	$686.12	$686.12	$686.12	$1,150.28	$1,150.28	$1,150.28

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

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	EssentialCare Platinum EssentialCare Platinum Restricted-D EssentialCare Platinum Restricted-F EssentialCare Platinum Restricted-DF Essential Care Platinum Dental Essential Care Platinum Dental Restricted-D Essential Care Platinum Dental Restricted-F Essential Care Platinum Dental Restricted-DF EssentialCare Platinum Age 29 Option EssentialCare Platinum Age 29 Option Restricted-D EssentialCare Platinum Age 29 Option Restricted-F EssentialCare Platinum Age 29 Option Restricted-DF Essential Care Platinum Dental Age 29 Option Essential Care Platinum Dental Age 29 Option Restricted-D Essential Care Platinum Dental Age 29 Option Restricted-F Essential Care Platinum Dental Age 29 Option Restricted-DF		EssentialCare Gold EssentialCare Gold Restricted-D EssentialCare Gold Restricted-F EssentialCare Gold Restricted-DF Essential Care Gold Dental Essential Care Gold Dental Restricted-D Essential Care Gold Dental Restricted-F Essential Care Gold Dental Restricted-DF EssentialCare Gold Age 29 Option EssentialCare Gold Age 29 Option Restricted-D EssentialCare Gold Age 29 Option Restricted-F EssentialCare Gold Age 29 Option Restricted-DF Essential Care Gold Dental Age 29 Option Essential Care Gold Dental Age 29 Option Restricted-D Essential Care Gold Dental Age 29 Option Restricted-F Essential Care Gold Dental Age 29 Option Restricted-DF	
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

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 Small Group Rate Filing		Freelancers Health Services Corporation 2014 Small Group Rate Filing	
	Benefit Grid - STANDARD PLANS			
	Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	**EssentialCare Silver** **EssentialCare Silver Restricted-D** **EssentialCare Silver Restricted-F** **EssentialCare Silver Restricted-DF** **Essential Care Silver Dental** **Essential Care Silver Dental Restricted-D** **Essential Care Silver Dental Restricted-F** **Essential Care Silver Dental Restricted-DF** **EssentialCare Silver Age 29 Option** **EssentialCare Silver Age 29 Option Restricted-D** **EssentialCare Silver Age 29 Option Restricted-F** **EssentialCare Silver Age 29 Option Restricted-DF** **Essential Care Silver Dental Age 29 Option** **Essential Care Silver Dental Age 29 Option Restricted-D** **Essential Care Silver Dental Age 29 Option Restricted-F** **Essential Care Silver Dental Age 29 Option Restricted-DF**		**EssentialCare Bronze** **EssentialCare Bronze Restricted-D** **EssentialCare Bronze Restricted-F** **EssentialCare Bronze Restricted-DF** **Essential Care Bronze Dental** **Essential Care Bronze Dental Restricted-D** **Essential Care Bronze Dental Restricted-F** **Essential Care Bronze Dental Restricted-DF** **EssentialCare Bronze Age 29 Option** **EssentialCare Bronze Age 29 Option Restricted-D** **EssentialCare Bronze Age 29 Option Restricted-F** **EssentialCare Bronze Age 29 Option Restricted-DF** **Essential Care Bronze Dental Age 29 Option** **Essential Care Bronze Dental Age 29 Option Restricted-D** **Essential Care Bronze Dental Age 29 Option Restricted-F** **Essential Care Bronze Dental Age 29 Option Restricted-DF**	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$2,000	Not Applicable	$3,000	Not Applicable
Coinsurance	100%	Not Applicable	50%	Not Applicable
Out of Pocket Maximum	$5,500	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	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	$100 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$150 after deductible is met	$150 after deductible is met	50% cost sharing after deductible is met	50% cost sharing after deductible is met
Ambulance	$150 after deductible is met	$150 after deductible is met	50% cost sharing after deductible is met	50% cost sharing after deductible is met
Urgent Care Center	$70 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	$100 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Skilled Nursing Facility	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
EKG	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Routine Radiology	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Advanced Radiology	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Mental Health	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Substance Abuse	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Cardiac Rehabilitation	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Pulmonary Rehabilitation	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	30% cost sharing after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	30% cost sharing after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Chemotherapy	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Home Health Care	$30 after deductible is met	Not Covered	50% cost sharing 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	$10 after deductible is met	Not Covered
Standard Plastic Lenses	30% cost sharing after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Frames	30% cost sharing after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	30% cost sharing after deductible is met	Not Covered	50% 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
	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 Small Group Rate Filing
Benefit Grid - NON-STANDARD PLANS

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	PrimarySelect Platinum PrimarySelect Platinum Restricted-D PrimarySelect Platinum Restricted-F PrimarySelect Platinum Restricted-DF Primary Select Platinum Dental Primary Select Platinum Dental Restricted-D Primary Select Platinum Dental Restricted-F Primary Select Platinum Dental Restricted-DF PrimarySelect Platinum Age 29 Option PrimarySelect Platinum Age 29 Option Restricted-D PrimarySelect Platinum Age 29 Option Restricted-F PrimarySelect Platinum Age 29 Option Restricted-DF Primary Select Platinum Dental Age 29 Option Primary Select Platinum Dental Age 29 Option Restricted-D Primary Select Platinum Dental Age 29 Option Restricted-F Primary Select Platinum Dental Age 29 Option Restricted-DF		PrimarySelect Gold PrimarySelect Gold Restricted-D PrimarySelect Gold Restricted-F PrimarySelect Gold Restricted-DF Primary Select Gold Dental Primary Select Gold Dental Restricted-D Primary Select Gold Dental Restricted-F Primary Select Gold Dental Restricted-DF PrimarySelect Gold Age 29 Option PrimarySelect Gold Age 29 Option Restricted-D PrimarySelect Gold Age 29 Option Restricted-F PrimarySelect Gold Age 29 Option Restricted-DF Primary Select Gold Dental Age 29 Option Primary Select Gold Dental Age 29 Option Restricted-D Primary Select Gold Dental Age 29 Option Restricted-F Primary Select Gold Dental Age 29 Option Restricted-DF	
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

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 Small Group Rate Filing
Benefit Grid - NON-STANDARD PLANS

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	PrimarySelect Silver PrimarySelect Silver Restricted-D PrimarySelect Silver Restricted-F PrimarySelect Silver Restricted-DF Primary Select Silver Dental Primary Select Silver Dental Restricted-D Primary Select Silver Dental Restricted-F Primary Select Silver Dental Restricted-DF PrimarySelect Silver Age 29 Option PrimarySelect Silver Age 29 Option Restricted-D PrimarySelect Silver Age 29 Option Restricted-F PrimarySelect Silver Age 29 Option Restricted-DF Primary Select Silver Dental Age 29 Option Primary Select Silver Dental Age 29 Option Restricted-D Primary Select Silver Dental Age 29 Option Restricted-F Primary Select Silver Dental Age 29 Option Restricted-DF		PrimarySelect Bronze PrimarySelect Bronze Restricted-D PrimarySelect Bronze Restricted-F PrimarySelect Bronze Restricted-DF Primary Select Bronze Dental Primary Select Bronze Dental Restricted-D Primary Select Bronze Dental Restricted-F Primary Select Bronze Dental Restricted-DF PrimarySelect Bronze Age 29 Option PrimarySelect Bronze Age 29 Option Restricted-D PrimarySelect Bronze Age 29 Option Restricted-F PrimarySelect Bronze Age 29 Option Restricted-DF Primary Select Bronze Dental Age 29 Option Primary Select Bronze Dental Age 29 Option Restricted-D Primary Select Bronze Dental Age 29 Option Restricted-F Primary Select Bronze Dental Age 29 Option Restricted-DF	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$2,000	Not Applicable	$6,350	Not Applicable
Coinsurance	20%	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	$0 Copay	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	Subject To Deductible	Subject To Deductible
Ambulance	$150 Copay	$150 Copay	Subject To Deductible	Subject To Deductible
Urgent Care Center	$100 Copay	Not Covered	Subject To Deductible	Not Covered
Hospital Services				
Inpatient Hospital	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Skilled Nursing Facility	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$75 Copay	Not Covered	Subject To Deductible	Not Covered
EKG	$75 Copay	Not Covered	Subject To Deductible	Not Covered
Routine Radiology	$75 Copay	Not Covered	Subject To Deductible	Not Covered
Advanced Radiology	$75 Copay	Not Covered	Subject To Deductible	Not Covered
Maternity Services				
Inpatient Maternity	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Outpatient Mental Health	$0 Copay	Not Covered	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Inpatient Substance Abuse - Detox	20% Cost Sharing	Not Covered	Subject To Deductible	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	Subject To Deductible	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay	Not Covered	Subject To Deductible	Not Covered
Cardiac Rehabilitation	$30 Copay	Not Covered	Subject To Deductible	Not Covered
Pulmonary Rehabilitation	$30 Copay	Not Covered	Subject To Deductible	Not Covered
Additional Services				
Durable Medical Equipment	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Prosthetics and Appliances	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Chemotherapy	$30 Copay	Not Covered	Subject To Deductible	Not Covered
Home Health Care	$30 Copay	Not Covered	Subject To Deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/Subject To Deductible/Subject To Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/Subject To Deductible/Subject To Deductible	Not Covered
Vision Services				
Medical Exam	$30 Copay after deductible is met	Not Covered	Subject To Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Frames	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Conventional Contact Lenses	20% Cost Sharing	Not Covered	Subject To Deductible	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	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 Small Group Rate Filing
Benefit Grid - NON-STANDARD PLANS

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:
PrimarySelect Silver EPO
PrimarySelect Silver EPO Restricted-D
PrimarySelect Silver EPO Restricted-F
PrimarySelect Silver EPO Restricted-DF
Primary Select Silver EPO Dental
Primary Select Silver EPO Dental Restricted-D
Primary Select Silver EPO Dental Restricted-F
Primary Select Silver EPO Dental Restricted-DF
PrimarySelect Silver EPO Age 29 Option
PrimarySelect Silver EPO Age 29 Option Restricted-D
PrimarySelect Silver EPO Age 29 Option Restricted-F
PrimarySelect Silver EPO Age 29 Option Restricted-DF
Primary Select Silver EPO Dental Age 29 Option
Primary Select Silver EPO Dental Age 29 Option Restricted-D
Primary Select Silver EPO Dental Age 29 Option Restricted-F
Primary Select Silver EPO Dental Age 29 Option Restricted-DF

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	$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	$0	Not Covered
Physician and Other Services			
Office Visit	$0 Copay if using selected Doctor	$30 Copay after Deductible	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 after Deductible	$30 Copay after Deductible	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

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.

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Freelancers Health Service Corporation
2014 Small Group Rate Filing
Rating Region Composition

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, 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 Small Group Rate Filing Commission Schedule	
Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003	
Small Group Schedule:	3% of Premium

Freelancers Health Service Corporation
2014 Small Group Rate Filing
Expected Loss Ratio

Form Numbers: FHSC-SHOP-D001, FHSC-SHOP001, FHSC-SHOP – D003, FHSC-SHOP003, FHSC-SHOP-D002, FHSC-SHOP002, FHSC-SHOP – D004, FHSC-SHOP004, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Federal ACA Loss Ratio *	89.6%

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

** This Loss Ratio differs from the Loss Ratio provided in the Actuarial Memorandum (Actuarial Memorandum was not correct)*

New York State Loss Ratio	87.1%

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):	Small Group Checklist_OffExch__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 shop 001 off exchange.pdf memo shop 002 off exchange.pdf memo shop 003 off exchange.pdf memo shop 004 off exchange.pdf
Item Status:	
Status Date:	

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

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	

State: New York **Filing Company:** Freelancers Health Service Corporation
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: FHSC Sm Group Off Exchange
Project Name/Number: /

Attachment(s):	Part III Actuarial Memorandum - FHSC - SG 4-26-13.pdf Act Memo - Attachment D -Quality Improvement Cost Containment.pdf Act Memo - Attachment E - Reliance Letter.pdf Attachment A SG (6-10-2013).pdf Attachment B SG (6-10-2013).pdf Attachment B SG (6-10-2013).xlsx Attachment C SG (6-10-2013).pdf Attachment C SG (6-10-2013).xlsx
Item Status:	
Status Date:	

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

Satisfied - Item:	Small Group Rate Intructions/Checklist
Comments:	No attachment required.
Attachment(s):	
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):	NY Exhibit 8 SG (6-10-2013).pdf NY Exhibit 8 SG (6-10-2013).xlsx

State: New York **Filing Company:** Freelancers Health Service Corporation
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: FHSC Sm Group Off Exchange
Project Name/Number: /

Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	
Attachment(s):	NY Exhibit 9 SG (6-15-2013).pdf NY Exhibit 9 SG (6-15-2013).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 Small Group Unified Rate Review Template (7-25-2013).xlsm
Item Status:	
Status Date:	

Review Standards for

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

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

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

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

LINE OF BUSINESS:	**Group Major Medical or Similar-Type Comprehensive Health Insurance**	LINE(S) OF INSURANCE	CODES
CODE:	H15G	Health – Hospital/Surgical/Medical Expense	H15G.001 H15G.002 H15G.003
	H16G	Health – Major Medical	H16G.001A H16G.001B H16G.001C H16G.002A H16G.002C H16G.003A H16G.003D
	H16G.003G		

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

REVIEW REQUIREMENT	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
GENERAL REQUIREMENTS FOR ALL FILINGS	*Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions*	*Note: This checklist is intended to provide guidance in the preparation of policy or contract forms for submission and is not intended as a substitute for statute or regulation.*	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement		This submission contains a complete policy or contract form. Yes ☒ No ☐ If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☒ No ☐	FHSC-SHOP003

		(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, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policyor contract form, the letter must identify the form number and	

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

		approval by the Department. §52.32(a)(3) • That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(4) *Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the group requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.*	
Statement of ERISA rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes ☐ No ☐	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.	FHSC-SHOP003, pg 69, 13.7
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	§3221(q)(1) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy or contract to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy or contract void. An agreement that acceptance of any policy or contract issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	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.	FHSC-SHOP003 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).	FHSC-SHOP003 Page 1
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	A table of contents is required.	FHSC-SHOP003, 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	§3221(k)(14) §4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	FHSC-SHOP003, pg 6, Section I - Paragraph 6
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	FHSC-SHOP003, pg 10, 2.3 - 2.4
Designation of Primary Care	§3217-e	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract	

Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	FHSC-SHOP003, pg 10, 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.	N/A
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.	FHSC-SHOP003, pg 10-11, 2.5, 2.6, and 2.7
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	FHSC-SHOP003, pg 11, 2.9
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.	FHSC-SHOP003, pg 12, 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) 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	FHSC-SHOP003, pg 13, 3.1

		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☒	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	N/A
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.	N/A
Specialty Care Center Model Language Used? Yes ☐ No ☒	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	N/A
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	FHSC-SHOP003, pg 13, 3.2
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	FHSC-SHOP003, pg 13, 3.3

		non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	FHSC-SHOP003, pg 14, 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.	FHSC-SHOP003, pg 14, 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.	FHSC-SHOP003, Front Page, 2nd para
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language		Form/Page/Para Reference
Spouse	§4235(f)(1)(A) §4305(c)(1) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the group, this policy or contract form must provide coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex partners legally performed in this state and in other jurisdictions.	FHSC-SHOP003, pg 8, Def of Spouse. And pg 15-16, 5.4
Dependents	§4235(f)(1)(A)(i) §4305(c)(1) §3221(a)(7) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until age 26. *Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	FHSC-SHOP003, pg 15, 5.2 - 5.3, para 1

Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	If dependent coverage is selected by the group, this policy or contract must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in 4235(f).	FHSC-SHOP003 pg 66, 12.2.2
Unmarried Students on Medical Leave of Absence	§3237 §4306-a 42 USC §300gg-7	If this policy or contract form provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	N/A
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4305(c)(1) Model Language	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	FHSC-SHOP003, pg 15, 5.3, para 2
Newborn Infants	§4235(f)(2) §4305(c)(1) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.*	FHSC-SHOP003, pg 15-16, 5.4
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3) §4305(c)(1)	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage	FHSC-SHOP003, pg 15, 5.3

		on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4235(f)(1)(A) §4305(c)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	FHSC-SHOP003, Domestic Partner Rider pg. 91
New Family Members Model Language Used? Yes ☒ No ☐	45 C.F.R. § 155.420 Model Language	The policy or contract form describes the requirements to add new family members to the policy or contract.	FHSC-SHOP003, pg 16, 5.4,
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	pg 14, item 5.4
Enrollment Periods	http://government.westlaw.com/linkedslice/default.asp?SP=nycrr-100011NYCRR52.70(e)(3) 45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	FHSC-SHOP003, pg 15-17; 5.4 and 5.5
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS		**Except where noted below, the following benefits must be included in the policy or contract forms.** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including higher visit	Form/Page/Para Reference

		limitations; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review. The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 18, 6.1.2
Federal Mandated Preventive Health Services Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 18-19, 6.1.2, 6.1.3, and 6.1.4
Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§3 221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	FHSC-SHOP003, pg 19, 6.1.4
Mammography Screening	§ 3221(l)(11) § 4303(p)	This policy or contract form includes the following coverage for mammography screening for occult breast cancer:	FHSC-SHOP003, pg 19, 6.1.5

Model Language Used? Yes ☒ No ☐	42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	• Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 19, 6.1.6
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	FHSC-SHOP003, pg 19-20, 6.1.7
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and	FHSC-SHOP003, pg 20, 6.1.8

		• An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§ 3221(l)(15) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	FHSC-SHOP003, pg 10-21, 6.2, 6.2.1, 6.2.2
Emergency Services Model Language Used? Yes ☒ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage	FHSC-SHOP003, p. 21, 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	that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	FHSC-SHOP003, pg 23, 6.3.4
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	45 CFR § 156.100	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT	FHSC-SHOP003,

Model Language Used? Yes ☒ No ☐	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pg 24, 6.4.2
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 24, 6.4.3
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 24, 6.4.4
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 24, 6.4.5
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3221(k)(11) §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	FHSC-SHOP003, pg 24, 6.4.6
Dialysis Coverage	§3221(k)(16) §4303(gg)	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis	FHSC-SHOP003,

Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	, pg 24, 6.4.7
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 Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 25, 6.4.8
Benefit explanation:			

Home Health Services Model Language Used? Yes ☒ No ☐	§3221(k)(1) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	FHSC-SHOP003, pg 25, 6.4.9
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit and may provide coverage that is more favorable.*	FHSC-SHOP003, pg 25, 6.4.10
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§3221(k)(6) 4303(s) 11 NYCRR 52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs;	FHSC-SHOP003, pg 25, 6.4.11

		cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 26, 6.4.12
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 26, 6.4.13
Office Visits Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 26, 6.4.16
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 26, 6.4.17
Preadmission Testing Model Language Used? Yes ☒ No ☐	§3221(k)(2) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 26, 6.4.18
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has	FHSC-SHOP003, pg 27, 6.4.19

Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.		undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.*	
Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§3221(k)(9) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	FHSC-SHOP003, pg 27, 6.4.20, 1st para
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§3221(k)(3) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 27, 6.4.20, 2nd para
Mandatory Second Surgical Opinion	§3221(k)(3) 4303(b)	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).	FHSC-SHOP003, pg 27, 6.4.20,

Model Language Used? Yes ☒ No ☐	Circular Letter No. 29 (1979) Model Language	Such coverage may not be subject to deductibles, copayments and/or coinsurance.	
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 27, 6.4.20, 4th para
Surgical Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.6 Model Language	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 27, 6.4.21
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 28, 6.4.22
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3221(k)(8) §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	FHSC-SHOP003, pg 34, 6.6.5
Post Mastectomy Reconstruction	§3221(k)(10) §4303(x) Women's Health and	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a	FHSC-SHOP003, pg 28, 6.4.23

Model Language Used? Yes ☒ No ☐	Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	
Transplants Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 28, 6.4.25
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy or contract provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.	FHSC-SHOP003, pg 29, 6.5.1

		The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: Plans may apply either a medical or a prescription benefit depending upon whichever will provide a more generous benefit.* *Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," the policy or contract form may not limit coverage to care prescribed by a physician.*	FHSC-SHOP003, pg 30. 6.5.2, 6.5.3 and pg 31, 6.5.4, 6.5.5
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 32, 6.5.6, 6.5.7 and 6.5.8
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for plans but the limit may be removed or modified so that coverage is more favorable.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for	FHSC-SHOP003, pg 32, 6.5.9

		malfunctions. *{Drafting Note: The limit on hearing aids is required for plans but this limit may be removed or modified so that coverage is more favorable.}* Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3221(l)(10) §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.*	FHSC-SHOP003, pg 32, 6.5.10
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for plans, but the limit may be removed or modified so that coverage is more favorable.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 33, 6.5.12

Hospital Services Model Language Used? Yes ☒ No ☐	11NYCRR52.5 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 33-34, 6.6.1
Maternity Care Model Language Used? Yes ☒ No ☐	§3221(k)(5) 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3221(k)(1), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	FHSC-SHOP004, pg 34, 6.6.4

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 35, 6.6.6
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 differs from the Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: Plans must cover 60 days; however plans may exceed the required 60 day, and also may remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	FHSC-SHOP003, pg 35, 6.6.7
Benefit explanation:			
Skilled Nursing Facility Model Language Used? Yes ☒ No ☐	§3221(l)(2) §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: Plans must cover 200 days, but may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 35, 6.6.8
End of Life Care Model Language Used?	§4805 PHL §4406-e 45 CFR § 156.100	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	FHSC-SHOP003, pg 35, 6.6.9

Yes ☒ No ☐	Model Language		
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§3221(l)(5) §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, small group health policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	FHSC-SHOP003, pg 36, 6.7.1, para A
Outpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	3221(l)(5) §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the*	FHSC-SHOP003, pg 36, 6.7.1, para B

		treatment of mental health conditions and substance use disorder consistent with the federal law.	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(6) §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	FHSC-SHOP003, pg 36, 6.7.2, para A
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(7) §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.	FHSC-SHOP003, pg 37, 6.7.2, para B

		Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	FHSC-SHOP003, pg 37, 6.8.1, para 1
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited	FHSC-SHOP003, pg 37, 6.8.1, para 2, item 7

		diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	FHSC-SHOP003, pg 37, 6.8.1, item 2
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	FHSC-SHOP003, pg 38, 6.8.3, B
Prohibition for Tier IV Drugs	§3221(a)(16) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	FHSC-SHOP003, pg 38. 6.8.3, A, 2nd para
Eye Drops Model Language Used? Yes ☒ No ☐	§3221(k)(17) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	FHSC-SHOP003, pg 38, 6.8.2
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§3221(l)(12-a) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	FHSC-SHOP003, pg 38, 6.8.1, 3rd para
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes ☒ No ☐	§3221(l)(18) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	FHSC-SHOP003, pg 40, 6.8.3, E
Contraceptive Drugs and Devices Model Language Used?	§3221(l)(16) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. For groups that meet the definition of a religious employer in §§3221(l)(16)(A); 4303(cc)(1)(A), the subscriber will have the option to purchase the stand alone contraceptive coverage rider. Contraceptive coverage	FHSC-SHOP003, pg 37, 6.8.1 & pg. 39, 6.8.3 D

Yes ☒ No ☐		must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 §3239 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: Plans may offer more comprehensive coverage or may substitute this benefit.*	FHSC-SHOP003, pg 44, 6.10
Benefit explanation:			
Other Wellness Benefits	45 CFR § 156.100 §3239	Additional Wellness Benefits may be covered. All additional wellness benefits must comply with § 3239 of Insurance Law.	N/A
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care	45 CFR § 156.100	This policy or contract form provides coverage for pediatric vision care including: emergency,	FHSC-SHOP003,

Model Language Used? Yes ☒ No ☐	Model Language	preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pg 45, 6.11
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☐ No ☒ Is dental coverage being provided by the insurer in this filing? Yes ☐ No ☒ If No, please provide information in the explanation box below as to how the insurer is meeting the requirement to offer the pediatric essential health benefit.	45 CFR § 156.100 45 CFR § 156.150 Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Insurers are required to offer the pediatric dental essential health benefit as either an embedded benefit (coverage provided by the insurer) or bundled benefit (coverage provided through an arrangement with another insurer).* *Embedded pediatric dental benefits must comply with all of the market reform and rating rules such guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums.* *If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:* *• The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the Exchange but offered outside the Exchange, including at the same premiums;* *• The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums;* *• The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost sharing and OOP maximums;* *• The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the Exchange but offered outside the Exchange.* *• The pediatric dental benefit meets the 70% or 85% actuarial value and $700 OOP maximum for one covered child (or $1,400 if more than one child in the family is covered);*	N/A

		• 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.	N/A
Orthotics Model Language Used? Yes ☐ No ☒	45 CFR § 156.100 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	N/A
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	N/A
Explanation:			

Acupuncture		This policy or contract form provides coverage for acupuncture.	Not covered
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(l)(2) § 4303(d)	This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	FHSC-SHOP003, pg 35, 6.6.8
Licensed Clinical Social Worker	§ 3221(l)(4) § 4303(i)	If this policyor contract provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments by physicians, psychiatrists or psychologists, the policy or contract must make available and if requested by the policyholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	FHSC-SHOP003, pg 30, 6.5.1 par 3
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	FHSC-SHOP003, pg 46, 7.1
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.	FHSC-SHOP003, pg 46, 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.	FHSC-SHOP003, pg 46, 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.	FHSC-SHOP003, pg 46, 7.4
Dental Services	11NYCRR52.16(c)(9	This policy or contract form excludes coverage for dental services except for: care or treatment due to	FHSC-SHOP003,

Model Language Used? Yes ☒ No ☐	) Model Language	accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	pg 46, 7.5
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	FHSC-SHOP003, pg 46, 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.	FHSC-SHOP003, pg 46, 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.	FHSC-SHOP003, pg 46, 7.8
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	FHSC-SHOP003, pg 47, 7.9
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.	FHSC-SHOP003, pg 47, 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).	FHSC-SHOP003 pg 47, 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.	FHSC-SHOP003, pg 47, 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.	FHSC-SHOP003 pg 47, 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.	FHSC-SHOP003 pg 47, 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.	FHSC-SHOP003 pg 47, 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.	FHSC-SHOP003 pg 47, 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 or contract form as being covered.	FHSC-SHOP003 pg 47, 7.17
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	FHSC-SHOP003 pg 47, 7.18
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.	FHSC-SHOP003 pg 47, 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.	FHSC-SHOP003 pg 47, 7.20
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim Model Language Used? Yes ☒ No ☐	§3221(a)(8) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	FHSC-SHOP003, pg 48, 8.1, 8.2
Submission of Claim Model Language Used? Yes ☒ No ☐	§3221(a)(9) §4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	FHSC-SHOP003, pg 48, 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)(p) PHL § 4408-a 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any.	FHSC-SHOP003, pg 50, 9.1
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	FHSC-SHOP003, pg 52, 9.2
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.	FHSC-SHOP003, pg 55, 9.3

COORDINATION OF BENEFITS Model Language Used? Yes ☒ No ☐	11 NYCRR 52.23 Model Language	If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	Form/Page/Para Reference
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language	*The following are the only termination provisions permissible under the Insurance Law.*	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	FHSC-SHOP003, pg 62, XI - para 1
Termination for Failure to Pay Premiums	§3221(p)(2)(A) §4305(j)(2)(A)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.	FHSC-SHOP003, pg 62, XI - para 1
Termination for Fraud	§3221(p)(2)(B) §4305(j)(2)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	FHSC-SHOP003, pg 62, Sec. XI, para - 7
Termination for Failure to Comply With a Material Plan Provision	§3221(p)(2)(C) §4305(j)(2)(C)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to terminate coverage if the group has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	FHSC-SHOP003, pg 62, Sec. XI - para 10
Discontinuation of a Class of Coverage	§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	FHSC-SHOP003, pg 62, Sec. XI, para 8
Discontinuation of all Policies/Contracts in the Small Market	§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	FHSC-SHOP003, pg 62, Sec XI, para 9
Termination for Failure to Meet Requirements of Group	§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under §4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	FHSC-SHOP003, pg 62, Sec. XI - para 11
Termination if there are No Longer Insureds in the Insurer's Service Area	§3221(p)(2)(F) §4305(j)(2)(F)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	FHSC-SHOP003, pg 62, Sec. XI -12
Termination for Spouses in cases of divorce		This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	FHSC-SHOP003, pg 62, Sec. XI - 4

Termination upon death of Subscriber		This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	FHSC-SHOP003, pg 62, Sec. XI - 3
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.	FHSC-SHOP003, pg 62, Sec XI - 6
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.	FHSC-SHOP003, pg 62, Sec XI - 7
Renewal	§3221(p) §3221(a)(5) 4305(j) 11 NYCRR 52.18(c)	This policy or contract provides that except as specified in §3221(p), or §4305(j) the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	FHSC-SHOP003, pg 71, 13.18
Premiums	§3221(a)(4)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	FHSC-SHOP003, pg 62, Sec. XI - 1
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☒ No ☐	11 NYCRR 52.18(b)(4); (5); and (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered persons' coverage terminates by reason of the termination of active employment, an extended benefit will be proved during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	FHSC-SHOP003, pg 64, 12.1
Continuation Coverage Model Language Used? Yes ☒ No ☐	§3221(e)(11) §3221(m) §4305(e) COBRA, Title X of Public Law 99-272 Model Language	This policy or contract form contains a provision regarding continuation coverage. §§3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage.	FHSC-SHOP003, pg 64, 12.2

		The continuation benefits terminate: • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	
Young Adult Option Model Language Used? Yes ☒ No ☐	§3221(r) §4305(l) Model Language	This policy or contract form provides notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy or contract, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r), and/or 4305(l). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy or contract. The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).	FHSC-SHOP003, pg 66, 12.2.2
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	FHSC-SHOP003, pg 65-66, 12.2.1
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language	If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	FHSC-SHOP003, pg 65-66, 12.2.1

Model Language Used? Yes ☒ No ☐			
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☐ No ☐	§3221(e) §4303(d)	This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents. Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates. The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	FHSC-SHOP003, pg 67, 12.3
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§3221(a)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	FHSC-SHOP003, pg 70, 13.11
Changes Model Language Used? Yes ☒ No ☐	§3221(a)(2) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	FHSC-SHOP003, pg 72, 13.28
Action in Law or Equity Model Language Used? Yes ☒ No ☐	§3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy or contract.	FHSC-SHOP003, pg 72, 13.24
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	FHSC-SHOP003, pg 72, 13.23

	Model Language		
Unilateral Modification Model Language Used? Yes ☒ No ☐	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	FHSC-SHOP003, pg 69 13.3
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	§3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	FHSC-SHOP003, pg 72, 13.25
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	Schedule of Benefits
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	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:	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not permit more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	N/A

Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☐			
Extended Dependent Coverage Model Language Used? Yes ☐ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f) or 4305(c)(1).	See Rider: FHSC -WMBT001
Contraceptive Drugs and Devices and Family Planning Services	§3221(l)(16)	This policy or contract form includes a rider for situations when a Group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§3221(l)(16)(A); 4303(cc)(1)(A). In accordance with law, if elected by an insured, this Rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the federal food and drug administration and provides coverage for family planning services.	See Rider: FHSC -WMBT002
PROVIDER NETWORKS Has network been submitted to and/or approved by the Department of Health or the Exchange? Yes ☐ No ☐ If yes, please indicate the name of the network, the network ID number, and the dates that the network was submitted to and/or approved by the Department of Health or the Exchange. Network Name: Network ID #: Date Submitted: Date Approved:	§3201(c)	If the insurance (other than HMO) policy or contract will be used in conjunction with a provider network, please identify in the adjacent box whether the insurer is using the same network that was submitted to and/or approved by the Department of Health and/or the Exchange. Please indicate the network name and network ID number and include the date that the network was submitted to and/or approved by the Department of Health and/or the Exchange. If the network differs in any respect from that which was submitted to and/or approved by the Department of Health and/or the Exchange, please provide details on how the network differs in the Supporting Documentation Tab in SERFF. This includes, but is not limited to, detailing the providers and specialty types in each county that differ from the network that was submitted to and/or approved by the Department of Health and/or the Exchange . In addition, the following items or information must be submitted as part of this filing: • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type by county. *Note: The Department will not permit more than a 30% differential between in-network and out-of-*	

		network coverage unless supported by scholarly literature or actual claims experience of the insurer.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans" has been posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3221 11NYCRR52.40(e) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 87.1 %.	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: 87.1 %.	

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

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

Name of Company: 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] Executive Director

Officer's Name 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]

Officer's Name

Executive Director

Officer's Title

Date: April 26, 2013

4814-3098-4467, v. 1

Freelancers Health Service Corporation
Memorandum of Variable Information
Small Group (SHOP) Certificate, Form #FHSC-SHOP001OFF
Off-Exchange 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]
Cover Page: the brackets allow the Plan to add the name of the employer/group sponsor to the Certificate.	[Group Contractholder]
Table of Contents: the brackets allow the Plan to add Riders as appropriate to the Employer group.	[Rider to Extend Coverage for Young Adults Through Age 29] [Rider for Coverage for Contraceptive] [Rider for Domestic Partnership]
Definitions, Participating Provider: the brackets allow the Plan to change the name of the website/URL. Any such change would apply to all contracts.	[www.newyorkcoop.org]
Definitions, Spouse: the brackets allow the Plan to include this definition whenever the Domestic Partners Rider is made a part of the Certificate.	[and a domestic partner]
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 occurring 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 available 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 IV, paragraph 4.4: the brackets allow the Plan to add the Primary Care Allowance language to non-standard Plans.	[4.4 Primary Care 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 XIV of this Certificate 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. Preventive services required to be covered at no Cost-Sharing do not count towards the allowance.]
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, 6.1.2, 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, 6.1.4, 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, 6.1.6, Family Planning & Reproductive Health Services: the brackets permit the Plan to remove this entire paragraph in those situations where these services are not to be covered under the group policy.	[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 Certificate, counseling on use of contraceptives, related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider. We also Cover vasectomies subject to Copayments, Deductibles, or Coinsurance. We do not Cover services related to the reversal of elective sterilizations.]
Section VI, 6.4.1, Outpatient and Professional Services, Acupuncture: the brackets allow the Plan to include Acupuncture benefits in non-standard Plans.	[6.4.1 Acupuncture. We cover acupuncture services (only for non-standard Plans).]
Section VI, 6.4.10, Interruption of Pregnancy: the brackets allow the Plan to remove this entire paragraph in those situations where this service is not be covered under the group policy.	[6.4.10 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.]
Section VI, 6.8.1, Covered Outpatient Prescription Drugs: the brackets allow the Plan to remove contraceptive drugs in those situations where they are not covered under the group policy.	[Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.]
Section VI, Prescription Drugs, 6.8.1: 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, 6.8.3: 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, 6.8.3B: 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, 6.8.3D: the brackets permit the Plan to remove contraceptive drugs in those situations where they are not covered under the group policy.	· [Contraceptives]
Section VI, Prescription Drugs, 6.8.3E: 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, 6.8.3H: 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, 6.8.4A: 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, 6.8.4C: 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, 6.9, Formulary: 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 XIII, 13.15, 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, 13.25, Translation Services: the brackets allow the Plan to change the phone number used to accept inquiries concerning translation 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] [EssentialCare Gold] [EssentialCare Platinum] [Primary Select Bronze] [Primary Select Silver] [Primary Select Gold] [Primary Select Platinum]
Schedule of Benefits: the brackets allow the Plan to exclude these benefits when they are not part of the group policy.	[Sterilization Procedures for Women] [Vasectomy]
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]
RIDER TO ADD COVERAGE FOR CONTRACEPTIVE DRUGS AND DEVICES, FAMILY PLANNING SERVICES, AND INTERRUPTION OF PREGNANCY: the brackets allow the Plan to include the Rider as appropriate.	[RIDER TO ADD COVERAGE FOR CONTRACEPTIVE DRUGS AND DEVICES, FAMILY PLANNING SERVICES, AND INTERRUPTION OF PREGNANCY]
Domestic Partner Rider: the brackets allow the Plan to include the Rider as appropriate.	[Domestic Partner Rider]

Freelancers Health Service Corporation
Memorandum of Variable Information
Small Group (SHOP) Certificate, Form #FHSC-SHOP002OFF
Off-Exchange Plans

Description	Variation
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Section VI, Prescription Drugs, 6.8.3B: 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, 6.8.3D: the brackets permit the Plan to remove contraceptive drugs in those situations where they are not covered under the group policy.	· [Contraceptives]
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HEALTH REPUBLIC
INSURANCE

This is Your

EXCLUSIVE PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE

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]~~

To

[Group contract holder]

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Freelancers Health Service Corporation DBA Health Republic Insurance of New York (hereinafter referred to as "We", "Us", or "Our") and the Group contractholder listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders, or endorsements may be delivered with the Certificate or added thereafter.

This Certificate 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 Choice network. You should always consider receiving health services first through Our preferred MagnaCare 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 Extra network. You should always consider receiving health care services first through Preferred Providers and then from Participating Providers that are not Preferred Providers.

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

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

Signed By: [redacted]

[redacted]

Chief Executive Officer

FHSC-SHOP004OFF

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SECTION I - DEFINITIONS

Defined terms will appear capitalized throughout the Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

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

- is appropriate for use in the home.

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

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

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

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

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

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

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

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

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

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

Health Care Professional: An appropriately licensed, registered, or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who

charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

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

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

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

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

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

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

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services 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 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: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

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

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 Certificate 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, Broome, Cayuga, Chemung, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Kings, Livingston, Monroe, Montgomery, Nassau, New York, Niagara, Onondaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, and Yates.

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

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

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

Subscriber: The person to whom this Certificate is issued.

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

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

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

You, Your: The Member

SECTION II - HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Certificate

Your employer (referred to as the "Group contractholder") has purchased a Group Contract from Us. We will provide the benefits described in this Certificate to members of the Group, that is, to employees of the Group and their Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

2.2 Covered Services

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

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in Section XIV of this Certificate; and
- Received while Your Certificate 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/network.~~[at www.newyorkcoop.org].~~

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

2.4 The Role of Primary Care Physicians

This Certificate does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a Referral from a PCP before receiving Specialist care from a Participating Provider.

2.5 Preferred Providers

Some Participating Providers are also Preferred Providers. Certain services must be obtained from Preferred Providers. See the Schedule of Benefits in section XIV of this Certificate for coverage of Preferred Provider services.

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 IV of this Certificate.

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

2.10 Care Must Be Medically Necessary

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

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

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;

- They are required for the direct care and treatment or management of that condition;

- Your condition would be adversely affected if the services were not provided;

- They are provided in accordance with generally-accepted standards of medical practice;

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

See Section IX of this Certificate 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

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 St.~~
~~Syracuse, NY 13206]~~
~~Phone: [315.432.9171 or 888-990-5702]~~

~~Fax: [315.432.9442 or 315.432.1689]~~

~~MEDICAL EMERGENCIES AND URGENT CARE~~
~~[Weekdays 8:00 a.m. – 5:00 p.m.]~~
~~Phone: [315.432.9171 or 888-990-5702]~~
~~Fax: [315.432.9442 or 315.432.1689]~~
~~[Evenings, Weekends & Holidays]~~
~~[315.432.9171 or 1.800.934.2459]~~

~~MEMBER SERVICES~~
~~[Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.]~~
~~Phone: [315.432.917 or 888-990-5702]~~

~~PREAUTHORIZATION~~
~~[Monday – Friday, 8:00 a.m. – 6:00 p.m. EST]~~
~~Phone: [1.800.766.2648 or 315.437.9518 or 888-990-5702]~~
~~Fax: [315.463.148]~~

~~OUR WEBSITE~~
~~[www.newyorkcoop.org]~~

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

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

SECTION IV - COST-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 XIV of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have coverage other than Individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible. However, after Deductible payments for all persons covered under this Certificate total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

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 XIV of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

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 benefit as shown in the Schedule of Benefits in Section XIV of this Certificate.

[4.4 Primary Care 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 XIV of this Certificate 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.

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 XIV of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If you have coverage other than Individual coverage, the individual Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit 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 Certificate, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

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

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

SECTION V - WHO IS COVERED

5.1 Who is Covered Under this Certificate

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under thisCertificate. 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 and Your Spouse and Your Children, as described below, are covered.

5.3 Children Covered Under This Certificate

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

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

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

5.4 When Coverage Begins

Coverage under this Certificate will begin as follows:

- If You, the Subscriber elect coverage before becoming eligible, or within 30 days of becoming eligible for reasons other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your group. Groups cannot impose waiting periods that exceed 90 days.

- If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for reasons other than a special enrollment period, You must wait until the group's next open enrollment period to enroll, except as provided below.
- If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the group's next open enrollment period to add Your Spouse.
- If You, the Subscriber, have Family or Parent and Child/Children coverage, and have a newborn Child, and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth. If You have Individual or Individual and Spouse coverage, You must notify Us of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 30 days from the date of birth in order for coverage to start at the moment of birth, otherwise Parent and Child/Children or Family coverage begins on the date on which We receive notice.
- If You, the Subscriber, have Family or Parent and Child/Children coverage, Your adopted newborn Child will be covered from the moment of birth if You notify us within 30 days of the birth, You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law or other applicable state law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have Individual or Individual and Spouse coverage, You must also notify Us of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 30 days from the date of birth in order for coverage to start at the moment of birth. Otherwise, Parent and Child/Children or Family coverage begins on the date on which We receive notice and the premium payment. However, We will not provide Hospital benefits for the newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay.

5.5 Special Enrollment Periods

You, Your Spouse or Child, can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment.
2. Termination of the other group health plan.
3. Death of the Spouse.
4. Legal separation, divorce or annulment.
5. Reduction of hours of employment.
6. Employer contributions towards the group health plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

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

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

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

SECTION VI – COVERED 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.

6.1 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 XX of the Certificate, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

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

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

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 Certificate. Bone mineral density measurements or tests, drugs, or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or

- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

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

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 XIV of this Certificate 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 Certificate 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 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 Certificate 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.
6.3.4 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.

6.4 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.

6.4.1 Acupuncture
We cover acupuncture services.

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

6.4.3 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.

6.4.4 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.

6.4.5 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 Certificate.

6.4.6 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 sublaxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

6.4.7 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.

6.4.8 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.

6.4.9 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".

6.4.10 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.]

6.4.11 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.

6.4.12 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.

6.4.13 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.

6.4.14 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 Certificate 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.

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

6.4.17 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.

6.4.18 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.

6.4.19 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.

6.4.20 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.

6.4.21 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.

6.4.22 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.

6.4.23 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.

6.4.24 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.

6.4.25 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.

6.5 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.

6.5.1 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 Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be

included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

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

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

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

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

6.5.2 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:

6.5.3 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.

6.5.4 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.

6.5.5 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.

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

6.5.7 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.

6.5.8 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.

6.5.9 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 that You are enrolled under this Certificate. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

6.5.10 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.

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

6.5.12a External Prosthetic Devices

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

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

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

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

6.5.12b 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.

6.6 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.

6.6.1 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.

6.6.2 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.

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

6.6.4 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 Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

6.6.5 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.

6.6.6 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.

6.6.7 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:

a. 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);
b. it is ordered by a Physician; and
c. 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:

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

6.6.8 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 Certificate.) 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.

6.6.9 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 Certificate until the External Appeal Agent renders a decision in Our favor.

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

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

6.6.10 Limitations/Terms of Coverage:

a. 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.
b. We do not Cover radio, telephone, and television expenses, or beauty or barber services.
c. 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.

6.7 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.

6.7.1 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 Certificate. However, Coverage for inpatient services for mental health care is limited to Facilities as defined by

New York Mental Hygiene Law § 1.03 subdivision 10.

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.

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

6.8 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.

6.8.1 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 Certificate.
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- [Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.]

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at http://newyork.healthrepublic.us/forumlary~~[www.newyorkcoop.org]~~. You may also inquire if a specific drug is Covered under this Certificate by contacting us at the number on Your ID card.

6.8.2. 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 XIV of this Certificate.

6.8.3 Benefit and Payment Information

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

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

   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 ~~[1.800.766.2648 or 315.437.9518 or~~ 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, 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 and 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 http://newyork.healthrepublic.us/formulary ~~[at www.newyorkcoop.org]~~ or by calling the Customer Service number on Your ID card.

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 Plan 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 http://newyork.healthrepublic.us ~~[at 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 Certificate.

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 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 http://newyork.healthrepublic.us ~~[at 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 Certificate.

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 XIV of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Certificate.

6.8.4 Medical Management

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

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. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

   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 http://newyork.healthrepublic.us ~~[at www.newyorkcoop.org]~~ or call the Customer Service at the phone number on Your ID Card.

6.8.5 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.

E. 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 Certificate

F. 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 Certificate.

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

H. 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.

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

J. 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.

K. Your benefit for insulin, diabetic Prescription Drugs, supplies,, and equipment is not provided under this Section of the Certificate and is Covered under Section VI of the Certificate.

L. 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 Certificate.

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

N. 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 of this Certificate.

6.8.6 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.

6.9 DEFINITIONS

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

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

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

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per PlanYear). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website http://newyork.healthrepublic.us/formulary ~~[at 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.

6.10 WELLNESS

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 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.

6.11 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.

6.11.1 Pediatric Vision Care

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

6.11.2 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;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

6.11.3 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 Certificate 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 Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in Section IX of this Certificate.

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 Certificate.

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 Certificate for non-investigational treatments. See Section IX of this Certificate 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 Certificate. For foot care related to diabetes, see Section VI of this Certificate.

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 Certificate.

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 Certificate 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 Certificate.

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 DETERMINATIONS

8.1 Claims

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

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. Completed claim forms should be sent to the address in Section II of this Certificate 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 Certificate.

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

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

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]~~at 888-990-5702 -in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

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

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

9.1.3 Grievance Appeals

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by

phone, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to [60] business days from receipt of the Grievance determination to file an Appeal.

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

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

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: that are not in relation to a claim or request for service.)	30 business days of receipt of all necessary information to make a determination

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

Call the New York State Department of 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.

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 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 First Level Appeal

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 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 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, 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.

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.

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

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

9.2.12 Second Level Appeal
If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level 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.

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 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 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, 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 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~~1~~
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

9.3 EXTERNAL APPEAL

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 Certificate and

- In general, You must have received a final adverse determination through ~~[~~the first level of~~]~~ Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of 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 ~~[~~the first level of~~]~~ Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

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

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission,

availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

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

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

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 – COORDINATION OF BENEFITS

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

10.1 Definitions

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

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

A. Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

B. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

C. Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

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

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

10.2 Rules to Determine Order of Payment

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

A. If the other plan does not have a provision similar to this one, then the other plan will be primary.

B. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

C. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result

the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

D. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

   a. The plan of the parent who has custody will be primary;

   b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

   c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

E. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

F. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

10.3 Effects of Coordination
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

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

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

10.6 Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

A. If this Certificate is primary, as defined in this Section, We will pay benefits first.

B. If this Certificate is secondary, as defined in this Section, We will pay only the amount We would pay as the secondary insurer;

C. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XI – TERMINATION OF COVERAGE

Group

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

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless You have coverage for Dependents. If You have coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the date the Dependent ceases to be eligible.

6. The end of the month during which the Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

7. If a Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if a Subscriber makes an intentional misrepresentation of material fact in writing on his/her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to the date of Your enrollment under the Certificate.

8. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.

9. If We elect to terminate or cease offering all hospital, surgical, and medical expense coverage in the small group market, in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.

10. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

11. The Group has failed to comply with a material plan provision relating to employer contribution or group participation rules.

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

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

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

See Sections XII of this Certificate for Your right to continuation of this coverage and Section XII of this Certificate for Your right to conversion to an individual Contract.

SECTION XII – WHAT HAPPENS IF YOU LOSE COVERAGE

12.1 EXTENSION OF BENEFITS

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

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

12.1.2 When You May Continue Benefits

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

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

12.1.3 Termination of Extension of Benefits

Extended benefits will end on the earliest of the following:

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

12.1.4 Limits on Extended Benefits

We will not pay extended benefits:

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

12.2 CONTINUATION OF COVERAGE

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

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

A. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse, and any of Your Covered Children.

B. If You are a Covered Spouse, You may continue coverage if Your coverage ends due to:
   a. Voluntary or involuntary termination of the Covered employee's employment;
   b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
   c. Divorce or legal separation of the Covered employee;
   d. Death of the Covered employee; or
   e. The Covered employee becoming entitled to Medicare.

C. If You are a Covered Child, You may continue coverage if Your coverage ends due to:
   a. Voluntary or involuntary termination of the Covered employee's employment;
   b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
   c. Loss of Covered Child status under the plan rules;
   d. Death of the Covered employee; or
   e. The Covered employee becoming entitled to Medicare.

D. If You want to continue coverage You must request continuation from Your employer in writing and make the first Premium payment within the 60-day period following the later of:
   a. The date coverage would otherwise terminate; or
   b. The date You are sent notice by first class mail of the right of continuation by the Group contractholder.

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

E. Continued coverage under this Section will terminate at the earliest of the following:
   a. The date 36 months after Your coverage would have terminated because of termination of employment;
   b. If You are a Covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the employee, divorce or legal separation, the employee's eligibility for Medicare, or the failure to qualify under the definition of "Children";
   c. The date You become Covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
   d. The date You become entitled to Medicare;
   e. The date to which Premiums are paid if You fail to make a timely payment; or
   f. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See Section XII of the Certificate.

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

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during

active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

2. You serve no more than four years of active duty.

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

Upon completion of active duty:

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

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

Age 29 Dependent Coverage Extensions Young Adult Option

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

Your Child may elect this coverage:

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

You or Your Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as

the coverage provided under this Certificate. Your Child's children are not eligible for coverage under this option.

12.3 CONVERSION RIGHT TO NEW CONTRACT AFTER TERMINATION

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

A. **Termination of the Group Contract.** If the Group Contract between Us and the Group Contractholder is terminated as set forth in Section XI of this Certificate, and the Group Contractholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as direct payment members.

B. **If You Are No Longer Covered in a Group.** If Your coverage terminates under Section XI of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

C. **On the Death of the Subscriber.** If coverage terminates under Section XI of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

D. **Termination of Your Marriage.** If a Spouse's coverage terminates under Section XI of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

E. **Termination of Coverage of a Child.** If a Child's coverage terminates under Section XI of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

F. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under Section XI of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

G. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under Section XI of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

12.3.1 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 coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

12.3.2 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. However, the coverage may not be the same as Your current coverage. However, if We determine that You do not reside in New York State, We may issue You or Your family members coverage on a form that we use for conversion in that state.

12.3.3 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.

XIII - GENERAL PROVISIONS

13.1 Agreements between Us and Participating Providers

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

13.2 Assignment

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

13.3 Changes in This Certificate

We may unilaterally change this Certificate upon renewal, if We give the Group Contractholder 30 days' prior written notice.

13.4 Choice of Law

This Certificate shall be governed by the laws of the State of New York.

13.5 Clerical Error

Clerical error, whether by the Group Contractholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

13.6 Continuation of Benefit Limitations

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

13.7 Enrollment ERISA

The Group Contractholder will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all group members covered under this Certificate, and any other information required to confirm their eligibility for coverage. The Group Contractholder will provide Us with this information upon request.

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

13.8 Entire Agreement

This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

13.9 Furnishing Information and Audit
The Group Contractholder and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group Contractholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to group enrollment at the Group Contractholder's New York office.

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

13.11 Incontestability
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

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

13.**13 Material Accessibility**
We will give the Group Contractholder, and the Group Contractholder will give You, identification cards, Certificates, riders, and other necessary materials.

13.14 More Information about Your Health Plan
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers, and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.

- The information that We provide the State regarding Our consumer complaints.

- A copy of Our procedures for maintaining confidentiality of Member information.

- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.

- A written description of Our quality assurance program.

- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.

- Provider affiliations with Participating Hospitals.

- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

13.15 Notice
Any notice that We give to You under this Certificate will be mailed to Your address as it appears on our records or to the address of the Group Contractholder. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: [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].

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

13.17 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.

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

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

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

13.21 Severability
The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate.

13.22 Significant Change in Circumstances
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a

significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

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

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

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

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

13.25 Translation Services
Translation services are available under this Certificate for non-English speaking Members. Please contact us at 888-990-5702~~[315.432.9171]~~ to access these services.

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

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

13.28 Who May Change This Certificate
The Certificate 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 Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

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

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

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

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

- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and

- Permit copying of Your medical records by Us.

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

Freelancers Health Service Corporation
Small Group 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) small group 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 small group 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:	Small Group
Effective Date:	January 1, 2014

Company Contact Information

Primary Contact Name:	[redacted]
Primary Contact Telephone Number:	
Primary Contact Email-Address:	

Consultant Contact Information

Primary Contact Names:	[redacted]
Primary Contact Telephone Number:	
Primary Contact Email-Address:	

II. PROPOSED RATE INCREASE(S)

This submission is for new small group medical products available for sale January 1, 2014. FHSC does not currently sell small group 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 small group 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 small group medical plans.

Credibility Man ual: We categorized utilization and cost information by benefit using *Milliman's Health Cost G uidelines* (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 small group medical plans.

VI. CREDIBILITY MANUAL RATE DEVELOPMENT

FHSC's rates are based 100% on manual rates since FHSC is new to the small group 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 the following:

Morbidity (a.k.a., Adverse Selection)

In order to approximate small group morbidity, we used the projected differences in health status between the 2014 small group and individual market and applied it to the morbidity for FHSC's individual product line.

Individual Morbidity Development

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.

Small Group

In the development described above, we also project the small group health status for 2014. We assumed that small group health status would be 90% of individual health status in 2014. Therefore, the adjustment shown in Exhibit 8, line 17 equals the overall change in morbidity relative to the current individual market:

Small group 2014 morbidity = Individual 2013 morbidity * Change in 2014 Individual Health Status * Ratio of Small Group/Individual morbidity
= (Individual 2013 morbidity) * 0.866 * 0.90
= (Individual 2013 morbidity) * 0.779

These factors do 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 small group 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).

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.

VII. CREDIBILITY OF EXPERIENCE

FHSC's rates are based 100% on manual rates since FHSC is new to the small group 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 no ACA reinsurance recoveries net of the $5.25 PMPM reinsurance contribution since the ACA reinsurance program is structured to solely benefit the individual insurance market.

Note that we included this fee in the Taxes and Fees PMPM of Worksheet 1, Section III in the URRT since the URRT does not allow us to populate Projected Reinsurance Recoveries, net of reinsurance premium with a small group filing.

X. NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

We estimate FHSC's administrative expenses to be $50.44 PMPM. 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%
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 loss ratio based on federally prescribed MLR methodology, excluding adjustments for credibility, is 90.4%. 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 87.1%. We assumed NY's projection method MLR equals the following:

NY MLR = (Incurred Claims + State Assessments) / 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 small group 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 small group 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 Small Group 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]	N/A

[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.*

Conversion of Plan Rates to Composite Rates (Required by New York)

New York requires rates not vary by age (i.e., composite rating) and are community rated. 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.

Semi-Annual Trending of Rates

Initial rates were developed for groups effective January 1, 2014 – June 30, 2014. FHSC will be using a semi-annual trend rate for groups effective July 1, 2014 – December 31, 2014. The semi-annual trend assumption is 2.5% and is reflected in the Rates Template.

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 71644NY0050001).

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.

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 small group 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 small group market.

Differences vs. Current: We made no comparison of the projections to current since FHSC does not currently insure members in the New York small group market.

Methodology to Project Cost Sharing Reduction (CSR) Eligibles: Not applicable for small group.

XVI. TERMINATED PRODUCTS

FHSC does not have any terminated products since they do not currently sell small group 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 ALERT

The following warning alert appears in Worksheet 2, Section IV of the URRT:

- Total Premium (TP) – The formula generating the comparison does not allow for marginal rounding errors. As such, the two values are not exactly equal and therefore produce an error.

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 [redacted] 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 small group 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.

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]

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.

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

Attachment A
Freelancers Health Service Corporation
Actuarial Value Calculator Outputs

Essential Care Platinum - 71644NY0050004

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

Essential Care Gold - 71644NY0050003

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

Essential Care Silver - 71644NY0050002

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

Essential Care Bronze - 71644NY0050001

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

Primary Select Platinum - 71644NY0070004

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 - 71644NY0070003

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 - 71644NY0070002

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 Bronze - 71644NY0070001

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 - 71644NY0080002

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 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:	Calculation Successful.
Actuarial Value:	70.9%
Metal Tier:	Silver

Attachment B
Freelancers Health Service Corporation

Benefit Designs - without Pediatric Dental

EssentialCare and EssentialCare Age 29 Option Plans
EssentialCare Restricted - F, EssentialCare Restricted - D, and EssentialCare - DF Plans

Product Name	EssentialCare Platinum	EssentialCare Gold	EssentialCare Silver	EssentialCare Bronze
Exchange Status	On and Off	On and Off	On and Off	On and Off
Plan ID	71644NY0050004	71644NY0050003	71644NY0050002	71644NY0050001
Metal Tier	Platinum	Gold	Silver	Bronze
Deductible	$0	$600	$2,000	$3,000
Co-insurance	100%	100%	100%	50%
Out-of-Pocket Max	$2,000	$4,000	$5,500	$6,350
ER Services	$100 after deductible is met	$150 after deductible is met	$150 after deductible is met	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
Office Visits – Primary and MH/SA	$15 after deductible is met	$25 after deductible is met	$30 after deductible is met	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
PT/ST/OT	$25 after deductible is met	$30 after deductible is met	$30 after deductible is met	Deductible & Coinsurance
Outpatient Facility Fee	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance
Outpatient Surgery Charge	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance
Rx Cost Share	$10/$30/$60	$10/$35/$70	$10/$35/$70	$10/$35/$70
Pediatric Dental	Not Covered	Not Covered	Not Covered	Not Covered
Actuarial Value	88.1%	79.0%	70.7%	62.0%
AV Requirement	88-92%	78-82%	68-72%	58-62%

FHSC Select and Select Age 29 Option Plans
FHSC Select Restricted - F, Select Restricted - D, and Select Restricted - DF 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	71644NY0070004	71644NY0070003	71644NY0070002	71644NY0070001
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 MH/SA	$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 and Select EPO Age 29 Option Plans
FHSC Select Restricted - F, Select Restricted - D, and Select Restricted - DF Plans

Product Name	Primary Select Silver EPO
Exchange Status	On and Off
Plan ID	71644NY0080002
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 MH/SA	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

Essential Care and Essential Care Age 29 Option Plans
Essential Care Restricted - F, Essential Care Restricted - D, and Essential Care - DF Plans

Product Name	EssentialCare Platinum	EssentialCare Gold	EssentialCare Silver	EssentialCare Bronze
Exchange Status	On and Off	On and Off	On and Off	On and Off
Plan ID	71644NY0620004	71644NY0620003	71644NY0620002	71644NY0620001
Metal Tier	Platinum	Gold	Silver	Bronze
Deductible	$0	$600	$2,000	$3,000
Co-insurance	100%	100%	100%	50%
Out-of-Pocket Max	$2,000	$4,000	$5,500	$6,350
ER Services	$100 after deductible is met	$150 after deductible is met	$150 after deductible is met	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
Office Visits – Primary and MH/SA	$15 after deductible is met	$25 after deductible is met	$30 after deductible is met	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
PT/ST/OT	$25 after deductible is met	$30 after deductible is met	$30 after deductible is met	Deductible & Coinsurance
Outpatient Facility Fee	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance
Outpatient Surgery Charge	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance
Rx Cost Share	$10/$30/$60	$10/$35/$70	$10/$35/$70	$10/$35/$70
Pediatric Dental	Covered	Covered	Covered	Covered
Actuarial Value	88.1%	79.0%	70.7%	62.0%
AV Requirement	88-92%	78-82%	68-72%	58-62%

FHSC Select and Select Age 29 Option Plans
FHSC Select Restricted - F, Select Restricted - D, and Select Restricted - DF 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	71644NY0640004	71644NY0640003	71644NY0640002	71644NY0640001
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 MH/SA	$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 and Select EPO Age 29 Option Plans
FHSC Select Restricted - F, Select Restricted - D, and Select Restricted - DF Plans

Product Name	Primary Select Silver EPO
Exchange Status	On and Off
Plan ID	71644NY0650002
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 MH/SA	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 C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	EssentialCare	EssentialCare	EssentialCare	EssentialCare	EssentialCare Restricted-D	EssentialCare Restricted-D	EssentialCare Restricted-D	EssentialCare Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0050004	71644NY0050003	71644NY0050002	71644NY0050001	71644NY0230004	71644NY0230003	71644NY0230002	71644NY0230001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.961**	**1.668**	**1.427**	**1.168**	**1.961**	**1.668**	**1.427**	**1.168**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-DF	EssentialCare Restricted-DF	EssentialCare Restricted-DF	EssentialCare Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0240004	71644NY0240003	71644NY0240002	71644NY0240001	71644NY0250004	71644NY0250003	71644NY0250002	71644NY0250001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.961**	**1.668**	**1.427**	**1.168**	**1.961**	**1.668**	**1.427**	**1.168**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0620004	71644NY0620003	71644NY0620002	71644NY0620001	71644NY0290004	71644NY0290003	71644NY0290002	71644NY0290001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
AV Pricing Value	**1.992**	**1.698**	**1.458**	**1.187**	**1.992**	**1.698**	**1.458**	**1.187**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0300004	71644NY0300003	71644NY0300002	71644NY0300001	71644NY0310004	71644NY0310003	71644NY0310002	71644NY0310001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
AV Pricing Value	**1.992**	**1.698**	**1.458**	**1.187**	**1.992**	**1.698**	**1.458**	**1.187**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0170004	71644NY0170003	71644NY0170002	71644NY0170001	71644NY0260004	71644NY0260003	71644NY0260002	71644NY0260001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.961**	**1.668**	**1.427**	**1.168**	**1.961**	**1.668**	**1.427**	**1.168**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0270004	71644NY0270003	71644NY0270002	71644NY0270001	71644NY0280004	71644NY0280003	71644NY0280002	71644NY0280001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.961**	**1.668**	**1.427**	**1.168**	**1.961**	**1.668**	**1.427**	**1.168**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0180004	71644NY0180003	71644NY0180002	71644NY0180001	71644NY0320004	71644NY0320003	71644NY0320002	71644NY0320001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
AV Pricing Value	**1.992**	**1.698**	**1.458**	**1.187**	**1.992**	**1.698**	**1.458**	**1.187**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0330004	71644NY0330003	71644NY0330002	71644NY0330001	71644NY0340004	71644NY0340003	71644NY0340002	71644NY0340001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.460	1.323	1.187	1.000	1.460	1.323	1.187	1.000
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
AV Pricing Value	**1.992**	**1.698**	**1.458**	**1.187**	**1.992**	**1.698**	**1.458**	**1.187**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	PrimarySelect	PrimarySelect	PrimarySelect	PrimarySelect	PrimarySelect Restricted-D	PrimarySelect Restricted-D	PrimarySelect Restricted-D	PrimarySelect Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0070004	71644NY0070003	71644NY0070002	71644NY0070001	71644NY0350004	71644NY0350003	71644NY0350002	71644NY0350001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.880**	**1.666**	**1.426**	**1.012**	**1.880**	**1.666**	**1.426**	**1.012**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0360004	71644NY0360003	71644NY0360002	71644NY0360001	71644NY0370004	71644NY0370003	71644NY0370002	71644NY0370001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.880**	**1.666**	**1.426**	**1.012**	**1.880**	**1.666**	**1.426**	**1.012**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0640004	71644NY0640003	71644NY0640002	71644NY0640001	71644NY0410004	71644NY0410003	71644NY0410002	71644NY0410001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
AV Pricing Value	**1.911**	**1.697**	**1.457**	**1.032**	**1.911**	**1.697**	**1.457**	**1.032**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0420004	71644NY0420003	71644NY0420002	71644NY0420001	71644NY0430004	71644NY0430003	71644NY0430002	71644NY0430001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
AV Pricing Value	**1.911**	**1.697**	**1.457**	**1.032**	**1.911**	**1.697**	**1.457**	**1.032**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0190004	71644NY0190003	71644NY0190002	71644NY0190001	71644NY0380004	71644NY0380003	71644NY0380002	71644NY0380001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.880**	**1.666**	**1.426**	**1.012**	**1.880**	**1.666**	**1.426**	**1.012**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0390004	71644NY0390003	71644NY0390002	71644NY0390001	71644NY0400004	71644NY0400003	71644NY0400002	71644NY0400001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV Pricing Value	**1.880**	**1.666**	**1.426**	**1.012**	**1.880**	**1.666**	**1.426**	**1.012**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0200004	71644NY0200003	71644NY0200002	71644NY0200001	71644NY0440004	71644NY0440003	71644NY0440002	71644NY0440001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
AV Pricing Value	**1.911**	**1.697**	**1.457**	**1.032**	**1.911**	**1.697**	**1.457**	**1.032**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF
Metal Level (or catastrophic)	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Plan ID	71644NY0450004	71644NY0450003	71644NY0450002	71644NY0450001	71644NY0460004	71644NY0460003	71644NY0460002	71644NY0460001
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.521	1.436	1.288	0.942	1.521	1.436	1.288	0.942
Pricing actuarial value induced utilization only	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
Impact of provider network characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
AV Pricing Value	**1.911**	**1.697**	**1.457**	**1.032**	**1.911**	**1.697**	**1.457**	**1.032**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	PrimarySelect EPO	PrimarySelect EPO Restricted-D	PrimarySelect EPO Restricted-F	PrimarySelect EPO Restricted-DF	Primary Select EPO Pediatric Dental	Primary Select EPO Pediatric Dental Restricted-D	Primary Select EPO Pediatric Dental Restricted-F	Primary Select EPO Pediatric Dental Restricted-DF
Metal Level (or catastrophic)	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
Plan ID	71644NY0080002	71644NY0470002	71644NY0480002	71644NY0490002	71644NY0650002	71644NY0500002	71644NY0510002	71644NY0520002
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.288	1.288	1.288	1.288	1.288	1.288	1.288	1.288
Pricing actuarial value induced utilization only	1.030	1.030	1.030	1.030	1.030	1.030	1.030	1.030
Impact of provider network characteristics	0.944	0.944	0.944	0.944	0.944	0.944	0.944	0.944
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.023	1.023	1.023	1.023
AV Pricing Value	**1.346**	**1.346**	**1.346**	**1.346**	**1.376**	**1.376**	**1.376**	**1.376**

Attachment C
Freelancers Health Service Corporation
AV Pricing Value Build Up - Small Group

Product	PrimarySelect EPO Age 29 Option	PrimarySelect EPO Age 29 Option Restricted-D	PrimarySelect EPO Age 29 Option Restricted-F	PrimarySelect EPO Age 29 Option Restricted-DF	Primary Select EPO Age 29 Option Pediatric Dental	Primary Select EPO Age 29 Option Pediatric Dental Restricted-D	Primary Select EPO Age 29 Option Pediatric Dental Restricted-F	Primary Select EPO Age 29 Option Pediatric Dental Restricted-DF
Metal Level (or catastrophic)	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
Plan ID	71644NY0210002	71644NY0530002	71644NY0540002	71644NY0550002	71644NY0220002	71644NY0560002	71644NY0570002	71644NY0660002
Pricing actuarial value relative to NY Standard Bronze plan (without induced utilization)	1.288	1.288	1.288	1.288	1.288	1.288	1.288	1.288
Pricing actuarial value induced utilization only	1.030	1.030	1.030	1.030	1.030	1.030	1.030	1.030
Impact of provider network characteristics	0.944	0.944	0.944	0.944	0.944	0.944	0.944	0.944
Impact of utilization management practices	0.921	0.921	0.921	0.921	0.921	0.921	0.921	0.921
Retention (including Profit)	1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Pediatric Dental	1.000	1.000	1.000	1.000	1.023	1.023	1.023	1.023
AV Pricing Value	**1.346**	**1.346**	**1.346**	**1.346**	**1.376**	**1.376**	**1.376**	**1.376**

Attachment A
Freelancers Health Service Corporation
Actuarial Value Calculator Outputs

Standard Platinum - 71644NY0050004

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 - 71644NY0050003

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		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 ($)	$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 - 71644NY0050002

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 Bronze - 71644NY0050001

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

Primary Select Platinum - 71644NY0070004

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 - 71644NY0070003

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 - 71644NY0070002

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 Bronze - 71644NY0070001

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 - 71644NY0080004

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 - 71644NY0080003

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 - 71644NY0080002

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 Bronze EPO - 71644NY0080001

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 Coinsurance	Tier 1 Coinsurance, if	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	☑	☑			☑	☑		
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: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare	EssentialCare	EssentialCare	EssentialCare	EssentialCare Restricted-D	EssentialCare Restricted-D	EssentialCare Restricted-D	EssentialCare Restricted-D
2	Product ID*	71644NY005	71644NY005	71644NY005	71644NY005	71644NY023	71644NY023	71644NY023	71644NY023
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan	EssentialCare Gold Plan	EssentialCare Silver Plan	EssentialCare Bronze Plan	EssentialCare Platinum Plan Restricted-D	EssentialCare Gold Plan Restricted-D	EssentialCare Silver Plan Restricted-D	EssentialCare Bronze Plan Restricted-D
8	Plan ID*	71644NY0050004	71644NY0050003	71644NY0050002	71644NY0050001	71644NY0230004	71644NY0230003	71644NY0230002	71644NY0230001
9	Exchange Plan?*	Yes	Yes	Yes	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	13055581.324							
10B	Member-Months for Latest Experience Period	33148.000							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	393.86							
11	Average Pricing Actuarial Value reflected in experience period	0.813							
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	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 **	0.779							
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	1.000							
19	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000							
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000							
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000							
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.050							
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)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare	EssentialCare	EssentialCare	EssentialCare	EssentialCare Restricted-D	EssentialCare Restricted-D	EssentialCare Restricted-D	EssentialCare Restricted-D
2	Product ID*	71644NY005	71644NY005	71644NY005	71644NY005	71644NY023	71644NY023	71644NY023	71644NY023
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan	EssentialCare Gold Plan	EssentialCare Silver Plan	EssentialCare Bronze Plan	EssentialCare Platinum Plan Restricted-D	EssentialCare Gold Plan Restricted-D	EssentialCare Silver Plan Restricted-D	EssentialCare Bronze Plan Restricted-D
8	Plan ID*	71644NY0050004	71644NY0050003	71644NY0050002	71644NY0050001	71644NY0230004	71644NY0230003	71644NY0230002	71644NY0230001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.285**	**1.093**	**0.935**	**0.765**	**1.285**	**1.093**	**0.935**	**0.765**

\# 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)**	**509.27**	**433.12**	**370.68**	**303.22**	**509.27**	**433.12**	**370.68**	**303.22**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-DF	EssentialCare Restricted-DF	EssentialCare Restricted-DF	EssentialCare Restricted-DF
2	Product ID*	71644NY024	71644NY024	71644NY024	71644NY024	71644NY025	71644NY025	71644NY025	71644NY025
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan Restricted-F	EssentialCare Gold Plan Restricted-F	EssentialCare Silver Plan Restricted-F	EssentialCare Bronze Plan Restricted-F	EssentialCare Platinum Plan Restricted-DF	EssentialCare Gold Plan Restricted-DF	EssentialCare Silver Plan Restricted-DF	EssentialCare Bronze Plan Restricted-DF
8	Plan ID*	71644NY0240004	71644NY0240003	71644NY0240002	71644NY0240001	71644NY0250004	71644NY0250003	71644NY0250002	71644NY0250001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-F	EssentialCare Restricted-DF	EssentialCare Restricted-DF	EssentialCare Restricted-DF	EssentialCare Restricted-DF
2	Product ID*	71644NY024	71644NY024	71644NY024	71644NY024	71644NY025	71644NY025	71644NY025	71644NY025
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan Restricted-F	EssentialCare Gold Plan Restricted-F	EssentialCare Silver Plan Restricted-F	EssentialCare Bronze Plan Restricted-F	EssentialCare Platinum Plan Restricted-DF	EssentialCare Gold Plan Restricted-DF	EssentialCare Silver Plan Restricted-DF	EssentialCare Bronze Plan Restricted-DF
8	Plan ID*	71644NY0240004	71644NY0240003	71644NY0240002	71644NY0240001	71644NY0250004	71644NY0250003	71644NY0250002	71644NY0250001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.285**	**1.093**	**0.935**	**0.765**	**1.285**	**1.093**	**0.935**	**0.765**

\# 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)**	**509.27**	**433.12**	**370.68**	**303.22**	**509.27**	**433.12**	**370.68**	**303.22**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D
2	Product ID*	71644NY062	71644NY062	71644NY062	71644NY062	71644NY029	71644NY029	71644NY029	71644NY029
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	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 Platinum Plan Restricted-D	Essential Care Gold Plan Restricted-D	Essential Care Silver Plan Restricted-D	Essential Care Bronze Plan Restricted-D
8	Plan ID*	71644NY0620004	71644NY0620003	71644NY0620002	71644NY0620001	71644NY0290004	71644NY0290003	71644NY0290002	71644NY0290001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D	Essential Care Pediatric Dental Restricted-D
2	Product ID*	71644NY062	71644NY062	71644NY062	71644NY062	71644NY029	71644NY029	71644NY029	71644NY029
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	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 Platinum Plan Restricted-D	Essential Care Gold Plan Restricted-D	Essential Care Silver Plan Restricted-D	Essential Care Bronze Plan Restricted-D
8	Plan ID*	71644NY0620004	71644NY0620003	71644NY0620002	71644NY0620001	71644NY0290004	71644NY0290003	71644NY0290002	71644NY0290001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.306**	**1.113**	**0.955**	**0.778**	**1.306**	**1.113**	**0.955**	**0.778**

\# 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)**	**517.43**	**441.08**	**378.54**	**308.34**	**517.43**	**441.08**	**378.54**	**308.34**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF
2	Product ID*	71644NY030	71644NY030	71644NY030	71644NY030	71644NY031	71644NY031	71644NY031	71644NY031
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan Restricted-F	Essential Care Gold Plan Restricted-F	Essential Care Silver Plan Restricted-F	Essential Care Bronze Plan Restricted-F	Essential Care Platinum Plan Restricted-DF	Essential Care Gold Plan Restricted-DF	Essential Care Silver Plan Restricted-DF	Essential Care Bronze Plan Restricted-DF
8	Plan ID*	71644NY0300004	71644NY0300003	71644NY0300002	71644NY0300001	71644NY0310004	71644NY0310003	71644NY0310002	71644NY0310001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-F	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF	Essential Care Pediatric Dental Restricted-DF
2	Product ID*	71644NY030	71644NY030	71644NY030	71644NY030	71644NY031	71644NY031	71644NY031	71644NY031
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan Restricted-F	Essential Care Gold Plan Restricted-F	Essential Care Silver Plan Restricted-F	Essential Care Bronze Plan Restricted-F	Essential Care Platinum Plan Restricted-DF	Essential Care Gold Plan Restricted-DF	Essential Care Silver Plan Restricted-DF	Essential Care Bronze Plan Restricted-DF
8	Plan ID*	71644NY0300004	71644NY0300003	71644NY0300002	71644NY0300001	71644NY0310004	71644NY0310003	71644NY0310002	71644NY0310001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.306**	**1.113**	**0.955**	**0.778**	**1.306**	**1.113**	**0.955**	**0.778**

\# 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)**	**517.43**	**441.08**	**378.54**	**308.34**	**517.43**	**441.08**	**378.54**	**308.34**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D
2	Product ID*	71644NY017	71644NY017	71644NY017	71644NY017	71644NY026	71644NY026	71644NY026	71644NY026
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan 29	EssentialCare Gold Plan 29	EssentialCare Silver Plan 29	EssentialCare Bronze Plan 29	EssentialCare Platinum Plan 29 Restricted-D	EssentialCare Gold Plan 29 Restricted-D	EssentialCare Silver Plan 29 Restricted-D	EssentialCare Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0170004	71644NY0170003	71644NY0170002	71644NY0170001	71644NY0260004	71644NY0260003	71644NY0260002	71644NY0260001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D	EssentialCare Age 29 Option Restricted-D
2	Product ID*	71644NY017	71644NY017	71644NY017	71644NY017	71644NY026	71644NY026	71644NY026	71644NY026
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan 29	EssentialCare Gold Plan 29	EssentialCare Silver Plan 29	EssentialCare Bronze Plan 29	EssentialCare Platinum Plan 29 Restricted-D	EssentialCare Gold Plan 29 Restricted-D	EssentialCare Silver Plan 29 Restricted-D	EssentialCare Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0170004	71644NY0170003	71644NY0170002	71644NY0170001	71644NY0260004	71644NY0260003	71644NY0260002	71644NY0260001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.285**	**1.093**	**0.935**	**0.765**	**1.285**	**1.093**	**0.935**	**0.765**

\# 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)**	**509.27**	**433.12**	**370.68**	**303.22**	**509.27**	**433.12**	**370.68**	**303.22**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF
2	Product ID*	71644NY027	71644NY027	71644NY027	71644NY027	71644NY028	71644NY028	71644NY028	71644NY028
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan 29 Restricted-F	EssentialCare Gold Plan 29 Restricted-F	EssentialCare Silver Plan 29 Restricted-F	EssentialCare Bronze Plan 29 Restricted-F	EssentialCare Platinum Plan 29 Restricted-DF	EssentialCare Gold Plan 29 Restricted-DF	EssentialCare Silver Plan 29 Restricted-DF	EssentialCare Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0270004	71644NY0270003	71644NY0270002	71644NY0270001	71644NY0280004	71644NY0280003	71644NY0280002	71644NY0280001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-F	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF	EssentialCare Age 29 Option Restricted-DF
2	Product ID*	71644NY027	71644NY027	71644NY027	71644NY027	71644NY028	71644NY028	71644NY028	71644NY028
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.961	1.668	1.427	1.168	1.961	1.668	1.427	1.168
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	EssentialCare Platinum Plan 29 Restricted-F	EssentialCare Gold Plan 29 Restricted-F	EssentialCare Silver Plan 29 Restricted-F	EssentialCare Bronze Plan 29 Restricted-F	EssentialCare Platinum Plan 29 Restricted-DF	EssentialCare Gold Plan 29 Restricted-DF	EssentialCare Silver Plan 29 Restricted-DF	EssentialCare Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0270004	71644NY0270003	71644NY0270002	71644NY0270001	71644NY0280004	71644NY0280003	71644NY0280002	71644NY0280001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.285**	**1.093**	**0.935**	**0.765**	**1.285**	**1.093**	**0.935**	**0.765**

\# 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)**	**509.27**	**433.12**	**370.68**	**303.22**	**509.27**	**433.12**	**370.68**	**303.22**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D
2	Product ID*	71644NY018	71644NY018	71644NY018	71644NY018	71644NY032	71644NY032	71644NY032	71644NY032
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan 29	Essential Care Gold Plan 29	Essential Care Silver Plan 29	Essential Care Bronze Plan 29	Essential Care Platinum Plan 29 Restricted-D	Essential Care Gold Plan 29 Restricted-D	Essential Care Silver Plan 29 Restricted-D	Essential Care Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0180004	71644NY0180003	71644NY0180002	71644NY0180001	71644NY0320004	71644NY0320003	71644NY0320002	71644NY0320001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D	Essential Care Age 29 Option Pediatric Dental Restricted-D
2	Product ID*	71644NY018	71644NY018	71644NY018	71644NY018	71644NY032	71644NY032	71644NY032	71644NY032
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan 29	Essential Care Gold Plan 29	Essential Care Silver Plan 29	Essential Care Bronze Plan 29	Essential Care Platinum Plan 29 Restricted-D	Essential Care Gold Plan 29 Restricted-D	Essential Care Silver Plan 29 Restricted-D	Essential Care Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0180004	71644NY0180003	71644NY0180002	71644NY0180001	71644NY0320004	71644NY0320003	71644NY0320002	71644NY0320001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.306**	**1.113**	**0.955**	**0.778**	**1.306**	**1.113**	**0.955**	**0.778**

\# 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)**	**517.43**	**441.08**	**378.54**	**308.34**	**517.43**	**441.08**	**378.54**	**308.34**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF
2	Product ID*	71644NY033	71644NY033	71644NY033	71644NY033	71644NY034	71644NY034	71644NY034	71644NY034
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan 29 Restricted-F	Essential Care Gold Plan 29 Restricted-F	Essential Care Silver Plan 29 Restricted-F	Essential Care Bronze Plan 29 Restricted-F	Essential Care Platinum Plan 29 Restricted-DF	Essential Care Gold Plan 29 Restricted-DF	Essential Care Silver Plan 29 Restricted-DF	Essential Care Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0330004	71644NY0330003	71644NY0330002	71644NY0330001	71644NY0340004	71644NY0340003	71644NY0340002	71644NY0340001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-F	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF	Essential Care Age 29 Option Pediatric Dental Restricted-DF
2	Product ID*	71644NY033	71644NY033	71644NY033	71644NY033	71644NY034	71644NY034	71644NY034	71644NY034
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.79	0.71	0.62	0.88	0.79	0.71	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.992	1.698	1.458	1.187	1.992	1.698	1.458	1.187
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan 29 Restricted-F	Essential Care Gold Plan 29 Restricted-F	Essential Care Silver Plan 29 Restricted-F	Essential Care Bronze Plan 29 Restricted-F	Essential Care Platinum Plan 29 Restricted-DF	Essential Care Gold Plan 29 Restricted-DF	Essential Care Silver Plan 29 Restricted-DF	Essential Care Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0330004	71644NY0330003	71644NY0330002	71644NY0330001	71644NY0340004	71644NY0340003	71644NY0340002	71644NY0340001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** 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	0.924	0.837	0.751	0.633
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.016	1.018	1.021	1.017	1.016	1.018	1.021	1.017
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.306**	**1.113**	**0.955**	**0.778**	**1.306**	**1.113**	**0.955**	**0.778**

\# 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)**	**517.43**	**441.08**	**378.54**	**308.34**	**517.43**	**441.08**	**378.54**	**308.34**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	PrimarySelect	PrimarySelect	PrimarySelect	PrimarySelect	PrimarySelect Restricted-D	PrimarySelect Restricted-D	PrimarySelect Restricted-D	PrimarySelect Restricted-D
2	Product ID*	71644NY007	71644NY007	71644NY007	71644NY007	71644NY035	71644NY035	71644NY035	71644NY035
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan	PrimarySelect Gold Plan	PrimarySelect Silver Plan	PrimarySelect Bronze Plan	PrimarySelect Platinum Plan Restricted-D	PrimarySelect Gold Plan Restricted-D	PrimarySelect Silver Plan Restricted-D	PrimarySelect Bronze Plan Restricted-D
8	Plan ID*	71644NY0070004	71644NY0070003	71644NY0070002	71644NY0070001	71644NY0350004	71644NY0350003	71644NY0350002	71644NY0350001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	PrimarySelect	PrimarySelect	PrimarySelect	PrimarySelect	PrimarySelect Restricted-D	PrimarySelect Restricted-D	PrimarySelect Restricted-D	PrimarySelect Restricted-D
2	Product ID*	71644NY007	71644NY007	71644NY007	71644NY007	71644NY035	71644NY035	71644NY035	71644NY035
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan	PrimarySelect Gold Plan	PrimarySelect Silver Plan	PrimarySelect Bronze Plan	PrimarySelect Platinum Plan Restricted-D	PrimarySelect Gold Plan Restricted-D	PrimarySelect Silver Plan Restricted-D	PrimarySelect Bronze Plan Restricted-D
8	Plan ID*	71644NY0070004	71644NY0070003	71644NY0070002	71644NY0070001	71644NY0350004	71644NY0350003	71644NY0350002	71644NY0350001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.232**	**1.092**	**0.935**	**0.663**	**1.232**	**1.092**	**0.935**	**0.663**

\# 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)**	**488.22**	**432.78**	**370.41**	**262.85**	**488.22**	**432.78**	**370.41**	**262.85**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF
2	Product ID*	71644NY036	71644NY036	71644NY036	71644NY036	71644NY037	71644NY037	71644NY037	71644NY037
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan Restricted-F	PrimarySelect Gold Plan Restricted-F	PrimarySelect Silver Plan Restricted-F	PrimarySelect Bronze Plan Restricted-F	PrimarySelect Platinum Plan Restricted-DF	PrimarySelect Gold Plan Restricted-DF	PrimarySelect Silver Plan Restricted-DF	PrimarySelect Bronze Plan Restricted-DF
8	Plan ID*	71644NY0360004	71644NY0360003	71644NY0360002	71644NY0360001	71644NY0370004	71644NY0370003	71644NY0370002	71644NY0370001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-F	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF	PrimarySelect Restricted-DF
2	Product ID*	71644NY036	71644NY036	71644NY036	71644NY036	71644NY037	71644NY037	71644NY037	71644NY037
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan Restricted-F	PrimarySelect Gold Plan Restricted-F	PrimarySelect Silver Plan Restricted-F	PrimarySelect Bronze Plan Restricted-F	PrimarySelect Platinum Plan Restricted-DF	PrimarySelect Gold Plan Restricted-DF	PrimarySelect Silver Plan Restricted-DF	PrimarySelect Bronze Plan Restricted-DF
8	Plan ID*	71644NY0360004	71644NY0360003	71644NY0360002	71644NY0360001	71644NY0370004	71644NY0370003	71644NY0370002	71644NY0370001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.232**	**1.092**	**0.935**	**0.663**	**1.232**	**1.092**	**0.935**	**0.663**

\# 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)**	**488.22**	**432.78**	**370.41**	**262.85**	**488.22**	**432.78**	**370.41**	**262.85**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D
2	Product ID*	71644NY064	71644NY064	71644NY064	71644NY064	71644NY041	71644NY041	71644NY041	71644NY041
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan	Primary Select Gold Plan	Primary Select Silver Plan	Primary Select Bronze Plan	Primary Select Platinum Plan Restricted-D	Primary Select Gold Plan Restricted-D	Primary Select Silver Plan Restricted-D	Primary Select Bronze Plan Restricted-D
8	Plan ID*	71644NY0640004	71644NY0640003	71644NY0640002	71644NY0640001	71644NY0410004	71644NY0410003	71644NY0410002	71644NY0410001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D	Primary Select Pediatric Dental Restricted-D
2	Product ID*	71644NY064	71644NY064	71644NY064	71644NY064	71644NY041	71644NY041	71644NY041	71644NY041
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan	Primary Select Gold Plan	Primary Select Silver Plan	Primary Select Bronze Plan	Primary Select Platinum Plan Restricted-D	Primary Select Gold Plan Restricted-D	Primary Select Silver Plan Restricted-D	Primary Select Bronze Plan Restricted-D
8	Plan ID*	71644NY0640004	71644NY0640003	71644NY0640002	71644NY0640001	71644NY0410004	71644NY0410003	71644NY0410002	71644NY0410001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.253**	**1.112**	**0.955**	**0.676**	**1.253**	**1.112**	**0.955**	**0.676**

\# 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)**	**496.38**	**440.74**	**378.27**	**267.96**	**496.38**	**440.74**	**378.27**	**267.96**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF
2	Product ID*	71644NY042	71644NY042	71644NY042	71644NY042	71644NY043	71644NY043	71644NY043	71644NY043
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan Restricted-F	Primary Select Gold Plan Restricted-F	Primary Select Silver Plan Restricted-F	Primary Select Bronze Plan Restricted-F	Primary Select Platinum Plan Restricted-DF	Primary Select Gold Plan Restricted-DF	Primary Select Silver Plan Restricted-DF	Primary Select Bronze Plan Restricted-DF
8	Plan ID*	71644NY0420004	71644NY0420003	71644NY0420002	71644NY0420001	71644NY0430004	71644NY0430003	71644NY0430002	71644NY0430001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-F	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF	Primary Select Pediatric Dental Restricted-DF
2	Product ID*	71644NY042	71644NY042	71644NY042	71644NY042	71644NY043	71644NY043	71644NY043	71644NY043
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan Restricted-F	Primary Select Gold Plan Restricted-F	Primary Select Silver Plan Restricted-F	Primary Select Bronze Plan Restricted-F	Primary Select Platinum Plan Restricted-DF	Primary Select Gold Plan Restricted-DF	Primary Select Silver Plan Restricted-DF	Primary Select Bronze Plan Restricted-DF
8	Plan ID*	71644NY0420004	71644NY0420003	71644NY0420002	71644NY0420001	71644NY0430004	71644NY0430003	71644NY0430002	71644NY0430001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.253**	**1.112**	**0.955**	**0.676**	**1.253**	**1.112**	**0.955**	**0.676**

\# 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)**	**496.38**	**440.74**	**378.27**	**267.96**	**496.38**	**440.74**	**378.27**	**267.96**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D
2	Product ID*	71644NY019	71644NY019	71644NY019	71644NY019	71644NY038	71644NY038	71644NY038	71644NY038
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan 29	PrimarySelect Gold Plan 29	PrimarySelect Silver Plan 29	PrimarySelect Bronze Plan 29	PrimarySelect Platinum Plan 29 Restricted-D	PrimarySelect Gold Plan 29 Restricted-D	PrimarySelect Silver Plan 29 Restricted-D	PrimarySelect Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0190004	71644NY0190003	71644NY0190002	71644NY0190001	71644NY0380004	71644NY0380003	71644NY0380002	71644NY0380001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D	PrimarySelect Age 29 Option Restricted-D
2	Product ID*	71644NY019	71644NY019	71644NY019	71644NY019	71644NY038	71644NY038	71644NY038	71644NY038
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan 29	PrimarySelect Gold Plan 29	PrimarySelect Silver Plan 29	PrimarySelect Bronze Plan 29	PrimarySelect Platinum Plan 29 Restricted-D	PrimarySelect Gold Plan 29 Restricted-D	PrimarySelect Silver Plan 29 Restricted-D	PrimarySelect Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0190004	71644NY0190003	71644NY0190002	71644NY0190001	71644NY0380004	71644NY0380003	71644NY0380002	71644NY0380001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.232**	**1.092**	**0.935**	**0.663**	**1.232**	**1.092**	**0.935**	**0.663**

\# 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)**	**488.22**	**432.78**	**370.41**	**262.85**	**488.22**	**432.78**	**370.41**	**262.85**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF
2	Product ID*	71644NY039	71644NY039	71644NY039	71644NY039	71644NY040	71644NY040	71644NY040	71644NY040
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan 29 Restricted-F	PrimarySelect Gold Plan 29 Restricted-F	PrimarySelect Silver Plan 29 Restricted-F	PrimarySelect Bronze Plan 29 Restricted-F	PrimarySelect Platinum Plan 29 Restricted-DF	PrimarySelect Gold Plan 29 Restricted-DF	PrimarySelect Silver Plan 29 Restricted-DF	PrimarySelect Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0390004	71644NY0390003	71644NY0390002	71644NY0390001	71644NY0400004	71644NY0400003	71644NY0400002	71644NY0400001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-F	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF	PrimarySelect Age 29 Option Restricted-DF
2	Product ID*	71644NY039	71644NY039	71644NY039	71644NY039	71644NY040	71644NY040	71644NY040	71644NY040
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.880	1.666	1.426	1.012	1.880	1.666	1.426	1.012
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	PrimarySelect Platinum Plan 29 Restricted-F	PrimarySelect Gold Plan 29 Restricted-F	PrimarySelect Silver Plan 29 Restricted-F	PrimarySelect Bronze Plan 29 Restricted-F	PrimarySelect Platinum Plan 29 Restricted-DF	PrimarySelect Gold Plan 29 Restricted-DF	PrimarySelect Silver Plan 29 Restricted-DF	PrimarySelect Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0390004	71644NY0390003	71644NY0390002	71644NY0390001	71644NY0400004	71644NY0400003	71644NY0400002	71644NY0400001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.232**	**1.092**	**0.935**	**0.663**	**1.232**	**1.092**	**0.935**	**0.663**

\# 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)**	**488.22**	**432.78**	**370.41**	**262.85**	**488.22**	**432.78**	**370.41**	**262.85**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D
2	Product ID*	71644NY020	71644NY020	71644NY020	71644NY020	71644NY044	71644NY044	71644NY044	71644NY044
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan 29	Primary Select Gold Plan 29	Primary Select Silver Plan 29	Primary Select Bronze Plan 29	Primary Select Platinum Plan 29 Restricted-D	Primary Select Gold Plan 29 Restricted-D	Primary Select Silver Plan 29 Restricted-D	Primary Select Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0200004	71644NY0200003	71644NY0200002	71644NY0200001	71644NY0440004	71644NY0440003	71644NY0440002	71644NY0440001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D	Primary Select Age 29 Option Pediatric Dental Restricted-D
2	Product ID*	71644NY020	71644NY020	71644NY020	71644NY020	71644NY044	71644NY044	71644NY044	71644NY044
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan 29	Primary Select Gold Plan 29	Primary Select Silver Plan 29	Primary Select Bronze Plan 29	Primary Select Platinum Plan 29 Restricted-D	Primary Select Gold Plan 29 Restricted-D	Primary Select Silver Plan 29 Restricted-D	Primary Select Bronze Plan 29 Restricted-D
8	Plan ID*	71644NY0200004	71644NY0200003	71644NY0200002	71644NY0200001	71644NY0440004	71644NY0440003	71644NY0440002	71644NY0440001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.936	0.884	0.793	0.580	0.936	0.884	0.793	0.580
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.030	1.000	1.150	1.080	1.030	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.253**	**1.112**	**0.955**	**0.676**	**1.253**	**1.112**	**0.955**	**0.676**

\# 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)**	**496.38**	**440.74**	**378.27**	**267.96**	**496.38**	**440.74**	**378.27**	**267.96**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group

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

Line #	General								
1	Product*	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF
2	Product ID*	71644NY045	71644NY045	71644NY045	71644NY045	71644NY046	71644NY046	71644NY046	71644NY046
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan 29 Restricted-F	Primary Select Gold Plan 29 Restricted-F	Primary Select Silver Plan 29 Restricted-F	Primary Select Bronze Plan 29 Restricted-F	Primary Select Platinum Plan 29 Restricted-DF	Primary Select Gold Plan 29 Restricted-DF	Primary Select Silver Plan 29 Restricted-DF	Primary Select Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0450004	71644NY0450003	71644NY0450002	71644NY0450001	71644NY0460004	71644NY0460003	71644NY0460002	71644NY0460001
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-F	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF	Primary Select Age 29 Option Pediatric Dental Restricted-DF
2	Product ID*	71644NY045	71644NY045	71644NY045	71644NY045	71644NY046	71644NY046	71644NY046	71644NY046
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.88	0.82	0.72	0.62	0.88	0.82	0.72	0.62
5	AV Pricing Value (total, risk pool experience based)*	1.911	1.697	1.457	1.032	1.911	1.697	1.457	1.032
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Primary Select Platinum Plan 29 Restricted-F	Primary Select Gold Plan 29 Restricted-F	Primary Select Silver Plan 29 Restricted-F	Primary Select Bronze Plan 29 Restricted-F	Primary Select Platinum Plan 29 Restricted-DF	Primary Select Gold Plan 29 Restricted-DF	Primary Select Silver Plan 29 Restricted-DF	Primary Select Bronze Plan 29 Restricted-DF
8	Plan ID*	71644NY0450004	71644NY0450003	71644NY0450002	71644NY0450001	71644NY0460004	71644NY0460003	71644NY0460002	71644NY0460001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
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30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
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32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.017	1.018	1.021	1.019	1.017	1.018	1.021	1.019
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.253**	**1.112**	**0.955**	**0.676**	**1.253**	**1.112**	**0.955**	**0.676**

\# 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)**	**496.38**	**440.74**	**378.27**	**267.96**	**496.38**	**440.74**	**378.27**	**267.96**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect EPO	PrimarySelect EPO Restricted-D	PrimarySelect EPO Restricted-F	PrimarySelect EPO Restricted-DF	Primary Select EPO Pediatric Dental	Primary Select EPO Pediatric Dental Restricted-D	Primary Select EPO Pediatric Dental Restricted-F	Primary Select EPO Pediatric Dental Restricted-DF
2	Product ID*	71644NY008	71644NY047	71644NY048	71644NY049	71644NY065	71644NY050	71644NY051	71644NY052
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.71	0.71	0.71	0.71	0.71	0.71	0.71	0.71
5	AV Pricing Value (total, risk pool experience based)*	1.346	1.346	1.346	1.346	1.376	1.376	1.376	1.376
6	Plan Type*	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
7	Plan Name*	PrimarySelect EPO Silver Plan	PrimarySelect EPO Silver Plan Restricted-D	PrimarySelect EPO Silver Plan Restricted-F	PrimarySelect EPO Silver Plan Restricted-DF	Primary Select EPO Silver Plan	Primary Select EPO Silver Plan Restricted-D	Primary Select EPO Silver Plan Restricted-F	Primary Select EPO Silver Plan Restricted-DF
8	Plan ID*	71644NY0080002	71644NY0470002	71644NY0480002	71644NY0490002	71644NY0650002	71644NY0500002	71644NY0510002	71644NY0520002
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect EPO	PrimarySelect EPO Restricted-D	PrimarySelect EPO Restricted-F	PrimarySelect EPO Restricted-DF	Primary Select EPO Pediatric Dental	Primary Select EPO Pediatric Dental Restricted-D	Primary Select EPO Pediatric Dental Restricted-F	Primary Select EPO Pediatric Dental Restricted-DF
2	Product ID*	71644NY008	71644NY047	71644NY048	71644NY049	71644NY065	71644NY050	71644NY051	71644NY052
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.71	0.71	0.71	0.71	0.71	0.71	0.71	0.71
5	AV Pricing Value (total, risk pool experience based)*	1.346	1.346	1.346	1.346	1.376	1.376	1.376	1.376
6	Plan Type*	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
7	Plan Name*	PrimarySelect EPO Silver Plan	PrimarySelect EPO Silver Plan Restricted-D	PrimarySelect EPO Silver Plan Restricted-F	PrimarySelect EPO Silver Plan Restricted-DF	Primary Select EPO Silver Plan	Primary Select EPO Silver Plan Restricted-D	Primary Select EPO Silver Plan Restricted-F	Primary Select EPO Silver Plan Restricted-DF
8	Plan ID*	71644NY0080002	71644NY0470002	71644NY0480002	71644NY0490002	71644NY0650002	71644NY0500002	71644NY0510002	71644NY0520002
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.793	0.793	0.793	0.793	0.793	0.793	0.793	0.793
29	Pricing actuarial value (only the induced demand factor) #	1.030	1.030	1.030	1.030	1.030	1.030	1.030	1.030
30	Impact of provider network characteristics ##	0.944	0.944	0.944	0.944	0.944	0.944	0.944	0.944
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.023	1.023	1.023	1.023
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**0.882**	**0.882**	**0.882**	**0.882**	**0.902**	**0.902**	**0.902**	**0.902**

\# 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)**	**349.49**	**349.49**	**349.49**	**349.49**	**357.36**	**357.36**	**357.36**	**357.36**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect EPO Age 29 Option	PrimarySelect EPO Age 29 Option Restricted-D	PrimarySelect EPO Age 29 Option Restricted-F	PrimarySelect EPO Age 29 Option Restricted-DF	Primary Select EPO Age 29 Option Pediatric Dental	Primary Select EPO Age 29 Option Pediatric Dental Restricted-D	Primary Select EPO Age 29 Option Pediatric Dental Restricted-F	Primary Select EPO Age 29 Option Pediatric Dental Restricted-DF
2	Product ID*	71644NY021	71644NY053	71644NY054	71644NY055	71644NY022	71644NY056	71644NY057	71644NY066
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.71	0.71	0.71	0.71	0.71	0.71	0.71	0.71
5	AV Pricing Value (total, risk pool experience based)*	1.346	1.346	1.346	1.346	1.376	1.376	1.376	1.376
6	Plan Type*	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
7	Plan Name*	PrimarySelect EPO Silver Plan 29	PrimarySelect EPO Silver Plan 29 Restricted-D	PrimarySelect EPO Silver Plan 29 Restricted-F	PrimarySelect EPO Silver Plan 29 Restricted-DF	Primary Select EPO Silver Plan 29	Primary Select EPO Silver Plan 29 Restricted-D	Primary Select EPO Silver Plan 29 Restricted-F	Primary Select EPO Silver Plan 29 Restricted-DF
8	Plan ID*	71644NY0210002	71644NY0530002	71644NY0540002	71644NY0550002	71644NY0220002	71644NY0560002	71644NY0570002	71644NY0660002
9	Exchange Plan?*	Yes	Yes	Yes	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								
10B	Member-Months for Latest Experience Period								
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)								
11	Average Pricing Actuarial Value reflected in experience period								
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**	**484.40**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate								
13	Impact of adjusting experience period data to EHB benefit level								
14	Market wide adjustment for changes in provider network **								
15	Market wide adjustment for fee schedule changes **								
16	Market wide adjustment for utilization management changes **								
17	Impact on risk pool of changes in expected covered membership risk characteristics **								
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**								
19	Adjustment for changes in distribution of risk pool membership by rating regions **								
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,								
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)								
22	Impact of adjustments due to experience period claim data not being sufficiently credible								
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)								
24	Other 1 (specify)								
25	Other 2 (specify)								
26	Other 3 (specify)								
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**	**0.818**

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Small Group
Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	PrimarySelect EPO Age 29 Option	PrimarySelect EPO Age 29 Option Restricted-D	PrimarySelect EPO Age 29 Option Restricted-F	PrimarySelect EPO Age 29 Option Restricted-DF	Primary Select EPO Age 29 Option Pediatric Dental	Primary Select EPO Age 29 Option Pediatric Dental Restricted-D	Primary Select EPO Age 29 Option Pediatric Dental Restricted-F	Primary Select EPO Age 29 Option Pediatric Dental Restricted-DF
2	Product ID*	71644NY021	71644NY053	71644NY054	71644NY055	71644NY022	71644NY056	71644NY057	71644NY066
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.71	0.71	0.71	0.71	0.71	0.71	0.71	0.71
5	AV Pricing Value (total, risk pool experience based)*	1.346	1.346	1.346	1.346	1.376	1.376	1.376	1.376
6	Plan Type*	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
7	Plan Name*	PrimarySelect EPO Silver Plan 29	PrimarySelect EPO Silver Plan 29 Restricted-D	PrimarySelect EPO Silver Plan 29 Restricted-F	PrimarySelect EPO Silver Plan 29 Restricted-DF	Primary Select EPO Silver Plan 29	Primary Select EPO Silver Plan 29 Restricted-D	Primary Select EPO Silver Plan 29 Restricted-F	Primary Select EPO Silver Plan 29 Restricted-DF
8	Plan ID*	71644NY0210002	71644NY0530002	71644NY0540002	71644NY0550002	71644NY0220002	71644NY0560002	71644NY0570002	71644NY0660002
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
28	Pricing actuarial value (without induced demand factor) #	0.793	0.793	0.793	0.793	0.793	0.793	0.793	0.793
29	Pricing actuarial value (only the induced demand factor) #	1.030	1.030	1.030	1.030	1.030	1.030	1.030	1.030
30	Impact of provider network characteristics ##	0.944	0.944	0.944	0.944	0.944	0.944	0.944	0.944
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.242	1.242	1.242	1.242	1.242	1.242	1.242	1.242
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	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	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Pediatric Dental benefit	1.000	1.000	1.000	1.000	1.023	1.023	1.023	1.023
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**0.882**	**0.882**	**0.882**	**0.882**	**0.902**	**0.902**	**0.902**	**0.902**

\# 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)**	**349.49**	**349.49**	**349.49**	**349.49**	**357.36**	**357.36**	**357.36**	**357.36**

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: SG

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

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.

D. This form must be submitted as an Excel file and as a PDF file.

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
Platinum	On Exchange - Std	EssentialCare Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	EssentialCare Gold Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	EssentialCare Silver Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%

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: SG

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

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.

D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Platinum	On Exchange - Std	EssentialCare Platinum Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	Essential Care Bronze Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	Essential Care Bronze Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	Essential Care Bronze Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	Essential Care Bronze Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	EssentialCare Gold Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	EssentialCare Silver Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70

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: SG

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

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.

D. This form must be submitted as an Excel file and as a PDF file.

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
Bronze	On Exchange - Std	Essential Care Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Std	Essential Care Platinum Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Std	Essential Care Gold Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Std	Essential Care Silver Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Std	Essential Care Bronze Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
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Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
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Gold	On Exchange - Non-Std	Primary Select Gold Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select Silver Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select Gold Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select Silver Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select Gold Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%

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: SG

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

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.

D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Bronze	On Exchange - Std	Essential Care Bronze Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	Essential Care Bronze Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Std	Essential Care Platinum Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Std	Essential Care Gold Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
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Gold	On Exchange - Std	Essential Care Gold Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Std	Essential Care Silver Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Std	Essential Care Bronze Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
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Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
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NAIC Code: 999999
SERFF Number:
Market Segment: SG

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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
Silver	On Exchange - Non-Std	Primary Select Silver Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect EPO Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect EPO Silver Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect EPO Silver Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select EPO Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select EPO Silver Plan Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select EPO Silver Plan Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Platinum	On Exchange - Non-Std	Primary Select EPO Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Gold	On Exchange - Non-Std	Primary Select EPO Silver Plan 29 Restricted-D	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan 29 Restricted-F	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%
Bronze	On Exchange - Non-Std	Primary Select EPO Silver Plan 29 Restricted-DF	01/01/14	12/31/14	5.00%	3.83%	0.71%	0.00%	1.75%	1.39%	11.78%	19.45%	-2.70%	0.00%	0.00%	0.00%

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: SG

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

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.

D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Silver	On Exchange - Non-Std	Primary Select Silver Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect EPO Silver Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect EPO Silver Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect EPO Silver Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	Primary Select EPO Silver Plan	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	Primary Select EPO Silver Plan Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select EPO Silver Plan Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Platinum	On Exchange - Non-Std	Primary Select EPO Silver Plan 29	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Gold	On Exchange - Non-Std	Primary Select EPO Silver Plan 29 Restricted-D	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan 29 Restricted-F	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70
Bronze	On Exchange - Non-Std	Primary Select EPO Silver Plan 29 Restricted-DF	0.00%	0.00%	16.75%	15.48	2.86	0.00	7.07	5.61	47.59	78.61	-10.91	0.00	0.00	0.00	67.70