Filing at a Glance

Company:	HIP Insurance Company of New York
Product Name:	NYS Off-Exchange Group EPO
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:	05/30/2013
SERFF Tr Num:	HPHP-129041150
SERFF Status:	Assigned
State Tr Num:	2013050240
State Status:	IA Awaiting Initial Action
Co Tr Num:	2013 0530 HIPIC SMALL GROUP OFF EXCHANGE 2014
Implementation Date Requested:	On Approval
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *HIP Insurance Company of New York*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NYS Off-Exchange Group EPO*
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
Filing Status Changed: 05/31/2013
State Status Changed: 06/03/2013
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: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

This filing contains the New York State Small Group EPO Certificate of Coverage, Policy, Schedule of Benefits and riders for use in the Off-Exchange marketplace, effective January 1, 2014. The forms are new and do not replace any forms currently on file with the Department. The forms provide in-network EPO benefits and were developed utilizing NYS model language text and directives.

Company and Contact

Filing Contact Information

[redacted]

Filing Company Information

HIP Insurance Company of New York
[redacted]

CoCode: 60094
Group Code: -99
Group Name:
FEIN Number: 13-3802010

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: *New York* **Filing Company:** *HIP Insurance Company of New York*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NYS Off-Exchange Group EPO*
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

State: *New York* **Filing Company:** *HIP Insurance Company of New York*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NYS Off-Exchange Group EPO*
Project Name/Number: */*

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
HIP Insurance Company of New York	New Product	%	%		3,800		%	%

Rate Review Detail

COMPANY:

Company Name: HIP Insurance Company of New York
HHS Issuer Id: 20984
Product Names: EmblemHealth Prime EPO 35/55
Trend Factors:

FORMS:

New Policy Forms: 151-23-SGOFFHIXCERT (04/13), 151-23-SGOFFHIXPOL (04/13), 151-23-SGOFFHIXSSchedule (04/13), 151-23-HIXD29 (04/13), 151-23-HIXDP (04/13), 151-23-HIXCONTRA (04/13)
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Other
Member Months: 105,665
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: 52,701,545.00
Projected Incurred Claims: 46,507,166.00
Annual $: Min: 491.03 Max: 503.30 Avg: 498.76

State: *New York* **Filing Company:** *HIP Insurance Company of New York*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NYS Off-Exchange Group EPO*
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		HIPIC SG Off Exchange Rate Manual 2014		New		Rate Manual- HIPIC Off Exchange - SG- CY 2014.pdf,

HIP Insurance Company (HIPIC)
New York City
Rates Effective 1/1/2014

						Current Rates				Proposed Rates				$ Change				% Change			
Metal Level	**Standard Plan or Age 29**	**Product Name**	**On Exchange**	**Metal AV Value**	**Tier**	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4	2014Q1 / 2013Q1	2014Q2 / 2013Q2	2014Q3 / 2013Q3	2014Q4 / 2013Q4	2014Q1 / 2013Q1	2014Q2 / 2013Q2	2014Q3 / 2013Q3	2014Q4 / 2013Q4
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Ind	$0.00	$0.00	$0.00	$0.00	$577.16	$595.63	$614.69	$634.36	$577.16	$595.63	$614.69	$634.36	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Ind + Sp	$0.00	$0.00	$0.00	$0.00	$1,154.32	$1,191.26	$1,229.38	$1,268.72	$1,154.32	$1,191.26	$1,229.38	$1,268.72	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Parent + Chld(rn)	$0.00	$0.00	$0.00	$0.00	$981.17	$1,012.57	$1,044.97	$1,078.41	$981.17	$1,012.57	$1,044.97	$1,078.41	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Family	$0.00	$0.00	$0.00	$0.00	$1,644.91	$1,697.55	$1,751.87	$1,807.93	$1,644.91	$1,697.55	$1,751.87	$1,807.93	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Ind	$0.00	$0.00	$0.00	$0.00	$594.47	$613.50	$633.13	$653.39	$594.47	$613.50	$633.13	$653.39	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Ind + Sp	$0.00	$0.00	$0.00	$0.00	$1,188.94	$1,226.99	$1,266.25	$1,306.77	$1,188.94	$1,226.99	$1,266.25	$1,306.77	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Parent + Chld(rn)	$0.00	$0.00	$0.00	$0.00	$1,010.60	$1,042.94	$1,076.31	$1,110.75	$1,010.60	$1,042.94	$1,076.31	$1,110.75	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Family	$0.00	$0.00	$0.00	$0.00	$1,694.24	$1,748.46	$1,804.41	$1,862.15	$1,694.24	$1,748.46	$1,804.41	$1,862.15	N/A	N/A	N/A	N/A

HIP Insurance Company (HIPIC)
Long Island
Rates Effective 1/1/2014

						Current Rates				Proposed Rates				$ Change				% Change			
Metal Level	**Standard Plan or Age 29**	**Product Name**	**On Exchange**	**Metal AV Value**	**Tier**	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4	2014Q1 / 2013Q1	2014Q2 / 2013Q2	2014Q3 / 2013Q3	2014Q4 / 2013Q4	2014Q1 / 2013Q1	2014Q2 / 2013Q2	2014Q3 / 2013Q3	2014Q4 / 2013Q4
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Ind	$0.00	$0.00	$0.00	$0.00	$591.58	$610.51	$630.05	$650.21	$591.58	$610.51	$630.05	$650.21	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Ind + Sp	$0.00	$0.00	$0.00	$0.00	$1,183.16	$1,221.02	$1,260.09	$1,300.41	$1,183.16	$1,221.02	$1,260.09	$1,300.41	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Parent + Chld(rn)	$0.00	$0.00	$0.00	$0.00	$1,005.69	$1,037.87	$1,071.08	$1,105.35	$1,005.69	$1,037.87	$1,071.08	$1,105.35	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Family	$0.00	$0.00	$0.00	$0.00	$1,686.00	$1,739.95	$1,795.63	$1,853.09	$1,686.00	$1,739.95	$1,795.63	$1,853.09	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Ind	$0.00	$0.00	$0.00	$0.00	$609.33	$628.83	$648.95	$669.72	$609.33	$628.83	$648.95	$669.72	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Ind + Sp	$0.00	$0.00	$0.00	$0.00	$1,218.66	$1,257.66	$1,297.91	$1,339.44	$1,218.66	$1,257.66	$1,297.91	$1,339.44	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Parent + Chld(rn)	$0.00	$0.00	$0.00	$0.00	$1,035.86	$1,069.01	$1,103.22	$1,138.52	$1,035.86	$1,069.01	$1,103.22	$1,138.52	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Family	$0.00	$0.00	$0.00	$0.00	$1,736.59	$1,792.16	$1,849.51	$1,908.69	$1,736.59	$1,792.16	$1,849.51	$1,908.69	N/A	N/A	N/A	N/A

HIP Insurance Company (HIPIC)
Mid-Hudson
Rates Effective 1/1/2014

						Current Rates				Proposed Rates				$ Change				% Change			
Metal Level	**Standard Plan or Age 29**	**Product Name**	**On Exchange**	**Metal AV Value**	**Tier**	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4	2014Q1 / 2013Q1	2014Q2 / 2013Q2	2014Q3 / 2013Q3	2014Q4 / 2013Q4	2014Q1 / 2013Q1	2014Q2 / 2013Q2	2014Q3 / 2013Q3	2014Q4 / 2013Q4
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Ind	$0.00	$0.00	$0.00	$0.00	$577.16	$595.63	$614.69	$634.36	$577.16	$595.63	$614.69	$634.36	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Ind + Sp	$0.00	$0.00	$0.00	$0.00	$1,154.32	$1,191.26	$1,229.38	$1,268.72	$1,154.32	$1,191.26	$1,229.38	$1,268.72	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Parent + Chld(rn)	$0.00	$0.00	$0.00	$0.00	$981.17	$1,012.57	$1,044.97	$1,078.41	$981.17	$1,012.57	$1,044.97	$1,078.41	N/A	N/A	N/A	N/A
Silver	Standard	EmblemHealth Prime EPO 35/55	Off	0.719	Family	$0.00	$0.00	$0.00	$0.00	$1,644.91	$1,697.55	$1,751.87	$1,807.93	$1,644.91	$1,697.55	$1,751.87	$1,807.93	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Ind	$0.00	$0.00	$0.00	$0.00	$594.47	$613.50	$633.13	$653.39	$594.47	$613.50	$633.13	$653.39	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Ind + Sp	$0.00	$0.00	$0.00	$0.00	$1,188.94	$1,226.99	$1,266.25	$1,306.77	$1,188.94	$1,226.99	$1,266.25	$1,306.77	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Parent + Chld(rn)	$0.00	$0.00	$0.00	$0.00	$1,010.60	$1,042.94	$1,076.31	$1,110.75	$1,010.60	$1,042.94	$1,076.31	$1,110.75	N/A	N/A	N/A	N/A
Silver	Age 29	EmblemHealth Prime EPO 35/55	Off	0.719	Family	$0.00	$0.00	$0.00	$0.00	$1,694.24	$1,748.46	$1,804.41	$1,862.15	$1,694.24	$1,748.46	$1,804.41	$1,862.15	N/A	N/A	N/A	N/A

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Form Name and Number

Form Name	Form Number
EPO Certificate	151-23-SGOFFHIXCERT (04/13)
EPO Policy	151-23-SGOFFHIXPOL (04/13)
EPO Select 35/55 Schedule of Benefits	151-23-SGOFFHIXSSchedule (04/13)
Age 29 Rider	151-23-HIXD29 (04/13)
Domestic Partner Rider	151-23-HIXDP (04/13)
Contraceptives Drugs & Devices Rider	151-23-HIXCONTRA (04/13)

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Region and Area Factors

County	Region	Area Factor
Bronx	New York City	0.9845
Kings	New York City	0.9845
New York	New York City	0.9845
Queens	New York City	0.9845
Richmond	New York City	0.9845
Rockland	New York City	0.9845
Westchester	New York City	0.9845
Nassau	Long Island	1.0091
Suffolk	Long Island	1.0091
Orange	Mid-Hudson	0.9845

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Expected Loss Ratios

HIPIC Small Group on Off Exchange Expected Loss Ratio	**88.2%**

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Benefit Summary

TYPE OF SERVICE	EmblemHealth Prime EPO 35/55 - Silver (AV = 0.719)
DEDUCTIBLE (single)	$ 2000 (Med) , $100 (RX)
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$6,000
COST SHARING - MEDICAL SERVICES	
Inpatient Facility/SNF/Hospice	Ded & Coins
Outpatient Facility-Surgery, including freestanding surgicenters	Ded & Coins
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	Ded & Coins
PCP	$35
Specialist	$55
PT/OT/ST - rehabilitative & habilitative therapies	$55
ER	$200
Ambulance	$150
Urgent Care	$60
DME/Medical supplies	30% cost sharing
Hearing aids	30% cost sharing
Eyewear	30% cost sharing
INPATIENT HOSPITAL SERVICES	
Observation stay	Ded & Coins
Hospital services - non-maternity	Ded & Coins
Maternity care stay (covers mother and well newborn combined)	Ded & Coins
Mental health/Behavorial health care	Ded & Coins
Detoxification	Ded & Coins
Substance abuse disorder services	Ded & Coins
Skilled nursing facility	Ded & Coins
Hospice (inpatient)	Ded & Coins
	Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility
EMERGENCY MEDICAL SERVICES	
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay) directly from the emergency room
Physician charge - Emergency Room visit	$0 copay per visit

Facility charge - Freestanding urgent care center	Urgent Care copay per visit
Physician charge - Free standing urgent care center visit	$0 copay per visit
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Ded & Coins
Pre-admission/pre-operative testing	$0 copay
Diagnostic and routine laboratory and pathology	Specialist copay per visit
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit
Imaging: CAT/PET scans, MRI	Specialist copay
Chemotherapy	PCP copay per visit
Radiation therapy	PCP copay per visit
Hemodialysis/Renal dialysis	PCP copay per visit
Mental health/Behavorial health care	PCP copay per visit
Substance abuse disorder services	PCP copay per visit
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit
Home care	PCP copay per visit
Hospice	PCP copay per visit

PREVENTIVE & PRIMARY CARE SERVICES

Allergy testing	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies.
Bone density testing	Otherwise the cost sharing indicated below applies to all services in this benefit service category.
Cervical cytology	
Colonoscopy screening	
Gynecological exams	PCP/Specialist copay per visit (based on type of physician performing the service)
Immunizations	
Mammography	
Prenatal maternity care	
Prostate cancer screening	
Routine exams	
Women's preventive health services	

PHYSICIAN/PROFESSIONAL SERVICES

Inpatient hospital surgery - surgeon	Ded & Coins
Outpatient hospital and freestanding surgicenter - surgeon	Ded & Coins
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit
Additional surgical opinion	Specialist copay per visit

Second medical opinion for cancer	Specialist copay per visit
Maternity delivery and post natal care - physician or midwife	Ded & Coins
In-hospital physician visits	$0 copay per visit
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit
Imaging: CAT/PET scans, MRI	Specialist copay per visit
Allergy shots	PCP/Specialist copay per visit
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)
Mental health/Behavorial health care	PCP copay per visit
Substance abuse disorder services	PCP copay per visit
Chemotherapy	PCP copay per visit
Radiation therapy	PCP copay per visit
Hemodialysis/Renal dialysis	PCP copay per visit
Chiropractic care	Specialist copay per visit

ADDITIONAL BENEFITS/SERVICES

ABA treatment for Autism Specturm Disorder	PCP copay per visit
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per device
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies
Hearing evaluations/testing	Specialist copay per visit
Hearing aids	Hearing aid coinsurance cost sharing applies
Diabetic drugs and supplies	PCP copay per 30 days supply
Diabetic education and self-management	PCP copay per visit
Home care	PCP copay per visit
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.

PEDIATRIC VISION SERVICES

Eye exam visit	PCP copay per visit
Prescribed lenses and frames	
Contact lenses	Eyewear coinsurance cost sharing applies

PRESCRIPTION DRUGS

Generic or Tier 1	$15
Formulary Brand or Tier 2	$35
Non-Formulary Brand or Tier 3	$75
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply	

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Underwriting Guidelines

Please refer to Underwriting Guidelines document submitted with this filing.

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Commission Schedule and Fees

Please refer to documents submitted in HPHP-128854670 on 01/17/2013.

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Effective January 1, 2014-December 31, 2014

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Underwriting Guidelines	10
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Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	Attached please find the Checklist for your review. Thanks.
Attachment(s):	Small Group Off-Exchange Checklist.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	Attached please find the Readability Certification for your review. Thanks.
Attachment(s):	SG Readability Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability
Comments:	Attached please find the Explanation of Variability for your review. Thanks.
Attachment(s):	SG Explanation of Variables.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	AV Calculations- Off Exchange - HIPIC SG CY 2014 .pdf
Item Status:	
Status Date:	

Bypassed - Item:	Small Group Rate Intructions/Checklist
Bypass Reason:	The checklist does not include any material to be inserted and a version does not need to be submitted with the rate filing.
Attachment(s):	
Item Status:	
Status Date:	

State: New York **Filing Company:** HIP Insurance Company of New York
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: NYS Off-Exchange Group EPO
Project Name/Number: /

Satisfied - Item:	Exhibit 7-Historical Data
Comments:	
Attachment(s):	Required Exhibit 7 - Off Exchange- HIPIC SG- 2014 PA .pdf Required Exhibit 7 - Off Exchange- HIPIC SG- 2014 PA .xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	
Attachment(s):	Required Exhibit 8 - Off Exchange- HIPIC SG- 2014 PA .pdf Required Exhibit 8 - Off Exchange- HIPIC SG- 2014 PA .xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	
Attachment(s):	Required Exhibit 9 - Off Exchange- HIPIC SG- 2014 PA .pdf Required Exhibit 9 - Off Exchange- HIPIC SG- 2014 PA .xls
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Documents for Web Posting-NG Off Exchange
Comments:	
Attachment(s):	Required Exhibit 1 - Off Exchange- HIPIC SG - 2014 PA - REDACTED.pdf Act Memo HIPIC SG Off Exchange 2014 2013 0530 REDACTED.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	HIPIC SG Off Exchange URRT.pdf HIPIC SG Off Exchange URRT.xlsm
Item Status:	

State: New York **Filing Company:** HIP Insurance Company of New York
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: NYS Off-Exchange Group EPO
Project Name/Number: /

Status Date:	

Satisfied - Item:	Filing Letter
Comments:	Attached please find the filing letter for your review. Thanks.
Attachment(s):	SG Filing Letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum Appendices
Comments:	
Attachment(s):	Act Memo Appendices - OffExchange- HIPIC SG CY 2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	EH Small Group Underwriting Guidelines
Comments:	
Attachment(s):	EH Small Group Underwriting Guidelines .pdf
Item Status:	
Status Date:	

Satisfied - Item:	Commissions Schedule
Comments:	
Attachment(s):	Broker Schedule HIPIC CR 0416 2013.pdf
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**

CODE:	LINE(S) OF INSURANCE	CODES
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 ☐	

		(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.	Complies
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.	See attached Readability Certification
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	See attached Letter of Submission

		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.	Complies
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	Complies

		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.	We provide the statement of ERISA only
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.	N/A
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	N/A
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).	N/A
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference

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

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.	Complies
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Complies
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	A table of contents is required.	Complies
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.	Complies
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.	Complies
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	N/A
Direct Access to OB/GYN	§3217-c	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female	Complies

Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§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	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.	
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.	Complies
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.	Complies
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.	Complies
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 insured can obtain such referral.	Complies
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?	§3217-a(a)(12) §3217-d(b) §4324(a)(12)	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	N/A

Yes ☐ No ☒	§4306-C(b) PHL § 4408(1)(l) Model Language	the procedure for requesting and obtaining such a standing referral.	
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.	Complies
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.	Complies
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	Complies
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service	§3201(c)(3)	If the cost of the service is less than the copayment for the service, the patient is responsible for the	Complies

Model Language Used? Yes ☒ No ☐	11 NYCRR 52.1(c) Model Language	lesser amount.	
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.	Complies
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.	Complies
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.	Complies
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.*	Complies
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).	Complies
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	Complies

		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.	
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.*	Complies
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.*	Complies
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 on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	Complies
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	Rider

		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.	
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.	Complies
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	Complies
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.	Complies
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 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	Form/Page/Para Reference
PREVENTIVE CARE			
Primary and Preventive Health Services	§3221(l)(8) §3221(k)(18)	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:	Complies

Model Language Used? Yes ☒ No ☐	§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	• 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.	
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.	Complies
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.	Complies
Mammography Screening Model Language Used? Yes ☒ No ☐	§ 3221(l)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	Complies

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.	Rider
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	Complies
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 • 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.	Complies
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services	§ 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	Complies

Model Language Used? Yes ☒ No ☐		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.	
Emergency Services Model Language Used? Yes ☒ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:*	Complies

		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.	Complies
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Complies
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.	Complies
Ambulatory Surgery Center Model Language Used?	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.	Complies

Yes ☒ No ☐		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
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.	Complies
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.*	Complies
Dialysis Coverage Model Language Used? Yes ☒ No ☐	§3221(k)(16) §4303(gg) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured;	Complies

		• 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.	
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.	Complies
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.	Complies

		• Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 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.*	Complies
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; 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.	Complies
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.	Complies
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used?	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.	Complies

Yes ☒ No ☐			
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.	Complies
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.	Complies
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.	Complies
Outpatient 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 therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: 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*	Complies

		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.	Complies
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.	Complies
Mandatory Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§3221(k)(3) 4303(b) Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	Complies
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.	Complies
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	Complies

		preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
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.	Complies
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.	Complies
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3221(k)(10) §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	Complies
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.	Complies
Autism Spectrum Disorder Model Language Used?	§3221(l)(17) §4303(ee) Model Language	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	Complies

Yes ☒ No ☐	11 NYCRR 440	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. 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*	Complies

		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.*	
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.	Complies
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 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.	Complies
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.	Complies

		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.*	
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.	Complies
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,	Complies

		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.	
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. 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.	Complies
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.	Complies
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐	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*	Complies

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 Languagebenefit in the space provided.		*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.*	
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.	Complies
End of Life Care Model Language Used? Yes ☒ No ☐	§4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	Complies
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	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*	Complies

	of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	*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.*	
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 treatment of mental health conditions and substance use disorder consistent with the federal law.*	Complies
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	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*	Complies

	45 CFR 146.136 45 CFR § 156.100 Model Language	*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.*	
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. 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*	Complies

		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.	Complies
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 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.	Complies
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.	Complies
Usual and Customary Cost	§4325(h)	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such	Complies

of Prescribed Drugs Model Language Used? Yes ☒ No ☐	PHL §4406-c(6) Model Language	prescribed drug.	
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).	N/A
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.	Complies
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.	Complies
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.	Complies
Contraceptive Drugs and Devices Model Language Used? Yes ☒ No ☐	§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 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.*	Rider
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐	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.	Complies

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.		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.*	
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 Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Complies
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☐ No ☒ Is dental coverage being provided by this QHP filing? Yes ☐ No ☒	45 CFR § 156.100 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.	N/A

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.	Complies
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.	Covered in base Certificate
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	N/A
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.	Complies
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.).	Complies
PERMISSIBLE EXCLUSIONS AND		*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.*	Form/Page/Para Reference

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

LIMITATIONS		*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.*	
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.	Complies
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.	Complies
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.	Complies
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.	Complies
Dental Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	Complies
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.	Complies
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.	Complies
Foot Care	11NYCRR52.16(c)(6)	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	Complies

Model Language Used? Yes ▣ No ☐	.Model Language	specifically listed in this policy or contract form.	
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.	Complies
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.	Complies
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).	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
Services not Listed	§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.	Complies

Model Language Used? Yes ☒ No ☐			
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies

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.	Complies
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.	Complies
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.	Complies
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.	Complies
Termination for Fraud	§3221(p)(2)(B)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the	Complies

	§4305(j)(2)(B) §3105	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.	
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies
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.	Complies

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.	Complies
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.	Complies
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. 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.	Complies
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	Complies

		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).	
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.	Complies
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard Model Language Used? Yes ☒ No ☐	§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.	Complies
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	Complies

		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.	
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.	Complies
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.	Complies
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.	Complies
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	Complies
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.	Complies
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.	Complies
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	§3217-f	The policy or contract form may not include a lifetime limit on essential health benefits. Essential	Complies

Dollar Limits Model Language Used? Yes ☒ No ☐	42 USC §300gg-11 45 CFR §147.126 Model Language	health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ 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.	Complies
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.	Complies
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☐ No ☒ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☐	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not 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
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).	Rider
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.	Rider

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.*	Prime Network
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.*	Please see Actuarial Memorandum
ACTUARIAL	11NYCRR52.40(a)(1)	Actuarial qualifications:	

MEMORANDUM		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 %.	Please see Actuarial Memorandum
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	Please see Actuarial
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	Please see Actuarial
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.	Please see Actuarial Memorandum
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	Please see Actuarial Memorandum
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.)*	F

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

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).	

HIP Insurance Company of New York ("HIPIC")

READABILITY CERTIFICATION

In accordance with the provisions of NY INS Section 3102 (d), I the undersigned hereby certify that I am knowledgeable of the laws and regulations governing the Flesch Reading Ease Score.

Pursuant to Section 3102 of the State of New York Insurance Law, the Form listed below has been reviewed for readability and has attained a lower than minimum Flesch Reading Ease Score that is required by the aforementioned Insurance Law but should be approved in accordance with subsection (d) of Insurance law due to the following:

- Is a readable and understandable insurance policy which is consistent with the purposes of the aforementioned Insurance Law.
- Is warranted by the nature of a particular insurance policy or type or class of insurance policies.
- Is caused by certain language which is drafted to conform to the requirements of any state law, regulation, agency or departmental interpretation.

Form(s)	151-23-SGOFFHIXCERT (04/13)
Flesch-Kincaid Grade Level Score	13.8
Flesch Reading Ease Score	32.7

Form(s)	151-23-SGOFFHIXPOL (04/13)
Flesch-Kincaid Grade Level Score	12.7
Flesch Reading Ease Score	39.0

Form(s)	151-23-SGOFFHIXSSchedule (04/13)
Flesch-Kincaid Grade Level Score	12.4
Flesch Reading Ease Score	22.5

Form(s)	151-23-HIXD29 (04/13)
Flesch-Kincaid Grade Level Score	10.0
Flesch Reading Ease Score	52.2

READABILITY CERTIFICATION – continued

Form(s)	151-23-HIXCONTRA (04/13)
Flesch-Kincaid Grade Level Score	13.1
Flesch Reading Ease Score	32.7

Form(s)	151-23-HIXDP (04/13)
Flesch-Kincaid Grade Level Score	11.6
Flesch Reading Ease Score	28.7

Date: May 28, 2013

[redacted]

HIP Insurance Company of New York ("HIPIC")

EXPLANATION OF VARIABLE MATERIAL

CERTIFICATE OF COVERAGE/POLICY/RIDER FORMS

- **151-23-SGOFFHIXCERT (04/13) – Certificate of Coverage**
- **151-23-SGOFFHIXPOL (04/13) – Policy**
- **151-23-HIXD29 (04/13) – Rider for Young Adults through Age 29**
- **151-23-HIXDP (04/13) – Domestic Partner Rider**

There are two types of variable material set forth in brackets within the enclosed Certificate and Policy forms. These types are:

- Illustrative Variable Material; and
- Specific Variable Material.

Illustrative Variable Material
Illustrative Variable Material consists of any entries such as names, dates, table of contents, rates, numbers, phone numbers, percentages, time periods and hypothetical fill-in examples, such as that shown in the Exhibits.

When the Illustrative Variable Material shows a range (such as percentages, time periods and rates), actual entries will always fall within that range.

Specific Variable Material
Specific Variable Material is marked as numerical items within the margins of the Certificate. Specific items marked will be changed only as indicated in the explanation set forth below. If an item will appear as shown or it may be omitted, the entire item will be bracketed and identified by an item number. If, when the item is included, wording within the item may vary, the wording that may vary is underscored and identified by an item number.

Page	Section	Variable	Explanation
17	Certificate of Coverage Section VI Covered Services – Preventive Care	(1)	Family Planning & Reproductive Health Services will appear as shown for non-religious groups but will be removed for groups that meet the religious exemption.
25	Certificate of Coverage Section VI Covered Services – Outpatient and Professional Services	(2)	Interruption of Pregnancy will appear as shown for non-religious groups but will be removed for groups that meet the religious exemption.

Page	Section	Variable	Explanation
43	Certificate of Coverage Section VI Covered Services – Prescription Drug Coverage	(3)	The contraceptive drugs or devices bullet will appear as shown for non-religious groups but will be removed for groups that meet the religious exemption.
1	Rider for Young Adults through Age 29	(4)	"Subscriber" will appear for individual plans but will be replaced with "Group" for small group plans.
1	Rider for Young Adults through Age 29	(5)	Contract, Certificate or Policy will appear depending on the plan to which this rider will be attached.
1 and 2	Domestic Partner Rider	(6)	Contract, Certificate or Policy will appear depending on the plan to which this rider will be attached.
1	Domestic Partner Rider	(7)	Contract or Policy will appear depending on the plan to which this rider will be attached.

APPENDIX C

EmblemHealth **Prime EPO 35/55**

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	$100.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%				
OOP Maximum ($)	$6,000.00					
OOP Maximum if Separate ($)						

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	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☑	☑		
Specialist Visit	☐	☐		$55.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$35.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$55.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$55.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$55.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$22.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$55.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☑	☑		

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):	☐

Emblem Health Prime EPO 35/55 - Silver

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.9%
Metal Tier:	Silver

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

Company Name: HIP Insurance Company (HIPIC)
NAIC Code: 60094
SERFF Number: HPHP-129041150
Market Segment: SG

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

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

C. In Column 4, market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (L drop down list to enter the market segment.

D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO base Indicate appropriate designation for policy form, etc.

E. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer t Include a region identifier in this column if needed.

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

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

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

Data Item for Specified Base Medical Policy Form											
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change	
151-23-EPOPOL (06/03)	EPO Select	EPO Select	SG EPO	N/A	SG	EPO	Yes	Open	0	0	XX
151-23-PPOPOL (06/03)	PPO Select	PPO Select	SG & SP PPO	N/A	SG & SP	PPO	Yes	Open	0	0	XX

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

.ING

?. Skip a row between the different rating pools.
HMO Upstate if rating pools vary by rating region.
G), Individual Healhty NY (HNY-IND), Small Group Healthy NY (HNY SG). Use the

d POS, Consumer Health Plans and Base+Supplemental.

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

in the actuarial memorandum).

			7	14	16	22	11	9	10	12	
		Data Item f	**Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)**								
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
151-23-EPOPOL (06/03)	EPO Select	EPO Select	10/01/11	09/30/12	176,180	63,905,319	82,070,752	62,043,490	63,159,265	-	3,410,013	9,323,184	XX
151-23-PPOPOL (06/03)	PPO Select	PPO Select	10/01/11	09/30/12	70,535	36,558,105	45,014,615	37,964,093	38,212,341	-	(1,276,016)	4,184,188	XX

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

						84	85	17	87	88	89	90	91	
		Data Item f	First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)											
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period ($)	15.5 Standardized earned premiums for experience period ($)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
151-23-EPOPOL (06/03)	EPO Select	EPO Select	1/1/2011	12/31/2011	169,838	57,170,243	84,876,979	55,619,877	59,099,436	-	1,757,124	7,992,909	XX
151-23-PPOPOL (06/03)	PPO Select	PPO Select	1/1/2011	12/31/2011	70,586	33,318,012	45,354,318	28,056,388	29,197,489	-	357,689	3,786,357	XX

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

					3	4	18	6	7	8	9	10	
		Data Item f	Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	16.1 Beginning date of the experience period (MM/DD/YY)	16.2 Ending Date of the experience period (MM/DD/YY)	16.3 Member months for experience period	16.4 Earned premiums for experience period ($)	16.5 Standardized earned premiums for experience period ($)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
151-23-EPOPOL (06/03)	EPO Select	EPO Select	1/1/2010	12/31/2010	144,166	42,799,123	74,600,468	40,774,139	42,754,767	-	1,449,710	5,510,599	XX
151-23-PPOPOL (06/03)	PPO Select	PPO Select	1/1/2010	12/31/2010	59,504	24,265,387	38,215,150	23,312,646	23,598,891	-	(324,605)	2,988,308	XX

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: HIP Insurance Company
NAIC Code: 60094
SERFF Number: HPHP-129041150
Market Segment: Small Group

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

Line #	General	
1	Product*	Prime EPO 35/55
2	Product ID*	20984NY010
3	Metal Level (or catastrophic)*	Silver
4	AV Metal Value (HHS Calculator)*	71.9%
5	AV Pricing Value (total, risk pool experience based)*	73.6%
6	Plan Type*	EPO
7	Plan Name*	Prime EPO 35/55
8	Plan ID*	20984NY0100001
9	Exchange Plan?*	No

* 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	$70,437,441
10B	Member-Months for Latest Experience Period	194,806
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	361.58
11	Average Pricing Actuarial Value reflected in experience period	0.813
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**444.80**

Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	1.012
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 **	1.000
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,	1.030
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)	1.333
24	Expected/Current Induced Demand	0.946
25	Required Revenue for Catastrophic	1.000
26	Expected Pricing AV	0.736
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.966**

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.736
29	Pricing actuarial value (only the induced demand factor) #	1.000
30	Impact of provider network characteristics ##	1.000
31	Impact of delivery system characteristics ##	1.000
32	Impact of utilization management practices ##	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.000
35	Profit/Contribution to surplus margins	1.000
36	Impact of eligibility categories (catastrophic plans only)	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000
39	1 / Expected Pricing AV	1.359
40	Other 2 (specify)	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.000**

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

Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)**	**429.86**

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

Company Name: HIP Insurance Company
NAIC Code: 60094
SERFF Number: HPHP-129041150
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
Silver	Off Exchange	EmbelmHealth Prime EPO 35/55	01/01/14	12/31/14	13.27%	0.95%	0.70%	0.00%	0.00%	2.60%	6.50%	10.75%	0.65%	0.00%

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

'ION

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Silver	Off Exchange	EmbelmHealth Prime EPO 35/55	0.00%	0.35%	35.00%	0.00%	11.75%

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Silver	Off Exchange	EmbelmHealth Prime EPO 35/55	4.74	3.49	0.00	0.00	12.99	32.42	53.64	3.24	0.00	1.75	0.00	58.62

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

HIP Insurance Company	A&H - 42	For Profit	60094
Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code

55 Water St. New York, NY, 10041
Company mailing address

B. Contact Person:

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

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address

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

1/1/2014-12/31/2014	1/1/2014	HPHP-129041150
New rate applicability period	New rate effective date	SERFF Tracking Number

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

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	N/A
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefiling.	No

Notes:

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

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

Use the following SERFF filing types for rate adjustment filings:

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

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

HIP Insurance Company of New York (HIPIC)
HIOS Issuer ID #20984, NAIC #60094

RATE FILING FOR SMALL GROUP OFF EXCHANGE PRODUCTS
ACTUARIAL MEMORANDUM

The purpose of this actuarial memorandum is to provide the details required for HIPIC 's 2014 premium rate filing for new EPO products to be sold outside of New York's Small Group Health Benefit Exchange. The proposed premium rates are based on a rolling rate structure with effective dates of January - March 2014 (1Q14), April – June 2014 (2Q14), July – September 2014 (3Q14) and October - - December 2014 (4Q14) and will be available to groups in the New York City region, Long Island region and Orange County in the Mid Hudson region.

Product Listing

HIPIC will be offering a Silver plan design:

Product Name	Metal Tier	Standard Plan Design
EmblemHealth Prime EPO 35/55	Silver (AV = **.719**)	No

The HHS Actuarial Value (AV) Calculator was used to determine the AV metal tiers.with one adjustment for outpatient facility copays since it is not compatible with the calculator. Outpatient Facility copays were converted into an estimated coinsurance to approximate the copay values.

- A listing of all plans in the Individual Risk Pool is attached as **Appendix A**.
- A listing of all plan cost sharing features and benefits are included in **Appendix B.**
- Printouts of the HHS AV Calculator pages for each plan design are provided in **Appendix C.**
- Descriptions of the quality improvement and cost containment programs that will impact these new plans are in **Appendix D**

Please note that the Appendices are not consecutively lettered. The appendix names correspond to those in our Health Insurance Plan of Greater New York (HIP) Individual Exchange rate filing and any unnecessary appendixes have been omitted.

Index Rate Determination

The new HIPIC small group off exchange plans will comprise HIPIC's single risk pool in the small group market. All existing HIPIC small group plans will be discontinued effective January 1, 2014.

HIPIC has determined an index rate and adjusted index rate for the small group risk pool using permissible market wide adjustments. HIPIC then used plan level adjustments to develop plan specific rates which conform to the New York State's standardized census tiers. All plan specific rates will be based on the same standard population with no differences in rates due to age, sex occupation or health status.

Experience Period Claims

HIPIC currently participates in the small group market and is using its small group claims experience as a starting point to determine the premiums rates for the Off Exchange small group plans.

HIPIC's existing small group product portfolio consists of:

- HIPIC Small Group: EPO Select, PPO Select (note Prime EPO and Prime PPO were discontinued earlier in 2013)

Inpatient, outpatient, professional and prescription drug paid claim experience for HIPIC's members (excluding the impact of the current Regulation 146) was compiled by product and neighborhood cohort for claims incurred from October 2011 through September 2012 paid through December 2012. Claims were completed using completion factors provided by the EmblemHealth Valuation Unit.

Exhibit 7: Historical Data: displays the Department's template completed for each of HIPIC's current small group products. For purposes of this rate filing, we have used the following experience periods:

> Most Recent Experience Period – The source data for this filing is experience from October 2011 through September 2012 with recast adjustments to reflect claims run out through December 2012.
>
> First Prior Experience Period – The first prior experience period is January 2011 through December 2011 with recast adjustments through April 2012.
>
> Second Prior Experience Period – The prior experience period is January 2010 through December 2010 with recast adjustments through April 2011.

Standardized Premium

Appendix E provides the support for the development of standardized premiums for the experience periods which are displayed in Exhibit 7.

For the base experience, factors for each policy form and market segment grouping were developed to determine the relationship between base earned premiums and 2013 standardized premiums. All rates used in this development were from the 2010 through 2013 HIPIC Rate Manuals.

In this development, January 2011 – December 2011 average weighted small group employee rates were used as a proxy for the prior base period earned premium PMPMs. These were developed first by calculating a blended base rate for each month of renewal. For example, for a February 2011 renewal, the average prior period rate reflects one month of the 1st Quarter 2010 rate and 11 months of the 1st quarter 2011 rate as displayed below:

$$\text{February 2011 Average Rate} = [(1 * \text{Q1 2010 Rate}) + (11 * \text{Q1 2011 Rate})] / 12$$

Once the blended base rate premium was developed for each renewal month, these were assigned weights based upon the proportion of total premiums received by renewal month. This weighting of the blended base rates resulted in the prior period average weighted rate.

The 4th quarter 2013 rates were then divided by the 2011 average weighted rates to develop factors at the policy form and market segment level of detail described above. These factors were multiplied by the prior base period earned premium in order to calculate the standardized premium at the same level of detail and which are summarized in the prior experience period section of the summary template.

The same approach was used to develop factors measuring the relationship between 4th quarter 2013 rates and the base period average weighted small group employee rates. These factors were similarly applied to the October 2011 – September 2012 earned premiums in order to develop the standardized premium in the most recent experience period section of the summary template.

Note that the standardized premium calculation does not reflect shifts in membership or changes in underlying benefits experienced over the last several years.

Credibility of Experience

The small group pool is partially credible under NAIC guidelines. However, the small group pool is fully credible under HIPIC's filed experience-rated methodology.

Trends

The components of HIPIC's medical trend factors for our fee for service providers are shown in **Appendix F** and exclude any changes included as part of the market wide adjustments described later in this Actuarial Memorandum. HIPIC is utilizing the trends as filed in HIPIC's 2013 Prior Approval filing (SERFF # HPHP 1285444439) except as noted below. It is assumed that the 2013 trends will be a reasonable estimate of trends into 2014.

- Unit Cost – the unit cost trend has been updated to reflect expected contracted increases for our most frequently utilized facilities and mix of services.
- Utilization - This assumption represents "pure" utilization independent of changes in underlying demographics and risk of the population and there are no changes from HIPIC's 2013 Prior Approval rate filing except for inpatient facility utilization. Inpatient facility utilization projections have been updated to reflect the underlying trends for a stable population with consistent risk characteristics over time. To develop these projections, we look at long term utilization trend for our Large Group HMO business, other large group business, and hospital association statistics from the American Hospital Association, health care trend surveys and reports, and federal government data including MedPac reports at www.medpac.go, in additional to conversations with our clinicians.
- Risk Score - The risk score component was largely based upon historical trends in prospective DCG risk scores (see **Appendix G**). DCG Prospective risk scores are an industry standard indicator of a population's future costs. The SOA Risk Score Study (http://www.soa.org/research/research-projects/health/hlth-risk-assement.aspx) contains

information on the accuracy of risk models. This component of trend remains unchanged from our 2013 Prior Approval filing.

- Provider Mix: This component measures the trend attributable to services moving to more expensive facilities and is unchanged from HIPIC's 2013 Prior Approval filing since we expect these trends to continue. Provider mix was determined by calculating the weighted average cost for facility claims for successive years where the weight is the facility specific share of total facility spend for each year and the cost per facility is the average admit cost in the second year. We have observed over time that there is a migration of business to higher cost facilities because lower cost facilities are more like to have financial problems and close or be acquired by higher cost systems. Also, the higher cost facilities are more likely to use direct to consumer advertising thus attracting more of our members. Higher cost facilities also are investing more in equipment and physical plant which attracts physicians to use these facilities.

Medical trends in **Appendix F** were applied using the following formula to derive the average 2014 claims PMPM projections for groups enrolling in the first quarter of 2014.

$$\text{2014 claims PMPM} = [\text{4Q11-3Q12 PMPM}]* [(1+ \text{2012 trend }\%)^{3/12}]*[(1 + \text{2013 trend }\%)^{25/12}]$$

Adjustments to the Projection Period Claims

The following market wide adjustments were applied to the projected 2014 claims PMPMs:

Expected Member Mix: We are projecting a shift in the regional membership mix and product mix for the new small group membership based on our marketing strategies for the new small group products. This results in an adjustment of **0.7%** when comparing our initial trended claim cost based on our current member mix versus our updated trended claim cost based on our projected member mix as shown in **Appendix H-1**.

Ancillary Capitations: Costs totaling **$8.04** for the following ancillary capitation arrangements are added to the projection period claims experience. The costs for these services are not included in the base period claims data and are based on commercial capitation rates for 2013 plus the anticipated capitation trend increase from 2013 to 2014.

	2014 Trend
Therapies	4%
Lab services	4%
Mental Health	4%
Radiology	5%

The provider arrangements for these services may revert back to a fee for service arrangement for the Off Exchange products for 2014 and we are assuming that capitation rates will represent the fee for service costs.

Any changes to the anticipated cost of these ancillary services due to changes in covered benefits are reflected in the adjustments described below.

HCRA Surcharge – An average HCRA surcharge of **8.62%** on all facility and outpatient claims has been added to the projected period claims. We are anticipating no change in the current surcharge of 9.63% on claims subject to the surcharge for 2014. The reduction from **9.63%** to **8.62%** accounts for claims which are not subject to the surcharge.

Pharmacy Adjustments

- HIPIC changed its drug formulary which was applicable to small group and individual products effective June 1, 2012. As such, this change was in effect for only a portion of the experience period. A reduction of $**0.36** PMPM was removed from the claims to adjust Rx claims for the period 10/1/2011-5/31/2012 when the formulary change was not in effect.
- Rebates – the base claims experience excludes the reduction of prescription drug cost due to rebates. We are assuming a rebate percentage of **10.6**% of claims for 2014.
- Prescription drugs - A portion of HIPIC's existing small group members do not have prescription drug coverage or have generic only drug coverage. The adjustments to bring drug coverage up to the EHB levels were determined using HIPIC's experience is **13.6**% of Pharmacy expense.

Compliance with Essential Health Benefits – The items listed below identify the significant adjustments used to bring all current plans in compliance with the Essential Health Benefits for a total market wide adjustment of $**5.60**. These are summarized in **Appendix J**.

- Women's Health – Benefits associated with the ACA Women's Preventive Mandate became effective on August 2012 and is partially included in our experience period date. The remaining costs totaling an average of **$1.78** has been added to our projections. These costs are based on HIPIC's Women's Health rate filing approved in SERFF # HPHP-128451961.
- NY State Autism Mandate – Benefits associated with the New York State Autism mandate became effective on November 2012. Costs of **$2.62** have been added to our projections for this mandate. These costs are based on HIPIC's Autism mandate rate filing approved in SERFF # HPHP-128511238.
- Mental Health and Substance Abuse – HIPIC's existing benefit plans generally have limited mental health and substance abuse benefits. To determine the cost increase to extend the benefits to unlimited days or visits, HIP's large group experience was used to estimate the additional cost of $**2.20** PMPM to shift from limited behavioral health benefits to unlimited behavioral health benefits.
- An additional $**1.00** PMPM has been removed for expected reductions in costs due to changes from the current small group and individual formulary to HIPIC's new Exchange/Off Exchange formulary. Note that HIPIC's new formulary does meet all EHB requirements.

All other benefit adjustments to comply with EHB have a minimal impact to claims costs.

Provider Network Changes (including Fee Schedule Changes) – there are no anticipated changes in network providers or fee schedules.

Pricing Actuarial Value (AV) Adjustments - Actuarial value (AV) pricing values were determined using a benefit pricing model based on HIP and HIPIC 's claims experience incurred October 2011 through September 2012 paid through December 2012 plus completion factors to account for claim incurred but not reported. The AV pricing values identify the relative value between plans due to changes in cost sharing and do not reflect induced demand which is the differences in spending pattern attributable to the richness of the plan design.

The AV of the current HIPIC experience described above is **81.29**%. The AV of HIPIC's small group membership is expected to be **73.60**%. The AV of **73.60**% was calculated based on expected membership distribution by plan design and the Pricing AV that was calculated for each plan design. The development of the Pricing AV for each plan design is described below. The resulting ratio of **73.60%/81.29% (.9055**) was applied to the projected costs to take into account the higher cost sharing anticipated in the HIPIC small group membership.

Induced Demand Adjustments
For our current HIPIC experience, we used the following induced demand factors based on the Induced Demand factors included in the HHS final rules re Risk Adjustment:

- 1.00 for Bronze Metal Products
- 1.03 for Silver Metal Products
- 1.08 for Gold Metal Products
- 1.15 for Platinum Metal Products

Induced demand was demonstrated and quantified in the Rand Health Insurance Experiment. These adjustments for induced demand do not reflect differences in the health status of our members.

Note that we interpolated Induced Demand factors based on the AV of the current plan designs. The resulting composite induced demand factor based on our current HIPIC experience was **1.0892.**

We then calculated expected Induced Demand for HIPIC's small group membership based on expected membership distribution by product and the HHS' induced demand factors above. The result is an expected Induced Demand factor of **1.0300**.

The composite HIPIC small group Induced Demand factor is **0.9456**. The resulting ratio of **1.0300/1.0892** was applied to projected claim costs to take into account the lower induced demand anticipated in the HIPIC small group membership.

Index Rate
The resulting HIP small group Index rate is **$417.38** PMPM per row 22 of **Appendix P.**

Adjustments to Index Rate

Federal Risk Adjustment Program – The results provided by the Department of Financial Services for the risk adjustment simulation were applied to the pricing of the small group products. Per **Appendix N-2**, the projected Risk Adjustment payment is estimated to be $**12.47** PMPM.

The resulting HIPIC small group Adjusted Index Rate is $**429.85** PMPM per row 25 of **Appendix P.**

Plan-Design Level Rate Adjustments

The following adjustments were made to develop plan-specific PMPM rates from the adjusted index rate.

Pricing AV by plan design
To develop Pricing AV, we took the projected HIP & HIPIC experience described above, but used allowed claim expenses. Depending on the plan design, continuance tables were then built to determine a Paid/Allowed ratio for each of the standardized plan designs. The Pricing AV was applied to the Index Rate described above, since the Risk Adjustment PMPM was applied separately per below.

The Pricing AV for each plan design was then divided by the average Pricing AV included in the adjusted index rate described above.

Induced Demand
The induced demand for each plan design was calculated using HHS's induced demand factors described above. The induced demand for each plan design was then divided by the average induced demand included in the adjusted rate described above.

Risk Adjustment PMPM
The Risk Adjustment PMPM described above was applied to each plan design to determine the plan-specific PMPM cost.

Provider Network, Delivery System, and Utilization Management Practice Adjustments – There are no provider network, delivery system or utilization management adjustments specific to plan design.

Plan-Specific PMPM costs
The resulting plan-specific PMPM costs are shown in row 39 of **Appendix P**.

Other Adjustments to Plan-Specific PMPM costs

Covered Lives Assessment (CLA)
Covered Lives Assessment was then added to the PMPM costs. The CLA is based on expected new membership. We assumed a **2**% trend from 2013 to 2014 for CLA.

ACA Fees
The derivation of ACA fees is as follows:

- Insurer Fee: This nation-wide fee associated with PPACA of $8 Billion will be spread to all eligible carriers based upon earned 2014 premiums with some exclusions. This fee is anticipated to cost **1.5%** of 2014 premium and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.

- Reinsurance Assessment: This assessment is expected to add $**5.25** PMPM to 2014 earned premium and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- PCORI Fee: This fee is anticipated to cost about $**2.10** PMPY, or $**0.175** PMPM for 2014 and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- Exchange User Fee: New York has not determined the amount of the Exchange User Fee so no adjustment is permitted to be included in the 2014 rates.
- Federal Risk Adjustment Program Fee: Plans will be charged a **$0.96** PMPMY fee, or $.**08** PMPM fee for the Federal Risk Adjustment Fee and has been included the "Other state and federal taxes and assessments" column of the standard Exhibit 9.

Administrative Expenses and Margin –
Please refer to Standard Exhibit 9, which contains the projected 2014 administrative expense components for each of the 2014 plan designs.

The derivation of expenses are discussed below:

- Section 332 Assessments: This is expected to be 0.**95**% of 2014 premiums.
- Activities that Improve Health Care Quality (as defined in the NAIC Annual Statement Supplement Health Care Exhibit): This is expected to be 0.**70**% of 2014 premiums. Please refer to Appendix D for a description of these activities.
- Commissions and broker fees: This is expected to be **0**% since we currently do not pay commission for our small group products.
- Premium Taxes: HIPIC is not subject to premium taxes
- Other administrative expenses: This is expected to be **6.50**%.
- Margin: We include a **1**% margin in the development of our premium rates of which .35% is attributable to projected income taxes.

PMPM rates
The resulting plan specific PMPM premium rates are shown in row 54 of **Appendix P**.

Calculating Premium Rates by Tier and Region

Regional rate adjustments
To calculate the premium rates by region, we used differences in Allowed Claim Cost divided by the risk adjustment risk scores for our HIPIC membership. The result is a "risk-normalized" Allowed Claim Cost by region. As shown in **Appendix Q**, we calculated a regional factor of **0.985** for the New York City rating region and a regional factor of **1.009** for the Long Island rating region. Due to the extremely low membership expected in Orange County (within the Mid-Hudson rating region), we will use the New York City rating factor for the Mid-Hudson rating region.

PEPM to Individual rate conversion factor and Family Rate tiers
We have mapped the membership from HIPIC's current product portfolio as a basis to project the expected membership distribution for the small group Products as shown in **Appendix R** to calculate the single conversion factor of **1.1754.**

Quarterly Step up Factors
Premium rates for 2Q14, 3Q14 and 4Q14 have been developed using the annual trend rates described previously plus the impact of changes in the ACA fees. The derivation of the **3.2%** quarterly step ups are shown in **Appendix R-1.**

A premium rate manual has been included which conforms to the New York State's standardized census tiers

Age 29 Rider
All metal level plans include an optional age 29 rider which extend coverage to unmarried, uninsured adult children up through age 29. The age 29 rider was priced using the adjustment factor of **3**% in our HIP Large HMO Prior Approval Rate Filing approved in SERFF # HPHP – 128543139.

Domestic Partner Rider
HIPIC will be providing domestic partner coverage at no additional cost.

Pediatric Dental
Pediatric dental will not be offered as an embedded benefit in HIPIC's off exchange product portfolio and rates for pediatric coverage are not included in the premium rate manual. We are in the process of arranging a contract with Dentcare Delivery Systems to provide stand-alone pediatric benefits to our members.

Loss Ratio

The requested premium rates result in an **88.2**% target loss ratio based on the above assumptions.

Standard Exhibits

Please note the following regarding the following standardized exhibits:

- Exhibit 7: All HIPIC small group products in the experience period of 4Q2011-3Q2012 are shown. As discussed in the "Expected Member Mix" section above, we used current member mix as the starting point to determine our projected new product member mix.

- Exhibit 8: Please note the following regarding Exhibit 8:
    - Please note the CLA, ACA Fees, and Administrative costs are not shown in Exhibit 8. These are shown in Appendix P. Line # 42 of Exhibit 8 corresponds to row 39 of Appendix P.
    - Pricing Actuarial Values:
        - In Appendix P, we apply the following adjustments:
            - Index Rate calculation
                - Row 13 shows current Pricing AV for the Experience Period **(0.8129)**
                - Row 14 shows expected Pricing AV for the small group Market **(0.7360)**

        - Row 15 shows the ratio of Row 14 / Row 13 **(0.9055** = **0.7360/0.8129)**. This reduced the paid claim cost in the Index rate to reflect the higher cost sharing anticipated in the new products.
    - Plan specific calculation
        - Row 29 is the plan-specific Pricing AV calculated for each plan (e.g., **0.7360** for Silver)
        - Row 30 is the expected Pricing AV for the small group Market **(0.7360**)
        - Row 31 is the ratio of Row 30 / Line 31 (e.g., **1.0000 = 0.7360/0.7360**)
  - In Exhibit 8:
    - Line # 11 corresponds to Row 13 of Appendix P
    - Line # 26 corresponds to Row 14 of Appendix P
    - Line # 28 corresponds to Row 29 of Appendix P
    - Line # 39 corresponds to Row 30 of Appendix P
- Line 10B corresponds to the Member Months from Exhibit 7. As discussed above and summarized in **Appendix H-1**, shows the initial projected claims cost, and then adjusted for expected new product member mix.
- **Appendix S** shows how the $**361.58** PMPM in Line # 10C was derived based on the $**453.32** PMPM in row 1 of **Appendix P**. In essence, this represents untrended base experience adjusted for certain items shown in Appendix P.

- Exhibit 9: A comparison of the ACA Fees and Administrative expenses in Exhibit 9 to the ACA Fees and Administrative expenses in Exhibit 2 of HIPIC's 2013 Small Group's Prior Approval filing is as follows:
    - 332 Assessments, etc.: Assumed **0.95**% in both filings
    - Administrative expenses that improve HC quality: Note that in the 2013 Prior Approval filing, this was classified as a "claims" expense when calculating our premium rate. The **0.70**% used for the 2014 filing.
    - Commissions: We have recently filed for a 0% commission rate on our small group products which will apply to our new 2014 products. We assumed **5.5%** were paid in our 2013 Small Group Prior Approval filing.
    - Other federal fees and assessments: This increased from **0.2%** to **2.6%** due to the new ACA fees described above that will become effective in 2014.
    - Other administrative expenses: This was reduced slightly from **6.6**% in the 2013 Prior Approval filing to **6.5**% in the 2014 Off Exchange filing.

Uniform Rate Review Template

Worksheet 1 of the Unified Rate Review Template (URRT): Worksheet 1 does not demonstrate the process used to develop the rates. It represents 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 Experience Period in the URRT contains incurred 2012 claims. These claims were derived from allowed claims, incurred from October 2011 through September 2012 paid through December 2012 (plus appropriate completion factors), trended forward 3 months. Trend, market wide factors and expense loads as previously described in this actuarial memorandum were applied to the experience period claims to project 2014 experience. Note that these factors have been adjusted to reflect the differences in URRT base period data.

As previously stated, this exhibit provides information required by Federal regulation and does not demonstrate the process to develop rates.

Actuarial Certification

I am a Member of the Society of Actuaries and member of the American Academy of Actuaries; and meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I further certify that to the best of my knowledge:

1. This filing, including the projected index rate, is in compliance with all applicable New York State and Federal laws and regulations (45 CFR 156.80(d)(1)).
2. The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
    - ASOP No. 5, Incurred Health and Disability Claims
    - ASOP No. 8, Regulatory Filings for Health Plan Entities
    - ASOP No. 12, Risk Classification
    - ASOP No. 23, Data Quality
    - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
    - ASOP No. 41, Actuarial Communications
3. The expected loss ration incorporated into the proposed rate tables meets the minimum requirement of the State of New York.
4. The benefits are reasonable in relation to the premiums charged.
5. The rates are not unfairly discriminatory.
6. Only the 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.
7. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans with one adjustment for outpatient copays as described above in the Actuarial Memorandum. The adjustment was developed in accordance with generally accepted actuarial principles and methodologies.

Please keep all information contained in this rate filing confidential.

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[redacted]

Actuary, EmblemHealth Actuarial Services

[redacted]

May 30, 2013

Data Collection Template

Company Legal Name: **HIP Insurance Company** State: **NY**
HIOS Issuer ID: **20984** Market: **Small Group**
Effective Date of Rate Change(s): **1/1/2014**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$72,677,308	$373.14	100.00%
Incurred Claims in Experience Period	$78,843,411	404.80	108.48%
Allowed Claims:	$87,730,562	450.43	120.71%
Index Rate of Experience Period		$0.00	
Experience Period Member Months	194,770		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	58.87	$23,144.29	$113.55	1.000	1.000	1.088	1.047	64.49	$27,386.87	$147.17	0.00	$0.00	$0.00
Outpatient Hospital	Services	611.51	1,425.23	72.63	1.000	1.000	1.089	1.089	724.65	1,691.13	102.12	0.00	0.00	0.00
Professional	Services	16,084.13	115.73	155.12	1.000	1.000	1.036	1.068	18,338.45	124.15	189.73	0.00	0.00	0.00
Other Medical	Other	12,000.00	24.69	24.69	1.000	1.000	1.033	1.000	12,000.00	26.37	26.37	0.00	0.00	0.00
Capitation	Other	12,000.00	8.04	8.04	1.000	1.000	1.000	1.000	12,000.00	8.04	8.04	0.00	0.00	0.00
Prescription Drug	Prescriptions	8,252.66	106.73	73.40	1.000	1.000	1.060	1.066	9,376.20	119.83	93.63	0.00	0.00	0.00
Total				$447.42							$567.06			$0.00

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$567.06	$59,915,796
Paid to Allowed Average Factor in Projection Period			0.736	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$417.38	$44,100,230
Projected Risk Adjustments PMPM			-12.47	(1,317,681)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$429.85	$45,417,911
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$429.85	$45,417,911
Administrative Expense Load		8.15%	39.70	4,194,580
Profit & Risk Load		1.00%	4.87	514,672
Taxes & Fees		2.60%	12.68	1,340,072
Single Risk Pool Gross Premium Avg. Rate, PMPM			$487.10	$51,467,234
Index Rate for Projection Period			$429.85	
% increase over Experience Period			30.54%	
% Increase, annualized:			14.25%	
Projected Member Months				105,660

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:	**HIP Insurance Company**	State:	**NY**
HIOS Issuer ID:	**20984**	Market:	**Small Group**
Effective Date of Rate Change(s):	**1/1/2014**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		EPO Select	PPO Select	Prime EPO 35/55
Product ID:		20984NY002	20984NY003	20984NY010
Metal:		Catastrophic	Catastrophic	Silver
AV Metal Value		0.812	0.784	0.719
AV Pricing Value		0.750	0.658	0.736
Plan Type:		EPO	PPO	EPO
Plan Name		EPO Select	PPO Select	Prime EPO 35/55
Plan ID (Standard Component ID):		20984NY0020001	20984NY0030001	20984NY0100001
Exchange Plan?		No	No	No
Historical Rate Increase - Calendar Year - 2		15.65%	15.65%	0.00%
Historical Rate Increase - Calendar Year - 1		17.40%	6.73%	0.00%
Historical Rate Increase - Calendar Year 0		16.70%	11.45%	0.00%
Effective Date of Proposed Rates		1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		16.70%	11.45%	0.00%
Proj'd Per Rate Change % (over Exper. Period)		-100.00%	-100.00%	#DIV/0!
Product Threshold Rate Increase %		#DIV/0!	#DIV/0!	0.00%

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

Plan ID (Standard Component ID):	Total	20984NY0020001	20984NY0030001	20984NY0100001
Inpatient	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$498.76	$0.00	$0.00	$498.76
Projected Member Months	105,665	0	0	105,665

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	20984NY0020001	20984NY0030001	20984NY0100001
Average Rate PMPM	$373.14	$362.73	$471.87	$0.00
Member Months	194,770	176,180	18,590	0
Total Premium (TP)	$72,677,308	$63,905,319	$8,771,989	$0
EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	0.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%	100.00%
Total Allowed Claims (TAC)	$87,730,562	$75,965,422	$11,765,140	$0
EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	0.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%	100.00%
Allowed Claims which are not the issuer's obligation:	$8,887,151	$7,248,395	$1,638,756	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	0.00%	#DIV/0!
Total Incurred claims, payable with issuer funds	$78,843,411	$68,717,027	$10,126,384	$0
Net Amt of Rein	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00

Incurred Claims PMPM	$404.80	$390.04	$544.72	#DIV/0!
Allowed Claims PMPM	$450.43	$431.18	$632.87	#DIV/0!
EHB portion of Allowed Claims, PMPM	$450.43	$431.18	$632.87	#DIV/0!

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	20984NY0020001	20984NY0030001	20984NY0100001
Average Rate PMPM	$498.76	$0.00	$0.00	$498.76
Member Months	105,665	-	-	105,665
Total Premium (TP)	$52,701,475	$0	$0	$52,701,475
EHB basis or full portion of TP, [see instructions]	100.00%	0.00%	0.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	100.00%	100.00%	0.00%
Total Allowed Claims (TAC)	$61,709,332	$0	$0	$61,709,332
EHB basis or full portion of TAC, [see instructions]	100.00%	0.00%	0.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	100.00%	100.00%	0.00%
Allowed Claims which are not the issuer's obligation	$16,288,993	$0	$0	$16,288,993
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0
insured person, as %	0.00%	#DIV/0!	#DIV/0!	0.00%
Total Incurred claims, payable with issuer funds	$45,420,339	$0	$0	$45,420,339
Net Amt of Rein	$0	$0	$0	$0
Net Amt of Risk Adj	$1,317,743	$0	$0	$1,317,743

Incurred Claims PMPM	$429.85	#DIV/0!	#DIV/0!	$429.85
Allowed Claims PMPM	$584.01	#DIV/0!	#DIV/0!	$584.01
EHB portion of Allowed Claims, PMPM	$584.01	#DIV/0!	#DIV/0!	$584.01

HIP
HEALTH PLAN OF NEW YORK

[redacted]

May 28, 2013

Superintendent of Insurance
State of New York
Agency Building One
Empire State Plaza
Albany, New York 12257

Re: GROUP ACCIDENT AND HEALTH INSURANCE
NAIC 60094
FEIN 13-3802010

Submission of:

- Form # 151-23-SGOFFHIXCERT (04/13) – EPO Select 35/55 Certificate of Coverage
- Form # 151-23-SGOFFHIXPOL (04/13) – EPO Select 35/55 Policy
- Form # 151-23-SGOFFHIXSSchedule (04/13) – EPO Select 35/55 Schedule of Benefits Silver
- Form # 151-23-HIXD29 (04/13) – Rider for Young Adults through Age 29
- Form # 151-23-HIXCONTRA (04/13) – Contraceptive Drugs and Devices Rider
- Form # 151-23-HIXDP (04/13) – Domestic Partner Rider

Dear Superintendent:

Enclosed for your review and approval are final copies of the above noted forms. This filing contains the New York State Small Group Certificate of Coverage, Policy, Schedule of Benefits and riders for use in the Off-Exchange marketplace, effective January 1, 2014. The forms are new and do not replace any forms currently on file with the Department. The forms provide in-network EPO benefits and were developed utilizing NYS model language text and directives.

Re: Rates

An actuarial statement is included as part of this submission.

Re: Readability Certification

A readability certification is included as part of this submission.

We trust that this submission is in complete order and will receive a prompt review and approval from your Department. If you have any questions or concerns, please do not hesitate to contact me directly at the telephone number enclosed herein. Thanking you in advance for your assistance.

Sincerely,

[redacted]

Appendix A

HIP Insurance Company (HIPIC)

Metal Level	Standard Plan / Non Standard Plan	Product Name	On Exchange	Metal AV Value
		Small Group Off Exchange Plans		
Silver	Non Standard	EmblemHealth Prime EPO 35/55	Off Exchange	0.719

HIP Insurance Company (HIPIC)
Small Group Off Exchange Products
Benefit Summary

TYPE OF SERVICE	EmblemHealth Prime EPO 35/55 - Silver (AV = 0.719)
DEDUCTIBLE (single)	$ 2000 (Med) , $100 (RX)
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$6,000
COST SHARING - MEDICAL SERVICES	
Inpatient Facility/SNF/Hospice	Ded & Coins
Outpatient Facility-Surgery, including freestanding surgicenters	Ded & Coins
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	Ded & Coins
PCP	$35
Specialist	$55
PT/OT/ST - rehabilitative & habilitative therapies	$55
ER	$200
Ambulance	$150
Urgent Care	$60
DME/Medical supplies	30% cost sharing
Hearing aids	30% cost sharing
Eyewear	30% cost sharing
INPATIENT HOSPITAL SERVICES	
Observation stay	Ded & Coins
Hospital services - non-maternity	Ded & Coins
Maternity care stay (covers mother and well newborn combined)	Ded & Coins
Mental health/Behavorial health care	Ded & Coins
Detoxification	Ded & Coins
Substance abuse disorder services	Ded & Coins
Skilled nursing facility	Ded & Coins
Hospice (inpatient)	Ded & Coins
	Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility
EMERGENCY MEDICAL SERVICES	
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay) directly from the emergency room
Physician charge - Emergency Room visit	$0 copay per visit

Facility charge - Freestanding urgent care center	Urgent Care copay per visit
Physician charge - Free standing urgent care center visit	$0 copay per visit
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Ded & Coins
Pre-admission/pre-operative testing	$0 copay
Diagnostic and routine laboratory and pathology	Specialist copay per visit
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit
Imaging: CAT/PET scans, MRI	Specialist copay
Chemotherapy	PCP copay per visit
Radiation therapy	PCP copay per visit
Hemodialysis/Renal dialysis	PCP copay per visit
Mental health/Behavorial health care	PCP copay per visit
Substance abuse disorder services	PCP copay per visit
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit
Home care	PCP copay per visit
Hospice	PCP copay per visit

PREVENTIVE & PRIMARY CARE SERVICES

Allergy testing	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies.
Bone density testing	Otherwise the cost sharing indicated below applies to all services in this benefit service category.
Cervical cytology	
Colonoscopy screening	
Gynecological exams	PCP/Specialist copay per visit (based on type of physician performing the service)
Immunizations	
Mammography	
Prenatal maternity care	
Prostate cancer screening	
Routine exams	
Women's preventive health services	

PHYSICIAN/PROFESSIONAL SERVICES

Inpatient hospital surgery - surgeon	Ded & Coins
Outpatient hospital and freestanding surgicenter - surgeon	Ded & Coins
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit
Additional surgical opinion	Specialist copay per visit

Second medical opinion for cancer	Specialist copay per visit
Maternity delivery and post natal care - physician or midwife	Ded & Coins
In-hospital physician visits	$0 copay per visit
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit
Imaging: CAT/PET scans, MRI	Specialist copay per visit
Allergy shots	PCP/Specialist copay per visit
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)
Mental health/Behavorial health care	PCP copay per visit
Substance abuse disorder services	PCP copay per visit
Chemotherapy	PCP copay per visit
Radiation therapy	PCP copay per visit
Hemodialysis/Renal dialysis	PCP copay per visit
Chiropractic care	Specialist copay per visit

ADDITIONAL BENEFITS/SERVICES

ABA treatment for Autism Specturm Disorder	PCP copay per visit
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per device
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies
Hearing evaluations/testing	Specialist copay per visit
Hearing aids	Hearing aid coinsurance cost sharing applies
Diabetic drugs and supplies	PCP copay per 30 days supply
Diabetic education and self-management	PCP copay per visit
Home care	PCP copay per visit
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.

PEDIATRIC VISION SERVICES

Eye exam visit	PCP copay per visit
Prescribed lenses and frames	
Contact lenses	Eyewear coinsurance cost sharing applies

PRESCRIPTION DRUGS

Generic or Tier 1	$15
Formulary Brand or Tier 2	$35
Non-Formulary Brand or Tier 3	$75
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply	

APPENDIX C

EmblemHealth **Prime EPO 35/55**

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	$100.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%				
OOP Maximum ($)	$6,000.00					
OOP Maximum if Separate ($)						

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	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☑	☑		
Specialist Visit	☐	☐		$55.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$35.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$55.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$55.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$55.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$22.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$55.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☑	☑		

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):	☐

Emblem Health Prime EPO 35/55 - Silver

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.9%
Metal Tier:	Silver

Appendix D

Quality Improvement and Cost Containment Programs

Expense Type	Detailed Description of Expense
1. Improve Health Outcomes	
A. Disease Management	Expenses related to providing – Rare Disease Management with unlimited access to specialty nurses, Disease specific and personalized health assessments, On going monitoring and care coordination, Collaboration with Member's personal physician and care team, Disease-specific information, educational brochures and quarterly news letters. Education, health support and disease management services to reduce limb amputations and hospitalizations and improve outcomes for members in poorest health with Diabetes as well as Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Asthma or chronic obstructive pulmonary disease (COPD) as co morbid conditions. Enhance the quality of life for members with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) and educate them on options such as kidney transplantation. Members may receive educational materials, HRA and telephonic nurse support. Emblem's Positive Action Toward Health (PATH) program which provides an opportunity to work one on one with a professional nurse health coach by telephone, who provides counseling to elicit change in behavior; Educational materials about symptom management, health risks and treatment for members with asthma, diabetes, CHF, COPD and CAD.
B. Case Management	Expenses related to providing – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes Case Management Nursing model that supports members with a focus on the home based fragile members with multiple conditions and several needs. Behavioral Health case and disease management services to members with depression, severe psychiatric conditions and multiple hospitalizations. Management of members with CHF by providing information to member's doctors through in home monitoring devices and nurse monitoring services.
C. Late Stage Cancer Program	This program lends support, guidance and education to members with late stage cancer, their caregivers and family during critical times of cancer care.
D. Interactive Voice Response based calling	Phone calls to members in support of various HEDIS and QARR initiatives.
E. Quality Improvement Committee Physician Fees	Physicians are paid to be part of a committee to review and provide feedback on the Company's quality improvement strategies and to review and provide input on quality of care complaints received.
F. New member surveys and health risk assessments	In order to determine the health status of new members and identify needs for complex case management and disease management programs, surveys and health risk assessments are performed on new members.

Quality Improvement and Cost Containment Programs

G. Patient satisfaction surveys	These surveys serve as a consumer assessment of healthcare providers and systems. The results are used to assess the patient-centeredness of care, compare and report on performance and improve the quality of care.
2. Activities to prevent Hospital Readmissions.	
End of Life/Palliative Care	This program is targeted at members with advanced/terminal illness no longer seeking curative treatment and helps members and family transition to end of life care.
4. Wellness and Health Promotion Activities	
Healthy Beginnings	The Healthy Beginnings Program provides incentives for expecting moms if they get post partum check up and complete a post partum depression surveys. It also provides health risk assessments, access to a 24 hour babyline staffed by nurses and stratification and education materials to members.
Smoking Cessation Programs	A tobacco free program in partnership with the American Cancer Society.
Biometrics Screenings	Biometrics screenings provided to members.
Flu Vaccines	Flu Vaccines provided to members.
Member Health and Fitness	Fitness facility for members and incentives for members who participate in health and wellness programs.
5. HIT Expenses for Health Care Quality Improvement	
A. Disease and Case Management software	Software license and maintenance expense for applications that support Disease and Case management programs.
B. HIT expenses in support of HEDIS	Hosting, data mapping and software license fees associated with HEDIS reporting initiatives.
C. Wellness and Health Promotion electronic tools	Expenses for member website tools such as personal health records, health risk assessments, self-guided Action Plans. The health risk assessment and personal health records provide triggered messaging related to disease management, weight loss and reminders for medical exams.
D. Treatment cost calculators	Web based tool that provides members with treatment choices and cost estimates for nearly 300 common treatments.
E. Data analysis tools	Tools used improve the effectiveness of case management by identifying gaps in care and identifying high impact populations.
F. Preauthorization and referral system	This system enables and expedites the referral and authorization process to direct appropriate care.
G. Data Warehouse	Warehouses used to house all clinical information used for disease management. This includes the cost of integrating data from third party administrators.

Appendix E-1

HIP EPO Select Standardized Premium Example

2011 Earned Premium PMPM	336.62	
4Q11-3Q12 Earned Premium PMPM	362.73	
1Q 2010 Rate Ratio	1.000	
2Q 2010 Rate Ratio	1.020	2.0%
3Q 2010 Rate Ratio	1.097	7.6%
4Q 2010 Rate Ratio	1.156	5.4%
1Q 2011 Rate Ratio	1.156	0.0%
2Q 2011 Rate Ratio	1.272	10.0%
3Q 2011 Rate Ratio	1.310	3.0%
4Q 2011 Rate Ratio	1.350	3.0%
1Q 2012 Rate Ratio	1.358	0.6%
2Q 2012 Rate Ratio	1.493	10.0%
3Q 2012 Rate Ratio	1.538	3.0%
4Q 2012 Rate Ratio	1.603	4.2%
1Q 2013 Rate Ratio	1.603	0.0%
2Q 2013 Rate Ratio	1.643	2.5%
3Q 2013 Rate Ratio	1.685	2.5%
4Q 2013 Rate Ratio	**1.727**	2.5%
1Q 2014 Rate Ratio	1.650	-4.5%

Renewal Distribution		**Average 2011 Rate by renewal month**		**Average 4Q11-3Q12 Rate by renewal month**	
Jan	61%	Jan 2011	1.16	Jan 2012	1.358
Feb	4%	Feb 2011	1.143	Feb 2012	1.341
Mar	4%	Mar 2011	1.130	Mar 2012	1.324
Apr	2%	Apr 2011	1.209	Apr 2012	1.438
May	3%	May 2011	1.188	May 2012	1.420
Jun	4%	Jun 2011	1.167	Jun 2012	1.401
Jul	2%	Jul 2011	1.204	Jul 2012	1.424
Aug	3%	Aug 2011	1.186	Aug 2012	1.405
Sep	4%	Sep 2011	1.168	Sep 2012	1.386
Oct	2%	Oct 2011	1.205	Oct 2011	1.205
Nov	3%	Nov 2011	1.189	Nov 2011	1.189
Dec	7%	Dec 2011	1.172	Dec 2011	1.172
		Average 2011 Rate Ratio	**1.163**	**Average 4Q11-3Q12 Rate Ratio**	**1.345**

** A February case would have 1 month at the 1Q rate and 11 months at the prior year 1Q rate*

2011 Standardized Premium		**4Q11-3Q12 Standardized Premi**	362.73
Average 2011 Rate Ratio	1.163	Average 4Q11-3Q12 Rate Ratio	1.345
4Q 2013 Rate Ratio	1.727	4Q 2013 Rate Ratio	1.727
% Change	1.485	% Change	1.284
Standardized Premium PMPM	**499.75**	Standardized Premium PMPM	**465.83**

Appendix E-2

HIP PPO Select SG Standardized Premium Example

2011 Earned Premium PMPM	441.92	
4Q11-3Q12 Earned Premium PMPM	471.87	
1Q 2010 Rate Ratio	1.000	
2Q 2010 Rate Ratio	1.020	2.0%
3Q 2010 Rate Ratio	1.097	7.6%
4Q 2010 Rate Ratio	1.156	5.4%
1Q 2011 Rate Ratio	1.156	0.0%
2Q 2011 Rate Ratio	1.171	1.2%
3Q 2011 Rate Ratio	1.206	3.0%
4Q 2011 Rate Ratio	1.242	3.0%
1Q 2012 Rate Ratio	1.249	0.6%
2Q 2012 Rate Ratio	1.374	10.0%
3Q 2012 Rate Ratio	1.415	3.0%
4Q 2012 Rate Ratio	1.475	4.2%
1Q 2013 Rate Ratio	1.409	-4.5%
2Q 2013 Rate Ratio	1.456	3.3%
3Q 2013 Rate Ratio	1.504	3.3%
4Q 2013 Rate Ratio	**1.553**	3.3%
1Q 2014 Rate Ratio	1.397	-10.1%

Renewal Distribution		**Average 2011 Rate by renewal month**		**Average 4Q11-3Q12 Rate by renewal month**	
Jan	20%	Jan 2011	1.16	Jan 2012	1.249
Feb	24%	Feb 2011	1.143	Feb 2012	1.242
Mar	9%	Mar 2011	1.130	Mar 2012	1.234
Apr	15%	Apr 2011	1.133	Apr 2012	1.323
May	4%	May 2011	1.120	May 2012	1.306
Jun	10%	Jun 2011	1.108	Jun 2012	1.289
Jul	5%	Jul 2011	1.151	Jul 2012	1.311
Aug	3%	Aug 2011	1.142	Aug 2012	1.293
Sep	3%	Sep 2011	1.133	Sep 2012	1.276
Oct	2%	Oct 2011	1.178	Oct 2011	1.178
Nov	2%	Nov 2011	1.171	Nov 2011	1.171
Dec	4%	Dec 2011	1.164	Dec 2011	1.164
		Average 2011 Rate Ratio	**1.141**	**Average 4Q11-3Q12 Rate Ratio**	**1.261**

** A February case would have 1 month at the 1Q rate and 11 months at the prior year 1Q rate*

2011 Standardized Premium		**4Q11-3Q12 Standardized Premi**	471.87
Average 2011 Rate Ratio	1.141	Average 4Q11-3Q12 Rate Ratio	1.261
4Q 2013 Rate Ratio	1.553	4Q 2013 Rate Ratio	1.553
% Change	1.361	% Change	1.231
Standardized Premium PMPM	**601.57**	Standardized Premium PMPM	**581.02**

Appendix F
HIPIC Medical Trend Factors

		CY 2012							CY 2013							CY 2014						
LOB	Product	Unit Cost	Utiliza-tion	Risc Score	Provider Mix	Total Cost	Total Utilization	Theoretical PMPM Trend	Unit Cost	Utiliza-tion	Risc Score	Provider Mix	Total Cost	Total Utilization	Theoretical PMPM Trend	Unit Cost	Utiliza-tion	Risc Score	Provider Mix	Total Cost	Total Utilization	Theoretical PMPM Trend
									Inpatient Facility FFS													
EPO	Select	9.2%	1.0%	6.0%	0.8%	10.0%	7.1%	17.8%	7.8%	0.0%	4.5%	0.8%	8.7%	4.5%	13.6%	7.8%	0.0%	4.5%	0.8%	8.7%	4.5%	13.6%
PPO	Select	9.2%	1.0%	9.0%	0.8%	10.0%	10.1%	21.1%	7.7%	0.0%	6.0%	0.8%	8.5%	6.0%	15.0%	7.7%	0.0%	6.0%	0.8%	8.5%	6.0%	15.0%
Total								**18.16%**							**13.75%**							**13.75%**
									OP Facility FFS													
EPO	Select	8.6%	4.0%	6.0%	0.8%	9.5%	10.2%	20.7%	8.0%	4.0%	4.5%	0.8%	8.9%	8.7%	18.3%	8.0%	4.0%	4.5%	0.8%	8.9%	8.7%	18.3%
PPO	Select	8.6%	4.0%	9.0%	0.8%	9.5%	13.4%	24.1%	7.9%	4.0%	6.0%	0.8%	8.8%	10.2%	19.9%	7.9%	4.0%	6.0%	0.8%	8.8%	10.2%	19.9%
Total								**21.25%**							**18.57%**							**18.57%**
									Professional FFS													
EPO	Select	4.8%	2.0%	6.0%	0.0%	4.8%	8.1%	13.3%	3.5%	2.0%	4.5%	0.0%	3.5%	6.6%	10.3%	3.5%	2.0%	4.5%	0.0%	3.5%	6.6%	10.3%
PPO	Select	4.8%	2.0%	9.0%	0.0%	4.8%	11.2%	16.5%	3.5%	2.0%	6.0%	0.0%	3.5%	8.1%	11.9%	3.5%	2.0%	6.0%	0.0%	3.5%	8.1%	11.9%
Total								**13.77%**							**10.58%**							**10.58%**
									RX													
EPO	Select	-0.1%	2.0%	6.0%	0.0%	-0.1%	8.1%	8.0%	5.73%	2.00%	4.50%	0.00%	5.73%	6.59%	12.70%	5.73%	2.00%	4.50%	0.00%	5.73%	6.59%	12.70%
PPO	Select	-0.1%	2.0%	9.0%	0.0%	-0.1%	11.2%	11.1%	5.73%	2.00%	6.00%	0.00%	5.73%	8.12%	14.31%	5.73%	2.00%	6.00%	0.00%	5.73%	8.12%	14.31%
Total								**8.51%**							**12.95%**							**12.95%**

Appendix G

Emblem Health

HIP Fully Insured Commercial Business by Line of Business and Market - Without Global Risk Entities

Relative Non-Rescaled Concurrent Risk Scores

New Medical/Rx Commercial DCG Model

DCG Time Period			Jan 08 to Dec 08	Jan 09 to Dec 09	Apr 09 to Mar 10	Oct 09 to Sep 10	Jan 10 to Dec 10	Apr 10 to Mar 11	Oct 10 to Sep 11	Jan 11 to Dec 11	Risk Score Trends				
Delivery System	Line of Business	Market	Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	Jan 09 to Dec 09/ Jan 08 to Dec 08	Jan 10 to Dec 10/ Jan 09 to Dec	Apr 10 to Mar 11/ Apr 09 to Mar 10	Oct 10 to Sep 11/ Oct 09 to Sep 10	Jan 11 to Dec 11/ Jan 10 to Dec 10
FFS	EPO	SG & SP	98.90	110.28	113.30	115.25	116.05	115.86	118.74	124.44	11.5%	5.2%	2.3%	3.0%	7.2%
	PPO	SG & SP	127.80	134.72	139.24	139.78	143.91	147.44	156.85	162.30	5.4%	6.8%	5.9%	12.2%	12.8%

Appendix H-1

Current to 2014 HIX Expected Membership and Claims Shift

		Current Membership		CY 2014
LOB	Product	**FFS Average Members**	**% of Members**	**Total Paid**
EPO	Prime	3	0.0%	$736.34
EPO	Select	14,677	90.4%	$427.62
PPO	Select	1,549	9.5%	$661.31
Total		**16,229**	**100.0%**	**449.99**

		2014 HIX Expected Membership		CY 2014
LOB	Product	**FFS Average Members**	**% of Members**	**Total Paid ***
HMO	CompreHealth	0	0.0%	$0.00
HMO	Gov Bill	0	0.0%	$0.00
HMO	Pre-gov	0	0.0%	$0.00
HMO	Healthy New York	0	0.0%	$0.00
HMO	Access 1	0	0.0%	$0.00
HMO	Classic	0	0.0%	$0.00
HMO	Prime	0	0.0%	$0.00
POS	Access 2	0	0.0%	$0.00
POS	Standardized	0	0.0%	$0.00
POS	Prime	0	0.0%	$0.00
EPO	Prime	1	0.0%	$11.79
EPO	Select	8,170	92.8%	$434.51
EPO	EPO Smart Start	0	0.0%	$0.00
PPO	PPO Prime	0	0.0%	$0.00
PPO	Select	635	7.2%	$695.92
Total		**8,805**	**100.0%**	**$453.32**

% Change	**0.7%**

** Total paid pmpm by product reflect shift in membership by region*

Appendix J

Mandates and EHB Adjustments

Mandates	**PMPM**
Women's Health	$ 1.78
Autism	$ 2.62
Total Mandates	**$ 4.40**

Essential Health Benefits	**PMPM**
Rx Formulary	$ (1.00)
Mental Health/Substance Abuse	$ 2.20
Total EHB	**$ 1.20**

Total Mandates and EHB	**$ 5.60**

Appendix N-2
Risk Adjustment Summary

Product Name	Group Size	Members	% of Members	Risk Adj
EPO Select	Small	8,170	92.8%	$ 12.47
PPO Select	Small	635	7.2%	$ 12.47
Total		**8,805**	**100.0%**	**$ 12.47**

Appendix P

Rate Development

		Row
Paid Total	**$ 453.32**	1

Ancillary Caps	$ 8.04	2
HCRA Surcharge	8.62%	3
No Rx Coverage Adjustment	13.6%	4
Formulary Adjustment	($0.36)	5
EHB Adjustment	$5.60	6
Rx Rebates	**-10.6%**	7
Include MG/GR members	**0.0%**	8
SelectCare Network Savings	**0.0%**	9
AgeSex Distribution	**0.0%**	10
Uninsured Pent-Up Demand	**0.0%**	11
Uninsured Morbidity	**0.0%**	12
Current Pricing AV	0.8129	13
Expected Pricing AV	0.7360	14
Expected/Current Pricing AV	**0.9055**	15
Current Induced Demand	1.0892	16
Expected Induced Demand	1.0300	17
CSR Induced Demand Factor	1.0000	18
Composite Expected and CSR Induced Demand	1.0300	19
Expected/Current Induced Demand	**0.9456**	20
Required Revenue due to Catastrophic	**1.0000**	21

Index Rate	**$ 417.38**	22
Risk Adjustments	$ 12.47	23
Reinsurance	$0.00	24
Adjusted Index Rate	**$ 429.85**	25

Appendix P

Rate Development

	HIPIC Silver
Deductible	$2,000
Coinsurance Max	$6,000
Coinsurance	30%
IP Copay	Ded & Coins
OP Facility/Surgery	Ded & Coins
PCP	$35
SPC	$55
PT/OT/ST	$55
ER	$200
Ambulance	$150
Urgent Care	$60
DME	30%
Rx	$15/$35/$75/$100

Percent Membership by Metal		100.0%	26
Members by Metal		**8,805**	27
Bottoms Up Model PMPM	**$**	**383.59**	28
Pricing Actuarial Value (Paid/Allowed ratio)		**0.7360**	29
Expected Pricing AV		0.7360	30
Composite Pricing AV		**1.0000**	31
Induced Demand Factor		1.0300	32
Expected Induced Demand		1.0300	33
Composite Induced Demand		**1.0000**	34
Age/Sex Factor for Castastrophic		1.0000	35
Top Down Adjusted PMPM - Adjusted for Plan Specific	**$**	**417.38**	36
Risk Adjustment	**$**	**12.47**	37
Top Down PMPM w Risk Adjustment	**$**	**429.85**	38
HNY Stop Loss Adjustment		100.0%	38a
HNY Stop Loss Adjustment PMPM	**$**	**-**	38b
Top Down Adjusted PMPM - Total	**$**	**429.85**	39
HCRA CLA	$	10.29	40
Top Down Adjusted PMPM w HCRA	**$**	**440.14**	41
PCORI	$	0.18	42
Exchange Fee	$	-	43
Reinsurance Fee	$	5.25	44
Insurance Fee		1.50%	45
Risk Adjustment Fee	$	0.08	46
Total ACA Fees - Based off Total PMPM	**$**	**12.99**	47
MLR Reclass		0.70%	48
332 Assessments		0.95%	49
Commissions		0.00%	50
All Other Admin		6.50%	51
Total Admin		**8.15%**	52
Margin		1.00%	53
Final PMPM - Total	**$**	**498.76**	54

Appendix P

Rate Development

New York City Area		0.985	55
Long Island		1.009	56
Mid-Hudson		0.985	57
Final PMPM - New York City Area	**$**	**491.03**	58
Final PMPM - Long Island	**$**	**503.30**	59
Final PMPM - Mid-Hudson	**$**	**491.03**	60
PEPM Adjustment		1.1754	61
New York City Area			
Individual	**$**	**577.16**	62
Individual + Spouse	**$**	**1,154.32**	63
Individual + Child(ren)	**$**	**981.17**	64
Family	**$**	**1,644.91**	65
Long Island			
Individual	**$**	**591.58**	66
Individual + Spouse	**$**	**1,183.16**	67
Individual + Child(ren)	**$**	**1,005.69**	68
Family	**$**	**1,686.00**	69
Mid-Hudson			
Individual	**$**	**577.16**	70
Individual + Spouse	**$**	**1,154.32**	71
Individual + Child(ren)	**$**	**981.17**	72
Family	**$**	**1,644.91**	73

Appendix Q

Regional Factors- Allowed/Risk Score

	Member Distribution	Risk Score	Ipt Allowed	Opt Allowed	Prf Allowed	Ipt Allowed/ Risk Score	Opt Allowed/ Risk Score	Prf Allowed/ Risk Score	
Total	100.0%	1.44	$133.82	$100.82	$187.49	$92.94	$70.03	$130.22	
Downstate Excl Long Island/Mid-Hudson	35.6%	1.42	$121.86	$95.41	$191.76	$85.99	$67.33	$135.31	
Long Island	64.3%	1.45	$140.50	$103.92	$185.06	$96.78	$71.58	$127.48	
Mid-Hudson	0.1%	1.94	$94.02	$24.94	$234.53	$48.38	$12.83	$120.67	
Regional Factors - Cost/Service Only						**Ipt**	**Opt**	**Prof**	**Weighted**
Weights						32%	24%	44%	
Downstate Excl Long Island/Mid-Hudson						0.925	0.961	1.039	0.985
Long Island						1.041	1.022	0.979	1.009
Mid-Hudson						0.521	0.183	0.927	0.620

Appendix R

PMPM to Individual Premium Rate Conversion Factor

Subscriber distribution	Current Distribution	Census Tiers
Ind	62.1%	1.000
HW	10.4%	2.000
PC1	2.5%	1.700
PC2	2.1%	1.700
Fam1	6.5%	2.850
Fam2	16.4%	2.850
Child	0.0%	0.412
Total (a)	100.0%	1.559
Avg Contract Size (b)		1.83
Proposed Conversion Factor (b)/(a)		1.175

Appendix R-1

Quarterly Rate Increase Calculation

Trend

2014	2015
13.3%	13.3%

2014Q1	2014Q2	2014Q3	2014Q4
$ 498.76	$ 514.58	$ 530.89	$ 547.73

PCORI 5%

10/13-9/14	10/14-9/15
$ 0.18	$ 0.20

2014Q1	2014Q2	2014Q3	2014Q4
$ -	$ 0.00	$ 0.00	$ 0.01

Reinsurance

2014	2015
$ 5.25	$ 3.41

2014Q1	2014Q2	2014Q3	2014Q4
$ -	$ (0.47)	$ (0.93)	$ (1.41)

Ins. Asmt.

2014	2015
1.5%	2.0%

2014Q1	2014Q2	2014Q3	2014Q4
$ -	$ 0.68	$ 1.41	$ 2.18

	2014Q1	2014Q2	2014Q3	2014Q4
Total	$ 498.76	$ 514.79	$ 531.38	$ 548.50
Quarterly Step-Up		**1.032**	**1.032**	**1.032**

Appendix S

Untrended to Trended Paids

	Untrended	Trended
Total Paid	**$337.47**	**$453.32**
Ancillary Caps	$8.04	$8.04
HCRA	$13.21	$18.68
No Rx Coverage Adj	$9.05	$9.85
Formulary Adj	-$0.36	-$0.36
Rx Rebates	-$5.83	-$7.66
Subtotal	**$361.58**	**$481.87**
MG Adjustment	0.0%	0.0%
AgeSex Adjustment	0.0%	0.0%
Total	**$361.58**	**$481.87**

Small Group Underwriting Guidelines[1]

New York

FOR BUSINESSES WITH 2-50 EMPLOYEES and Sole Proprietors

EmblemHealth Products

Underwritten by GHI and HIP

Small Group Underwriting Guidelines

EmblemHealth's community-rated plans are available for purchase by qualified small groups that employ no fewer than two (2) and no more than fifty (50) eligible employees.

Application	▪ The initial payment equivalent to one month's premium must be made payable to EmblemHealth and submitted with the new group application form. Only business checks are acceptable forms of payment. ▪ New business contract periods will begin on the 1st of a month only ▪ New business must be submitted by the first day of the month prior to the requested effective date, e.g. new business with a requested effective date of February 1st must be received by EmblemHealth on or before January 1st ▪ Documentation requested by EmblemHealth to determine group or employee eligibility must be supplied within **five (5) business days** from the date of EmblemHealth's request in order to secure the requested effective date of coverage. If documentation is not supplied within five (5) business days, EmblemHealth will establish an effective date of coverage pending receipt and verification of the data. **Family verification** ▪ EmblemHealth will request a Federal 1040 form and/or a marriage certificate to verify the marriage of two individuals with different last names. In addition, EmblemHealth will require a birth certificate and/or Federal 1040 Form as proof that a dependent is eligible for coverage if the dependent has a last name different from the subscriber.
Benefit Changes	**Benefit downgrades**: A plan change is a downgrade when the premium rates for the new product are lower than the premium rates for the old product as of the requested plan change date. ▪ A group can downgrade its coverage at any time during the year <u>except in the three months preceding the contract anniversary date</u>. The effective date of the benefit downgrade will become the group's new anniversary date. **Benefit upgrades:** • A group can only upgrade coverage at its contract anniversary date. **All plan change requests must be received by EmblemHealth five business days prior to the desired effective date.**

Domestic Partners	Domestic partner coverage is available with EmblemHealth. ▪ A domestic partner will be treated as a dependent. ▪ Eligible dependents of the domestic partner may be added. ▪ Domestic partners are not recognized by the IRS and may not receive tax benefits afforded to non-domestic partners (e.g., Health Savings Accounts). ▪ Domestic partners must submit the following form to EmblemHealth. This form must be notarized. 1. EmblemHealth's Declaration of Cohabitation & Financial Interdependence Form (DCFIF). In addition, the partners must also provide three documents showing a similar residence and financial interdependence. The specific list of acceptable documents is shown on the Declaration of Cohabitation & Financial Interdependence Form.
EmblemHealth Suite	• Multiple option plans (employee choice at point of enrollment) are allowed, choosing from among any of the products marketed through the EmblemHealth Suite. • Each group may choose up to two EmblemHealth Suite options to be available to its employees provided, they have a minimum of 5 enrolled employees. A group may choose up to three EmblemHealth Suite options to be available to its employees provided they have a minimum of 20 enrolled employees. Only one plan of any particular Plan Type may be included in the plans offered. • A group may change the Plan Types offered only on the group's anniversary. • An employee may only change the plan option elected on the group's anniversary.
Rating Tiers	• EmblemHealth small group business (2-50 eligible employees) will be offered on a 4-tier rating basis only.

Employee Eligibility	Groups must demonstrate an employer/employee relationship for all eligible employees.
	
	EmblemHealth evaluates eligibility based on the United States Internal Revenue Service's definition of an employee of an employer group or a bona fide employer member of an association group.
	
	▪ EmblemHealth only covers full-time employees. EmblemHealth defines full-time eligible employees as employees who work 20 or more hours per week, each week. If an employer requires a longer number of hours worked in order to meet eligibility, then EmblemHealth will use the employer's criteria to define full-time eligible employees.
	▪ The following categories of employees are not eligible for small group coverage:
	  ▪ Retirees and their dependent(s).
	  ▪ Individuals who receive 1099 Forms and their dependents.
	  ▪ Seasonal employees and their dependents.
	  ▪ Leased employees.
	
	A group must provide proof of employment for each employee at the time of application or at the time of periodic eligibility audits. Each employee to be enrolled must appear on a NYS-45 or NYS-45-ATT. Individuals and/or groups not meeting eligibility requirements as a result of these audits will be terminated.
	
	▪ The NYS-45 or NYS-45-ATT must be the filed copy for the quarter preceding the desired

effective date of coverage. The status of each employee must be indicated on the form as applicable: Full-time, Part-time (less than 20 hours worked per week), Permanent, Temporary, Waiving, Eligible, not-Eligible, Enrolling, Class distinction if applicable.

- In the absence of providing a NYS-45 or a NYS-45-ATT, the group must provide a signed copy of its full tax return, such as an 1120, 1065, 1120S, LLC or LLP with Schedule K-1, Schedule C or Schedule E.
- If the employer has a benefit waiting period, the employer must provide documentation verifying the terms of the waiting period.

Recent Hires

- In the event that a newly hired employee is not yet listed on filed tax documentation, then a copy of the employee's W-4 or recent payroll check stub must be supplied to qualify for provisional enrollment. If a payroll check stub is supplied, it must include the company name, employee name, number of hours worked and payroll dates. The payroll dates cannot be more than 30 days prior to the date of application.
- The group must produce tax documents within 90 days after the effective date of coverage to substantiate a recent hire's eligibility. If acceptable documentation is not provided to EmblemHealth, then coverage will be terminated as of the individuals and/or groups original effective date.

COBRA Members

- COBRA enrollees must supply a letter of election and a copy of their last payroll report.

Employer Eligibility

A group must be actively operating its business at all times that EmblemHealth coverage will be in effect.

A group applying for a community-rated plan must provide EmblemHealth with all of the following documentation:

- a Federal Employer Identification Number (EIN) and evidence of authority to conduct business in New York State
- confirmation that the group's worksite(s) is in New York State. Street addresses must be provided even for worksite(s) with post office box listings.

If a new business is not able to supply the data above, then EmblemHealth's Letter of Certification from the group's attorney or certified public accountant explaining the specific situation will temporarily suffice. Neither the attorney nor the C.P.A. can be an employee or the relative of an employee of the group. In addition, the Letter of Certification must be accompanied by:

- Articles of Incorporation issued by the State of New York, or
- a certificate to do business issued by the State of New York and
- a payroll record acceptable to EmblemHealth.

The group must produce tax documents within 90 days after the effective date of coverage to substantiate its business operation. Coverage will be terminated if acceptable documentation is not provided within 90 days.

- If a group has been terminated within the prior 12 months due to **non-payment of premium**, EmblemHealth will not issue the group a contract.

Enrollment Policy

- New enrollees must enroll as of their date of hire.
- If the employer has a benefit waiting period, the employee must enroll on the first day of benefit eligibility.
- New groups enrolling with EmblemHealth may waive the waiting period for all employees at the time of initial enrollment.

Eligible employees and/or dependents who do not enroll on the first day of benefit eligibility will not be eligible to enroll until the employer's next annual enrollment period, except in the circumstances below. The enrollment period commences on the anniversary date of coverage and ends after 30 days.

- The individual was covered under another plan or policy at the time the individual was initially eligible to enroll and has lost coverage under the other plan or policy as a result of

	exhaustion of the period of continuation under State of Federal law or
	▪ The loss of eligibility was related to one or more of the following reasons:
	  ▪ termination of employment
	  ▪ termination of the other plan or contract
	  ▪ death of the spouse
	  ▪ legal separation, divorce or annulment
	  ▪ reduction in the number of hours of employment
	  ▪ contract holder contributions toward the payment of premium for the other plan or contract were terminated.
	▪ A court has ordered coverage be provided for a spouse or minor children under a covered employee or member's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order.

Headquarters in New York	If a group has: ▪ its principal location **within** New York State and ▪ it employs no fewer than two (2) and no more than fifty (50) eligible employees at a worksite(s) in New York State then the group can purchase community-rated coverage for its eligible employees, subject to any applicable service area restrictions. Groups with more than one office/location within the State of New York must identify each location and the employees that work at that location.
Headquarters outside New York	If a group has: ▪ its principal location **outside** New York State and ▪ it employs no fewer than two (2) and no more than fifty (50) eligible employees at a worksite(s) in New York State then, • The group can purchase community-rated coverage for its New York employees. The contract for coverage must be delivered to a New York worksite and the contract will only cover employees working at the New York worksite(s).
High Deductible Health Plans	▪ The same member may not have an underlying insured or non-insured plan in conjunction with an HDHP product. ▪ EmblemHealth will require a signed statement that the deductible is not being funded by the employer or any other first dollar coverage plan.
Ongoing Qualification	Periodic surveys of enrolled small groups may be taken by EmblemHealth and/or EmblemHealth's designated administrators to ensure that the group is actively operating its business and remains qualified to be enrolled in a community-rated product. The survey can include, but not be limited to, any or all of the following to verify continued eligibility: ▪ The group's most recently-filed NYS-45 or NYS-45-ATT ▪ Tax documentation as requested by EmblemHealth and/or EmblemHealth's designated administrators. ▪ Payroll information as requested by EmblemHealth and/or EmblemHealth's designated administrators.

Participation	▪ **Non-HMO requirement:** A minimum of two (2) contracts or 60% of the eligible employees, which ever is greater, excluding waivers, must be covered by EmblemHealth. ▪ **HMO Only:** if there is no enrollment in a non-HMO product, there is no minimum participation requirement. ▪ The 60% threshold will be determined by multiplying the number of eligible employees by .60 and rounding fractions down to the nearest whole number. ▪ For groups offering multiple EmblemHealth Suite products, the total number of individuals enrolled in all products will count toward the above minimums. For example, a group with 9 eligible employees has 2 employees waiving coverage, leaving 7 eligible for the purposes of determining participation. Of those 7, 60%, or 4 employees must enroll in order for the group to qualify for coverage. (7 eligible employees x .60 = 4.2, rounded down to 4) ▪ Valid waivers for the purpose of determining participation requirements are: o Covered under spousal coverage, o Covered by Medicare, o Covered by COBRA o Covered through the VA

Premium Rates	Premium rates are based on the group's New York State worksite location(s). Premium rates are not based on the residence of the employee. ▪ Premium rates for satellite office(s) within New York State but outside of the principal worksite's rating region will be rated based on the rating region of the satellite office. ▪ Groups with 2-50 eligible employees (even if only one employee actually enrolls) will receive small group premium rates; groups with one eligible employee (i.e., Sole Proprietors) will receive the Sole Proprietor rates.

[1] *These guidelines do not encompass Government Sponsored programs that EmblemHealth may offer for sale (e.g., Medicare, Healthy New York, etc.) The product sponsor should be consulted for policies and procedures that are applicable to their products. Additionally, these guidelines do not apply to legacy GHI or HIP products, as defined by EmblemHealth. The respective legacy product organization's guidelines apply.*

"EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, HIP Insurance Company of New York, GHI HMO Select Inc., The PerfectHealth Insurance Company, Connecticare of New York Inc. and EmblemHealth Services Company, L.L.C."

HIP INSURANCE COMPANY OF NEW YORK

BROKER COMPENSATION
for COMMUNITY RATED BUSINESS
APPLICABLE TO POS, EPO, and PPO PRODUCTS
EFFECTIVE JUNE 1, 2013

I. Standard Broker Commission Schedule

A. Selling Agent Commissions for New Business and Renewals

	Small Groups (1-50 eligible employees)	Large Groups (51+ eligible employees)
POS [2]		4%
Select EPO	0% [1]	4%
Select PPO	0% [1]	4%

Commissions are paid on first $0-$10 million in annual premium per account. No commission are paid on annual premiums above $10 million

[1] For renewing business where the commission rate or administrative fee changes from that of the previous year, the commission rate or administrative rate will change on the group's renewal date

[2] Applies to the out of network portion of POS cases insured under dual HIP/HIPIC contracts

B. General Agents Administrative Fees for New Business and Renewal Groups

	Small Groups (1-50 eligible employees)	Large Groups (51+ eligible employees)
POS [2]		2%
Prime EPO		2%
Prime PPO		2%
Select EPO	$0 to $10 PCPM[3][4]	2%
Select PPO	$0 to $10 PCPM[3][4]	2%
Maximum Limits	$50,000 per account	On annual premium from $0-$10 million

[3] Per Contract Per Month.
[4] No fees ($0) are payable in connection with 0% commission products

ALL COMMISSIONS AND FEES ARE SUBJECT TO CHANGE
DUE TO REGULATORY OR PLAN INSTRUCTION

HIP INSURANCE COMPANY OF NEW YORK

BROKER COMPENSATION
for COMMUNITY RATED BUSINESS
APPLICABLE TO POS, EPO, and PPO PRODUCTS
EFFECTIVE JUNE 1, 2013

II. Standard Broker Commission Policies

A. Direct Pay

- No commissions or service fees will be paid on any direct pay product

B. Broker of Record Letter on Business Previously Written Directly by HIP

- Commissions will be paid on any Broker of Record Letter business previously written directly with HIP only when the Broker substantially increases HIP's membership to the levels stated below:

  Small Groups

  - HIP will pay Broker if option/slice is converted into total replacement

  Large Groups

  - HIP will pay commissions when account penetration is increased by the higher of the following: 25 subscribers or 50%

- Commissions will be paid using the Standard Broker Commission Schedule I

C. Broker of Record Letter on Business Currently Subject to Broker Commissions

Small Groups (1-50 eligible employees)	Large Groups (51+ eligible employees)
0% [1]	4%

Commissions are paid on first $0-$5 million in annual premium per account. No commissions are paid on annual premiums above $5 million.

Commissions are paid using the above schedule starting the first month following the date of the Broker of Record Letter.

[1] For renewing business where the commission rate or administrative fee changes from that of the previous year, the commission rate or administrative rate will change on the group's renewal date

ALL COMMISSIONS AND FEES ARE SUBJECT TO CHANGE
DUE TO REGULATORY OR PLAN INSTRUCTION

III. Administrative Fees

This section describes alternative compensation available to Agents who perform administrative services normally performed by HIP employees ("Administrative Services"). Such Administrative Services are compensated based upon a per contract per month methodology ("PCPM") or a per member per month ("PMPM"). The PCPM or PMPM amount will be between $0 and $10, depending upon the scope and extent of the services provided, the experience and reputation of the Agent and negotiated market forces. Some of the more common Administrative Services are set forth below:

i. Process insurance applications;
ii. Bill, collect and receive premium due;
iii. Generate and issue the appropriate termination documentation;
iv. Generate and issue change in enrollment/eligibility forms;
v. Perform routine services for Groups;
vi. Recruit Selling Agents;
vii. Provide other administrative functions, at HIP's discretion, consistent with HIP policies and procedures; and
viii. Provide appropriate reporting services.

ALL COMMISSIONS AND FEES ARE SUBJECT TO CHANGE
DUE TO REGULATORY OR PLAN INSTRUCTION