

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

Filing at a Glance

Company: Independent Health Benefits Corporation
Product Name: Individual - off Exchange
State: New York
TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI: HOrg02I.005B Individual - Point-of-Service (POS)
Filing Type: Off Exchange NG Forms & Rates
Date Submitted: 05/14/2013
SERFF Tr Num: NDPD-129027745
SERFF Status: Assigned
State Tr Num: 2013050105
State Status: IA Awaiting Initial Action
Co Tr Num: IHBC-C1024

Implementation 01/01/2014

Date Requested:

Author(s):

[Redacted]

Reviewer(s):

[Redacted]

Disposition Date:

Disposition Status:

Implementation Date:

State Filing Description:

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

General Information

Project Name: Individual - off Exchange	Status of Filing in Domicile:
Project Number: IHBC-C1024	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact:	Filing Status Changed: 05/15/2013
	State Status Changed: 05/15/2013
Deemer Date:	Created By: [REDACTED]
Submitted By: [REDACTED]	Corresponding Filing Tracking Number: IHBC-C1024

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Independent Health is submitting our Individual products for plans off The Exchange, including Child-Only, for your review and approval.

The enclosed information contains trade secrets that are maintained for the regulation of Independent Health. If this information is disclosed it will cause substantial injury to Independent Health's competitive position in the New York State health and insurance markets.

For these reasons, the information being submitted should be excepted from any Freedom of Information Law disclosure pursuant to §87 of the Public Officers Law. Should there be a Freedom of Information Law request for the information being submitted, Independent Health intends to fully exercise any rights it may have pursuant to §89 of the Public Officers Law.

Company and Contact

Filing Contact Information

[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

Filing Company Information

Independent Health Benefits Corporation	CoCode: 47034	State of Domicile: New York
[REDACTED]	Group Code: -99	Company Type: Health Article 43
[REDACTED]	Group Name:	State ID Number: 16-1483784
[REDACTED]	FEIN Number: 16-1483784	

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

State Specific

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: Article 43
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation.): No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): o
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:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

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):
Independent Health Benefits Corporation	New Product	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

Rate Review Detail

COMPANY:

Company Name: Independent Health Benefits Corporation
HHS Issuer Id: 18029
Product Names: Platinum Plan A, Platinum Plan A (CO), Platinum Plan B, Platinum Plan B (CO), Gold Plan A, Gold Plan A (CO), Silver Plan A, Silver Plan A (CO), Bronze Plan A, Bronze Plan A (CO)

Trend Factors:

FORMS:

New Policy Forms: IHBC-R1064, IHBC-SBB002-4, IHBC-SBB001-4, IHBC-SBS002-4, IHBC-SBS001-4, IHBC-SBG002-4, IHBC-SBG001-4, IHBC-SBP008-4, IHBC-SBP002-4, IHBC-SBP003-4, IHBC-SBP001-4, IHBC-C1024

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 0
Benefit Change: None
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

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

REQUESTED RATE:

Projected Earned Premium: 0.00
Projected Incurred Claims: 0.00
Annual \$: Min: 0.00 Max: 0.00 Avg: 0.00

SERFF Tracking #:

NDPD-129027745

State Tracking #:

2013050105

Company Tracking #:

IHBC-C1024

State:

New York

Filing Company:

Independent Health Benefits Corporation

TOI/Sub-TOI:

HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)

Product Name:

Individual - off Exchange

Project Name/Number:

Individual - off Exchange/IHBC-C1024

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Material	IHBC-C1024	New		A43_Ind_offEx_Manual_2014_Rev_2013_5_14.pdf,



*Dedicated to
Making a Difference*

Independent Health Benefits Corporation

Independent Health's Individual Rate Manual

For Plans offered Off the New York State's Health Insurance Exchange

Effective January 1, 2014



*Dedicated to
Making a Difference*

Independent Health Benefits Corporation

511 Farber Lakes Drive

Buffalo, NY 14221

**Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange**

Table of Contents

Section	Description	Start Page
A.	Premium Pages	1
B.	Benefit Grids	2
C.	Rating Regions / Expected Loss Ratio	6

Independent Health Benefits Corporation
Individual Off Exchange Premium Rates Effective January 1, 2014

HIOS Plan ID	Form Numbers		Product Name	Product Description	NCC	Single	Double	Employee / Child(ren)	Family	
Platinum Plans										
18029NY1180001-00	IHBC-C1024	IHBC-SBP001-4	Platinum Plan A	Base	\$467 73	\$644 51	\$1,289 02	\$1,095 67	\$1,836 85	
18029NY1180002-00	IHBC-C1024	IHBC-SBP001-4	IHBC-R1064	Platinum Plan A	Base with Dependent to 29	\$469 46	\$646 87	\$1,293 74	\$1,099 68	\$1,843 58
18029NY1180009-00	IHBC-C1024	IHBC-SBP003-4	Platinum Plan A (CO)	Base	\$467 73	\$265 54	N/A	N/A	N/A	
18029NY1190001-00	IHBC-C1024	IHBC-SBP002-4	Platinum Plan B	Base	\$467 70	\$644 47	\$1,288 94	\$1,095 60	\$1,836 74	
18029NY1190002-00	IHBC-C1024	IHBC-SBP002-4	IHBC-R1064	Platinum Plan B	Base with Dependent to 29	\$469 43	\$646 83	\$1,293 66	\$1,099 61	\$1,843 47
18029NY1190005-00	IHBC-C1024	IHBC-SBP008-4	Platinum Plan B (CO)	Base	\$467 70	\$265 52	N/A	N/A	N/A	
Gold Plans										
18029NY1220001-00	IHBC-C1024	IHBC-SBG001-4	Gold Plan A	Base	\$405 94	\$560 21	\$1,120 42	\$952 36	\$1,596 60	
18029NY1220002-00	IHBC-C1024	IHBC-SBG001-4	IHBC-R1064	Gold Plan A	Base with Dependent to 29	\$407 44	\$562 25	\$1,124 50	\$955 83	\$1,602 41
18029NY1220009-00	IHBC-C1024	IHBC-SBG002-4	Gold Plan A (CO)	Base	\$405 94	\$230 81	N/A	N/A	N/A	
Silver Plans										
18029NY1260001-00	IHBC-C1024	IHBC-SBS001-4	Silver Plan A	Base	\$354 58	\$490 14	\$980 28	\$833 24	\$1,396 90	
18029NY1260002-00	IHBC-C1024	IHBC-SBS001-4	IHBC-R1064	Silver Plan A	Base with Dependent to 29	\$355 90	\$491 94	\$983 88	\$836 30	\$1,402 03
18029NY1260009-00	IHBC-C1024	IHBC-SBS002-4	Silver Plan A (CO)	Base	\$354 58	\$201 94	N/A	N/A	N/A	
Bronze Plans										
18029NY1310009-00	IHBC-C1024	IHBC-SBB001-4	Bronze Plan A	Base	\$296 79	\$411 30	\$822 60	\$699 21	\$1,172 21	
18029NY1310010-00	IHBC-C1024	IHBC-SBB001-4	IHBC-R1064	Bronze Plan A	Base with Dependent to 29	\$297 89	\$412 80	\$825 60	\$701 76	\$1,176 48
18029NY1310013-00	IHBC-C1024	IHBC-SBB002-4	Bronze Plan A (CO)	Base	\$296 79	\$169 45	N/A	N/A	N/A	

Benefits	Platinum Plan A	Platinum Plan A (CO)	Platinum Plan B	Platinum Plan B (CO)
Deductible	\$0	\$0	\$0	\$0
Standard plans = Embedded Non-standard = True Family				
Coinsurance, if applicable (plan responsibility)	100%	100%	100%	100%
OOP Maximum	\$2,000	\$2,000	\$2,000	\$2,000
Rx	\$10/\$30/\$60	\$10/\$30/\$60	\$10/\$30/\$60	\$10/\$30/\$60
Medical Benefits:				
Emergency Room Services	\$100	\$100	\$100	\$100
All Inpatient Hospital Services (inc. MHSA)	\$500	\$500	\$500	\$500
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	\$15	\$15	\$15	\$15
Specialist Visit	\$35	\$35	\$35	\$35
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$15	\$15	\$15	\$15
Imaging (CT/PET Scans, MRIs)	\$35	\$35	\$35	\$35
Rehabilitative Speech Therapy	\$25	\$25	\$25	\$25
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$25	\$25	\$25	\$25
Preventive Care/Screening/Immunization	\$0 preventive	\$0 preventive	\$0 preventive	\$0 preventive
Laboratory Outpatient and Professional Services	\$35	\$35	\$35	\$35
X-rays and Diagnostic Imaging	\$35	\$35	\$35	\$35
Skilled Nursing Facility	\$500	\$500	\$500	\$500
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100	\$100	\$100	\$100
Outpatient Surgery Physician/Surgical Services	\$100	\$100	\$100	\$100
\$250 First Dollar Primary Care Allowance: See Assumptions #17	N/A	N/A	N/A	N/A
Wellness benefit (required as part of Essential Health Benefits)	Oxford Gym	Oxford Gym	Oxford Gym	Oxford Gym
In-Network Deductible (single) Standard Plans = Embedded Non-standard = True Family	\$0	\$0	\$0	\$0
In-Network Coinsurance	100%	100%	100%	100%
In-Network Out-of-Pocket Max Limit (single) Includes the deductible	\$2,000	\$2,000	\$2,000	\$2,000
Out-of-Network Deductible (Separate)	\$2000	\$2,000	N/A	N/A
Out-of-Network Coinsurance	40%	40%	N/A	N/A
Out-of-Network Out-of-Pocket Max :	Unlimited	Unlimited	N/A	N/A

Benefits	Gold Plan A	Gold Plan A (CO)
Deductible	\$600	\$600
Standard plans = Embedded Non-standard = True Family		
Coinsurance, if applicable (plan responsibility)	100%	100%
OOP Maximum	\$4,000	\$4,000
Rx	\$10/\$35/\$70	\$10/\$35/\$70
Medical Benefits:		
Emergency Room Services	\$150	\$150
All Inpatient Hospital Services (inc. MHSA)	\$1,000	\$1,000
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	\$25	\$25
Specialist Visit	\$40	\$40
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$25	\$25
Imaging (CT/PET Scans, MRIs)	\$40	\$40
Rehabilitative Speech Therapy	\$30	\$30
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30	\$30
Preventive Care/Screening/Immunization	\$0 preventive	\$0 preventive
Laboratory Outpatient and Professional Services	\$40	\$40
X-rays and Diagnostic Imaging	\$40	\$40
Skilled Nursing Facility	\$1,000	\$1,000
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100	\$100
Outpatient Surgery Physician/Surgical Services	\$100	\$100
\$250 First Dollar Primary Care Allowance: See Assumptions #17	N/A	N/A
Wellness benefit (required as part of Essential Health Benefits)	Oxford Gym	Oxford Gym
In-Network Deductible (single) Standard Plans = Embedded Non-standard = True Family	\$600	\$600
In-Network Coinsurance	100%	100%
In-Network Out-of-Pocket Max Limit (single) Includes the deductible	\$4,000	\$4,000
Out-of-Network Deductible (Separate)	\$2,500	\$2,500
Out-of-Network Coinsurance	40%	40%
Out-of-Network Out-of-Pocket Max :	Unlimited	Unlimited

Benefits	Silver Plan A	Silver Plan A (CO)
Deductible	\$2,000	\$2,000
Standard plans = Embedded		
Non-standard = True Family		
Coinsurance, if applicable (plan responsibility)	100%	100%
OOP Maximum	\$5,500	\$5,500
Rx	\$10/\$35/\$70	\$10/\$35/\$70
Medical Benefits:		
Emergency Room Services	\$150	\$150
All Inpatient Hospital Services (inc. MHSA)	\$1,500	\$1,500
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	\$30	\$30
Specialist Visit	\$50	\$50
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$30	\$30
Imaging (CT/PET Scans, MRIs)	\$50	\$50
Rehabilitative Speech Therapy	\$30	\$30
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30	\$30
Preventive Care/Screening/Immunization	\$0 preventive	\$0 preventive
Laboratory Outpatient and Professional Services	\$50	\$50
X-rays and Diagnostic Imaging	\$50	\$50
Skilled Nursing Facility	\$1,500	\$1,500
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100	\$100
Outpatient Surgery Physician/Surgical Services	\$100	\$100
\$250 First Dollar Primary Care Allowance: See Assumptions #17	N/A	N/A
Wellness benefit (required as part of Essential Health Benefits)	Oxford Gym	Oxford Gym
In-Network Deductible (single) Standard Plans = Embedded Non-standard = True Family	\$2,000	\$2,000
In-Network Coinsurance	100%	100%
In-Network Out-of-Pocket Max Limit (single) Includes the deductible	\$5,500	\$5,500
Out-of-Network Deductible (Separate)	\$3,000	\$3,000
Out-of-Network Coinsurance	40%	40%
Out-of-Network Out-of-Pocket Max :	Unlimited	Unlimited

Benefits	Bronze Plan A	Bronze Plan A (CO)
Deductible Standard plans = Embedded Non-standard = True Family	\$3,000	\$3,000
Coinsurance, if applicable (plan responsibility)	50%	50%
OOP Maximum	\$6,350	\$6,350
Rx	\$10/\$35/\$70	\$10/\$35/\$70
Medical Benefits:		
Emergency Room Services	50%	50%
All Inpatient Hospital Services (inc. MHSA)	50%	50%
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	50%	50%
Specialist Visit	50%	50%
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	50%	50%
Imaging (CT/PET Scans, MRIs)	50%	50%
Rehabilitative Speech Therapy	50%	50%
Rehabilitative Occupational and Rehabilitative Physical Therapy	50%	50%
Preventive Care/Screening/Immunization	0% preventive	0% preventive
Laboratory Outpatient and Professional Services	50%	50%
X-rays and Diagnostic Imaging	50%	50%
Skilled Nursing Facility	50%	50%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50%	50%
Outpatient Surgery Physician/Surgical Services	50%	50%
\$250 First Dollar Primary Care Allowance: See Assumptions #17	N/A	N/A
Wellness benefit (required as part of Essential Health Benefits)	Oxford Gym	Oxford Gym
In-Network Deductible (single) Standard Plans = Embedded Non-standard = True Family	\$3,000	\$3,000
In-Network Coinsurance	50%	50%
In-Network Out-of-Pocket Max Limit (single) Includes the deductible	\$6,350	\$6,350
Out-of-Network Deductible (Separate)	\$5,000	\$5,000
Out-of-Network Coinsurance	50%	50%
Out-of-Network Out-of-Pocket Max :	Unlimited	Unlimited

Independent Health Benefits Corporation

511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual For Plans Offered Off the NYS Health Insurance Exchange

Rating Regions

The rating region for this rate manual is the Western New York service area including Erie, Chautauqua, Cattaraugus, Genesee, Niagara, Wyoming, Allegany, and Orleans Counties.

Expected Loss Ratio

The Expected Loss Ratio for all products in this manual is 87%

Since this rate manual applies to individual business only, broker commissions do not apply. However, IHBC has filed it's broker commissions on SERFF under state tracking number 2013030148.

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	The applicable Product Checklists are attached.
Attachment(s):	Individual Product Checklist NON-Standard - off.pdf Individual Product Checklist Standard - off.pdf Individual Product Checklist Standard Child-only - off.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Readability Certification
Comments:	The applicable readability certificates are attached.
Attachment(s):	IHBC-C1024 Individual PLC.pdf Schedule of Benefits Individual OFF Exch PLC.pdf Individual Rider PLC.pdf IHBC-C1025 Child Only PLC.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Explanation of Variability
Comments:	The applicable Explanation of Variability is attached.
Attachment(s):	Explanation of Variability Child Only IHBC-C1025.pdf Explanation of Variability Individual (on & off Exchange) IHBC-C1024.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Black-lined Copy of Model Language
Comments:	The applicable redlined documents are attached.

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

Attachment(s):

Section VII - Exclusions LANGUAGE redlined.pdf
 Cover Page Redlined.pdf
 Table of Contents Individual redlined.pdf
 Section I Definitions Redlined Redlined.pdf
 Section II How Your Coverage Works Redlined.pdf
 Section III Access to Care Redlined.pdf
 Section IV Cost-Sharing Redlined.pdf
 Section VIII - Claims Model Language redlined.pdf
 Section IX - Grievance Model Language #1 redlined.pdf
 Section IX - UR Model Language #2 redlined.pdf
 Section IX - External Appeal language #3 redlined.pdf
 Section X - Termination redlined.pdf
 Section XI - Extension of Benefits #1 redlined.pdf
 Section XI - Conversion #2 redlined.pdf
 Section XI - Temporary Rights for Members of Armed Forces of the United States #3 redlined.pdf
 B001-4 Individual Off Standardized Plan redlined.pdf
 B002-4 Individual Off Standardized Child Only Plan redlined.pdf
 Section XII - General Contract Provisions redlined.pdf
 Section V WHO IS COVERED Redlined.pdf
 Section VI - Additional Benefits redlined.pdf
 Section VI - Dental Care #11 redlined.pdf
 Section VI - Emergency and Urgent Care #3 redlined.pdf
 Section VI - Prescription Drug Coverage #8 redlined.pdf
 Section VI - Primary Preventive Care DFS #1 redlined.pdf
 Section VI - Wellness #9 redlined.pdf
 Section VI - Inpatient Services #6 redlined.pdf
 Section VI - Mental Health and Substance Use Services #7 redlined.pdf
 Section VI - Outpatient and Professional Services language #4 redlined.pdf
 Section VI - Pediatric Vision #10 redlined.pdf
 Section VI - Pre-Hospital Emergency Medical Services #2 redlined.pdf
 Child Only Cover Page Redlined.pdf
 Section I Child Only Definitions redlined.pdf

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

	Section II Child Only How Your Coverage Works redlined.pdf Section V Child Only Who is Covered Language redlined.pdf Section X - Child Only Termination redlined.pdf P001-4 Ind. Off Standardized Plan redlined.pdf P002-4 Ind. Off Standardized Plan redlined.pdf P003-4 Ind Off Standardized Plan redlined.pdf P008-4 Ind Off Standardized Child Only redlined.pdf G001-4 Individual Off Standard redlined.pdf G002-4 Individual Off Child Only Standard redlined.pdf S001-4 Redline.pdf S002-4 Redline.pdf Rider Age 29 redlined.pdf
--	--

Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Individual Medical Rate Instructions/Checklist
Comments:	IHBC checked the attached Individual checklist.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	AV Calculator_IHBC IND_Off Exchange.pdf
Item Status:	
Status Date:	

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: Individual - off Exchange
Project Name/Number: Individual - off Exchange/IHBC-C1024

Bypassed - Item:	Exhibit 7-Historical Data
Bypass Reason:	IHBC did not sell individual products prior to 2014.
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	
Attachment(s):	Exhibit 8_Individual_IHBC_Off exchange.pdf Exhibit 8_Individual_IHBC_Off exchange.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	
Attachment(s):	Exhibit 9_IND_IHBC_OffExchange.pdf Exhibit 9_IND_IHBC_OffExchange.xls
Item Status:	
Status Date:	
Satisfied - Item:	Redacted Documents for Web Posting-NG Off Exchange
Comments:	
Attachment(s):	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508_Redacted.pdf Exhibit 1 IHBC IND Off Exchange_Redacted.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	plan_management_data_templates_unified_INDIVIDUAL_OFF_Exchange.pdf plan_management_data_templates_unified_INDIVIDUAL_OFF_Exchange.xlsm
Item Status:	
Status Date:	

SERFF Tracking #:

NDPD-129027745

State Tracking #:

2013050105

Company Tracking #:

IHBC-C1024

State:

New York

Filing Company:

Independent Health Benefits Corporation

TOI/Sub-TOI:

HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)

Product Name:

Individual - off Exchange

Project Name/Number:

Individual - off Exchange/IHBC-C1024

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

<u>TOI</u>	<u>LINE(S) OF INSURANCE</u>	<u>Sub-TOI</u>
H0rg021	Individual Health Organization Health Maintenance (HMO)	H0rg021.005B Individual POS H0rg021.005D Individual HMO
Individual Health	Major Medical	H161.005A Individual PPO H161.005C Individual Other
Individual Health	Hospital Surgical Medical Expense	H15I.001 Health
H06	Health Conversion	H06.000 Conversion

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

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

**NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist**

		<p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions. <i>Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.</i></p> <p>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 <input type="checkbox"/> No <input type="checkbox"/> (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.</p>	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by group” to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF. 	Compliant
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.	Compliant
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	<p>The filing must include a SERFF filing description or a letter of submission that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) 	
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	Compliant

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Compliant
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	Section II, page 1
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	Section II, page 1-2
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	Section II, page 1-2
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	Section II, page 2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	\$500.00, whichever is less, is permissible.	
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	Section II, page 3
Contact Information Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	Section II, page 3
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	Section III, page 1
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured’s medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	Section III, page 1
Standing Referrals Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	Section III, page 1
Specialty Care Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	Section III, page 1
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			Section IV, page 3
ELIGIBILITY	Model Language	For each of the following eligibility provisions model language <u>must</u> be used.	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	Section V, page 1
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	Section V, page 1
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	Section V, page 1
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. <i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i>	Section V, page 1
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. <i>Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the</i>	Section V, page 3

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.</i>	
Adopted Children and Step-Children	11NYCRR52.17(a)(30) , (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	Section V, page 1
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	Section V, page 3-4
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	Section V, page 2-3
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	<i>The following benefits <u>must</u> be included in the policy or contract form.</i> Standard Products: Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.</p> <p><u>Non-Standard Products:</u> Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	Section VI, page 1
Federally Mandated Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	Section VI, page 1

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>Section VI, page 2</p>
<p>Mammography Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>Section VI, page 2</p>
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 2</p>
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for 	<p>Section VI, page 2-3</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>osteoporosis.</p> <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance</p>	
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>Section VI, page 3</p>
<p>EMERGENCY SERVICES AND URGENT CARE</p>			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(24) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p>	<p>Section VI, page 3</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting. 	
<p>Emergency Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage 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. <p><i>Note the following definitions must be used:</i></p> <p><i>Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph” to stabilize” means, with respect to an emergency condition, to provide such medical treatment of the condition as may be</i></p>	<p>Section VI, page 4-5</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).</i>	
Urgent Care Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	Section VI, page 7

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>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.</p> <p><i>Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.</p>	<p>Section VI, page 7</p>
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the</i></p>	<p>§4328 §3216(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 8</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p><i>addition of benefits to EHB categories are only permissible in Non-Standard Products.</i></p> <p>Non-Standard Product? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>		<p><i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.</i></p>	
<p>Non-Standard Benefit explanation: Benefit will not vary for Standard vs. Non-Standard</p>			
<p>Home Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(6) §4303(a)(3) Model Language</p>	<p>This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p>	<p>Section VI, page 8</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.</i>	
Interruption of Pregnancy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. <i>Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.</i>	Section VI, page 8
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form. 	Section VI, page 8
Infusion Therapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) Model Language</p>	<p>injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 9</p>
<p>Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language</p>	<p>This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 9</p>
<p>Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(7) §4303(a)(1) Model Language</p>	<p>This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 9</p>
<p>Outpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how</p>	<p>45 CFR § 156.100 §4328 §3216(l) Model Language</p>	<p>This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i> Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more</i></p>	<p>Section VI, page 9-10</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

this substitution or addition differs from the Standard benefit in the space provided.		<i>visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.</i>	
<u>Non-Standard Benefit explanation:</u> Benefit will not vary for Standard vs. Non-Standard			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. <ul style="list-style-type: none"> • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	Section VI, page 10
Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Mandatory Second Surgical Opinion Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	Not Applicable
Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Surgical Services	45 CFR § 156.100 §4328	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed	Section VI , page 10

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) 11 NYCRR § 52.6 Model Language</p>	<p>reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician’s assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Oral Surgery</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language</p>	<p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures:</p> <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 10</p>
<p>Mastectomy Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §3216(i)(20) §4328 §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>Section VI, page 11</p>
<p>Post Mastectomy Reconstruction</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(20) §4328 §4303(x) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.</p>	<p>Section VI, page 11</p>
<p>Transplants</p>	<p>45 CFR § 156.100 §3215(l)</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart,</p>	<p>Section VI, page 11</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(25) Model Language 11 NYCRR 440	<p>This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p> <p>The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.</p> <p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p>	Section VI, page 11-12

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. <i>Note: For Standard Products, the medical benefit cost-sharing must apply. For Non-Standard Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.</i> <i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i>	Section VI, page 13-14
Durable Medical Equipment and Braces Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 14
Hearing Aids Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. <i>{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i> Bone anchored hearing aids must be covered only if an insured has either of the following: <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. <i>{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i>	Section VI, page 15

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
<p>Hospice Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member’s immediate family cope with the emotional and social issues related to the Member’s death.</p> <p>Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.</i></p>	<p>Section VI, page 15</p>
<p>Prosthetics</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>External Prosthetic Devices: This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown.</p> <p><i>Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.</i></p> <p>Internal Prosthetic Devices: This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 15-16</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 16</p>
<p>Maternity Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(10) §4328 4303(c) Model Language</p>	<p>This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951.</p> <p>Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.</p>	<p>Section VI, page 17</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 17
Inpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. <i>Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the “per condition” and/or “per lifetime” limit.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>For the purposes of this benefit, “per condition” means the disease or injury causing the need for the therapy.</i>	Section VI, page 17
<u>Non-Standard Benefit explanation:</u> Benefits will not vary for Standard vs. Non-Standard			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(d) 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 17</p>
<p>End of Life Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.</p>	<p>Section VI, page 18</p>
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
<p>Inpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>Section VI, page 18</p>
<p>Outpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.</p>	<p>This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p>	<p>Section VI, page 18</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>Section VI, page 19</p>
<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to</p>	<p>This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of</p>	<p>Section VI, page 19</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 20</p>
<p>Off-Label Cancer Drug Usage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(12) §4328 §4303(q) Model Language</p>	<p>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.</p>	<p>Section VI, page 20</p>
<p>Usual and Customary Cost of Prescribed Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language</p>	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	<p>Section VI, page 21</p>
<p>Prohibition for Tier IV Drugs</p>	<p>§4328 §3216(l) §4303(gg) PHL §4406-c(7)</p>	<p>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).</p>	<p>Compliant</p>
<p>Eye Drops</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(hh) Model Language</p>	<p>The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not</p>	<p>Section VI, page 20</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(12-a)(A) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	Section VI, page 23
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	Section VI, page 22
Contraceptive Drugs and Devices Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. Contraceptive coverage must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	Section VI, page 20
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of \$200.00 for the subscriber and \$100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. <i>Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

provided by this QHP filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<u>Explanation:</u>			
ADDITIONAL BENEFITS		Additional benefits may be covered in the non-standard Exchange plans only.	
Family Vision Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	Not Applicable
Orthotics Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	Not Applicable
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	Not Applicable
<u>Explanation:</u>			
Acupuncture		This policy or contract form provides coverage for acupuncture.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	Section VII, Page 1
Convalescent and Custodial Care	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Necessary.	Section VII, Page 1
Cosmetic Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(5)) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	Section VII, Page 1
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	Section VII, Page 1
Dental Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	Section VII, Page 1
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 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.	Section VII, Page 1
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	Section VII, Page 1
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(6)) Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	Section VII, Page 2
Government Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	Section VII, Page 2
Medically Necessary Model Language Used?	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent	Section VII, Page 2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		certified by the State.	
Medicare or Other Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	Section VII, Page 2
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4) (i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	Section VII, Page 2
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	Section VII, Page 2
Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	Section VII, Page 2
Services Provided by a Family Member Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services 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.	Section VII, Page 2
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	Section VII, Page 2
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	Section VII, Page 2
Vision Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	Section VII, Page 2
Workers' Compensation	11NYCRR52.16(c)(8))	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		Section VII, Page 2
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	Section VII, Page 2
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	Section VIII, Page 1
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	Section VIII, Page 1
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 	Section IX, Pages 1-2
Utilization Review Policies and Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; 	Section IX, Pages 2-5

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language	<ul style="list-style-type: none"> the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; the right to designate a representative; a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and further appeal rights, if any. 	
External Appeal Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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: <ul style="list-style-type: none"> Instructions on how to request an external appeal; The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and The timeframe for submitting an external appeal. 	Section IX, Pages 5-8
TERMINATION OF COVERAGE Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language §4306(c) §4304(c)	<i>The following are the only termination provisions permissible under the Insurance Law.</i> <i>The model language must be used for each of the following termination provisions.</i>	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	Section X, Page 1
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	Section X, Page 1
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	Section XII, Page 19
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	Section X, Page 1-2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

**NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist**

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§2.17(a)(15) Model Language</p>	<p>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.</p> <p>If the covered persons' coverage terminates, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.</p>	
<p>Suspension of Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension. 	<p>Section XI, Page 2</p>
<p>Conversion - Right to a New Contract After Termination Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306(i) §3216(c)(5)</p>	<p>This policy or contract form provides that (a) if an individual is no longer covered under a “family policy or contract” because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e. bronze, silver, gold, or platinum) that covers all benefits required by state and federal law.</p> <p>Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the “family policy or contract” or whose young adult coverage terminates.</p> <p>Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.</p>	<p>Section XI, Pages 1-2</p>
<p>GENERAL PROVISIONS</p>			<p>Form/Page/Para Reference</p>
<p>Incontestability Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306 §3216(d)(1)(B)(1) Model Language</p>	<p>The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.</p>	<p>Section XII, Page 2</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	Section XII, Page 1
Action in Law or Equity Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	Section XII, Page 4
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) 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).	Section XII, Pages 3-4
Unilateral Modification Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR52.17(a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	Section XII, Page 1
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	Section XII, Page 4
SCHEDULE OF BENEFITS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Standard Benefit Design Description Chart Model Language	This policy or contract <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization <u>must</u> be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	Compliant
Limitations on Annual Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose “restricted” annual dollar limits for essential health benefits.	Compliant

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language		
Insured's Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	Compliant
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Rider <input type="checkbox"/>	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	In our plans with Out-of-Network coverage, it is built into the base Contract. No Rider will be made available
Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	Compliant
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF. <i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 87 %.	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	IHBC Ind Prod Off-Exchange
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	IHBC Ind Prod Off-Exchange
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.	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 87 %.	IHBC Ind Prod Off-Exchange 2014 Act Memo
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none">e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions.f. Description of revised rating classes, factors and discounts.g. Examples of rate calculations.h. Outline of marketing rules and methods.i. Underwriting guidelines.j. Expected loss ratio(s).	
--	--	--	--

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

<u>TOI</u>	<u>LINE(S) OF INSURANCE</u>	<u>Sub-TOI</u>
H0rg021	Individual Health Organization Health Maintenance (HMO)	H0rg021.005B Individual POS H0rg021.005D Individual HMO
Individual Health	Major Medical	H161.005A Individual PPO H161.005C Individual Other
Individual Health	Hospital Surgical Medical Expense	H15I.001 Health
H06	Health Conversion	H06.000 Conversion

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions. <i>Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.</i></p> <p>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 <input type="checkbox"/> No <input type="checkbox"/> (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.</p>	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by group” to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF. 	Compliant
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.	Compliant
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	<p>The filing must include a SERFF filing description or a letter of submission that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) 	
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	Compliant

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Compliant
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	Section II, page 1
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	Section II, page 1-2
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	Section II, page 1-2
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	Section II, page 2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	\$500.00, whichever is less, is permissible.	
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	Section II, page 3
Contact Information Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	Section II, page 3
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	Section III, page 1
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured’s medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	Section III, page 1
Standing Referrals Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	Section III, page 1
Specialty Care Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	Section III, page 1
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			Section IV, page 3
ELIGIBILITY	Model Language	For each of the following eligibility provisions model language <u>must</u> be used.	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	Section V, page 1
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	Section V, page 1
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	Section V, page 1
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. <i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i>	Section V, page 1
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. <i>Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the</i>	Section V, page 3

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.</i>	
Adopted Children and Step-Children	11NYCRR52.17(a)(30) , (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	Section V, page 1
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	Section V, page 3-4
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	Section V, page 2-3
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	<i>The following benefits <u>must</u> be included in the policy or contract form.</i> Standard Products: Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.</p> <p><u>Non-Standard Products:</u> Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	Section VI, page 1
Federally Mandated Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	Section VI, page 1

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>Section VI, page 2</p>
<p>Mammography Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>Section VI, page 2</p>
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 2</p>
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for 	<p>Section VI, page 2-3</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>osteoporosis.</p> <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance</p>	
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>Section VI, page 3</p>
<p>EMERGENCY SERVICES AND URGENT CARE</p>			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(24) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p>	<p>Section VI, page 3</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting. 	
<p>Emergency Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage 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. <p><i>Note the following definitions must be used:</i></p> <p><i>Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph” to stabilize” means, with respect to an emergency condition, to provide such medical treatment of the condition as may be</i></p>	<p>Section VI, page 4-5</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).</i>	
Urgent Care Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	Section VI, page 7

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>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.</p> <p><i>Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.</p>	<p>Section VI, page 7</p>
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the</i></p>	<p>§4328 §3216(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 8</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p><i>addition of benefits to EHB categories are only permissible in Non-Standard Products.</i></p> <p>Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>		<p><i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.</i></p>	
<p><u>Non-Standard Benefit explanation:</u></p>			
<p>Home Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(6) §4303(a)(3) Model Language</p>	<p>This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p>	<p>Section VI, page 8</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.</i>	
Interruption of Pregnancy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. <i>Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.</i>	Section VI, page 8
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form. 	Section VI, page 8
Infusion Therapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) Model Language	injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Outpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i> Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more</i>	Section VI, page 9-10

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

this substitution or addition differs from the Standard benefit in the space provided.		<i>visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.</i>	
<u>Non-Standard Benefit explanation:</u>			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. <ul style="list-style-type: none">• This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist.• This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. 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.	Section VI, page 10
Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Mandatory Second Surgical Opinion Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	Not Applicable
Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider’s recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Surgical Services	45 CFR § 156.100 §4328	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed	Section VI , page 10

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) 11 NYCRR § 52.6 Model Language</p>	<p>reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician’s assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Oral Surgery Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language</p>	<p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures:</p> <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 10</p>
<p>Mastectomy Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §3216(i)(20) §4328 §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>Section VI, page 11</p>
<p>Post Mastectomy Reconstruction Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(20) §4328 §4303(x) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.</p>	<p>Section VI, page 11</p>
<p>Transplants</p>	<p>45 CFR § 156.100 §3215(l)</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart,</p>	<p>Section VI, page 11</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(25) Model Language 11 NYCRR 440	<p>This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p> <p>The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.</p> <p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p>	Section VI, page 11-12

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. <i>Note: For Standard Products, the medical benefit cost-sharing must apply. For Non-Standard Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.</i> <i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i>	Section VI, page 13-14
Durable Medical Equipment and Braces Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 14
Hearing Aids Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. <i>{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i> Bone anchored hearing aids must be covered only if an insured has either of the following: <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. <i>{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i>	Section VI, page 15

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	<p>This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member’s immediate family cope with the emotional and social issues related to the Member’s death.</p> <p>Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.</i></p>	Section VI, page 15
Prosthetics Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	<p>External Prosthetic Devices: This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown.</p> <p><i>Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.</i></p> <p>Internal Prosthetic Devices: This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	Section VI, page 15-16

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 16</p>
<p>Maternity Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(10) §4328 4303(c) Model Language</p>	<p>This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951.</p> <p>Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.</p>	<p>Section VI, page 17</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 17
Inpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. <i>Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the “per condition” and/or “per lifetime” limit.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>For the purposes of this benefit, “per condition” means the disease or injury causing the need for the therapy.</i>	Section VI, page 17
<u>Non-Standard Benefit explanation:</u>			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(d) 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 17</p>
<p>End of Life Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.</p>	<p>Section VI, page 18</p>
<p>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES</p>			
<p>Inpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>Section VI, page 18</p>
<p>Outpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.</p>	<p>This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p>	<p>Section VI, page 18</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>Section VI, page 19</p>
<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to</p>	<p>This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of</p>	<p>Section VI, page 19</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>Section VI, page 20</p>
<p>Off-Label Cancer Drug Usage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(12) §4328 §4303(q) Model Language</p>	<p>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.</p>	<p>Section VI, page 20</p>
<p>Usual and Customary Cost of Prescribed Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language</p>	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	<p>Section VI, page 21</p>
<p>Prohibition for Tier IV Drugs</p>	<p>§4328 §3216(l) §4303(gg) PHL §4406-c(7)</p>	<p>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).</p>	<p>Compliant</p>
<p>Eye Drops</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(hh) Model Language</p>	<p>The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not</p>	<p>Section VI, page 20</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(12-a)(A) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	Section VI, page 23
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	Section VI, page 22
Contraceptive Drugs and Devices Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. Contraceptive coverage must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	Section VI, page 20
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of \$200.00 for the subscriber and \$100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. <i>Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

provided by this QHP filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<u>Explanation:</u>			
ADDITIONAL BENEFITS		Additional benefits may be covered in the non-standard Exchange plans only.	
Family Vision Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	Not Applicable
Orthotics Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	Not Applicable
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	Not Applicable
<u>Explanation:</u>			
Acupuncture		This policy or contract form provides coverage for acupuncture.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	Section VII, Page 1
Convalescent and Custodial Care	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Necessary.	Section VII, Page 1
Cosmetic Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(5)) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	Section VII, Page 1
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	Section VII, Page 1
Dental Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	Section VII, Page 1
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 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.	Section VII, Page 1
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)) 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.	Section VII, Page 1
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(6)) Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	Section VII, Page 2
Government Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	Section VII, Page 2
Medically Necessary Model Language Used?	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent	Section VII, Page 2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		certified by the State.	
Medicare or Other Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	Section VII, Page 2
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4) (i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	Section VII, Page 2
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	Section VII, Page 2
Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	Section VII, Page 2
Services Provided by a Family Member Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services 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.	Section VII, Page 2
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	Section VII, Page 2
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	Section VII, Page 2
Vision Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	Section VII, Page 2
Workers' Compensation	11NYCRR52.16(c)(8))	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		Section VII, Page 2
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	Section VII, Page 2
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	Section VIII, Page 1
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	Section VIII, Page 1
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 	Section IX, Pages 1-2
Utilization Review Policies and Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; 	Section IX, Pages 2-5

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language	<ul style="list-style-type: none"> the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; the right to designate a representative; a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and further appeal rights, if any. 	
External Appeal Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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: <ul style="list-style-type: none"> Instructions on how to request an external appeal; The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and The timeframe for submitting an external appeal. 	Section IX, Pages 5-8
TERMINATION OF COVERAGE Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language §4306(c) §4304(c)	<i>The following are the only termination provisions permissible under the Insurance Law.</i> <i>The model language must be used for each of the following termination provisions.</i>	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	Section X, Page 1
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	Section X, Page 1
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	Section XII, Page 19
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	Section X, Page 1-2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§2.17(a)(15) Model Language</p>	<p>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.</p> <p>If the covered persons' coverage terminates, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.</p>	
<p>Suspension of Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension. 	<p>Section XI, Page 2</p>
<p>Conversion - Right to a New Contract After Termination</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306(i) §3216(c)(5)</p>	<p>This policy or contract form provides that (a) if an individual is no longer covered under a “family policy or contract” because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e. bronze, silver, gold, or platinum) that covers all benefits required by state and federal law.</p> <p>Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the “family policy or contract” or whose young adult coverage terminates.</p> <p>Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.</p>	<p>Section XI, Pages 1-2</p>
<p>GENERAL PROVISIONS</p>			<p>Form/Page/Para Reference</p>
<p>Incontestability</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306 §3216(d)(1)(B)(1) Model Language</p>	<p>The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.</p>	<p>Section XII, Page 2</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	Section XII, Page 1
Action in Law or Equity Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	Section XII, Page 4
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) 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).	Section XII, Pages 3-4
Unilateral Modification Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR52.17(a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	Section XII, Page 1
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	Section XII, Page 4
SCHEDULE OF BENEFITS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Standard Benefit Design Description Chart Model Language	This policy or contract <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization <u>must</u> be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	Compliant
Limitations on Annual Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose “restricted” annual dollar limits for essential health benefits.	Compliant

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language		
Insured's Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	Compliant
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Rider <input type="checkbox"/>	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	In our plans with Out-of-Network coverage, it is built into the base Contract. No Rider will be made available
Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	Compliant
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF. <i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i>	

**NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist**

		<i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 87 %.	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	IHBC Ind Prod Off-Exchange
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	IHBC Ind Prod
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.	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 87 %.	IHBC Ind Prod Off-Exchange 2014 Act Memo
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none">e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions.f. Description of revised rating classes, factors and discounts.g. Examples of rate calculations.h. Outline of marketing rules and methods.i. Underwriting guidelines.j. Expected loss ratio(s).	
--	--	--	--

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions. <i>Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.</i></p> <p>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 <input type="checkbox"/> No <input type="checkbox"/> (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.</p>	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by group” to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF. 	Compliant
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.	Compliant
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	<p>The filing must include a SERFF filing description or a letter of submission that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) 	
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	Compliant

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

APPLICATION FORMS	Model Language		Form/Page/Para Reference
Model Application Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
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.	
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	IHBC-C1025
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Compliant
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	Compliant
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	Compliant
Table of Contents	§ 3102(c)(1)(G) Model Language	A table of contents is required.	Compliant
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
DEFINITIONS	§ 3217 Model Language	<i>Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.</i>	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Compliant
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	IHBC-C1025 Section II, page 1
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	IHBC-C1025 Section II, page 1-2
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	IHBC-C1025 Section II, page 1-2
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	IHBC-C1025 Section II, page 2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	\$500.00, whichever is less, is permissible.	
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	IHBC-C1025 Section II, page 3
Contact Information Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	IHBC-C1025 Section II, page 3
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	IHBC-C1024 Section III, page 1
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured’s medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	IHBC-C1024 Section III, page 1
Standing Referrals Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	IHBC-C1024 Section III, page 1
Specialty Care Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	IHBC-C1024 Section III, page 1
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>PHL §4403(6)(e) Model Language</p>	<p>provider’s contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer’s contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured’s care and adhere to the insurer’s policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.</p>	<p>IHBC-C1024 Section III, page 2</p>
<p>Transitional Care For A New Member in a Course of Treatment</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language</p>	<p>If an insured is in an ongoing course of treatment with a non-participating provider when the insured’s coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured’s coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the 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.</p>	<p>IHBC-C1024 Section III, page 2</p>
<p>COST-SHARING EXPENSES AND ALLOWED AMOUNT.</p>			
<p>Cost of Service</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3201(c)(3) 11 NYCRR 52.1(c) Model Language</p>	<p>If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.</p>	
<p>Reimbursement of Providers</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language</p>	<p>This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.</p>	<p>IHBC-C1024 Section IV, page 3</p>
<p>Non-Participating Providers and Non-Authorized Services</p>	<p>§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language</p>	<p>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.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			IHBC-C1024 Section IV, page
ELIGIBILITY	Model Language	For each of the following eligibility provisions model language <u>must</u> be used.	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	IHBC-C1025 Section V, page 1
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	Not Applicable
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	Not Applicable
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. <i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i>	Not Applicable
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. <i>Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the</i>	Not Applicable

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.</i>	
Adopted Children and Step-Children	11NYCRR52.17(a)(30) , (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	Not Applicable
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	Not Applicable
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	IHBC-C1025 Section V, page 1-3
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	<i>The following benefits <u>must</u> be included in the policy or contract form.</i> Standard Products: Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.</p> <p><u>Non-Standard Products:</u> Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	IHBC-C1024 Section VI, page 1
Federally Mandated Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	IHBC-C1024 Section VI, page 1

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>IHBC-C1024 Section VI, page 2</p>
<p>Mammography Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>IHBC-C1024 Section VI, page 2</p>
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 2</p>
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for 	<p>IHBC-C1024 Section VI, page 2-3</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>osteoporosis.</p> <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance</p>	
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>IHBC-C1024 Section VI, page 3</p>
<p>EMERGENCY SERVICES AND URGENT CARE</p>			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(24) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p>	<p>IHBC-C1024 Section VI, page 3</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting. 	
<p>Emergency Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage 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. <p><i>Note the following definitions must be used:</i> <i>Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph” to stabilize” means, with respect to an emergency condition, to provide such medical treatment of the condition as may be</i></p>	<p>IHBC-C1024 Section VI, page 4-5</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).</i>	
Urgent Care Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 7
Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 7
Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 7
Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 7
Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	IHBC-C1024 Section VI, page 7

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>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.</p> <p><i>Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.</p>	<p>IHBC-C1024 Section VI, page 7</p>
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the</i></p>	<p>§4328 §3216(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 8</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p><i>addition of benefits to EHB categories are only permissible in Non-Standard Products.</i></p> <p>Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>		<p><i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.</i></p>	
<p><u>Non-Standard Benefit explanation:</u></p>			
<p>Home Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(6) §4303(a)(3) Model Language</p>	<p>This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p>	<p>IHBC-C1024 Section VI, page 8</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.</i>	
Interruption of Pregnancy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. <i>Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.</i>	IHBC-C1024 Section VI, page 8
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form. 	IHBC-C1024 Section VI, page 8
Infusion Therapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 9
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 9
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) Model Language</p>	<p>injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 9</p>
<p>Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language</p>	<p>This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 9</p>
<p>Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(7) §4303(a)(1) Model Language</p>	<p>This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 9</p>
<p>Outpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how</p>	<p>45 CFR § 156.100 §4328 §3216(l) Model Language</p>	<p>This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i> Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more</i></p>	<p>IHBC-C1024 Section VI, page 9-10</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

this substitution or addition differs from the Standard benefit in the space provided.		<i>visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.</i>	
<u>Non-Standard Benefit explanation:</u>			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. <ul style="list-style-type: none">• This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist.• This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. 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.	IHBC-C1024 Section VI, page 10
Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 10
Mandatory Second Surgical Opinion Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	Not Applicable
Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 10
Surgical Services	45 CFR § 156.100 §4328	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed	IHBC-C1024 Section VI , page

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) 11 NYCRR § 52.6 Model Language	reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician’s assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Oral Surgery Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 10
Mastectomy Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §3216(i)(20) §4328 §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	IHBC-C1024 Section VI, page 11
Post Mastectomy Reconstruction Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(20) §4328 §4303(x) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	IHBC-C1024 Section VI, page 11
Transplants	45 CFR § 156.100 §3215(l)	This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart,	IHBC-C1024 Section VI, page

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(25) Model Language 11 NYCRR 440	<p>This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p> <p>The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.</p> <p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p>	IHBC-C1024 Section VI, page 11-12

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. <i>Note: For Standard Products, the medical benefit cost-sharing must apply. For Non-Standard Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.</i> <i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i>	IHBC-C1024 Section VI, page 13-14
Durable Medical Equipment and Braces Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 14
Hearing Aids Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. <i>{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i> Bone anchored hearing aids must be covered only if an insured has either of the following: <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. <i>{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i>	IHBC-C1024 Section VI, page 15

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Hospice Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language</p>	<p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p>This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member’s immediate family cope with the emotional and social issues related to the Member’s death.</p> <p>Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.</i></p>	<p>IHBC-C1024 Section VI, page 15</p>
<p>Prosthetics</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>External Prosthetic Devices: This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown.</p> <p><i>Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.</i></p> <p>Internal Prosthetic Devices: This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 15-16</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 16</p>
<p>Maternity Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(10) §4328 4303(c) Model Language</p>	<p>This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951.</p> <p>Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.</p>	<p>IHBC-C1024 Section VI, page 17</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IHBC-C1024 Section VI, page 17
Inpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. <i>Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the “per condition” and/or “per lifetime” limit.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>For the purposes of this benefit, “per condition” means the disease or injury causing the need for the therapy.</i>	IHBC-C1024 Section VI, page 17
<u>Non-Standard Benefit explanation:</u>			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(d) 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 17</p>
<p>End of Life Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.</p>	<p>IHBC-C1024 Section VI, page 18</p>
<p>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES</p>			
<p>Inpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>IHBC-C1024 Section VI, page 18</p>
<p>Outpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.</p>	<p>This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p>	<p>IHBC-C1024 Section VI, page 18</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>IHBC-C1024 Section VI, page 19</p>
<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to</p>	<p>This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of</p>	<p>IHBC-C1024 Section VI, page 19</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>IHBC-C1024 Section VI, page 20</p>
<p>Off-Label Cancer Drug Usage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(12) §4328 §4303(q) Model Language</p>	<p>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.</p>	<p>IHBC-C1024 Section VI, page 20</p>
<p>Usual and Customary Cost of Prescribed Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language</p>	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	<p>IHBC-C1024 Section VI, page 21</p>
<p>Prohibition for Tier IV Drugs</p>	<p>§4328 §3216(l) §4303(gg) PHL §4406-c(7)</p>	<p>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).</p>	<p>Compliant</p>
<p>Eye Drops</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(hh) Model Language</p>	<p>The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not</p>	<p>IHBC-C1024 Section VI, page 20</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(12-a)(A) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	IHBC-C1024 Section VI, page 23
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	IHBC-C1024 Section VI, page 22
Contraceptive Drugs and Devices Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. Contraceptive coverage must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	IHBC-C1024 Section VI, page 20
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of \$200.00 for the subscriber and \$100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. <i>Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

provided by this QHP filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<u>Explanation:</u>			
ADDITIONAL BENEFITS		Additional benefits may be covered in the non-standard Exchange plans only.	
Family Vision Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	Not Applicable
Orthotics Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	Not Applicable
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	Not Applicable
<u>Explanation:</u>			
Acupuncture		This policy or contract form provides coverage for acupuncture.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	IHBC-C1024 Section VII, Page 1
Convalescent and Custodial Care	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Necessary.	IHBC-C1024 Section VII, Page
Cosmetic Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(5)) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	IHBC-C1024 Section VII, Page 1
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	IHBC-C1024 Section VII, Page 1
Dental Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	IHBC-C1024 Section VII, Page 1
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 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.	IHBC-C1024 Section VII, Page 1
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)) (i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	IHBC-C1024 Section VII, Page 1
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(6)) Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	IHBC-C1024 Section VII, Page 2
Government Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	IHBC-C1024 Section VII, Page 2
Medically Necessary Model Language Used?	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent	IHBC-C1024 Section VII, Page 2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		certified by the State.	
Medicare or Other Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	IHBC-C1024 Section VII, Page 2
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4) (i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	IHBC-C1024 Section VII, Page 2
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	IHBC-C1024 Section VII, Page 2
Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	IHBC-C1024 Section VII, Page 2
Services Provided by a Family Member Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services 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.	IHBC-C1024 Section VII, Page 2
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	IHBC-C1024 Section VII, Page 2
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	IHBC-C1024 Section VII, Page 2
Vision Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	IHBC-C1024 Section VII, Page 2
Workers' Compensation	11NYCRR52.16(c)(8))	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		IHBC-C1024 Section VII, Page
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	IHBC-C1024 Section VII, Page 2
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	IHBC-C1024 Section VIII, Page 1
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	IHBC-C1024 Section VIII, Page 1
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 	IHBC-C1024 Section IX, Pages 1-2
Utilization Review Policies and Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; 	IHBC-C1024 Section IX, Pages 2-5

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language	<ul style="list-style-type: none"> the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; the right to designate a representative; a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and further appeal rights, if any. 	
External Appeal Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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: <ul style="list-style-type: none"> Instructions on how to request an external appeal; The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and The timeframe for submitting an external appeal. 	IHBC-C1024 Section IX, Pages 5-8
TERMINATION OF COVERAGE Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language §4306(c) §4304(c)	<i>The following are the only termination provisions permissible under the Insurance Law.</i> <i>The model language must be used for each of the following termination provisions.</i>	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	iHBC-C1025 Section X, Page 1
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	IHBC-C1025 Section X, Page 1
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	IHBC-C1024 Section XII, Page 19
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	IHBC-C1024 Section X, Page 1-2

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	Not Applicable
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	Not Applicable
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Not Applicable
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	Not Applicable
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	Not Applicable
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.	IHBC-C1025 Section X, Page 1
Rescission Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	IHBC-C1025 Section X, Page 1
Renewal	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	IHBC-C1024 Section XII, Page 3
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	IHBC-C1025 Section X, Page 1
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits	11 NYCRR	This policy or contract form provides that when coverage under this policy or contract form ends,	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§2.17(a)(15) Model Language</p>	<p>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.</p> <p>If the covered persons' coverage terminates, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.</p>	<p>IHBC-C1024 Section XI, Page 1</p>
<p>Suspension of Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension. 	<p>IHBC-C1024 Section XI, Page 2</p>
<p>Conversion - Right to a New Contract After Termination</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306(i) §3216(c)(5)</p>	<p>This policy or contract form provides that (a) if an individual is no longer covered under a “family policy or contract” because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e. bronze, silver, gold, or platinum) that covers all benefits required by state and federal law.</p> <p>Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the “family policy or contract” or whose young adult coverage terminates.</p> <p>Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.</p>	<p>IHBC-C1024 Section XI, Pages 1-2</p>
<p>GENERAL PROVISIONS</p>			<p>Form/Page/Para Reference</p>
<p>Incontestability</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306 §3216(d)(1)(B)(1) Model Language</p>	<p>The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.</p>	<p>IHBC-C1024 Section XII, Page 2</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	IHBC-C1024 Section XII, Page 1
Action in Law or Equity Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	IHBC-C1024 Section XII, Page 4
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) 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).	IHBC-C1024 Section XII, Pages 3-4
Unilateral Modification Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR52.17(a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	IHBC-C1024 Section XII, Page 1
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	IHBC-C1024 Section XII, Page 4
SCHEDULE OF BENEFITS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Standard Benefit Design Description Chart Model Language	This policy or contract <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization <u>must</u> be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	Compliant
Limitations on Annual Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose “restricted” annual dollar limits for essential health benefits.	Compliant

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language		
Insured's Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	Compliant
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Rider <input type="checkbox"/>	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	In our plans with Out-of-Network coverage, it is built into the base Contract. No Rider will be made available
Extended Dependent Coverage Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	Not Applicable
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF. <i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 87 %.	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	IHBC Ind Prod Off-Exchange
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	IHBC Ind Prod Off-Exchange
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.	IHBC Ind Prod Off-Exchange 2014 Act Memo 20130508.pdf
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 87 %.	IHBC Ind Prod Off-Exchange 2014 Act Memo
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none">e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions.f. Description of revised rating classes, factors and discounts.g. Examples of rate calculations.h. Outline of marketing rules and methods.i. Underwriting guidelines.j. Expected loss ratio(s).	
--	--	--	--

New York Readability Certificate

This is to certify that the forms listed below are in compliance with New York's Insurance Policy Readability Law.

A. Scoring Option *(select one)*

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is .
2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for each policy form are indicated below.

B. Scope of Test *(select one)*

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

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

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

The undersigned officer of the insurer certifies that the forms in this filing meet the minimum reading ease score. Following are the individual Flesch Scores for each form submitted in this filing:

Form#	Words	Sentences	Syllables	Flesch Score
IHBC-C1024	566	37		46.1
IHBC-C1024 Table of Contents	181	13		64.8
IHBC-C1024 Definitions	2703	104		45.9
IHBC-C1024 How Your Coverage Works	1566	67		45.3
IHBC-C1024 Access to Care and Transitional Care	1205	43		45.7
IHBC-C1024 Cost Sharing Expenses and Allowed Amount	1692	78		45.8
IHBC-C1024 Who is Covered	2039	56		45.4
IHBC-C1024 Covered Services	15,457	615		45.7
IHBC-C1024 Exclusions and Limitations	936	53		47.5

Quality Improvement / Cost Containment Programs

Expense Type (per Supplemental Health Care Exhibit)

Improve Health Outcomes

- Health A to Z: provides members with access to health solutions
- PCIP: Primary Care Coordination
- NIA Cardiac: connects patients with the most appropriate cardiac diagnostic exams

Activities to Prevent Hospital Readmissions

- Case management: coordination of patient services
- Care Transitions: program to prepare members with the knowledge and skills to avoid readmissions to hospitals

Improve Patient Safety and Reduce Medical Errors

- SIU (Special Investigations Unit): recoveries through claims investigations

Wellness & Health Promotion Activities

- P4Pathways: Oncology management services
- Smoking Cessation: programs to help members quit smoking

HIT Expenses for Health Care Quality Improvements

- WNY QMC: P2/QMC data aggregation
- WNYCIE: Clinical Information Exchange
- HEALTHeNET: optimizes delivery of patient information to the healthcare community by leveraging shared infrastructure, technology and intellectual capital.

Note that the above items are considered part of claims expense for Federal MLR purposes; however, certain of these activities, such as case management and SIU, are considered part of administrative expense under New York State regulations.

Actuarial Value Calculations

Independent Health Benefits Corporation

Individual Off Exchange

*****STANDARD PLATINUM PLAN (3-5-2013)*****

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?

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

Desired Metal Tier: **Platinum**

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$0.00	\$0.00	
100.00%	100.00%	
OOP Maximum (\$)		\$2,000.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

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

Options for Additional Benefit Design Limits:

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

*****STANDARD PLATINUM PLAN (3-5-2013)*****

Output

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

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?

*****STANDARD GOLD PLAN (3-5-2013)*****

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

Desired Metal Tier: **Gold**

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$600.00	\$0.00	
100.00%	100.00%	
\$4,000.00		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			Tier 2		
	Subject to Deductible?	Subject to Coinsurance?	Copay, if different	Subject to Deductible?	Subject to Coinsurance?	Copay, if different
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input type="checkbox"/> All	
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$150.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$1,000.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$25.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$25.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$30.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$30.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input checked="" type="checkbox"/> 100%	\$0.00	<input type="checkbox"/>	<input checked="" type="checkbox"/> 100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$1,000.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	96.120%
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	93.220%
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input type="checkbox"/> All	
Generics	<input type="checkbox"/>	<input type="checkbox"/>	\$10.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>	\$35.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>	\$70.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>	\$70.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Options for Additional Benefit Design Limits:

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

*****STANDARD GOLD PLAN (3-5-2013)*****

Status/Error Messages: Calculation Successful.
 Actuarial Value: 79.0%
 Metal Tier: Gold

*****STANDARD SILVER PLAN (3-5-2013)*****

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?

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

Desired Metal Tier: Silver

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$2,000.00	\$0.00	
100.00%	100.00%	
OOP Maximum (\$): \$5,500.00		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			Tier 2		
	Subject to Deductible?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>		95.570%	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>		92.340%	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

*****STANDARD SILVER PLAN (3-5-2013)*****

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 70.7%
 Metal Tier: Silver

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?

*****STANDARD BRONZE PLAN (3-5-2013)*****

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

Desired Metal Tier: **Bronze**

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$3,000.00
		50.00%
		\$6,350.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			Tier 2		
	Subject to Deductible?	Subject to Coinsurance?	Coinurance, if different	Subject to Deductible?	Subject to Coinsurance?	Coinurance, if different
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All	
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	<input type="checkbox"/>	<input type="checkbox"/>	100%
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All	
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

Options for Additional Benefit Design Limits:

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

*****STANDARD BRONZE PLAN (3-5-2013)*****

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 62.0%
 Metal Tier: Bronze

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name Independent Health Benefits Corporation
 NAIC Code 47034
 SERFF Number NDPD-129001055
 Market Segment IND

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

Line #	General								
1	Product*	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold
2	Product ID*	18029NY118	18029NY118	18029NY118	18029NY119	18029NY119	18029NY119	18029NY122	18029NY122
3	Metal Level (or catastrophic)*	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.881	0.881	0.881	0.881	0.881	0.881	0.790	0.790
5	AV Pricing Value (total, risk pool experience based)*	1.041	1.045	1.041	1.041	1.045	1.041	0.904	0.907
6	Plan Type*	POS	POS	POS	EPO	EPO	EPO	POS	POS
7	Plan Name*	Platinum Plan A	Platinum Plan A	Platinum Plan A (CO)	Platinum Plan B	Platinum Plan B	Platinum Plan B (CO)	Gold Plan A	Gold Plan A
8	Plan ID*	18029NY1180001	18029NY1180002	18029NY1180009	18029NY1190001	18029NY1190002	18029NY1190005	18029NY1220001	18029NY1220002
9	Exchange Plan?*	No	No	No	No	No	No	No	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	n/a							
10B	Member-Months for Latest Experience Period	n/a							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	n/a							
11	Average Pricing Actuarial Value reflected in experience period	n/a							
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	515.90							

Market Wide Adjustments to the AV Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	1.000
14	Market wide adjustment for changes in provider network **	1.000
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Impact on risk pool of changes in expected covered membership risk characteristics **	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 ** by the standard rating regions	1.000
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	1.071
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.923
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name Independent Health Benefits Corporation
 NAIC Code 47034
 SERFF Number NDPD-129001055
 Market Segment IND

23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.000							
24	Other 1 (specify)	1.000							
25	Other 2 (specify)	1.000							
26	Other 3 (specify)	1.000							
27	Impact of Market Wide Adjustments (product L13 through L26)	0.988							

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.925	0.925	0.925	0.925	0.925	0.925	0.855	0.855
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	0.939	0.939
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.989	0.989	0.989	0.989	0.989	0.989	0.989	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.004	1.000	1.000	1.004	1.000	1.000	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.187	1.187	1.187	1.187	1.187	1.187	1.189	1.189
35	Profit/Contribution to surplus margins	0.999	0.999	0.999	0.999	0.999	0.999	0.999	0.999
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.001	1.001
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Adjustment for Federal Reinsurance by Plan	0.977	0.977	0.977	0.977	0.977	0.977	0.971	0.971
40	Adjustment for Risk Adjustment by Plan	1.001	1.001	1.001	1.001	1.001	1.001	1.001	1.001
	Adjustment for CSR Plans	1.026	1.026	1.026	1.026	1.026	1.026	1.030	1.030
41	Impact of Plan Level Adjustments (product L28 through L40)	1.088	1.092	1.088	1.088	1.092	1.088	0.946	0.949

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)	554.65	556.69	554.65	554.62	556.65	554.62	482.10	483.87
----	--	---------------	---------------	---------------	---------------	---------------	---------------	---------------	---------------

Exhibit 8 - Index Rate/Plan Design Level Adjus

Company Name Independent Health Benefits Co
 NAIC Code 47034
 SERFF Number NDPD-129001055
 Market Segment IND

Line #	General							
1	Product*	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze
2	Product ID*	18029NY122	18029NY126	18029NY126	18029NY126	18029NY131	18029NY131	18029NY131
3	Metal Level (or catastrophic)*	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.790	0.707	0.707	0.707	0.620	0.620	0.620
5	AV Pricing Value (total, risk pool experience based)*	0.904	0.789	0.792	0.789	0.661	0.663	0.661
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Gold Plan A (CO)	Silver Plan A	Silver Plan A	Silver Plan A (CO)	Bronze Plan A	Bronze Plan A	Bronze Plan A (CO)
8	Plan ID*	18029NY1220009	18029NY1260001	18029NY1260002	18029NY1260009	18029NY1310009	18029NY1310010	18029NY1310013
9	Exchange Plan?*	No	No	No	No	No	No	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							
10B	Member-Months for Latest Experience Period							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)							
11	Average Pricing Actuarial Value reflected in experience period							
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	515.90						

Market Wide Adjustments to the AV Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	
14	Market wide adjustment for changes in provider network **	
15	Market wide adjustment for fee schedule changes **	
16	Market wide adjustment for utilization management changes **	
17	Impact on risk pool of changes in expected covered membership risk characteristics **	
18	Post ACA Ratio Individual risk pool to Small Group risk pool (Indiv. Only)	
19	Adjustment for changes in distribution of risk pool membership by rating regions ** by the standard rating regions	
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	
22	Impact of adjustments due to experience period claim data not being sufficiently credible	

Exhibit 8 - Index Rate/Plan Design Level Adjus

Company Name Independent Health Benefits Co
 NAIC Code 47034
 SERFF Number NDPD-129001055
 Market Segment IND

23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 (specify)							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	Impact of Market Wide Adjustments (product L13 through L26)	0.988						

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.855	0.785	0.785	0.785	0.685	0.685	0.685
29	Pricing actuarial value (only the induced demand factor) #	0.939	0.896	0.896	0.896	0.870	0.870	0.870
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.989	0.989	0.989	0.989	0.989	0.989	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.004	1.000	1.000	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.189	1.191	1.191	1.191	1.194	1.194	1.194
35	Profit/Contribution to surplus margins	0.999	0.999	0.999	0.999	0.999	0.999	0.999
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.001	1.003	1.003	1.003	1.001	1.001	1.001
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Adjustment for Federal Reinsurance by Plan	0.971	0.964	0.964	0.964	0.949	0.949	0.949
40	Adjustment for Risk Adjustment by Plan	1.001	1.001	1.001	1.001	1.001	1.001	1.001
	Adjustment for CSR Plans	1.030	1.034	1.034	1.034	1.041	1.041	1.041
41	Impact of Plan Level Adjustments (product L28 through L40)	0.946	0.827	0.830	0.827	0.694	0.697	0.694

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)	482.10	421.81	423.35	421.81	353.96	355.25	353.96
----	--	---------------	---------------	---------------	---------------	---------------	---------------	---------------

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

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

Company Name: Independent Health Benefits Corporation

NAIC Code: 47034

SERFF Number: NDPD-129001055

Market Segment: IND

- A. Complete a separate ROW for Metal Level/Exchange product in the current new On/Off Exchange product filing.
 - Information should be for all the benefits included in that plan design (medical, drugs, etc).
 - Enter the Metal Tier the On/Off Exchange product belongs to using the drop down menu, or enter a value.
 - Enter the On/Off Designation using the drop down menu.
 - Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.
- B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).
- C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.
- D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium
Platinum	Off Exchange	Platinum Plan A	01/01/14	12/31/14	N/A	0.76%	1.87%	1.44%	0.00%	0.00%	9.10%
Platinum	Off Exchange	Platinum Plan B	01/01/14	12/31/14	N/A	0.76%	1.87%	1.44%	0.00%	0.00%	9.10%
Gold	Off Exchange	Gold Plan A	01/01/14	12/31/14	N/A	0.76%	1.87%	1.44%	0.00%	0.00%	9.10%
Silver	Off Exchange	Silver Plan A	01/01/14	12/31/14	N/A	0.76%	1.87%	1.44%	0.00%	0.00%	9.10%
Bronze	Off Exchange	Bronze Plan A	01/01/14	12/31/14	N/A	0.76%	1.87%	1.44%	0.00%	0.00%	9.10%

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

ND INCLUDED IN CURRENT RATE APPLICATION

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm
Platinum	Off Exchange	Platinum Plan A	13.17%	-0.09%	0.00%	0.00%	-0.04%	34.00%	-0.48%	12.56%	4.23
Platinum	Off Exchange	Platinum Plan B	13.17%	-0.09%	0.00%	0.00%	-0.04%	34.00%	-0.48%	12.56%	4.23
Gold	Off Exchange	Gold Plan A	13.17%	-0.09%	0.00%	0.00%	-0.04%	34.00%	-0.48%	12.56%	3.67
Silver	Off Exchange	Silver Plan A	13.17%	-0.09%	0.00%	0.00%	-0.04%	34.00%	-0.48%	12.56%	3.21
Bronze	Off Exchange	Bronze Plan A	13.17%	-0.09%	0.00%	0.00%	-0.04%	34.00%	-0.48%	12.56%	2.70

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	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Platinum	Off Exchange	Platinum Plan A	10.39	8.00	-	-	50.45	73.06	(0.48)	-	(0.25)	(2.69)	69.64
Platinum	Off Exchange	Platinum Plan B	10.39	8.00	-	-	50.44	73.06	(0.48)	-	(0.25)	(2.69)	69.63
Gold	Off Exchange	Gold Plan A	9.03	6.95	-	-	43.85	63.50	(0.42)	-	(0.22)	(2.34)	60.53
Silver	Off Exchange	Silver Plan A	7.90	6.08	-	-	38.36	55.56	(0.37)	-	(0.19)	(2.05)	52.96
Bronze	Off Exchange	Bronze Plan A	6.63	5.10	-	-	32.19	46.62	(0.31)	-	(0.16)	(1.72)	44.44



Independent Health Benefits Corporation

Individual Off-Exchange Plans

2014 Premium Rates

Prepared for:
Independent Health Benefits Corporation

Prepared by:


Milliman, Inc., New York

One Pennsylvania Plaza
38th Floor
New York, NY 10119 USA

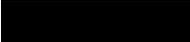

milliman.com

TABLE OF CONTENTS

GENERAL INFORMATION	4
PURPOSE	4
ACTUARIAL QUALIFICATIONS	4
PROPOSED RATE INCREASE(S)	4
EXPERIENCE PERIOD PREMIUM AND CLAIMS	5
BENEFIT CATEGORIES	5
PROJECTION FACTORS	6
CREDIBILITY MANUAL RATE DEVELOPMENT	6
CREDIBILITY OF EXPERIENCE	10
PAID TO ALLOWED RATIO	10
RISK ADJUSTMENT AND REINSURANCE	10
NON-BENEFIT EXPENSES AND PROFIT & RISK	11
PROJECTED LOSS RATIO	12
INDEX RATE	12
AV METAL VALUES	12
AV PRICING VALUES	13
MEMBERSHIP PROJECTIONS	13
TERMINATED PRODUCTS	13
WARNING ALERTS	13
DATA RELIANCE AND CAVEATS	13
ACTUARIAL CERTIFICATION	15

ATTACHMENTS

Attachment A	Proposed rates for Independent Health's Individual Plans
Attachment B	Conversion factor development
Attachment C	Printouts of AV Calculator calculation pages
Attachment D	Description of quality improvement/cost containment programs [Provided by Independent Health]

GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

Company legal name: Independent Health Benefits Corporation

State: New York

HIOS Issuer ID: 18029

Market: Individual

Effective Date: January 1, 2014

COMPANY CONTACT INFORMATION

Primary Contact Name: [REDACTED]

Primary Contact Telephone Number: [REDACTED]

Primary Contact E-mail Address: [REDACTED]

PURPOSE

The purpose of this actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template and the New York State Department of Financial Services Exhibit 8: Index Rate/Plan Design Adjustment Worksheet, which supports compliance with the market rating rules and reasonableness of applicable rate increases.

ACTUARIAL QUALIFICATIONS

I, [REDACTED] am a consulting actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

PROPOSED RATE INCREASE(S)

The proposed rates for Independent Health Benefit's Corporation's (IHBC's) individual plans to be offered for sale outside of the New York Health Benefit Exchange are presented in Attachment A.

All the plans shown in Attachment A are new plans to be offered for sale outside of the New York Health Benefit Exchange effective January 1, 2014. The rate development for these products is consistent with the approach used for IHBC's individual plans on the New York Health Benefit Exchange. All plans on and off the exchange are part of the same risk pool. We used the following methodology to develop these rates.

- **Underlying Claims Experience:** We used the incurred claims from Independent Health's Article 44 sister company Independent Health Association (IHA) for January 1, 2012 through December 31, 2012, paid through March, 2013, as the experience basis for our projections (Individual, FHP, and a portion of the Medicaid population). We also utilized a portion of the 2-4 group size market segment of the IHBC small group market. Commencing in January, in 2014, Independent Health is moving all of its individual products into IHBC. The incurred claims amount includes an estimate for incurred but not reported (IBNR) claims. We used these claims as the basis for the manual rates.

-
- **Morbidity:** We adjusted the 2012 experience to reflect the change in the population we expect in 2014 as a result of the market changes due to the Patient Protection and Affordable Care Act (ACA).
 - **Other:** Independent Health adjusted the IHA Individual, FHP and Medicaid claims experience to reflect IHBC commercial provider contracts as opposed to IHA commercial and Medicaid provider contracts.
 - **Trend:** We applied utilization and cost trends to the underlying claims to reflect the expected claim levels in 2014.
 - **Risk Adjustment and Transitional Reinsurance:** We adjusted the projected claims to reflect payments to or from the individual risk adjustment pool as a result of the ACA risk adjustment effective in 2014. We also reduced the claims for the expected amount of reimbursement from the Federal Transitional Reinsurance Program.
 - **Benefit Adjustment:** The projected claims were adjusted to reflect the benefits that will be offered for each of the products off of the Individual Exchange.
 - The resulting incurred claim estimate was converted to premium rates using a loss ratio of 87%, plus additional taxes and fees.
 - The premium rates also reflect the following taxes and fees that are new for 2014:
 - Contributions to the Federal Transitional Reinsurance Program - \$5.25 PMPM
 - Patient Centered Outcomes Research Fee - \$2 PMPY
 - Risk adjustment user fee - \$0.96 PMPY
 - Health Insurance Tax (HIT) – 2.1% of premium
 - Exchange User Fee – 0% of premium for 2014

The rate development is based on generally accepted actuarial rating principals for rating community rated individual blocks of business.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. IHBC did not sell individual products prior to 2014.

BENEFIT CATEGORIES

Independent Health's claims experience is allocated into benefit categories using the Milliman's Health Cost Guidelines grouper algorithm. This algorithm uses Diagnosis Based Groups (DRGs), Current Procedural Terminology Codes – Fourth Edition (CPT-4 codes), Healthcare Common Procedural Coding System codes (HCPC), and revenue codes to allocate claims into roughly 60 benefit categories. Service classification may also be dependent on criteria such as site of service, physician specialty and procedure code modifier (e.g., anesthesia modifier).

Independent Health then collapsed the 60 categories into the five categories required by Worksheet 1, Section I of the Part 1 Unified Rate Review Template.

PROJECTION FACTORS

Not applicable. IHBC does not currently sell any individual products

CREDIBILITY MANUAL RATE DEVELOPMENT

Source and Appropriateness of Experience Data Used: Prior to 2014 Independent Health offered its individual products through its HMO, IHA. Commencing in January, 2014, the individual plans will be sold through IHBC.

However, the make-up of the New York state individual pool will look very different in 2014 due to the new market rules implemented as a result of the ACA. IHBC believes that 55% of their individual pool membership will come from those currently uninsured. The remaining 45% will come from their current insured membership as follows:

- Current IHA individual insured population – Direct Pay and Healthy New York
- Current IHA & IHBC small group population – Healthy New York Sole Proprietor and Small Groups (<5 employees)
- Current IHA low income insurance population – Medicaid (members whose eligibility changes during the year) and Family Health Plus

For each group we used IHA's claims experience for calendar year 2012, paid through March, 2013 as a starting point for our underlying claims experience. We included an adjustment for IBNR claims. We calculate the IBNR as estimated incurred claims from plan inception through the valuation date less claims paid through the valuation date on those claims.

We use a combination of a claim lag methodology and projection methodology. Using the claim lag methodology, we estimate incurred claims using "claim run-out" methods, which analyze the average lag in payment from the incurral month to the paid month. This historical lag pattern is then used to estimate monthly incurred claims. The lag patterns are derived from the claims data provided, which is the same data that comprises the experience period used in the rate projection. We also calculate estimated incurred claims *per enrollee* for each month in the experience period. Generally, claims per enrollee should fall within a predictable range, and thus, these statistics are used to check the reasonableness of our incurred claims estimates.

For any recent months in the experience period where the claim experience may be too recent to be considered credible, we use a projection methodology. We project our estimate of incurred claims per enrollee per month, derived using the claim lag methodology described above, to the more recent incurred months using an estimated trend factor. The trend factor is selected to reflect anticipated changes in per unit volume of services, mix of services and provider reimbursement levels.

The results of both methods are blended to calculate the final incurred claims estimate. The final IBNR estimate is estimated incurred claims less paid claims through the valuation date.

We pooled the claims experience for these various groups. This experience represents the historical claims experience for 45% of the expected pool post-2014. The remaining 55% will come from the currently uninsured population.

Deloitte, in their report "Impact of the Affordable Care Act on the New York Small Group and Non-Group Markets", March 2013, estimates that the uninsured population has a health status that is 20% better than the currently insured population. However, as these individuals have not had prior insurance we believe there will be some pent up demand in the first year. We estimate a 10% higher cost for the newly insured in the first year due to pent up demand. Therefore, we adjust the experience data as follows to reflect the experience of the anticipated morbidity of the uninsured population:

MARKET	RELATIVE MORBIDITY	PENT-UP DEMAND	DISTRIBUTION
Uninsured	0.75	1.10	55%
Currently Insured (DP/HNY/Medicaid/FHP)	1.00	1.00	45%
Final Adjustment			0.904

We use a relative morbidity for the uninsured of 0.75, slightly healthier than Deloitte’s assumption, this is based on Independent Health’s expectation for the Buffalo uninsured population. We weight the two populations 55% newly insured and 45% currently insured to get a factor of 0.904 as the impact to the existing currently insured population of the morbidity and demographics of the uninsured population.

We then made the following additional adjustments to our starting claim experience pool:

OTHER ADJUSTMENTS

Independent Health adjusted the IHA Individual, FHP and Medicaid claims experience to reflect IHBC commercial provider contracts.

CHANGES IN BENEFITS

All of the benefits provided in IHA’s current individual products would be considered essential health benefits for 2014. The claims experience does not include any non-essential health benefits. However, IHA’s individual products did not cover all New York essential health benefits prior to 2014. The claims experience was adjusted to add the required essential health benefits not offered in 2012. We estimated claims costs from other sources for the following benefits:

- Pediatric dental,
- Pediatric vision,
- Autism coverage, and
- Wellness Benefit (exercise facility)

Pediatric dental: Off the Exchange the pediatric dental benefit will be bundled with the medical benefits. The pediatric dental benefit will be provided via a capitation arrangement with Delta Dental (DDNY Individual PPO filing: SERFF # DDPA-128975982).

Pediatric vision: The pediatric vision benefit is capitated through EyeMed.

Autism: The Autism benefit extends coverage for autism treatment by mandating coverage for Applied Behavioral Analysis therapy and Assistive Communication Devices. We developed the net claims cost PMPM amount for this mandate using a combination of Milliman’s HCGs and published research, including the Oliver Wyman Report titled “Actuarial Cost Estimate: New York Senate Bill S7000A and Assembly Bill A10372”.

Wellness: We estimate the claims costs for the wellness benefit as follows:

- Exercise facility reimbursement: This benefit reimburses \$200 per subscriber and an additional \$100 for another dependent, up to a maximum reimbursement of \$300 per family contract every six months if the member has qualified for the benefit (i.e., completed 60 gym visits in 6 months), in addition to filling out a health risk assessment. We estimated the value of the exercise facility reimbursement benefit by assuming a 5% take-up rate of the benefit in combination with demographics from Milliman’s Health Cost Guidelines.

TREND FACTORS

Independent Health developed the average charge and utilization trends for each of 60 types of medical benefit categories, and we reviewed them for reasonableness. Utilization trend assumptions were generally estimated using the least-squares-based “FORECAST” Excel function and the prior three years’ utilization experience; some manual overrides were employed where FORECAST results appeared to be unreasonable – due to low credibility of the type of service category. Average charge trends were developed based on anticipated (or contracted) provider fee increases.

To estimate prescription drug trends we analyzed IHBC’s prescription drug data from January 2009 through December 2012 to determine recent prescription drug trends and to project future trends into 2014. For our analysis, we first reclassified all the drugs to reflect IHBC’s new ACA-compliant formulary for 2014. Drugs that are no longer on the formulary were allocated to the most likely on-formulary substitute drug. We then reviewed trends by tier to eliminate the effects of changes in tier mix on trend.

The resulting average trend assumptions rolled up to the broad type of service category are summarized below. Please note that these are first dollar or “allowed” trends.

**IHBC COMMERCIAL ALLOWED TREND ASSUMPTIONS 2012 TO 2014 (ANNUALIZED)
BY BROAD TYPE OF SERVICE CATEGORY
BASE MEDICAL SERVICES
INDIVIDUAL**

SERVICE CATEGORY	UTILIZATION	ALLOWED CHARGE	PMPM
Hospital Inpatient	0.1%	6.3%	6.3%
Hospital Outpatient	5.7%	1.8%	7.7%
Physician	3.4%	3.5%	7.0%
Prescription Drugs	3.1%	7.3%	10.6%
Other	6.7%	-1.2%	5.4%
Total Trend			7.6%

INDUCED DEMAND

We applied induced demand at a global level using the HHS induced demand factors presented in the *HHS Notice of Benefit and Payment Parameters for 2014* as shown in the table below. Prior to using the factors we normalized them to the average tier underlying Independent Health’s claims experience, which has an AV equivalent to a platinum plan.

**INDUCED DEMAND ADJUSTMENT USED FOR EACH METAL TIER
IN THE PAYMENT TRANSFER FORMULA**

Metal Level	Induced Demand Adjustment
Catastrophic	1.000
Bronze	1.000
Silver	1.030
Gold	1.080
Platinum	1.150

We used the same induced demand adjustment for each plan within each metal level tier.

ADJUSTMENT FOR COST SHARING REDUCTION PLANS

Individuals with income less than 250% of the federal poverty level (FPL) may purchase the cost sharing reduction (CSR) variation of IHBC’s Silver plans offered on the New York Health Benefit Exchange. When a member purchases one of these plans a portion of the member cost share is paid for by Federal subsidy. The amount of the subsidy is based on the difference in cost sharing based on the assumed utilization for the Silver plan. However, from the member’s perspective the resulting plan has an actuarial value closer to Platinum with the expected increase in utilization due to the lower cost sharing. The risk transfer does not account for the cost of this increased utilization, therefore an adjustment needs to be made to include this cost in the premium rate development.

To develop the value of this adjustment we multiplied the On-Exchange Silver plan allowed cost PMPM by the difference in the induced demand factor between a silver plan and a platinum plan. We assumed no change in induced demand for the CSR plans for 200-250% of FPL. We multiplied this cost by the IHBC’s projected member months for the 100-150% and 150-200% FPL CRS plans. Finally we divided the result by total projected member months in the pool, on- and off-exchange, to get an expected cost of \$11.64 PMPM.

CONVERSION FACTOR

Independent Health expects that in 2014 about 55% of its individual population will come from the currently uninsured market and 45% will be from Independent Health’s currently insured population. The currently insured population will come from Independent Health’s Direct Pay, Healthy New York, Medicaid, and Family Health Plus (FHP), and 20% of the 2-4 group size segment of IHBC’s small group plans. The population in these plans is heavily weighted towards the single premium tier. Independent Health expects the distribution by tier of those currently uninsured to more closely resemble a small group distribution. The conversion factor, developed using the members and subscribers enrolled in Independent Health’s current Direct Pay, Healthy New York and FHP plans, is approximately 1.093. The conversion factor based on Independent Health’s current small group distribution is 1.253. Blending based on the expected uninsured and insured distribution results in a conversion factor for Independent Health’s entire individual risk pool of 1.162. Attachment B shows the detail underlying the calculation of the individual conversion factor.

The tier factors are the New York State mandated standardized tiers. The child only rate is 41.2% of the corresponding single rate as prescribed by New York State.

STANDARD RATING REGION

IHBC is filing rates for Region 2, Buffalo Area.

CREDIBILITY OF EXPERIENCE

Not applicable. IHBC did not sell individual plans prior to 2014. Therefore IHBC's individual plans are 100% manually rated.

PAID TO ALLOWED RATIO

The *Paid to Allowed Average Factor in the Projection Period* for the market is shown on Worksheet 1, Section III of the Part 1 Unified Rate Review Template.

As described above we calculated expected net claims costs PMPM for each plan. We then took a weighted average across the entire pool using projected member months by plan as the weighting to estimate the *Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM*. We then divided this by the *Projected Allowed Experience Claims PMPM* to develop the *Paid to Allowed Average Factor in the Projection Period*.

RISK ADJUSTMENT AND REINSURANCE

PROJECTED RISK ADJUSTMENT

To estimate IHBC's risk factor for the individual pool for 2014 we started with the risk simulation performed by Deloitte and Deloitte's report, *Impact of the Affordable Care Act on the New York Small Group and Non-Group Markets*, March 2013. Using this data we estimated Statewide 2014 membership and risk score for the individual pool for the following categories of individuals: insured prior to 2014, formerly uninsured, formerly small group (assuming 10% leakage from the small group market), and formerly large group (assuming 5% leakage from the large group market). From this we calculated an estimate of the statewide risk score in 2014 for the individual pool.

We then performed a similar exercise for IHBC's expected 2014 individual population. Risk scores for Independent Health's insured population prior to 2014 and the formerly small group population were based on the Deloitte risk simulation. We assumed the formerly uninsured would have a risk score equal to 75% of the insured prior to 2014 group, i.e., slightly healthier than Independent Health's current individual population.

Using the projected statewide and projected Independent Health risk scores, we calculated the expected risk pool transfer as a percent of the statewide average premium. The result was an estimated payment into the pool of 6.7% of premium. We divided IHBC's projected 2014 net claims costs by 1 minus 6.7% to determine the expected net claims costs after risk adjustment.

PROJECTED ACA REINSURANCE RECOVERIES NET OF REINSURANCE PREMIUM

We priced all of IHBC's individual plans to be offered outside of the Exchange using cost models based on Independent Health's claims experience, as described above. As part of that process we calibrated CPDs to each benefit design that reflected the expected frequency and cost of claims for that plan. This CPD was used to calculate the value of the deductible and out-of-pocket maximum for that particular plan and was also used to estimate the value of any recoveries from the transitional reinsurance program. The premium rate for each plan is reduced by the value of the expected recoveries.

To estimate the market-wide impact of the transitional reinsurance program we multiplied the plan specific value by the projected member months for each plan. We assume that Independent Health will receive 80% of the value of these recoveries.

We estimate the net market-wide PMPM impact of the transitional reinsurance program to be:

Assessment	\$5.25
Recoveries	(\$42.71)
Net impact	(\$37.46)

NON-BENEFIT EXPENSES AND PROFIT & RISK

The proposed premium rates reflect a 13% administrative and profit load, exclusive of additional Health Care Reform taxes and fees (e.g., Health Insurer Tax, reinsurance fee). This load was developed by Independent Health as follows.

ADMINISTRATIVE EXPENSE LOAD

Independent Health is using a 13% administrative and profit load (net of ACA taxes), consistent with its currently approved IHBC large group and IHA large and small group filings. However, IHBC anticipates that there will be significant additional ongoing expenses incurred during, at a minimum, the first six months of 2014 due to the impacts of health care reform. For example, billing systems must be enhanced to support the additional complexity necessitated by the potential for members within the same family to purchase different products on different rating tiers. Additionally it will be necessary to reconcile multiple revenue streams and subsidy levels. Furthermore, new IT processes and structures may need to be developed and maintained with external partners (e.g., dental) to accommodate cross-accumulation of deductibles and out-of-pocket maximums. Conversion to ICD-10 is also expected to become effective at the end of 2014 which is a very expensive endeavor for a plan of Independent Health's size.

The allocation of administrative cost components is detailed on the required Exhibit 9 (for simplicity, child-only and cost-share variants have been omitted from this exhibit.) Allocations by cost component were completed in a manner consistent with those reflected in Exhibit 2 submitted for in-force plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment submission, as well as the most recent audited financial statements.

PROFIT (CONTRIBUTION TO SURPLUS) & RISK MARGIN

The proposed rates reflect -0.09% as a risk/profit margin. This load was applied to all products and plans. The expected shortfall will be absorbed by IHBC's accumulated fund balance.

TAXES AND FEES

The following taxes and fees are included in the premium rates:

Contributions to the Federal Transitional Reinsurance Program	\$5.25 PMPM
Patient Centered Outcomes Research Fee	\$2.00 PMPY
Risk Adjustment User Fee	\$0.96 PMPY
Health Insurance Provider Fee	2.1% ¹
New York State Exchange User Fee	0.0% ¹

¹ Percent of premium

The above taxes and fees are subtracted from premiums for the purposes of calculating medical loss ratio (MLR) rebates. Other taxes and fees are included in the administrative expense load described above.

PROJECTED LOSS RATIO

Under section 4308(c)(3)(A) of New York Insurance Law¹, the expected minimum loss ratio for an individual contract form cannot be less than 82%. The target pricing loss ratio for IHBC's individual products in 2014 is 87%. One minus the target loss ratio reflects the percent administrative load.

INDEX RATE

As reported in the Unified Rate Review Template, the Index Rate represents the estimated total combined allowed claims experience PMPM of all non-grandfathered plans for essential health benefits within a market and state. It is allowed claims PMPM for essential health benefits. It is not adjusted for payments and charges under the risk adjustment and reinsurance program or for Exchange user fees.

As IHBC did not sell individual plans prior to 2014 it has no claims experience, therefore it does not have an experience period index rate.

The projection period index rate is the projected allowed claims PMPM for essential health benefits, as shown in Section III in Worksheet 1 of the Unified Rate Review Template. The index rate was calculated by taking a weighted average of the essential health benefit claims for each of the individual plans that IHBC intends to offer for sale outside of the Health Benefit Exchange. The plan index rates were weighted based on projected member months by plan.

AV METAL VALUES

The AV Metal Values included in Worksheet 2 of the Part 1 Unified Rate Review Template were based on the Department of Health and Human Services (HHS) Actuarial Value Calculator (AV Calculator),.

¹ As amended by Chapter 107 of the laws of 2010.

Copies of the AV Calculator pages are provided as Attachment C to this actuarial memorandum. The AV Calculator pages for these standard plans are those provided by the New York Department of Financial Services.

AV PRICING VALUES

The Unified Rate Review Template requires the calculation of an AV Pricing Value for each plan based on a comparison to a fixed reference plan. For Independent Health the fixed reference plan is the standard Platinum plan for ages to 26.

The AV Pricing Value is defined as “the cost to the issuer of providing coverage under the plan (i.e., incurred claims and administrative costs) as a percent of the cost of providing coverage for a fixed reference plan”, that is paid claims plus admin for Plan A divided by allowed claims for the reference plan. Every plan is compared to the reference plan.

MEMBERSHIP PROJECTIONS

For the individual off-exchange market, IHBC is projecting no members by year end. For purposes of filling out the Unified Rate Review Template we have assumed that there will be one member with 12 months of coverage in each plan.

TERMINATED PRODUCTS

Not applicable. IHBC did not sell any individual products prior to 2014.

WARNING ALERTS

UNIFIED RATE REVIEW TEMPLATE

For the individual off-exchange market, IHBC is projecting no members by year end however, for purposes of filling out the Unified Rate Review Template, we have assumed that there will be one member with 12 months of coverage in each plan.

EXHIBIT 8

The New York State Department of Financial Services Required Exhibit 8 includes an additional Plan-Level adjustment to appropriately capture reinsurance recoveries at the plan level. The Market Wide Reinsurance Recovery Adjustment was calculated as one minus the total reinsurance recovery PMPM (estimated as the reinsurance recoveries by plan times the projected member months by plan) divided by the total index rate PMPM. However, since reinsurance recoveries will ultimately vary at the plan level (i.e., plans with higher actuarial values will likely qualify for more reinsurance recoveries) an additional plan-level reinsurance adjustment was incorporated to reconcile to the actual reinsurance recoveries expected under each plan.

We make a similar adjustment for Federal Risk Adjustment.

DATA RELIANCE AND CAVEATS

In developing the premium rates presented in this actuarial memorandum, I relied upon data prepared by [REDACTED] of Independent Health. I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate.

The claims costs suggested were developed from assumptions that have been established based on the available data and other information provided by IHBC. If more relevant data becomes available, the assumptions should be revised. A revision to these might change the results and possibly, the related conclusions.

This Actuarial Memorandum has been prepared by me on behalf of Independent Health Benefits Corporation and provided to insurance regulators in New York State and the Department of Health and Human Services for their internal use in accordance with established regulatory procedures.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this memorandum. Any reader of this report must possess a substantial level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions used in the analysis, and the impact of the assumptions on the illustrated results.

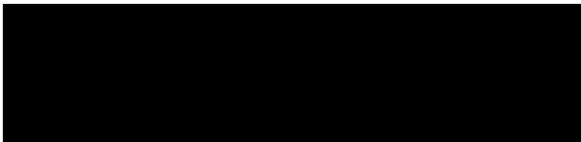
ACTUARIAL CERTIFICATION

I, [REDACTED] am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification. I am associated with the firm of Milliman, Inc. My firm has been retained to provide this certification.

I certify that to the best of my knowledge:

- The submission is in compliance with all applicable laws and regulations of the State of New York
- The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
 - ASOP No. 5, Incurred Health and Disability Claims
 - ASOP No. 8, Regulatory Filings for Health Plan Entities
 - ASOP No. 12, Risk Classification
 - ASOP No. 23, Data Quality
 - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
 - ASOP No. 41, Actuarial Communications
- The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York
- The benefits are reasonable in relation to the premium charged
- The rates are not unfairly discriminatory
- The projected index rate is:
 - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1))
 - Reasonable in relation to the benefits provided and the population anticipated to be covered
 - Neither excessive nor deficient
- The index rate was generated at each plan level with only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV of the Unified Rate Review Template were calculated in accordance with actuarial standards of practice

The Part 1 Unified Rate Review Template and Exhibit 8 do not demonstrate the process used by IHBC to develop the rates presented in this actuarial memorandum. Rather they represent information required by Federal and State regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the index rate is developed in accordance with Federal and State regulation and used consistently and only adjusted by the allowable modifiers.

Signed: 

Title: Principal and Consulting Actuary

Date: May 8, 2013

Attachment A

Independent Health Benefits Corporation
Individual Off Exchange Premium Rates Effective January 1, 2014

HIOS Plan ID	Form Numbers		Product Name	Product Description	NCC	Single	Double	Employee / Child(ren)	Family	
Platinum Plans										
18029NY1180001-00	IHBC-C1024	IHBC-SBP001-4	Platinum Plan A	Base	\$467.73	\$644.51	\$1,289.02	\$1,095.67	\$1,836.85	
18029NY1180002-00	IHBC-C1024	IHBC-SBP001-4	IHBC-R1064	Platinum Plan A	Base with Dependent to 29	\$469.46	\$646.87	\$1,293.74	\$1,099.68	\$1,843.58
18029NY1180009-00	IHBC-C1024	IHBC-SBP003-4	Platinum Plan A (CO)	Base	\$467.73	\$265.54	N/A	N/A	N/A	
18029NY1190001-00	IHBC-C1024	IHBC-SBP002-4	Platinum Plan B	Base	\$467.70	\$644.47	\$1,288.94	\$1,095.60	\$1,836.74	
18029NY1190002-00	IHBC-C1024	IHBC-SBP002-4	IHBC-R1064	Platinum Plan B	Base with Dependent to 29	\$469.43	\$646.83	\$1,293.66	\$1,099.61	\$1,843.47
18029NY1190005-00	IHBC-C1024	IHBC-SBP008-4	Platinum Plan B (CO)	Base	\$467.70	\$265.52	N/A	N/A	N/A	
Gold Plans										
18029NY1220001-00	IHBC-C1024	IHBC-SBG001-4	Gold Plan A	Base	\$405.94	\$560.21	\$1,120.42	\$952.36	\$1,596.60	
18029NY1220002-00	IHBC-C1024	IHBC-SBG001-4	IHBC-R1064	Gold Plan A	Base with Dependent to 29	\$407.44	\$562.25	\$1,124.50	\$955.83	\$1,602.41
18029NY1220009-00	IHBC-C1024	IHBC-SBG002-4	Gold Plan A (CO)	Base	\$405.94	\$230.81	N/A	N/A	N/A	
Silver Plans										
18029NY1260001-00	IHBC-C1024	IHBC-SBS001-4	Silver Plan A	Base	\$354.58	\$490.14	\$980.28	\$833.24	\$1,396.90	
18029NY1260002-00	IHBC-C1024	IHBC-SBS001-4	IHBC-R1064	Silver Plan A	Base with Dependent to 29	\$355.90	\$491.94	\$983.88	\$836.30	\$1,402.03
18029NY1260009-00	IHBC-C1024	IHBC-SBS002-4	Silver Plan A (CO)	Base	\$354.58	\$201.94	N/A	N/A	N/A	
Bronze Plans										
18029NY1310009-00	IHBC-C1024	IHBC-SBB001-4	Bronze Plan A	Base	\$296.79	\$411.30	\$822.60	\$699.21	\$1,172.21	
18029NY1310010-00	IHBC-C1024	IHBC-SBB001-4	IHBC-R1064	Bronze Plan A	Base with Dependent to 29	\$297.89	\$412.80	\$825.60	\$701.76	\$1,176.48
18029NY1310013-00	IHBC-C1024	IHBC-SBB002-4	Bronze Plan A (CO)	Base	\$296.79	\$169.45	N/A	N/A	N/A	

Attachment B

**Independent Health Benefits Corporation
Development of Conversion Factor for Individual Rating Pool**

PRIOR TO 2014

Individual Business (includes DP/HNY Ind/FHP/SP)

	Sbrs	Mbrs	Actual Contract Size	NYS Rate Ratio
Single	80,994	80,994	1.000	1.000
Single + Spouse	7,020	14,042	2.000	2.000
Single + Child	63	126	1.997	1.700
Single + Child(ren)	641	2,171	3.388	1.700
Single + Spouse + Child	163	490	3.000	2.850
Single + Spouse + Child(ren)	4,019	18,549	4.615	2.850
Child Only	3,372	3,372	1.000	0.412
	<u>96,273</u>	<u>119,743</u>	<u>1.244</u>	<u>1.138</u>

Conversion Factor: 1.093

SG Business (proxy for new uninsured)

	Sbrs	Mbrs	Actual Contract Size	Rate Ratio
	164,642	164,642	1.000	1.000
	47,089	94,176	2.000	2.000
	557	1,114	2.000	1.700
	5,201	17,374	3.340	1.700
	1,983	5,949	3.000	2.850
	43,971	199,808	4.544	2.850
	36,642	36,642	1.000	0.412
	<u>300,085</u>	<u>519,704</u>	<u>1.732</u>	<u>1.382</u>

Conversion Factor: 1.253

Assume 53.5/46.5 split of Currently Uninsured/Insured:

Total Uninsured Market:	87,000
Percent in Exchange in Year 1:	70.0%
IH Market Share:	25.0%
IH Individual from Uninsured:	15,225
Existing Ind/SP/HNY/FHP:	13,245
% from Uninsured	53.5%

EXPECTED INDIVIDUAL POPULATION IN 2014

From Currently Insured Individual Business

	Sbrs	Mbrs	Contract Size	Rate Ratio
Single	36,187	36,187	1.000	1.000
Single + Spouse	3,137	6,274	2.000	2.000
Single + Child	28	56	1.997	1.700
Single + Child(ren)	286	970	3.388	1.700
Single + Spouse + Child	73	219	3.000	2.850
Single + Spouse + Child(ren)	1,796	8,287	4.615	2.850
Child Only	1,506	1,506	1.000	0.412
	<u>43,014</u>	<u>53,500</u>	<u>1.244</u>	<u>1.138</u>

Conversion Factor: 1.093

From Currently Uninsured

	Sbrs	Mbrs	Contract Size	Rate Ratio
68%	14,731	14,731	1.000	1.000
12%	4,213	8,426	2.000	2.000
0%	50	100	2.000	1.700
2%	465	1,554	3.340	1.700
0%	177	532	3.000	2.850
15%	3,934	17,878	4.544	2.850
3%	3,279	3,279	1.000	0.412
100%	<u>26,850</u>	<u>46,500</u>	<u>1.732</u>	<u>1.382</u>

Conversion Factor: 1.253

Blended Conversion Factor for 2014 Individual Pool

	Sbrs	Mbrs	Contract Size	Rate Ratio
32%	50,919	50,919	1.000	1.000
18%	7,350	14,700	2.000	2.000
0%	78	156	1.999	1.700
3%	752	2,524	3.358	1.700
1%	250	751	3.000	2.850
38%	5,730	26,165	4.566	2.850
7%	4,785	4,785	1.000	0.412
100%	<u>69,863</u>	<u>100,000</u>	<u>1.431</u>	<u>1.232</u>

Conversion Factor: 1.162

Attachment C

*****STANDARD PLATINUM PLAN (3-5-2013)*****

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?

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

Platinum

Desired Metal Tier

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$0.00	\$0.00	
100.00%	100.00%	
OOP Maximum (\$)		
\$2,000.00		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Deductible (\$)
 \$0.00
 \$0.00
 Coinsurance (%; Insurer's Cost Share)
 100.00%
 100.00%
 OOP Maximum (\$)
 \$2,000.00
 OOP Maximum if Separate (\$)

[Click Here for Important Instructions](#)

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

Options for Additional Benefit Design Limits:

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

*****STANDARD PLATINUM PLAN (3-5-2013)*****

Output

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

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?

*****STANDARD GOLD PLAN (3-5-2013)*****

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

Desired Metal Tier: **Gold**

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$600.00	\$0.00	
100.00%	100.00%	
\$4,000.00		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			Tier 2		
	Subject to Deductible?	Subject to Coinsurance?	Coinurance, if different	Subject to Deductible?	Subject to Coinsurance?	Coinurance, if different
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All	
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	<input type="checkbox"/>	<input type="checkbox"/>	100%
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	96.120%	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93.220%	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All	
Generics	<input type="checkbox"/>	<input type="checkbox"/>	\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>	\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>	\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>	\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

Options for Additional Benefit Design Limits:

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

*****STANDARD GOLD PLAN (3-5-2013)*****

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 79.0%
 Metal Tier: Gold

*****STANDARD SILVER PLAN (3-5-2013)*****

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?

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

Desired Metal Tier: Silver

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$2,000.00	\$0.00	
100.00%	100.00%	
\$5,500.00		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Deductible (\$) \$0.00
 Coinsurance (%; Insurer's Cost Share) 100.00%
 OOP Maximum (\$) \$5,500.00
 OOP Maximum if Separate (\$) \$5,500.00

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			Tier 2		
	Subject to Deductible?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input type="checkbox"/> All	
Emergency Room Services	<input checked="" type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	95.570%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	92.340%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All		<input type="checkbox"/> All	<input type="checkbox"/> All	
Generics	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

*****STANDARD SILVER PLAN (3-5-2013)*****

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 70.7%
 Metal Tier: Silver

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?

*****STANDARD BRONZE PLAN (3-5-2013)*****

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

Desired Metal Tier: **Bronze**

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$3,000.00
		50.00%
		\$6,350.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			Tier 2		
	Subject to Deductible?	Subject to Coinsurance?	Coinurance, if different	Subject to Deductible?	Subject to Coinsurance?	Coinurance, if different
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All	
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	<input type="checkbox"/>	<input type="checkbox"/>	100%
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All	
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

Options for Additional Benefit Design Limits:

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

*****STANDARD BRONZE PLAN (3-5-2013)*****

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 62.0%
 Metal Tier: Bronze

Attachment D

Quality Improvement / Cost Containment Programs

Expense Type (per Supplemental Health Care Exhibit)

Improve Health Outcomes

- Health A to Z: provides members with access to health solutions
- PCIP: Primary Care Coordination
- NIA Cardiac: connects patients with the most appropriate cardiac diagnostic exams

Activities to Prevent Hospital Readmissions

- Case management: coordination of patient services
- Care Transitions: program to prepare members with the knowledge and skills to avoid readmissions to hospitals

Improve Patient Safety and Reduce Medical Errors

- SIU (Special Investigations Unit): recoveries through claims investigations

Wellness & Health Promotion Activities

- P4Pathways: Oncology management services
- Smoking Cessation: programs to help members quit smoking

HIT Expenses for Health Care Quality Improvements

- WNY QMC: P2/QMC data aggregation
- WNYCIE: Clinical Information Exchange
- HEALTHeNET: optimizes delivery of patient information to the healthcare community by leveraging shared infrastructure, technology and intellectual capital.

Note that the above items are considered part of claims expense for Federal MLR purposes; however, certain of these activities, such as case management and SIU, are considered part of administrative expense under New York State regulations.

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	Independent Health Benefits Corporation <small>Company submitting the rate adjustment request</small>	Not-For-Profit - 43 <small>Company Type</small>	Not-for-Profit <small>Org. Type</small>	47034 <small>Company NAIC Code</small>
	511 Farber Lakes Drive, Buffalo NY 14221 <small>Company mailing address</small>			
B. Contact Person:	[REDACTED] <small>Rate filing contact person name, title</small>	[REDACTED] <small>Contact phone number</small>	[REDACTED] <small>Contact Email address</small>	
C. Actuarial Contact (If different from above):	[REDACTED] <small>Actuary name, title</small>	[REDACTED] <small>Actuary phone number</small>	[REDACTED] <small>Actuary Email address</small>	
D. New Rate Information (See Note #1):	1/1/2014 - 12/31/2014 <small>New rate applicability period</small>	1/1/2014 <small>New rate effective date</small>	NDPD-129001055 <small>SERFF Tracking Number</small>	
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	Individual			
F. Provide responses for the following questions:	Response			
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	N/A			
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.	N/A			

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.

Data Collection Template

Company Legal Name: **Independent Health Benefits** (State: **NY**)
 HIOS Issuer ID: **18029** Market: **Individual**
 Effective Date of Rate Change(s): **1/1/2014**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period:	1/1/2014	to	12/31/2014
	<u>Experience Period</u>		
	<u>Aggregate Amount</u>	<u>PMPM</u>	<u>% of Prem</u>
Premiums (net of MLR Rebate) in Experience Period:	\$15	\$1.00	100.00%
Incurred Claims in Experience Period	\$15	1.00	100.00%
Allowed Claims:	\$15	1.00	100.00%
Index Rate of Experience Period		\$0.00	
Experience Period Member Months	15		

Section II: Allowed Claims, PMPM basis

Benefit Category	Experience Period				Projection Period: 1/1/2014 to 12/31/2014				Mid-point to Mid-point, Experience to Projection: 0 months							
	on Actual Experience Allowed				Adj't. from Experience Annualized Trend Factors				Projections, before credibility Adjustment				Credibility Manual			
	Utilization Description	Utilization per 1,000	Average Cost/Service	PMPM	Pop'l risk		Utilization per 1,000	Average Cost/Service	PMPM	Utilization per 1,000	Average Cost/Service	PMPM	Utilization per 1,000	Average Cost/Service	PMPM	
Inpatient Hospital	Days	1.00	\$2,000.00	\$0.17	1.000	1.000	1.000	1.000	1.00	\$2,000.00	\$0.17	466.96	\$3,433.09	\$133.59		
Outpatient Hospital	Visits	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	16370.64	71.53	97.58		
Professional	Other	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	14931.78	96.51	120.09		
Other Medical	Other	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	536.02	761.27	34.00		
Capitation	Benefit Period	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	1.00	1.00	0.00		
Prescription Drug	Prescriptions	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	16575.71	72.36	99.95		
Total				\$1.00							\$1.00			\$485.22		

Section III: Projected Experience:

	Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	After Credibility	Projected Period Totals
	Paid to Allowed Average Factor in Projection Period			\$485.22	\$87,339
	Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			0.833	
	Projected Risk Adjustments PMPM			\$404.15	\$72,747
	Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			-37.60	(6,769)
	Projected ACA reinsurance recoveries, net of rein prem, PMPM			\$441.75	\$79,516
	Projected Incurred Claims			42.71	7,689
	Administrative Expense Load			\$399.04	\$71,827
	Profit & Risk Load			13.09%	62.05
	Taxes & Fees			-0.09%	(0.43)
	Single Risk Pool Gross Premium Avg. Rate, PMPM			2.82%	13.34
	Index Rate for Projection Period			\$474.00	\$85,321
	% increase over Experience Period			\$484.33	
	% Increase, annualized:			47300.45%	
	Projected Member Months			#DIV/0!	180

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:
 HIOS Issuer ID:
 Effective Date of Rate Change(s):

Independent Health Benefits Corporation
18029
1/1/2014

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

Product/Plan Level Calculations														
Claims Information	Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!												
	Total Incurred claims, payable with issuer funds	\$15	\$1	\$1	\$1	\$1	\$1	\$1	\$1	\$1	\$1	\$1	\$1	\$1
	Net Amt of Rein	\$15.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
	Net Amt of Risk Adj	\$15.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
Incurred Claims PMPM	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	
Allowed Claims PMPM	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	
EHB portion of Allowed Claims, PMPM	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	18029NY1180001	18029NY1180002	18029NY1180009	18029NY1190001	18029NY1190002	18029NY1190005	18029NY1220001	18029NY1220002	18029NY1220009	18029NY1260001	18029NY1260002	18029NY1260009
Average Rate PMPM	\$474.00	\$554.65	\$556.69	\$554.65	\$554.62	\$556.65	\$554.62	\$482.10	\$483.87	\$482.10	\$421.81	\$423.35	\$421.81
Member Months	180	12	12	12	12	12	12	12	12	12	12	12	12
Total Premium (TP)	\$85,321	\$6,656	\$6,680	\$6,656	\$6,655	\$6,680	\$6,655	\$5,785	\$5,806	\$5,785	\$5,062	\$5,080	\$5,062
EHB basis or full portion of TP, [see instructions]	99.83%	99.95%	99.58%	99.95%	99.95%	99.58%	99.95%	99.95%	99.58%	99.95%	99.95%	99.58%	99.95%
state mandated benefits portion of TP that are other than EHB	0.17%	0.05%	0.42%	0.05%	0.05%	0.42%	0.05%	0.05%	0.42%	0.05%	0.05%	0.42%	0.05%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$86,409	\$6,143	\$6,165	\$6,143	\$6,069	\$6,091	\$6,069	\$5,765	\$5,787	\$5,765	\$5,489	\$5,509	\$5,489
EHB basis or full portion of TAC, [see instructions]	99.83%	99.95%	99.58%	99.95%	99.95%	99.58%	99.95%	99.95%	99.58%	99.95%	99.95%	99.58%	99.95%
state mandated benefits portion of TAC that are other than EHB	0.17%	0.05%	0.42%	0.05%	0.05%	0.42%	0.05%	0.05%	0.42%	0.05%	0.05%	0.42%	0.05%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	\$14,582	\$530	\$532	\$530	\$456	\$458	\$456	\$894	\$897	\$894	\$1,234	\$1,239	\$1,234
Portion of above payable by HHS's funds on behalf of insured person in dollars	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
insured person, as %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Incurred claims, payable with issuer funds	\$71,827	\$5,613	\$5,634	\$5,613	\$5,612	\$5,633	\$5,612	\$4,871	\$4,889	\$4,871	\$4,255	\$4,271	\$4,255
Net Amt of Rein	\$7,689	\$560	\$562	\$560	\$559	\$561	\$559	\$511	\$512	\$511	\$476	\$478	\$476
Net Amt of Risk Adj	\$6,769	\$506	\$508	\$506	\$506	\$508	\$506	\$457	\$458	\$457	\$415	\$417	\$415
Incurred Claims PMPM	\$399.04	\$467.73	\$469.46	\$467.73	\$467.70	\$469.43	\$467.70	\$405.94	\$407.44	\$405.94	\$354.58	\$355.90	\$354.58
Allowed Claims PMPM	\$480.05	\$511.88	\$513.78	\$511.88	\$505.71	\$507.59	\$505.71	\$480.43	\$482.21	\$480.43	\$457.42	\$459.12	\$457.42
EHB portion of Allowed Claims, PMPM	\$479.22	\$511.63	\$511.63	\$511.63	\$505.46	\$505.46	\$505.46	\$480.19	\$480.19	\$480.19	\$457.20	\$457.20	\$457.20

Product-Plan Data Collection

Company Legal Name:

HIOS Issuer ID:

Effective Date of Rate Change(s):

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Bronze		
Product ID	18029NY131		
Metal:	Bronze	Bronze	Bronze
AV Metal Value	0.620	0.620	0.620
AV Pricing Value	0.661	0.663	0.661
Plan Type:	POS	POS	POS
Plan Name	Bronze Plan A	Bronze Plan A	Bronze Plan A (CO)
Plan ID (Standard Component ID):	18029NY1310009	18029NY1310010	18029NY1310013
Exchange Plan?	No	No	No
Historical Rate Increase - Calendar Year - 2	0.00%		
Historical Rate Increase - Calendar Year - 1	0.00%		
Historical Rate Increase - Calendar Year 0	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)	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	35295.50%	35424.74%	35295.50%
Product Threshold Rate Increase %	0.00%		

Section II: Components of Premium Increase (PMPM)

Plan ID (Standard Component ID):	18029NY1310009	18029NY1310010	18029NY1310013
Inpatient	\$0.00	\$0.00	\$0.00
Outpatient	\$0.00	\$0.00	\$0.00
Professional	\$0.00	\$0.00	\$0.00
Prescription Drug	\$0.00	\$0.00	\$0.00
Other	\$0.00	\$0.00	\$0.00
Capitation	\$0.00	\$0.00	\$0.00
Administration	\$0.00	\$0.00	\$0.00
Taxes & Fees	\$0.00	\$0.00	\$0.00
Risk & Profit Charge	\$0.00	\$0.00	\$0.00
Total Rate Increase	\$0.00	\$0.00	\$0.00
Member Cost Share Increase	\$0.00	\$0.00	\$0.00

Average Current Rate PMPM	\$353.96	\$355.25	\$353.96
Projected Member Months	12	12	12

Section III: Experience Period Information

Plan ID (Standard Component ID):	18029NY1310009	18029NY1310010	18029NY1310013
Average Rate PMPM	\$1.00	\$1.00	\$1.00
Member Months	1	1	1
Total Premium (TP)	\$1	\$1	\$1
EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$1	\$1	\$1
EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%

Product-Plan Data Collection

Company Legal Name:

HIOS Issuer ID:

Effective Date of Rate Change(s):

Product/Plan Level Calculations				
Claims Information	Other benefits portion of TAC	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	\$0	\$0	\$0
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	\$0	\$0
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	\$1	\$1	\$1
	Net Amt of Rein	\$1.00	\$1.00	\$1.00
	Net Amt of Risk Adj	\$1.00	\$1.00	\$1.00
Incurring Claims PMPM	\$1.00	\$1.00	\$1.00	
Allowed Claims PMPM	\$1.00	\$1.00	\$1.00	
EHB portion of Allowed Claims, PMPM	\$1.00	\$1.00	\$1.00	

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):		18029NY1310009	18029NY1310010	18029NY1310013
Premium Information	Average Rate PMPM	\$353.96	\$355.25	\$353.96
	Member Months	12	12	12
	Total Premium (TP)	\$4,247	\$4,263	\$4,247
	EHB basis or full portion of TP, [see instructions]	99.95%	99.58%	99.95%
Claims Information	state mandated benefits portion of TP that are other than EHB	0.05%	0.42%	0.05%
	Other benefits portion of TP	0.00%	0.00%	0.00%
	Total Allowed Claims (TAC)	\$5,302	\$5,322	\$5,302
	EHB basis or full portion of TAC, [see instructions]	99.95%	99.58%	99.95%
	state mandated benefits portion of TAC that are other than EHB	0.05%	0.42%	0.05%
	Other benefits portion of TAC	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	\$1,741	\$1,747	\$1,741
	Portion of above payable by HHS's funds on behalf of insured person in dollars	\$0	\$0	\$0
	insured person, as %	0.00%	0.00%	0.00%
	Total Incurred claims, payable with issuer funds	\$3,561	\$3,575	\$3,561
	Net Amt of Rein	\$455	\$456	\$455
	Net Amt of Risk Adj	\$369	\$370	\$369
Incurring Claims PMPM	\$296.79	\$297.89	\$296.79	
Allowed Claims PMPM	\$441.85	\$443.49	\$441.85	
EHB portion of Allowed Claims, PMPM	\$441.63	\$441.63	\$441.63	