State:	*New York*	**Filing Company:**	*Independent Health Benefits Corporation*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard*		
Product Name:	*Small Group - off Exchange*		
Project Name/Number:	*Small Group - off Exchange/IHBC-C1027*		

Filing at a Glance

Company:	Independent Health Benefits Corporation
Product Name:	Small Group - off Exchange
State:	New York
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.004D Small Group Only - POS Standard
Filing Type:	Off Exchange NG Forms & Rates
Date Submitted:	05/14/2013
SERFF Tr Num:	NDPD-129028050
SERFF Status:	Assigned
State Tr Num:	2013050106
State Status:	IA Awaiting Initial Action
Co Tr Num:	IHBC-C1027
Implementation Date Requested:	01/01/2014
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *Independent Health Benefits Corporation*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard*
Product Name: *Small Group - off Exchange*
Project Name/Number: *Small Group - off Exchange/IHBC-C1027*

General Information

Project Name: Small Group - off Exchange
Project Number: IHBC-C1027
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 05/15/2013
State Status Changed: 05/15/2013
Created By: [redacted]
Corresponding Filing Tracking Number: IHBC-C1027

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

Deemer Date:
Submitted By: [redacted]

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Independent Health is submitting for your review and approval our Small Group plans for Off the Exchange.

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]

Filing Company Information

Independent Health Benefits Corporation
[redacted]

CoCode: 47034
Group Code: -99
Group Name:
FEIN Number: 16-1483784

State of Domicile: New York
Company Type: Health Article 43
State ID Number: 16-1483784

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State:	*New York*	**Filing Company:**	*Independent Health Benefits Corporation*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard*		
Product Name:	*Small Group - off Exchange*		
Project Name/Number:	*Small Group - off Exchange/IHBC-C1027*		

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.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard
Product Name: Small Group - off Exchange
Project Name/Number: Small Group - off Exchange/IHBC-C1027

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	4,949	$109,848,669	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:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard*		
Product Name:	*Small Group - off Exchange*		
Project Name/Number:	*Small Group - off Exchange/IHBC-C1027*		

Rate Review Detail

COMPANY:

Company Name:	Independent Health Benefits Corporation
HHS Issuer Id:	18029
Product Names:	Platinum Plan C, Gold Plan C, Gold Plan D, Gold Plan E, Gold Plan G, Gold Plan H, Gold Plan F, Silver Plan C, Silver Plan E, Silver Plan G, Silver Plan H, Silver Plan I, Silver Plan F, Bronze Plan B, Bronze Plan C, Bronze Plan D, Bronze Plan E, Bronze Plan F
Trend Factors:	

FORMS:

New Policy Forms:	IHBC-SBP005-3, IHBC-SBG005-3, IHBC-SBG006-3, IHBC-SBG007-3, IHBC-SBG009-3, IHBC-SBG011-3, IHBC-SBG008-3, IHBC-SBS009-3, IHBC-SBS013-3, IHBC-SBS015-3, IHBC-SBS016-3, IHBC-SBS017-3, IHBC-SBS014-3, IHBC-SBB005-3, IHBC-SBB006-3, IHBC-SBB007-3, IHBC-SBB008-3, IHBC-SBB009-3, IHBC-R1064, IHBC-R1066, IHBC-R1065, IHBC-C1027
Affected Forms:	
Other Affected Forms:	

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Quarterly
Member Months:	253,205
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:	109,848,669.00
Projected Incurred Claims:	89,253,597.00
Annual $:	Min: 270.73 Max: 834.13 Avg: 433.83

State: New York **Filing Company:** Independent Health Benefits Corporation
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Product Name: Small Group - off Exchange
Project Name/Number: Small Group - off Exchange/IHBC-C1027

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	The applicable product checklists are attached.
Attachment(s):	Group Product Checklist - Non-Standard - off.pdf Group Product Checklist - Standard - off.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	The applicable readability certificates are attached.
Attachment(s):	Group Riders PLC.pdf IHBC-C1027 Group PLC.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability
Comments:	The applicable explanation of variability is attached.
Attachment(s):	Explanation of Variability Group (on & off Exchange) IHBC-C1027.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Black-lined Copy of Model Language
Comments:	

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard
Product Name: Small Group - off Exchange
Project Name/Number: Small Group - off Exchange/IHBC-C1027

Attachment(s):	Cover Page Redlined.pdf Table of Contents Group FINAL 04.09.pdf Section I Definitions Redlined.pdf Section II How Your Coverage Works Redlined.pdf Section III Access to Care Redlined.pdf Section IV Cost-Sharing 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 - 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 Section VI - Prescription Drug Coverage #8 redlined.pdf Section VI - Primary Preventive Care DFS #1 redlined.pdf Section VII - Exclusions LANGUAGE redlined.pdf Section VI - Wellness #9 redlined.pdf Section VIII - Claims Model Language redlined.pdf Section IX - External Appeal language #3 redlined.pdf Section IX - Grievance Model Language #1 (IHBC) redlined.pdf Section IX - UR Model Language #2 redlined.pdf Section X - COB redlined.pdf Section XI - Termination redlined.pdf Section XII - Continuation of Coverage (COBRA) #2 redlined.pdf Section XII - Conversion #3 redlined.pdf Section XII - Extension of Benefits #1 redlined.pdf Section XIII - General Contract Provisions redlined.pdf P005-3 Group Non Standard OFF Option 2 redlined.pdf G005-3 Group Non Standard OFF Option 2 redlined.pdf G006-3 Group Non Standard OFF Option 3 redlined.pdf

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard
Product Name: Small Group - off Exchange
Project Name/Number: Small Group - off Exchange/IHBC-C1027

	G007-3 Group Non-Standard OFF Option 4 redlined.pdf G008-3 Group Non-Standard OFF Option 15 redlined.pdf G009-3 Group Off Non-Standard Opt 5 Choice Plus redlined.pdf G011-3 Group Off Non Standard Prime Access redlined.pdf S009 -3 Redline.pdf S013 -3 Redline.pdf S015 -3 Redline.pdf S016 -3 Redline.pdf S017 -3 Redline.pdf B005-3 Group Off Non-Standard Opt 1 Choice Plus redlined.pdf B006-3 Group off Non-Standard Opt 2 Prime Access redlined.pdf S014 -3 Redline.pdf B007-3 Group Off Non-Standard Opt 3 redlined.pdf B008-3 Group Off Non-Standard Opt 16 redlined.pdf B009-3 Group Off Non-Standard Opt 17 redlined.pdf P009-3 Group Non Standard Off Option 2a redlined.pdf S021-3 Redline.pdf Rider Domestic Partner redlined.pdf Rider Age 29 redlined.pdf Rider Family Planning redlined.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	IHBC Off Exchange Sml Grp 2014 Act Memo 20130508.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	IHBC Off Exchange Sml Grp 2014 Act Memo 20130508.pdf

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard
Product Name: Small Group - off Exchange
Project Name/Number: Small Group - off Exchange/IHBC-C1027

Item Status:	
Status Date:	

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

Satisfied - Item:	Small Group Rate Intructions/Checklist
Comments:	IHBC checked the attached small group checklist
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 1-General Information
Comments:	
Attachment(s):	Exhibit 1 IHBC SG Off Exchange.pdf Exhibit 1 IHBC SG Off Exchange.xls
Item Status:	
Status Date:	

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

Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	
Attachment(s):	Exhibit 8_Small Group_IHBC_Off exchange.pdf Exhibit 8_Small Group_IHBC_Off exchange.xlsx

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004D Small Group Only - POS Standard
Product Name: Small Group - off Exchange
Project Name/Number: Small Group - off Exchange/IHBC-C1027

Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	
Attachment(s):	Exhibit 9_SG_IHBC_OffExchange.pdf Exhibit 9_SG_IHBC_OffExchange.xls
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Documents for Web Posting-NG Off Exchange
Comments:	
Attachment(s):	IHBC Off Exchange Sml Grp 2014 Act Memo 20130508_Redacted.pdf Exhibit 1 IHBC SG Off Exchange_Redacted.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	plan_management_data_templates_unified_IHBC_SMALL_GROUP_OFF_EXCHANGE.pdf plan_management_data_templates_unified_IHBC_SMALL_GROUP_OFF_EXCHANGE.xlsm
Item Status:	
Status Date:	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Small Business Health Options Program (SHOP) Checklist

As of 3/19/13

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 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".

Small Business Health Options Program (SHOP) Checklist

LINE OF BUSINESS: **Small Business Health Options Program**

TOI	LINE(S) OF INSURANCE	Sub-TOI
H15G	Health – Hospital/Surgical/Medical Expense	H15G.003 - Small Group Only
H16G	Health – Major Medical	H16G.003A - Small Group Only - PPO
		H16G.003D - Small Group Only - POS
		H16G.003G - Small Group Only - Other
HOrg02G	Group Health Organization - HMO	HOrg02G.004C - POS Basic
		HOrg02G.004D - POS Standard
		HOrg02G.004F - HMO

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

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

		by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	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)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e)	Compliant
Group Status and Recognition	§ 4235(c)(1)(A) §3201(b)(1) 11 NYCRR 59	The SERFF filing description or submission letter should include a statement that policy or contract forms will only be sold to a small group specified in Insurance Law §4235(c)(1)(A).	Compliant
Statement of ERISA rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes ☐ No ☐	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.	Compliant
APPLICATION FORMS	Model Language		Form/Page/Para Reference

Model Application Used? Yes ▣ No ☐			
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.	Application not submitted in this filing
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	Application not submitted in this
Prohibited Questions and Provisions	§3221(q)(1) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy 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).	Application not submitted in this filing.
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ▣ No ☐	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	Compliant
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Yes
Table of Contents Model Language Used? Yes ▣ No ☐	§ 3217 Model Language	A table of contents is required.	Compliant
DEFINITIONS Model Language Used? Yes ▣ No ☐	§ 3217 Model Language	*Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§3221(k)(14) §4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Compliant

HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ▣ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	Section II, page 1
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☐ Model Language Used? Yes ▣ No ☐	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	Section II, page 1
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☐ Model Language Used? Yes ▣ No ☐	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	Section II, page 1
Preauthorization			
Preauthorization Requirements Model Language Used? Yes ▣ No ☐	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or $500.00, whichever is less, is permissible.	Section II, page 2
Medical Necessity			
Definition of Medical Necessity	§3217-a(a)(1) §4324(a)(1) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	Section II, page 3

Model Language Used? Yes ☒ No ☐			
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	Section II, page 3-4
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	Section III, page 1
Specialty Care Provider as PCP Model Language Used? Yes ☒ No ☐	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) 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 ☒ No ☐	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	Section III, page 1
Specialty Care Center Model Language Used? Yes ☒ No ☐	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	Section III, page 1
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider	Section III, page 2

		and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ▣ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	Section III, page 2
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ▣ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	Compliant
Reimbursement of Providers Model Language Used? Yes ▣ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	Section IV, page 3
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes ▣ No ☐	§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	Section IV, page 3
ELIGIBILITY Model Language Used? Yes ▣ No ☐	Model Language	For each of the following eligibility provisions model language must be used.	Form/Page/Para Reference
Spouse	§4235(f)(1)(A)	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful	

	§4305(c)(1) Circular Letter No. 27 (2008) Model Language	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) §4305(c)(1) §3221(a)(7) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	Section V, page 1
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	Section V, page 1
Newborn Infants	§4235(f)(2) §4305(c)(1) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.*	Section V, page 2
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3) §4305(c)(1)	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)	This policy or contract form may cover domestic partners, who are financially interdependent on the	Rider available

	§4305(c)(1) OGC Opinion 01-11-23 Model Language	employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	Section V, page 1
Enrollment Periods	11NYCRR52.70(e)(3) 45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	Section V, page 2-4
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	*The following benefits must be included in the policy or contract form.* **Standard Products:** Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. **Non-Standard Products:** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health	Form/Page/Para Reference

		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	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	Section VI, page 1-3
Federal Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	Section VI, page 1
Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§3 221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	Section VI, page 2
Mammography Screening Model Language Used? Yes ☒ No ☐	§ 3221(l)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer.	Section VI, page 2

	HRSA Guidelines	• A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	
Family Planning & Reproductive Health Services Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 2
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☐ No ☐	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, dand devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	Section VI, page 2-3
Prostate Cancer Screening Model Language Used? Yes ☐ No ☐	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk	Section VI, page 3

		factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§ 3221(l)(15) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	Section VI, page 3-4
Emergency Services Model Language Used? Yes ☒ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002)	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services	Section VI, page 4-6

	PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	Section VI, page 6
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	45 CFR § 156.100	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT	

Model Language Used? Yes ▣ No ☐	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Allergy Testing and Treatment Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Ambulatory Surgery Center Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chemotherapy Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chiropractic Care Model Language Used? Yes ▣ No ☐	§3221(k)(11) §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	Section VI, page 7
Dialysis Coverage	§3221(k)(16)	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney	

Model Language Used? Yes ☒ No ☐	§4303(gg) 45 CFR § 156.100 Model Language	ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	Section VI, page 7
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance. *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.*	Section VI, page 8

If yes , please explain how this substitution or addition differs from the Standard benefit in the space provided .			
Non-Standard Benefit explanation: Benefit does not vary for Standard vs. Non-Standard			
Home Health Services Model Language Used? Yes ☒ No ☐	§3221(k)(1) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments. *Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.*	Section VI, page 8
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.*	Section VI, page 8
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility	§3221(k)(6) 4303(s) 11 NYCRR	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.	

Treatments Model Language Used? Yes ▣ No ☐	52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language	• 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 8-9
Infusion Therapy Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Office Visits Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Outpatient Hospital Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Preadmission Testing Model Language Used? Yes ▣ No ☐	§3221(k)(2) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the	Section VI, page 9-10

		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.	
Outpatient Rehabilitative Services Model Language Used? Yes ▣ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ▣ No ☐ Is this benefit being substituted? Yes ☐ No ▣ Are additional benefits being added to this EHB category? Yes ☐ No ▣ If yes , please explain how this substitution or addition differs from the Standard benefit in the space provided .	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.*	Section VI, page 10
Non-Standard Benefit explanation: Benefit does not vary for Standard vs. Non-Standard.			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ▣ No ☐	§3221(k)(9) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of	Section VI, page 10

		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.	
Second Surgical Opinion Model Language Used? Yes ■ No ☐	§3221(k)(3) §4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Mandatory Second Surgical Opinion Model Language Used? Yes ☐ No ■	§3221(k)(3) §4303(b) Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	Not Applicable
Second Opinion in Other Cases Model Language Used? Yes ■ No ☐	45 CFR § 156.100 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Surgical Services Model Language Used? Yes ■ No ☐	45 CFR § 156.100 11 NYCRR §52.6 Model Language	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10-11
Oral Surgery Model Language Used? Yes ■ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary	Section VI, page 11

		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.	
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3221(k)(8) §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	Section VI, page 11
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3221(k)(10) §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	Section VI, page 11
Transplants Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 11
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription	Section VI, page 12-13

		drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: For **Standard Products**, the medical benefit cost-sharing must apply. For **Non-Standard** Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," the policy or contract form may not limit coverage to care prescribed by a physician.*	Section VI, page 13-14

Durable Medical Equipment and Braces Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 15
Hearing Aids Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 15
Hospice Care Model Language Used? Yes ▣ No ☐	§3221(l)(10) §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification	Section VI, page 15-16

		process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.*	
Prosthetics Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 16
Hospital Services Model Language Used? Yes ▣ No ☐	11NYCRR52.5 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;	Section VI, page 16-17

		• Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Maternity Care Model Language Used? Yes ▣ No ☐	§3221(k)(5) §4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3221(k)(1), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	Section VI, page 17
Autologous Blood Banking Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 17
Inpatient Rehabilitative Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: The Standard Exchange Plan must cover 60days.. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the "per condition"*	Section VI, page 17-18

Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products. Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes , please explain how this substitution or addition differs from the Standard benefit in the space provided .		*and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	
Non-Standard Benefit explanation: Benefit does not vary for Standard vs. Non-Standard			
Skilled Nursing Facility Model Language Used? Yes ☒ No ☐	§3221(l)(2) §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 18
End of Life Care Model Language Used? Yes ☐ No ☐	§4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	Section VI, page 18
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			

Inpatient Mental Health Care Services Model Language Used? Yes ▣ No ☐	§3221(l)(5) §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, small group health policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Section VI, page 19
Outpatient Mental Health Care Services Model Language Used? Yes ▣ No ☐	§3221(l)(5) §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Section VI, page 19
Inpatient Substance Use Services	§3221(l)(6) §4303(k)	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	

Model Language Used? Yes ☒ No ☐	Cicular Letter No. 20 (2009) Supplement No. 1 to Cicular 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	coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Section VI, page 19
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(7) §4303(l) Cicular Letter No. 20 (2009) Supplement No. 1 to Cicular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.	Section VI, page 19

		Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 20
Enteral Formulas Model Language Used? Yes ▣ No ☐	§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food	Section VI, page 20

		products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes ■ No ☐	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	Section VI, page 20
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ■ No ☐	§4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	Section VI, page 21
Prohibition for Tier IV Drugs	§3221(a)(16) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	
Eye Drops Model Language Used? Yes ■ No ☐	§3221(k)(17) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	Section VI, page 21
Orally Administered Anticancer Medications Model Language Used? Yes ■ No ☐	§3221(l)(12-a) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	Section VI, page 21
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes ■ No ☐	§3221(l)(18) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	Section VI, page 26
Contraceptive Drugs and Devices Model Language Used?	§3221(l)(16) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. For groups that meet the definition of a religious employer in §§3221(l)(16)(A); 4303(cc)(1)(A), the subscriber will have the option to purchase the stand alone contraceptive coverage rider. Contraceptive coverage	

Yes ▣ No ☐		must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	Section VI, page 21
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ▣ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ▣ No ☐ Is this benefit being substituted? Yes ▣ No ☐ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ▣ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3239 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.*	Section VI, page 27

Non-Standard Benefit explanation: For non-standard plans on-exchange, the standard gym reimbursement benefit will be replaced with a Nutrition benefit. Additionally, the non-standard off-exchange gym reimbursement benefit will be replaced with one of the following, which varies by plan option: Nutrition benefit, Gym and Wellness Services, a Point-of-Enrollment where the member at the time of enrollment a member chooses either Nutrition or Gym and Wellness, and for our PPO offerings with National			
Other Wellness Benefits Is this a Standard Exchange Plan? Yes ☒ No ☐ If yes, Additional Wellness Benefits may not be offered.	45 CFR § 156.100 §3239	Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits must comply with § 3239 of Insurance Law.	
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 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.	Section VI, page 31-32
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being provided by this QHP filing? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 32-33
Explanation:			
ADDITIONAL BENEFITS		**Additional benefits may be covered in the non-standard Exchange plans only.**	
Family Vision Model Language Used? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics	45 CFR § 156.100 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a	

Model Language Used? Yes ☐ No ☐		condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	Not Applicable
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	Section VII, page 1
Convalescent and Custodial Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.	Section VII, page 1
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	Section VII, page 1
Coverage Outside of the United States, Canada or Mexico	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

Model Language Used? Yes ▣ No ☐			
Dental Services Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	Section VII, page 1
Experimental or Investigational Treatment. Model Language Used? Yes ▣ No ☐	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	Section VII, page 1
Felony Participation Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	Section VII, page 1
Foot Care Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	Section VII, page 2
Government Facility Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	Section VII, page 2
Medically Necessary Model Language Used? Yes ▣ No ☐	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent certified by the State.	Section VII, page 2
Medicare or Other Governmental Program Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	Section VII, page 2
Military Service Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	Section VII, page 2

No-Fault Automobile Insurance Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	Section VII, page 2
Services Separately Billed by Hospital Employees Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	Section VII, page 2
Services Provided by a Family Member Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	Section VII, page 2
Services With No Charge Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	Section VII, page 2
Services not Listed Model Language Used? Yes ▣ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	Section VII, page 2
Vision Services Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	Section VII, page 2
Workers' Compensation Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	Section VII, page 2
War Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	Section VII, page 2
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3221(a)(8)	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	Section VIII, page 1

		or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Submission of Claim Model Language Used? Yes ▣ No ☐	§3221(a)(9) §4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	Section VIII, page 1
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ▣ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(p) PHL § 4408-a 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any.	Section IX, page 1
Utilization Review Policies and Procedures Model Language Used? Yes ▣ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	Section IX, page 3
External Appeal Procedures	Article 49	This policy or contract form includes a description of the external appeal procedures, including:	

Model Language Used? Yes ▣ No ☐	PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	• 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, page 6-9
COORDINATION OF BENEFITS Model Language Used? Yes ▣ No ☐	11 NYCRR 52.23 Model Language	If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	Form/Page/Para Reference
TERMINATION OF COVERAGE Model Language Used? Yes ▣ No ☐	Model Language	*The following are the only termination provisions permissible under the Insurance Law.* *The model language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	Section XI, page 1
Termination for Failure to Pay Premiums	§3221(p)(2)(A) §4305(j)(2)(A)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.	Section XI, page 1
Termination for Fraud	§3221(p)(2)(B) §4305(j)(2)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	Section XI, page 1
Termination for Failure to Comply With a Material Plan Provision	§3221(p)(2)(C) §4305(j)(2)(C)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to terminate coverage if the group has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	Section XI, page 1
Discontinuation of a Class of Coverage	§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	Section XI, page 1
Discontinuation of all Policies/Contracts in the Small Market	§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	Section XI, page 1

Termination for Failure to Meet Requirements of Group	§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under §4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	Section XI, page 2
Termination if there are No Longer Insureds in the Insurer's Service Area	§3221(p)(2)(F) §4305(j)(2)(F)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Section XI, page 2
Termination for Spouses in cases of divorce		This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	Section XI, page 1
Termination upon death of Subscriber		This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	Section XI, 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 XI, page 1
Rescission Model Language Used? Yes ☒ No ☐	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	Section XI, page 1
Renewal	§3221(p) §3221(a)(5) §4305(j) 11 NYCRR 52.18(c)	This policy or contract provides that except as specified in §3221(p), or §4305(j) the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	Section XI, page 1
Premiums	§3221(a)(4)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Section XI, page 1
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☒ No ☐	11 NYCRR 52.18(b)(4); (5); and (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered persons' coverage terminates by reason of the termination of active employment, an extended benefit will be proved during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	Section XII, page 1
Continuation Coverage Model Language Used?	§3221(e)(11) §3221(m) §4305(e)	This policy or contract form contains a provision regarding continuation coverage. §§3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue	

Yes ▣ No ☐	COBRA, Title X of Public Law 99-272 Model Language	hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage. The continuation benefits terminate: • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	Section XII, page 1-4
Young Adult Option Model Language Used? Yes ▣ No ☐	§3221(r) §4305(l) Model Language	This policy or contract form provides notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy or contract, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r), and/or 4305(l). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy or contract. The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).	Section XII, page 3
Suspension of Coverage Model Language Used? Yes ▣ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose	Section XII, page 2-3

		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.	
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard Model Language Used? Yes ■ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language	If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	Section XII, page 2-3
Conversion - Right to a New Contract After Termination Model Language Used? Yes ■ No ☐	§3221(e) §4303(d)	This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents. Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates. The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	Section XII, page 3-5
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☐ No ☐	§3221(a)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	Section XIII, page 2
Changes	§3221(a)(2)	The policy or contract form must provide that no agent has the authority to change the policy or	

Model Language Used? Yes ☒ No ☐	Model Language	contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	Section XIII, page 1
Action in Law or Equity Model Language Used? Yes ☒ No ☐	§3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy or contract.	Section XIII, page 4
Subrogation Model Language Used? Yes ☐ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	Section XIII, page 4
Unilateral Modification Model Language Used? Yes ☒ No ☐	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	Section XIII, page 1
Non-English Speaking Insureds Model Language Used? Yes ☐ No ☐	§3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	Section XIII, page 4
SCHEDULE OF BENEFITS Model Language Used? Yes ☐ No ☐	Standard Benefit Design Description Chart Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§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 ☒ No ☐	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	Compliant
Insured's Financial	§3217-a(a)(5)	This policy or contract form includes a description of the insured's financial responsibility for	Compliant

Responsibility for Payment	§4324(a)(5) PHL §4408(1)(e)	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.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☐ No ☒ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☐	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	Not Applicable
Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f) or 4305(c)(1).	IHBC-R1064
Contraceptive Drugs and Devices and Family Planning Services	§3221(l)(16)	This policy or contract form includes a rider for situations when a Group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§3221(l)(16)(A); 4303(cc)(1)(A). In accordance with law, if elected by an insured, this Rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the federal food and drug administration and provides coverage for family planning services.	IHBC-R1066
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 <u>NEW PRODUCT</u> RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Checklist for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or*	

		advertising, OR ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3221 11NYCRR52.40(e) 11NYCRR360.10 11NYCRR360.11 §3201(e)(1)(B) §4308(c)(3)(A)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 87 %. a.	IHBC Off Exchange Sml Grp 2014 Act Memo 20130508.pdf
Loss Ratios	§3201(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	IHBC Off Exchange Sml Grp 2014 Act
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	IHBC Off Exchange Sml
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 Off Exchange Sml Grp 2014 Act Memo 20130508.pdf
Expected Loss Ratio Certification	§3201(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 87 %.	IHBC Off Exchange Sml
GROUP RATE MANUAL	11NYCRR52.40(e)(2) §3201(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations.	A43_S_offEx_Manual_2014_Rev_2013_5_9.pdf

		h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		*Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.* *(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)*	F
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(e)	a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Provide New York and nationwide claims experience respectively, including: (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes.	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3201(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _ %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(e)(2)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees.	

		i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Small Business Health Options Program (SHOP) Checklist

As of 3/19/13

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 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".

Small Business Health Options Program (SHOP) Checklist

LINE OF BUSINESS: **Small Business Health Options Program**

TOI	LINE(S) OF INSURANCE	Sub-TOI
H15G	Health – Hospital/Surgical/Medical Expense	H15G.003 - Small Group Only
H16G	Health – Major Medical	H16G.003A - Small Group Only - PPO
		H16G.003D - Small Group Only - POS
		H16G.003G - Small Group Only - Other
HOrg02G	Group Health Organization - HMO	HOrg02G.004C - POS Basic
		HOrg02G.004D - POS Standard
		HOrg02G.004F - HMO

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

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

		by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	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)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e)	Compliant
Group Status and Recognition	§ 4235(c)(1)(A) §3201(b)(1) 11 NYCRR 59	The SERFF filing description or submission letter should include a statement that policy or contract forms will only be sold to a small group specified in Insurance Law §4235(c)(1)(A).	Compliant
Statement of ERISA rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes ☐ No ☐	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.	Compliant
APPLICATION FORMS	Model Language		Form/Page/Para Reference

Model Application Used? Yes ▣ No ☐			
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.	Application not submitted in this filing
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	Application not submitted in this
Prohibited Questions and Provisions	§3221(q)(1) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy 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).	Application not submitted in this filing.
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ▣ No ☐	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	Compliant
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Yes
Table of Contents Model Language Used? Yes ▣ No ☐	§ 3217 Model Language	A table of contents is required.	Compliant
DEFINITIONS Model Language Used? Yes ▣ No ☐	§ 3217 Model Language	*Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§3221(k)(14) §4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Compliant

HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ▣ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	Section II, page 1
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☐ Model Language Used? Yes ▣ No ☐	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	Section II, page 1
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☐ Model Language Used? Yes ▣ No ☐	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	Section II, page 1
Preauthorization			
Preauthorization Requirements Model Language Used? Yes ▣ No ☐	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or $500.00, whichever is less, is permissible.	Section II, page 2
Medical Necessity			
Definition of Medical Necessity	§3217-a(a)(1) §4324(a)(1) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	Section II, page 3

Model Language Used? Yes ☒ No ☐			
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	Section II, page 3-4
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	Section III, page 1
Specialty Care Provider as PCP Model Language Used? Yes ☒ No ☐	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) 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 ☒ No ☐	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	Section III, page 1
Specialty Care Center Model Language Used? Yes ☒ No ☐	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	Section III, page 1
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider	Section III, page 2

		and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ▣ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	Section III, page 2
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ▣ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	Compliant
Reimbursement of Providers Model Language Used? Yes ▣ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	Section IV, page 3
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes ▣ No ☐	§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	Section IV, page 3
ELIGIBILITY Model Language Used? Yes ▣ No ☐	Model Language	For each of the following eligibility provisions model language must be used.	Form/Page/Para Reference
Spouse	§4235(f)(1)(A)	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful	

	§4305(c)(1) Circular Letter No. 27 (2008) Model Language	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) §4305(c)(1) §3221(a)(7) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	Section V, page 1
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	Section V, page 1
Newborn Infants	§4235(f)(2) §4305(c)(1) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.*	Section V, page 2
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3) §4305(c)(1)	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)	This policy or contract form may cover domestic partners, who are financially interdependent on the	Rider available

	§4305(c)(1) OGC Opinion 01-11-23 Model Language	employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	Section V, page 1
Enrollment Periods	11NYCRR52.70(e)(3) 45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	Section V, page 2-4
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	*The following benefits must be included in the policy or contract form.* **Standard Products:** Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. **Non-Standard Products:** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health	Form/Page/Para Reference

		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	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	Section VI, page 1-3
Federal Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	Section VI, page 1
Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§3 221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	Section VI, page 2
Mammography Screening Model Language Used? Yes ☒ No ☐	§ 3221(l)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer.	Section VI, page 2

	HRSA Guidelines	• A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	
Family Planning & Reproductive Health Services Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 2
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☐ No ☐	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, dand devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	Section VI, page 2-3
Prostate Cancer Screening Model Language Used? Yes ☐ No ☐	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk	Section VI, page 3

		factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§ 3221(l)(15) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	Section VI, page 3-4
Emergency Services Model Language Used? Yes ☒ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002)	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services	Section VI, page 4-6

	PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	Section VI, page 6
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	45 CFR § 156.100	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT	

Model Language Used? Yes ▣ No ☐	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Allergy Testing and Treatment Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Ambulatory Surgery Center Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chemotherapy Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 7
Chiropractic Care Model Language Used? Yes ▣ No ☐	§3221(k)(11) §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	Section VI, page 7
Dialysis Coverage	§3221(k)(16)	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney	

Model Language Used? Yes ☒ No ☐	§4303(gg) 45 CFR § 156.100 Model Language	ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	Section VI, page 7
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☐ No ☒ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance. *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.*	Section VI, page 8

If yes , please explain how this substitution or addition differs from the Standard benefit in the space provided .			
Non-Standard Benefit explanation:			
Home Health Services Model Language Used? Yes ☒ No ☐	§3221(k)(1) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments. *Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.*	Section VI, page 8
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.*	Section VI, page 8
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility	§3221(k)(6) 4303(s) 11 NYCRR	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.	

Treatments Model Language Used? Yes ▣ No ☐	52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language	• 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 8-9
Infusion Therapy Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Office Visits Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Outpatient Hospital Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 9
Preadmission Testing Model Language Used? Yes ▣ No ☐	§3221(k)(2) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the	Section VI, page 9-10

		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.	
Outpatient Rehabilitative Services Model Language Used? Yes ■ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☐ No ■ Is this benefit being substituted? Yes ☐ No ■ Are additional benefits being added to this EHB category? Yes ☐ No ■ If yes , please explain how this substitution or addition differs from the Standard benefit in the space provided .	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.*	Section VI, page 10
Non-Standard Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ■ No ☐	§3221(k)(9) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of	Section VI, page 10

		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.	
Second Surgical Opinion Model Language Used? Yes ■ No ☐	§3221(k)(3) §4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Mandatory Second Surgical Opinion Model Language Used? Yes ☐ No ■	§3221(k)(3) §4303(b) Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	Not Applicable
Second Opinion in Other Cases Model Language Used? Yes ■ No ☐	45 CFR § 156.100 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10
Surgical Services Model Language Used? Yes ■ No ☐	45 CFR § 156.100 11 NYCRR §52.6 Model Language	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 10-11
Oral Surgery Model Language Used? Yes ■ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary	Section VI, page 11

		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.	
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3221(k)(8) §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	Section VI, page 11
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3221(k)(10) §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	Section VI, page 11
Transplants Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 11
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription	Section VI, page 12-13

		drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: For **Standard Products**, the medical benefit cost-sharing must apply. For **Non-Standard** Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," the policy or contract form may not limit coverage to care prescribed by a physician.*	Section VI, page 13-14

Durable Medical Equipment and Braces Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 15
Hearing Aids Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 15
Hospice Care Model Language Used? Yes ▣ No ☐	§3221(l)(10) §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification	Section VI, page 15-16

		process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.*	
Prosthetics Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 16
Hospital Services Model Language Used? Yes ▣ No ☐	11NYCRR52.5 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;	Section VI, page 16-17

		• Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Maternity Care Model Language Used? Yes ▣ No ☐	§3221(k)(5) §4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3221(k)(1), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	Section VI, page 17
Autologous Blood Banking Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 17
Inpatient Rehabilitative Services Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: The Standard Exchange Plan must cover 60days.. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the "per condition"*	Section VI, page 17-18

Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products. Non-Standard Product? Yes ☐ No ☒ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes , please explain how this substitution or addition differs from the Standard benefit in the space provided .		*and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	
Non-Standard Benefit explanation:			
Skilled Nursing Facility Model Language Used? Yes ☒ No ☐	§3221(l)(2) §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 18
End of Life Care Model Language Used? Yes ☐ No ☐	§4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	Section VI, page 18
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			

Inpatient Mental Health Care Services Model Language Used? Yes ▣ No ☐	§3221(l)(5) §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, small group health policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Section VI, page 19
Outpatient Mental Health Care Services Model Language Used? Yes ▣ No ☐	§3221(l)(5) §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Section VI, page 19
Inpatient Substance Use Services	§3221(l)(6) §4303(k)	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	

Model Language Used? Yes ☒ No ☐	Cicular Letter No. 20 (2009) Supplement No. 1 to Cicular 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	coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Section VI, page 19
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(7) §4303(l) Cicular Letter No. 20 (2009) Supplement No. 1 to Cicular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.	Section VI, page 19

		Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ▣ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 20
Enteral Formulas Model Language Used? Yes ▣ No ☐	§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food	Section VI, page 20

		products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes ■ No ☐	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	Section VI, page 20
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ■ No ☐	§4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	Section VI, page 21
Prohibition for Tier IV Drugs	§3221(a)(16) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	
Eye Drops Model Language Used? Yes ■ No ☐	§3221(k)(17) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	Section VI, page 21
Orally Administered Anticancer Medications Model Language Used? Yes ■ No ☐	§3221(l)(12-a) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	Section VI, page 21
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes ■ No ☐	§3221(l)(18) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	Section VI, page 26
Contraceptive Drugs and Devices Model Language Used?	§3221(l)(16) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. For groups that meet the definition of a religious employer in §§3221(l)(16)(A); 4303(cc)(1)(A), the subscriber will have the option to purchase the stand alone contraceptive coverage rider. Contraceptive coverage	

Yes ▣ No ☐		must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	Section VI, page 21
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ▣ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☐ No ▣ Is this benefit being substituted? Yes ▣ No ☐ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ▣ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3239 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.*	Section VI, page 27

Non-Standard Benefit explanation:			
Other Wellness Benefits Is this a Standard Exchange Plan? Yes ☒ No ☐ If yes, Additional Wellness Benefits may not be offered.	45 CFR § 156.100 §3239	Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits must comply with § 3239 of Insurance Law.	
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 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.	Section VI, page 31-32
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being provided by this QHP filing? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Section VI, page 32-33
Explanation:			
ADDITIONAL BENEFITS		**Additional benefits may be covered in the non-standard Exchange plans only.**	
Family Vision Model Language Used? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics	45 CFR § 156.100 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a	

Model Language Used? Yes ☐ No ☐		condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	Not Applicable
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	Section VII, page 1
Convalescent and Custodial Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.	Section VII, page 1
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	Section VII, page 1
Coverage Outside of the United States, Canada or Mexico	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

Model Language Used? Yes ▣ No ☐			
Dental Services Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	Section VII, page 1
Experimental or Investigational Treatment. Model Language Used? Yes ▣ No ☐	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	Section VII, page 1
Felony Participation Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	Section VII, page 1
Foot Care Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	Section VII, page 2
Government Facility Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	Section VII, page 2
Medically Necessary Model Language Used? Yes ▣ No ☐	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent certified by the State.	Section VII, page 2
Medicare or Other Governmental Program Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	Section VII, page 2
Military Service Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	Section VII, page 2

No-Fault Automobile Insurance Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	Section VII, page 2
Services Separately Billed by Hospital Employees Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	Section VII, page 2
Services Provided by a Family Member Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	Section VII, page 2
Services With No Charge Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	Section VII, page 2
Services not Listed Model Language Used? Yes ▣ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	Section VII, page 2
Vision Services Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	Section VII, page 2
Workers' Compensation Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	Section VII, page 2
War Model Language Used? Yes ▣ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	Section VII, page 2
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3221(a)(8)	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	Section VIII, page 1

		or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Submission of Claim Model Language Used? Yes ▣ No ☐	§3221(a)(9) §4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	Section VIII, page 1
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ▣ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(p) PHL § 4408-a 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any.	Section IX, page 1
Utilization Review Policies and Procedures Model Language Used? Yes ▣ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	Section IX, page 3
External Appeal Procedures	Article 49	This policy or contract form includes a description of the external appeal procedures, including:	

Model Language Used? Yes ▣ No ☐	PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	• 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, page 6-9
COORDINATION OF BENEFITS Model Language Used? Yes ▣ No ☐	11 NYCRR 52.23 Model Language	If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	Form/Page/Para Reference
TERMINATION OF COVERAGE Model Language Used? Yes ▣ No ☐	Model Language	*The following are the only termination provisions permissible under the Insurance Law.* *The model language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	Section XI, page 1
Termination for Failure to Pay Premiums	§3221(p)(2)(A) §4305(j)(2)(A)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.	Section XI, page 1
Termination for Fraud	§3221(p)(2)(B) §4305(j)(2)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	Section XI, page 1
Termination for Failure to Comply With a Material Plan Provision	§3221(p)(2)(C) §4305(j)(2)(C)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to terminate coverage if the group has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	Section XI, page 1
Discontinuation of a Class of Coverage	§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	Section XI, page 1
Discontinuation of all Policies/Contracts in the Small Market	§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	Section XI, page 1

Termination for Failure to Meet Requirements of Group	§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under §4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	Section XI, page 2
Termination if there are No Longer Insureds in the Insurer's Service Area	§3221(p)(2)(F) §4305(j)(2)(F)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Section XI, page 2
Termination for Spouses in cases of divorce		This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	Section XI, page 1
Termination upon death of Subscriber		This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	Section XI, 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 XI, page 1
Rescission Model Language Used? Yes ☒ No ☐	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	Section XI, page 1
Renewal	§3221(p) §3221(a)(5) §4305(j) 11 NYCRR 52.18(c)	This policy or contract provides that except as specified in §3221(p), or §4305(j) the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	Section XI, page 1
Premiums	§3221(a)(4)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Section XI, page 1
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☒ No ☐	11 NYCRR 52.18(b)(4); (5); and (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered persons' coverage terminates by reason of the termination of active employment, an extended benefit will be proved during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	Section XII, page 1
Continuation Coverage Model Language Used?	§3221(e)(11) §3221(m) §4305(e)	This policy or contract form contains a provision regarding continuation coverage. §§3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue	

Yes ▣ No ☐	COBRA, Title X of Public Law 99-272 Model Language	hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage. The continuation benefits terminate: • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	Section XII, page 1-4
Young Adult Option Model Language Used? Yes ▣ No ☐	§3221(r) §4305(l) Model Language	This policy or contract form provides notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy or contract, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r), and/or 4305(l). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy or contract. The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).	Section XII, page 3
Suspension of Coverage Model Language Used? Yes ▣ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose	Section XII, page 2-3

		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.	
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard Model Language Used? Yes ■ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language	If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	Section XII, page 2-3
Conversion - Right to a New Contract After Termination Model Language Used? Yes ■ No ☐	§3221(e) §4303(d)	This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents. Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates. The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	Section XII, page 3-5
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☐ No ☐	§3221(a)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	Section XIII, page 2
Changes	§3221(a)(2)	The policy or contract form must provide that no agent has the authority to change the policy or	

Model Language Used? Yes ☒ No ☐	Model Language	contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	Section XIII, page 1
Action in Law or Equity Model Language Used? Yes ☒ No ☐	§3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy or contract.	Section XIII, page 4
Subrogation Model Language Used? Yes ☐ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	Section XIII, page 4
Unilateral Modification Model Language Used? Yes ☒ No ☐	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	Section XIII, page 1
Non-English Speaking Insureds Model Language Used? Yes ☐ No ☐	§3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	Section XIII, page 4
SCHEDULE OF BENEFITS Model Language Used? Yes ☐ No ☐	Standard Benefit Design Description Chart Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§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 ☒ No ☐	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	Compliant
Insured's Financial	§3217-a(a)(5)	This policy or contract form includes a description of the insured's financial responsibility for	Compliant

Responsibility for Payment	§4324(a)(5) PHL §4408(1)(e)	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.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☐ No ☒ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☐	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	Not Applicable
Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f) or 4305(c)(1).	IHBC-R1064
Contraceptive Drugs and Devices and Family Planning Services	§3221(l)(16)	This policy or contract form includes a rider for situations when a Group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§3221(l)(16)(A); 4303(cc)(1)(A). In accordance with law, if elected by an insured, this Rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the federal food and drug administration and provides coverage for family planning services.	IHBC-R1066
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 <u>NEW PRODUCT</u> RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Checklist for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or*	

		advertising, OR ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3221 11NYCRR52.40(e) 11NYCRR360.10 11NYCRR360.11 §3201(e)(1)(B) §4308(c)(3)(A)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 87 %. a.	IHBC Off Exchange Sml Grp 2014 Act Memo 20130508.pdf
Loss Ratios	§3201(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	IHBC Off Exchange Sml Grp 2014 Act
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	IHBC Off Exchange Sml
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 Off Exchange Sml Grp 2014 Act Memo 20130508.pdf
Expected Loss Ratio Certification	§3201(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 87 %.	IHBC Off Exchange Sml
GROUP RATE MANUAL	11NYCRR52.40(e)(2) §3201(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations.	A43_S_offEx_Manual_2014_Rev_2013_5_9.pdf

		h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		*Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.* *(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)*	F
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(e)	a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Provide New York and nationwide claims experience respectively, including: (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes.	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3201(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _ %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(e)(2)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees.	

		i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	

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. <u>Scoring Option</u> *(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. <u>Scope of Test</u> *(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. <u>Standards of Certification</u> (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-R1064	190	6		48.9
IHBC-R1065	477	7		59.9
IHBC-R1066	262	12		50.7

(insert signature, name of officer, title of officer, and name of insurer)

John R. Rodgers
EVP, Chief Operating Officer
Independent Health Benefits Corporation

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. <u>Scoring Option</u> *(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. <u>Scope of Test</u> *(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. <u>Standards of Certification</u> (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-C1027	572	39		48.7
IHBC-C1027 Table of Contents				
IHBC-C1027 Definitions	2733	105		46.2
IHBC-C1027 How Your Coverage Works	1596	68		45.6
IHBC-C1027 Access to Care and Transitional Care	1205	43		4537
IHBC-C1027 Cost Sharing Expenses and Allowed Amount	1684	77		45.2
IHBC-C1027 Who is Covered	1717	60		46.8
IHBC-C1027 Covered Services	15,454	615		45.7
IHBC-C1027 Exclusions and Limitations	939	53		47.5

IHBC-C1027 Claim Determinations	810	41		52.9
IHBC-C1027 Grievance, Utilization Review, and External Appeal	4237	144		45.3
IHBC-C1027 Coordination of Benefits	1191	39		46.4
IHBC-C1027 Termination of Coverage	556	27		53.4
IHBC-C1027 What Happens if You Lose Coverage	2110	63		50.1
IHBC-C1027 General Provisions	2455	125		50.2

(insert signature, name of officer, title of officer, and name of insurer)

[redacted]

User Inputs for Plan Parameters

Platinum Plan C

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐		
Specialist Visit	☐	☐		$30.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐		
X-rays and Diagnostic Imaging	☐	☐		$30.00	☐	☐		
Skilled Nursing Facility	☐	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	94%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☐	☑	98%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	89.6%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Gold Plan C

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☐	☐		
Specialist Visit	☑	☐		$45.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$45.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$45.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$45.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	97%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.5%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan D

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan E

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan F

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan G

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:	$0.00	1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00		$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		60.00%	100.00%	
OOP Maximum ($)	$5,000.00			$6,350.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑	60%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☐		$30.00
Specialist Visit	☑	☐		$50.00	☑	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☐		$100.00
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☐		$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☐		$50.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☐		$30.00
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☐		$50.00
Skilled Nursing Facility	☑	☐		$500.00	☑	☑	60%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	97%		☑	☑	60%	
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☑	50%		☐	☑	50%	
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☑	50%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan H

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$63.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	97%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	77.9%
Metal Tier:	

User Inputs for Plan Parameters

	Silver Plan C
Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan E

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan F

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan G

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:	$0.00	1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			$2,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%			60.00%
OOP Maximum ($)			$5,000.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		$200.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑	60%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☐		$30.00
Specialist Visit	☑	☐		$50.00	☑	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☐		$100.00
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☐		$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☐		$50.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☐		$30.00
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☐		$50.00
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑	60%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☑	☑	60%	
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☑	☐		$4.00
Preferred Brand Drugs	☑	☐		$30.00	☑	☐		$30.00
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.6%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan H

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$63.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.7%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan I

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$750.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$63.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$750.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	93%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

User Inputs for Plan Parameters

Bronze Plan B

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			$5,500.00
Coinsurance (%, Insurer's Cost Share)			80.00%			60.00%
OOP Maximum ($)			$6,350.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑	80%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑	60%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑	80%	
Specialist Visit	☑	☑	80%		☑	☑	80%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑	80%	
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑	80%	
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑	80%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑	80%	
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑	80%	
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑	80%	
Skilled Nursing Facility	☑	☑	70%		☑	☑	60%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑	60%	
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☑	☑	50%	
Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.4%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan C

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑	64%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.5%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan D

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan E

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan F

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze

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

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

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

B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
C. In Column 4, market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healhty NY (HNY-IND), Small Group Healthy NY (HNY SG). Use the drop down list to enter the market segment.
D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans and Base+Supplemental. Indicate appropriate designation for policy form, etc.
E. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department). Include a region identifier in this column if needed.
F. Note that many cells include a drop down list. Use the drop down list for entries.
G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form											Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical po icy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change	14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
IHBC-C1009	In-Network Product	Encompass Essential Plus Easy Access	POS SM	01/14/13	SG	Non-HMO based POS	Yes	Open	412	3 134	XX	01/01/12	12/31/12	43 489	$15 980 406.13	$17 798 934.26	$14 207 998.77	$14 384 647.94	$0.00	$0.00	$2 087 872.57	XX
IHBC-POSC-001	Encompass Plus D	Encompass Plus D	POS SM	01/14/13	SG	Non-HMO based POS	Yes	Open	709	5,071	XX	01/01/12	12/31/12	64,780	$25,030,448.99	$27,814,022.87	$25,467,834.47	$25,795,982.66	$0.00	$0.00	$3,302,047.09	XX
IHBC-C-601	FlexFit Select 43	FlexFit Selec	POS SM	01/14/13	SG	Non-HMO based POS	Yes	Open	0	0	XX	01/01/12	12/31/12	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
IHBC-C1005	FlexFit Select 43	FlexFit Selec	POS SM	01/14/13	SG	Non-HMO based POS	Yes	Open	1 897	12 297	XX	01/01/12	12/31/12	158 241	$59 888 107.97	$66 616 084.39	$52 480 194.46	$53 170 169.41	$0.00	$0.00	$7 900 511.61	XX
500103-43	Passport Plan Select	Passport Plan Select	POS SM	01/14/13	SG	PPO	Yes	Open	307	2,017	XX	01/01/12	12/31/12	26,598	$8,444,019.23	$9,379,447.80	$7,359,616.46	$7,444,057.45	$0.00	$0.00	$1,034,558.25	XX
			POS SM						3 325	22 519	XX	01/01/12	12/31/12	293 108	$109 342 982.32	$121 608 489.32	$99 515 644.16	$100 794 857.47	$0.00	$0.00	$14 324 989.51	XX
IHBC-HSAQE-C-001	1Series HSA Qual	Direct 1Series	HDHP SM	01/14/13	SG	HSA Qua ified HDHP	Yes	Open	1,125	8,987	XX	01/01/12	12/31/12	113,443	$29,846,909.05	$34,675,106.16	$24,477,290.33	$24,834,468.81	$0.00	$0.00	$3,917,422.72	XX
IHBC-HSAQP-C-001	2Series HSA Qual	Direct 2Series	HDHP SM	01/14/13	SG	HSA Qua ified HDHP	Yes	Open	42	426	XX	01/01/12	12/31/12	5,170	$1,266,101.03	$1,456,061.31	$786,360.25	$798,441.36	$0.00	$0.00	$166,176.43	XX
IHBC-HSAQ-C-003	3Series HSA Qual	Direct 3Series	HDHP SM	01/14/13	SG	HSA Qual fied HDHP	Yes	Open	251	1 619	XX	01/01/12	12/31/12	22 279	$5 259 729.06	$6 197 058.99	$5 488 908.01	$5 569 426.02	$0.00	$0.00	$690 342.24	XX
IHBC-HSAQ-C-004	4Series HSA Qual	Direct 4Series	HDHP SM	01/14/13	SG	HSA Qual fied HDHP	Yes	Open	19	103	XX	01/01/12	12/31/12	1,077	$285,016.48	$300,215.69	$162,853.34	$164,617.72	$0.00	$0.00	$37,408.56	XX
IHBC-C1001	5Series HSA Qual	Direct 5Series	HDHP SM	01/14/13	SG	HSA Qual fied HDHP	Yes	Open	29	145	XX	01/01/12	12/31/12	1 939	$492 602.41	$552 973.58	$441 329.82	$443 400.24	$0.00	$0.00	$64 654.33	XX
IHBC-HRAE-C-001B	1Series B-Style non-HSA Qua	Direct 1Series	HDHP SM	01/14/13	SG	Non-HSA Qualified HDHP	Yes	Open	391	2,732	XX	01/01/12	12/31/12	27,039	$7,292,308.13	$8,372,202.05	$6,398,906.66	$6,503,328.16	$0.00	$0.00	$957,119.33	XX
IHBC-HRAE-C-001C	1Series C-Style non-HSA Qua	Direct 1Series	HDHP SM	01/14/13	SG	Non-HSA Qualified HDHP	Yes	Open	645	6,931	XX	01/01/12	12/31/12	65,695	$17,994,884.48	$20,577,912.36	$15,171,881.67	$15,415,190.62	$0.00	$0.00	$2,361,838.18	XX
IHBC-HRAP-C-001	2Series non-HSA Qual	Direct 2Series	HDHP SM	01/14/13	SG	Non-HSA Qualified HDHP	Yes	Open	54	346	XX	01/01/12	12/31/12	2 840	$750 459.59	$853 372.55	$583 907.69	$596 695.29	$0.00	$0.00	$98 498.22	XX
IHBC-C1008	Evolve	Evolve	HDHP SM	01/14/13	SG	HDHP	Yes	Open	171	796	XX	01/01/12	12/31/12	2,492	$654,811.65	$723,212.60	$428,540.22	$436,022.88	$0.00	$0.00	$85,944.38	XX
			HDHP SM						2 727	22 085	XX	01/01/12	12/31/12	241 974	$63 842 821.87	$73 708 115.30	$53 939 978.00	$54 761 591.09	$0.00	$0.00	$8 379 404.40	XX
IHBC-C1019	Passport Plan Select Out of Area	Passport Plan Select Out of Area	PPO OOA SM	01/14/13	SG	PPO	Yes	Open	4	7	XX	04/01/12	12/31/12	16	$6,658.69	$6,695.77	$571.18	$589.73	$0.00	$0.00	$815.82	XX
			PPO OOA SM						4	7	XX	04/01/12	12/31/12	16	$6 658.69	$6 695.77	$571.18	$589.73	$0.00	$0.00	$815.82	XX
IHBC-C1014	iDirect 1Series B Style HSA Qua	iDirect 1Series Out of Area	HDHP OOA SM	01/14/13	SG	HSA Qual fied HDHP	Yes	Open	2	2	XX	04/01/12	12/31/12	9	$6,609.29	$7,360.21	$595.76	$607.13	$0.00	$0.00	$867.47	XX
IHBC-C1015	iDirect 1Series C Style HSA Qua	iDirect 1Series Out of Area	HDHP OOA SM	01/14/13	SG	HSA Qual fied HDHP	Yes	Open	8	21	XX	04/01/12	12/31/12	3	$1 693.30	$1 779.66	$64.96	$65.58	$0.00	$0.00	$222.25	XX
			HDHP OOA SM						10	23	XX	04/01/12	12/31/12	12	$8,302.59	$9,139.87	$660.72	$672.71	$0.00	$0.00	$1,089.72	XX

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

			First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)											Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period ($)	15.5 Standardized earned premiums for experience period ($)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)		16.1 Beginning date of the experience period (MM/DD/YY)	16.2 Ending Date of the experience period (MM/DD/YY)	16.3 Member months for experience period	16.4 Earned premiums for experience period ($)	16.5 Standardized earned premiums for experience period ($)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
IHBC-C1009	In-Network Product	Encompass Essential Plus, Easy Access	01/01/11	12/31/11	52 749	$18 473 841.41	$22 645 434.39	$15 484 025.85	$15 484 025.85	$0.00	$124 343.97	$2 474 239.12	XX	01/01/10	12/31/10	61 663	$19 652 176.41	$27 136 109.85	$16 513 970.11	$16 513 970.11	$0.00	$123 144.48	$2 268 784.31	XX
IHBC-POSC-001	Encompass Plus D	Encompass Plus D	01/01/11	12/31/11	67,448	$24,897,306.50	$30,344,456.63	$25,004,647.55	$25,004,647.55	$0.00	$200,547.89	$3,339,820.34	XX	01/01/10	12/31/10	64,434	$22,059,178.34	$30,189,856.61	$22,500,160.67	$22,500,160.67	$0.00	$167,783.43	$2,546,665.40	XX
IHBC-C-601	FlexFit Select 43	FlexFit Select	01/01/11	12/31/11	66,569	$22,422,993.55	$27,151,176.59	$19,986,083.09	$19,986,083.09	$0.00	$160,296.87	$3,007,906.49	XX	01/01/10	12/31/10	225,398	$70,660,893.44	$91,877,763.80	$63,286,127.05	$63,286,127.05	$0.00	$471,923.89	$8,157,586.37	XX
IHBC-C1005	FlexFit Select 43	FlexFit Select	01/01/11	12/31/11	119 482	$41 365 121.46	$49 182 134.90	$37 080 682.11	$37 080 682.11	$0.00	$297 402.82	$5 548 876.29	XX	01/01/10	12/31/10	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
500103-43	Passport Plan Select	Passport Plan Select	01/01/11	12/31/11	31,292	$10,318,812.72	$12,131,126.05	$9,199,360.09	$9,199,360.09	$0.00	$97,457.07	$1,444,244.44	XX	01/01/10	12/31/10	41,269	$13,034,722.83	$15,750,812.10	$11,128,763.87	$11,128,763.87	$0.00	$124,632.57	$1,369,382.91	XX
			01/01/11	12/31/11	337 540	$117 478 075.64	$141 454 328.56	$106 754 798.68	$106 754 798.68	$0.00	$880 048.63	$15 815 086.68	XX	01/01/10	12/31/10	392 764	$125 406 971.02	$164 954 542.36	$113 429 021.69	$113 429 021.69	$0.00	$887 484.36	$14 342 418.98	XX
IHBC-HSAQE-C-001	1Series HSA Qua	iDirect 1Series	01/01/11	12/31/11	107,433	$24,659,724.50	$31,866,876.55	$21,495,205.18	$21,495,205.18	$0.00	$218,804.87	$3,549,372.29	XX	01/01/10	12/31/10	92,180	$19,556,040.27	$28,061,411.43	$16,551,333.38	$16,551,333.38	$0.00	$139,691.97	$2,226,551.92	XX
IHBC-HSAQP-C-001	2Series HSA Qua	iDirect 2Series	01/01/11	12/31/11	4,685	$984,965.60	$1,247,474.05	$571,783.03	$571,783.03	$0.00	$5,820.32	$141,770.02	XX	01/01/10	12/31/10	5,339	$1,072,455.20	$1,536,235.90	$1,055,025.96	$1,055,025.96	$0.00	$8,904.34	$122,104.33	XX
IHBC-HSAQ-C-003	3Series HSA Qua	iDirect 3Series	01/01/11	12/31/11	19 904	$4 052 581.40	$5 322 620.90	$3 865 571.33	$3 865 571.33	$0.00	$39 348.58	$583 304.17	XX	01/01/10	12/31/10	16 186	$2 885 579.40	$4 236 108.36	$2 954 181.56	$2 954 181.56	$0.00	$24 933.06	$328 537.49	XX
IHBC-HSAQ-C-004	4Series HSA Qua	iDirect 4Series	01/01/11	12/31/11	1,425	$325,642.85	$393,105.05	$686,786.73	$686,786.73	$0.00	$6,990.97	$46,871.07	XX	01/01/10	12/31/10	999	$204,865.30	$284,294.61	$547,338.79	$547,338.79	$0.00	$4,619.50	$23,324.93	XX
IHBC-C1001	5Series HSA Qua	iDirect 5Series	01/01/11	12/31/11	538	$115 908.25	$136 801.52	$190 246.28	$190 246.28	$0.00	$1 936.56	$16 683.14	XX	01/01/10	12/31/10	10	$1 938.57	$2 628.77	$108.89	$108.89	$0.00	$0.92	$220.72	XX
IHBC-HRAE-C-001B	1Series B-Style non-HSA Qua	iDirect 1Series	01/01/11	12/31/11	22,448	$5,543,191.26	$6,832,283.51	$5,537,408.58	$5,537,408.58	$0.00	$56,366.62	$797,853.58	XX	01/01/10	12/31/10	17,692	$4,084,372.03	$5,524,294.25	$3,551,450.83	$3,551,450.83	$0.00	$29,973.97	$465,025.96	XX
IHBC-HRAE-C-001C	1Series C-Style non-HSA Qua	iDirect 1Series	01/01/11	12/31/11	42,489	$10,472,107.71	$12,905,354.71	$9,637,831.64	$9,637,831.64	$0.00	$98,105.81	$1,507,292.14	XX	01/01/10	12/31/10	34,766	$7,859,888.64	$10,722,516.44	$8,151,267.30	$8,151,267.30	$0.00	$68,796.06	$894,887.20	XX
IHBC-HRAP-C-001	2Series non-HSA Qua	iDirect 2Series	01/01/11	12/31/11	939	$219 042.85	$261 260.00	$98 498.99	$98 498.99	$0.00	$1 002.64	$31 527.71	XX	01/01/10	12/31/10	258	$44 524.53	$62 998.32	$15 263.46	$15 263.46	$0.00	$128.82	$5 069.34	XX
IHBC-C1008	Evolve	Evolve	01/01/11	12/31/11	6	$1,665.50	$1,785.30	$255.90	$255.90	$0.00	$0.00	$239.72	XX	01/01/10	12/31/10	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
			01/01/11	12/31/11	199 867	$46 374 829.92	$58 967 561.59	$42 083 587.65	$42 083 587.65	$0.00	$428 376.37	$6 674 913.84	XX	01/01/10	12/31/10	167 430	$35 709 663.94	$50 430 488.09	$32 825 970.16	$32 825 970.16	$0.00	$277 048.64	$4 065 721.87	XX
IHBC-C1019	Passport Plan Select Out of Area	Passport Plan Select Out of Area			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
					0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
IHBC-C1014	iDirect 1Series B Style HSA Qua	iDirect 1Series Out of Area			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
IHBC-C1015	iDirect 1Series C Style HSA Qua	iDirect 1Series Out of Area			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
					0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

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

Line #	General							
1	Product*	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum
2	Product ID*	18029NY117	18029NY117	18029NY117	18029NY117	18029NY117	18029NY117	18029NY117
3	Metal Level (or catastrophic)*	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum
4	AV Metal Value (HHS Calculator)*	0.897	0.897	0.897	0.897	0.897	0.897	0.897
5	AV Pricing Value (total, risk pool experience based)*	0.990	0.999	0.994	0.990	0.995	0.999	0.994
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Platinum Plan C	Platinum Plan C	Platinum Plan C	Platinum Plan C	Platinum Plan C	Platinum Plan C	Platinum Plan C
8	Plan ID*	18029NY1170017	18029NY1170019	18029NY1170020	18029NY1170021	18029NY1170024	18029NY1170027	18029NY1170029
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	152,118,017						
10B	Member-Months for Latest Experience Period	535 110						
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	284.27						
11	Average Pricing Actuarial Value reflected in experience period	0.778						
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate							
13	Impact of adjusting experience period data to EHB benefit level	1.017						
14	Market wide adjustment for changes in provider network **	1.000						
15	Market wide adjustment for fee schedule changes *	0.941						
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)	0.983						
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000						
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000						
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.159						
24	Other 1 - Adjustment for Rx Rebates	0.997						
25	Other 2 (specify)	1.000						
26	Other 3 (specify)	1.000						
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.891	0.891	0.891	0.891	0.891	0.891	0.891
29	Pricing actuarial value (only the induced demand factor) #	1.065	1.065	1.065	1.065	1.065	1.065	1.065
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	1.004	1.004	1.000	1.000	1.004	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.186	1.186	1.186	1.186	1.186	1.186	1.186
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	0.995	0.995	1.000	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**1.110**	**1.120**	**1.114**	**1.110**	**1.116**	**1.120**	**1.114**

\# 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)**	**441.12**	**445.01**	**442.73**	**441.12**	**443.38**	**445.01**	**442.73**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Platinum	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY117	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120
3	Metal Level (or catastrophic)*	Platinum	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.897	0.807	0.807	0.807	0.807	0.807	0.807
5	AV Pricing Value (total, risk pool experience based)*	0.995	0.847	0.855	0.850	0.847	0.852	0.855
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Platinum Plan C	Gold Plan C	Gold Plan C	Gold Plan C	Gold Plan C	Gold Plan C	Gold Plan C
8	Plan ID*	18029NY1170030	18029NY1200017	18029NY1200019	18029NY1200020	18029NY1200021	18029NY1200024	18029NY1200027
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.891	0.811	0.811	0.811	0.811	0.811	0.811
29	Pricing actuarial value (only the induced demand factor) #	1.065	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
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	1.004	1.000	1.000	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.186	1.189	1.189	1.189	1.189	1.189	1.189
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.000	1.001	1.001	1.001	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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	1.000	0.995	0.995	1.000	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**1.116**	**0.952**	**0.960**	**0.955**	**0.952**	**0.957**	**0.960**

\# 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)**	**443.38**	**378.28**	**381.60**	**379.66**	**378.28**	**380.21**	**381.60**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.807	0.807	0.784	0.784	0.784	0.784	0.784
5	AV Pricing Value (total, risk pool experience based)*	0.850	0.852	0.824	0.832	0.828	0.824	0.829
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Gold Plan C	Gold Plan C	Gold Plan D	Gold Plan D	Gold Plan D	Gold Plan D	Gold Plan D
8	Plan ID*	18029NY1200029	18029NY1200030	18029NY1200049	18029NY1200051	18029NY1200052	18029NY1200053	18029NY1200056
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.811	0.811	0.789	0.789	0.789	0.789	0.789
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
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)	1.004	1.000	1.000	1.004	1.004	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.189	1.189	1.189	1.189	1.189	1.189	1.189
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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	1.001	1.002	1.002	1.002	1.002	1.002
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	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	0.995	1.000	0.995	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.955**	**0.957**	**0.927**	**0.935**	**0.930**	**0.927**	**0.932**

\# 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)**	**379.66**	**380.21**	**368.28**	**371.52**	**369.63**	**368.28**	**370.17**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.784	0.784	0.784	0.784	0.784	0.784	0.784
5	AV Pricing Value (total, risk pool experience based)*	0.832	0.828	0.829	0.794	0.801	0.797	0.794
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Gold Plan D	Gold Plan D	Gold Plan D	Gold Plan G	Gold Plan G	Gold Plan G	Gold Plan G
8	Plan ID*	18029NY1200059	18029NY1200061	18029NY1200062	18029NY1200065	18029NY1200067	18029NY1200068	18029NY1200069
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.789	0.789	0.789	0.786	0.786	0.786	0.786
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	1.000	1.000	1.000	0.980	0.980	0.980	0.980
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	0.975	0.975	0.975	0.975
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.004	1.000	1.000	1.004	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.189	1.189	1.189	1.190	1.190	1.190	1.190
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	1.000	0.995	1.000	0.995	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.935**	**0.930**	**0.932**	**0.893**	**0.901**	**0.896**	**0.893**

\# 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)**	**371.52**	**369.63**	**370.17**	**354.79**	**357.91**	**356.09**	**354.79**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.784	0.784	0.784	0.784	0.781	0.781	0.781
5	AV Pricing Value (total, risk pool experience based)*	0.798	0.801	0.797	0.798	0.803	0.811	0.806
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Gold Plan G	Gold Plan G	Gold Plan G	Gold Plan G	Gold Plan H	Gold Plan H	Gold Plan H
8	Plan ID*	18029NY1200072	18029NY1200075	18029NY1200077	18029NY1200078	18029NY1200097	18029NY1200099	18029NY1200100
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.786	0.786	0.786	0.786	0.786	0.786	0.786
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	0.980	0.980	0.980	0.980	0.985	0.985	0.985
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 ##	0.975	0.975	0.975	0.975	0.982	0.982	0.982
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.004	1.004	1.000	1.000	1.004	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.190	1.190	1.190	1.190	1.190	1.190	1.190
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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	Other 1 - Adjustment for removal of Family Planning services	1.000	1.000	0.995	1.000	0.995	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.897**	**0.901**	**0.896**	**0.897**	**0.903**	**0.911**	**0.907**

\# 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)**	**356.61**	**357.91**	**356.09**	**356.61**	**359.02**	**362.17**	**360.33**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY120	18029NY120	18029NY120	18029NY120	18029NY120	18029NY121	18029NY121
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.781	0.781	0.781	0.781	0.781	0.784	0.784
5	AV Pricing Value (total, risk pool experience based)*	0.803	0.808	0.811	0.806	0.808	0.919	0.927
6	Plan Type*	POS	POS	POS	POS	POS	PPO	PPO
7	Plan Name*	Gold Plan H	Gold Plan H	Gold Plan H	Gold Plan H	Gold Plan H	Gold Plan E	Gold Plan E
8	Plan ID*	18029NY1200101	18029NY1200104	18029NY1200107	18029NY1200109	18029NY1200110	18029NY1210001	18029NY1210003
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.786	0.786	0.786	0.786	0.786	0.801	0.801
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	0.985	0.985	0.985	0.985	0.985	1.098	1.098
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 ##	0.982	0.982	0.982	0.982	0.982	0.989	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.004	1.004	1.000	1.000	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.190	1.190	1.190	1.190	1.190	1.188	1.187
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	1.000	0.995	1.000	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.903**	**0.908**	**0.911**	**0.907**	**0.908**	**1.032**	**1.041**

\# 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)**	**359.02**	**360.85**	**362.17**	**360.33**	**360.85**	**409.95**	**413.56**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY121	18029NY121	18029NY121	18029NY121	18029NY121	18029NY121	18029NY121
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.784	0.784	0.784	0.784	0.784	0.784	0.784
5	AV Pricing Value (total, risk pool experience based)*	0.923	0.919	0.924	0.927	0.923	0.924	1.803
6	Plan Type*	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*	Gold Plan E	Gold Plan E	Gold Plan E	Gold Plan E	Gold Plan E	Gold Plan E	Gold Plan F
8	Plan ID*	18029NY1210004	18029NY1210005	18029NY1210008	18029NY1210011	18029NY1210013	18029NY1210014	18029NY1210057
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.801	0.801	0.801	0.801	0.801	0.801	0.858
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	1.098	1.098	1.098	1.098	1.098	1.098	2.013
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	0.987
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.000	1.000	1.004	1.004	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.187	1.188	1.187	1.187	1.187	1.187	1.180
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.002	1.002	1.002	1.002	1.002	1.002	1.003
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	Other 1 - Adjustment for removal of Family Planning services	0.995	0.995	1.000	1.000	0.995	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**1.035**	**1.032**	**1.037**	**1.041**	**1.035**	**1.037**	**2.011**

\# 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)**	**411.45**	**409.95**	**412.05**	**413.56**	**411.45**	**412.05**	**799.05**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
2	Product ID*	18029NY121	18029NY121	18029NY121	18029NY121	18029NY121	18029NY121	18029NY121
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.784	0.784	0.784	0.784	0.784	0.784	0.784
5	AV Pricing Value (total, risk pool experience based)*	1.820	1.810	1.803	1.813	1.820	1.810	1.813
6	Plan Type*	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*	Gold Plan F	Gold Plan F	Gold Plan F	Gold Plan F	Gold Plan F	Gold Plan F	Gold Plan F
8	Plan ID*	18029NY1210058	18029NY1210059	18029NY1210060	18029NY1210061	18029NY1210062	18029NY1210063	18029NY1210064
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.858	0.858	0.858	0.858	0.858	0.858	0.858
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##	2.013	2.013	2.013	2.013	2.013	2.013	2.013
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 ##	0.987	0.987	0.987	0.987	0.987	0.987	0.987
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.004	1.000	1.000	1.004	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.180	1.180	1.180	1.180	1.180	1.180	1.180
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.003	1.003	1.003	1.003	1.003	1.003	1.003
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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	0.995	1.000	1.000	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**2.029**	**2.018**	**2.011**	**2.021**	**2.029**	**2.018**	**2.021**

\# 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)**	**806.13**	**801.99**	**799.05**	**803.17**	**806.13**	**801.99**	**803.17**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.697	0.697	0.697	0.697	0.697	0.697	0.697
5	AV Pricing Value (total, risk pool experience based)*	0.715	0.722	0.718	0.715	0.719	0.722	0.718
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Silver Plan C	Silver Plan C	Silver Plan C	Silver Plan C	Silver Plan C	Silver Plan C	Silver Plan C
8	Plan ID*	18029NY1240033	18029NY1240035	18029NY1240036	18029NY1240037	18029NY1240040	18029NY1240043	18029NY1240045
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.717	0.717	0.717	0.717	0.717	0.717	0.717
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.954
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	1.004	1.004	1.000	1.000	1.004	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.192	1.192	1.192	1.192	1.192	1.192	1.192
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.003	1.003	1.003	1.003	1.003	1.003	1.003
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	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	0.995	0.995	1.000	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.806**	**0.813**	**0.809**	**0.806**	**0.810**	**0.813**	**0.809**

\# 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)**	**320.23**	**323.04**	**321.40**	**320.23**	**321.86**	**323.04**	**321.40**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.697	0.699	0.699	0.699	0.699	0.699	0.699
5	AV Pricing Value (total, risk pool experience based)*	0.719	0.708	0.714	0.711	0.708	0.712	0.714
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Silver Plan C	Silver Plan G	Silver Plan G	Silver Plan G	Silver Plan G	Silver Plan G	Silver Plan G
8	Plan ID*	18029NY1240046	18029NY1240049	18029NY1240051	18029NY1240052	18029NY1240053	18029NY1240056	18029NY1240059
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.717	0.735	0.735	0.735	0.735	0.735	0.735
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.954
30	Impact of provider network characteristics ##	1.000	0.980	0.980	0.980	0.980	0.980	0.980
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	0.975	0.975	0.975	0.975	0.975	0.975
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.004	1.004	1.000	1.000	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.192	1.192	1.192	1.192	1.192	1.192	1.192
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.003	1.003	1.003	1.003	1.003	1.003	1.003
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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	1.000	0.995	0.995	1.000	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.810**	**0.797**	**0.804**	**0.800**	**0.797**	**0.802**	**0.804**

\# 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)**	**321.86**	**316.88**	**319.66**	**318.04**	**316.88**	**318.50**	**319.66**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.699	0.699	0.700	0.700	0.700	0.700	0.700
5	AV Pricing Value (total, risk pool experience based)*	0.711	0.712	0.721	0.727	0.724	0.721	0.725
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Silver Plan G	Silver Plan G	Silver Plan H	Silver Plan H	Silver Plan H	Silver Plan H	Silver Plan H
8	Plan ID*	18029NY1240061	18029NY1240062	18029NY1240081	18029NY1240083	18029NY1240084	18029NY1240085	18029NY1240088
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.735	0.735	0.739	0.739	0.739	0.739	0.739
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.954
30	Impact of provider network characteristics ##	0.980	0.980	0.985	0.985	0.985	0.985	0.985
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 ##	0.975	0.975	0.982	0.982	0.982	0.982	0.982
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.000	1.000	1.004	1.004	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.192	1.192	1.192	1.192	1.192	1.192	1.192
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.003	1.003	1.002	1.002	1.002	1.002	1.002
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	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	0.995	1.000	0.995	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.800**	**0.802**	**0.812**	**0.819**	**0.815**	**0.812**	**0.816**

\# 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)**	**318.04**	**318.50**	**322.69**	**325.52**	**323.87**	**322.69**	**324.34**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124	18029NY124
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.700	0.700	0.700	0.704	0.704	0.704	0.704
5	AV Pricing Value (total, risk pool experience based)*	0.727	0.724	0.725	0.746	0.753	0.749	0.746
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Silver Plan H	Silver Plan H	Silver Plan H	Silver Plan I	Silver Plan I	Silver Plan I	Silver Plan I
8	Plan ID*	18029NY1240091	18029NY1240093	18029NY1240094	18029NY1240113	18029NY1240115	18029NY1240116	18029NY1240117
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.739	0.739	0.739	0.748	0.748	0.748	0.748
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.954
30	Impact of provider network characteristics ##	0.985	0.985	0.985	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 ##	0.982	0.982	0.982	0.989	0.989	0.989	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.004	1.000	1.000	1.004	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.192	1.192	1.192	1.191	1.191	1.191	1.191
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	1.000	0.995	1.000	0.995	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.819**	**0.815**	**0.816**	**0.840**	**0.847**	**0.843**	**0.840**

\# 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)**	**325.52**	**323.87**	**324.34**	**333.81**	**336.74**	**335.03**	**333.81**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY124	18029NY124	18029NY124	18029NY124	18029NY125	18029NY125	18029NY125
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.704	0.704	0.704	0.704	0.697	0.697	0.697
5	AV Pricing Value (total, risk pool experience based)*	0.750	0.753	0.749	0.750	0.805	0.812	0.808
6	Plan Type*	POS	POS	POS	POS	PPO	PPO	PPO
7	Plan Name*	Silver Plan I	Silver Plan I	Silver Plan I	Silver Plan I	Silver Plan E	Silver Plan E	Silver Plan E
8	Plan ID*	18029NY1240120	18029NY1240123	18029NY1240125	18029NY1240126	18029NY1250001	18029NY1250003	18029NY1250004
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.748	0.748	0.748	0.748	0.735	0.735	0.735
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.954
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.098	1.098	1.098
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	1.004	1.004	1.000	1.000	1.004	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.191	1.191	1.191	1.191	1.190	1.190	1.190
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.002	1.002	1.002	1.002	1.003	1.003	1.003
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	Other 1 - Adjustment for removal of Family Planning services	1.000	1.000	0.995	1.000	0.995	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.844**	**0.847**	**0.843**	**0.844**	**0.905**	**0.913**	**0.908**

\# 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)**	**335.52**	**336.74**	**335.03**	**335.52**	**359.66**	**362.82**	**360.97**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY125	18029NY125	18029NY125	18029NY125	18029NY125	18029NY125	18029NY125
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.697	0.697	0.697	0.697	0.697	0.697	0.697
5	AV Pricing Value (total, risk pool experience based)*	0.805	0.809	0.812	0.808	0.809	1.641	1.655
6	Plan Type*	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*	Silver Plan E	Silver Plan E	Silver Plan E	Silver Plan E	Silver Plan E	Silver Plan F	Silver Plan F
8	Plan ID*	18029NY1250005	18029NY1250008	18029NY1250011	18029NY1250013	18029NY1250014	18029NY1250033	18029NY1250035
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.735	0.735	0.735	0.735	0.735	0.818	0.818
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.954
30	Impact of provider network characteristics ##	1.098	1.098	1.098	1.098	1.098	2.013	2.013
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	0.987	0.987
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.004	1.004	1.000	1.000	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.190	1.190	1.190	1.190	1.190	1.181	1.180
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.003	1.003	1.003	1.003	1.003	1.003	1.003
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	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	1.000	0.995	1.000	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.905**	**0.910**	**0.913**	**0.908**	**0.910**	**1.830**	**1.847**

\# 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)**	**359.66**	**361.50**	**362.82**	**360.97**	**361.50**	**727.38**	**733.82**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Silver	Silver	Silver	Silver	Silver	Silver	Bronze
2	Product ID*	18029NY125	18029NY125	18029NY125	18029NY125	18029NY125	18029NY125	18029NY127
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Silver	Silver	Bronze
4	AV Metal Value (HHS Calculator)*	0.697	0.697	0.697	0.697	0.697	0.697	0.619
5	AV Pricing Value (total, risk pool experience based)*	1.647	1.641	1.649	1.655	1.647	1.649	0.690
6	Plan Type*	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*	Silver Plan F	Silver Plan F	Silver Plan F	Silver Plan F	S lver Plan F	Silver Plan F	Bronze Plan E
8	Plan ID*	18029NY1250036	18029NY1250037	18029NY1250040	18029NY1250043	18029NY1250045	18029NY1250046	18029NY1270001
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.818	0.818	0.818	0.818	0.818	0.818	0.652
29	Pricing actuarial value (only the induced demand factor) #	0.954	0.954	0.954	0.954	0.954	0.954	0.926
30	Impact of provider network characteristics ##	2.013	2.013	2.013	2.013	2.013	2.013	1.098
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 ##	0.987	0.987	0.987	0.987	0.987	0.987	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.000	1.000	1.004	1.004	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.181	1.181	1.180	1.180	1.181	1.180	1.193
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.003	1.003	1.003	1.003	1.003	1.003	0.999
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	Other 1 - Adjustment for removal of Family Planning services	0.995	0.995	1.000	1.000	0.995	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**1.837**	**1.830**	**1.840**	**1.847**	**1.837**	**1.840**	**0.778**

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

Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE PMPM (L12 x L27 x L41)**	**730.06**	**727.38**	**731.13**	**733.82**	**730.06**	**731.13**	**309.27**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY127	18029NY127	18029NY127	18029NY127	18029NY127	18029NY127	18029NY127
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.619	0.619	0.619	0.619	0.619	0.619	0.619
5	AV Pricing Value (total, risk pool experience based)*	0.697	0.693	0.690	0.694	0.697	0.693	0.694
6	Plan Type*	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*	Bronze Plan E	Bronze Plan E	Bronze Plan E	Bronze Plan E	Bronze Plan E	Bronze Plan E	Bronze Plan E
8	Plan ID*	18029NY1270003	18029NY1270004	18029NY1270005	18029NY1270008	18029NY1270011	18029NY1270013	18029NY1270014
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.652	0.652	0.652	0.652	0.652	0.652	0.652
29	Pricing actuarial value (only the induced demand factor) #	0.926	0.926	0.926	0.926	0.926	0.926	0.926
30	Impact of provider network characteristics ##	1.098	1.098	1.098	1.098	1.098	1.098	1.098
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)	1.004	1.004	1.000	1.000	1.004	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.193	1.193	1.193	1.193	1.193	1.193	1.193
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	0.999	0.999	0.999	0.999	0.999	0.999	0.999
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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	0.995	1.000	1.000	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.785**	**0.781**	**0.778**	**0.782**	**0.785**	**0.781**	**0.782**

\# 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)**	**311.99**	**310.40**	**309.27**	**310.85**	**311.99**	**310.40**	**310.85**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY127	18029NY127	18029NY127	18029NY127	18029NY127	18029NY127	18029NY127
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.619	0.619	0.619	0.619	0.619	0.619	0.619
5	AV Pricing Value (total, risk pool experience based)*	1.468	1.481	1.473	1.468	1.475	1.481	1.473
6	Plan Type*	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*	Bronze Plan F	Bronze Plan F	Bronze Plan F	Bronze Plan F	Bronze Plan F	Bronze Plan F	Bronze Plan F
8	Plan ID*	18029NY1270033	18029NY1270035	18029NY1270036	18029NY1270037	18029NY1270040	18029NY1270043	18029NY1270045
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.757	0.757	0.757	0.757	0.757	0.757	0.757
29	Pricing actuarial value (only the induced demand factor) #	0.926	0.926	0.926	0.926	0.926	0.926	0.926
30	Impact of provider network characteristics ##	2.013	2.013	2.013	2.013	2.013	2.013	2.013
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 ##	0.987	0.987	0.987	0.987	0.987	0.987	0.987
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.004	1.004	1.000	1.000	1.004	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.182	1.182	1.182	1.182	1.182	1.182	1.182
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	0.995	0.995	1.000	1.000	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**1.639**	**1.653**	**1.645**	**1.639**	**1.647**	**1.653**	**1.645**

\# 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)**	**651.29**	**657.05**	**653.68**	**651.29**	**654.65**	**657.05**	**653.68**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY127	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.619	0.608	0.608	0.608	0.608	0.608	0.608
5	AV Pricing Value (total, risk pool experience based)*	1.475	0.582	0.587	0.584	0.582	0.585	0.587
6	Plan Type*	PPO	POS	POS	POS	POS	POS	POS
7	Plan Name*	Bronze Plan F	Bronze Plan B	Bronze Plan B	Bronze Plan B	Bronze Plan B	Bronze Plan B	Bronze Plan B
8	Plan ID*	18029NY1270046	18029NY1300017	18029NY1300019	18029NY1300020	18029NY1300021	18029NY1300024	18029NY1300027
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.757	0.625	0.625	0.625	0.625	0.625	0.625
29	Pricing actuarial value (only the induced demand factor) #	0.926	0.926	0.926	0.926	0.926	0.926	0.926
30	Impact of provider network characteristics ##	2.013	0.980	0.980	0.980	0.980	0.980	0.980
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 ##	0.987	0.975	0.975	0.975	0.975	0.975	0.975
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.004	1.004	1.000	1.000	1.004
34	Administrative costs (excluding Exchange user fees and profits)	1.182	1.197	1.197	1.197	1.197	1.197	1.197
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	1.000	0.995	0.995	1.000	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**1.647**	**0.659**	**0.664**	**0.661**	**0.659**	**0.662**	**0.664**

\# 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)**	**654.65**	**261.76**	**264.05**	**262.72**	**261.76**	**263.10**	**264.05**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.608	0.608	0.610	0.610	0.610	0.610	0.610
5	AV Pricing Value (total, risk pool experience based)*	0.584	0.585	0.594	0.599	0.596	0.594	0.597
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Bronze Plan B	Bronze Plan B	Bronze Plan C	Bronze Plan C	Bronze Plan C	Bronze Plan C	Bronze Plan C
8	Plan ID*	18029NY1300029	18029NY1300030	18029NY1300033	18029NY1300035	18029NY1300036	18029NY1300037	18029NY1300040
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.625	0.625	0.629	0.629	0.629	0.629	0.629
29	Pricing actuarial value (only the induced demand factor) #	0.926	0.926	0.926	0.926	0.926	0.926	0.926
30	Impact of provider network characteristics ##	0.980	0.980	0.985	0.985	0.985	0.985	0.985
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 ##	0.975	0.975	0.982	0.982	0.982	0.982	0.982
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.000	1.000	1.004	1.004	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.197	1.197	1.196	1.196	1.196	1.196	1.196
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 - Adjustment for removal of Family Planning services	0.995	1.000	0.995	1.000	0.995	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.661**	**0.662**	**0.671**	**0.677**	**0.674**	**0.671**	**0.675**

\# 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)**	**262.72**	**263.10**	**266.82**	**269.16**	**267.79**	**266.82**	**268.18**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General							
1	Product*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130	18029NY130
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.610	0.610	0.610	0.619	0.619	0.619	0.619
5	AV Pricing Value (total, risk pool experience based)*	0.599	0.596	0.597	0.607	0.612	0.609	0.607
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Bronze Plan C	Bronze Plan C	Bronze Plan C	Bronze Plan D	Bronze Plan D	Bronze Plan D	Bronze Plan D
8	Plan ID*	18029NY1300043	18029NY1300045	18029NY1300046	18029NY1300049	18029NY1300051	18029NY1300052	18029NY1300053
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)**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**	**365.60**

	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							
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)							
24	Other 1 - Adjustment for Rx Rebates							
25	Other 2 (specify)							
26	Other 3 (specify)							
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
28	Pricing actuarial value (without induced demand factor) #	0.629	0.629	0.629	0.628	0.628	0.628	0.628
29	Pricing actuarial value (only the induced demand factor) #	0.926	0.926	0.926	0.926	0.926	0.926	0.926
30	Impact of provider network characteristics ##	0.985	0.985	0.985	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 ##	0.982	0.982	0.982	0.989	0.989	0.989	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.004	1.004	1.000	1.000	1.004	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.196	1.196	1.196	1.196	1.196	1.196	1.196
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002	1.002	1.002	1.002
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)	1.000	1.000	1.000	0.999	0.999	0.999	0.999
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	Other 1 - Adjustment for removal of Family Planning services	1.000	0.995	1.000	0.995	1.000	0.995	0.995
40	Other 2	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.677**	**0.674**	**0.675**	**0.686**	**0.692**	**0.688**	**0.686**

\# 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)**	**269.16**	**267.79**	**268.18**	**272.45**	**274.83**	**273.44**	**272.45**

Exhibit 8 - Index Rate/Plan Design Level Adju

Company Name: Independent Health Benefits Corpo
NAIC Code: 47034
SERFF Number: NDPD-129001076
Market Segment: SG

Line #	General				
1	Product*	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY130	18029NY130	18029NY130	18029NY130
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	0.619	0.619	0.619	0.619
5	AV Pricing Value (total, risk pool experience based)*	0.610	0.612	0.609	0.610
6	Plan Type*	POS	POS	POS	POS
7	Plan Name*	Bronze Plan D	Bronze Plan D	Bronze Plan D	Bronze Plan D
8	Plan ID*	18029NY1300056	18029NY1300059	18029NY1300061	18029NY1300062
9	Exchange Plan?*	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)**	**365.60**	**365.60**	**365.60**	**365.60**

	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				
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)				
24	Other 1 - Adjustment for Rx Rebates				
25	Other 2 (specify)				
26	Other 3 (specify)				
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**1.087**	**1.087**	**1.087**	**1.087**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments				
28	Pricing actuarial value (without induced demand factor) #	0.628	0.628	0.628	0.628
29	Pricing actuarial value (only the induced demand factor) #	0.926	0.926	0.926	0.926
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	0.989	0.989	0.989	0.989
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.004	1.004	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.196	1.196	1.196	1.196
35	Profit/Contribution to surplus margins	1.002	1.002	1.002	1.002
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	0.999	0.999	0.999	0.999
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000
39	Other 1 - Adjustment for removal of Family Planning services	1.000	1.000	0.995	1.000
40	Other 2	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40**	**0.689**	**0.692**	**0.688**	**0.689**

\# 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)**	**273.84**	**274.83**	**273.44**	**273.84**

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

Company Name Independent Health Benefits Corporation
NAIC Code 47034
SERFF Number NDPD-129001076
Market Segment SG

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

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

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

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)
Platinum	Off Exchange	Platinum Plan C	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Gold	Off Exchange	Gold Plan C	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Gold	Off Exchange	Gold Plan D	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Gold	Off Exchange	Gold Plan E	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Gold	Off Exchange	Gold Plan F	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Gold	Off Exchange	Gold Plan G	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Gold	Off Exchange	Gold Plan H	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Silver	Off Exchange	Silver Plan C	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Silver	Off Exchange	Silver Plan E	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Silver	Off Exchange	Silver Plan F	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Silver	Off Exchange	Silver Plan G	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Silver	Off Exchange	Silver Plan H	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Silver	Off Exchange	Silver Plan I	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Bronze	Off Exchange	Bronze Plan B	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Bronze	Off Exchange	Bronze Plan C	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Bronze	Off Exchange	Bronze Plan D	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Bronze	Off Exchange	Bronze Plan E	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%
Bronze	Off Exchange	Bronze Plan F	01/01/14	12/31/14	7.00%	0.74%	1.81%	1.40%	0.00%	0.00%	8.81%	12.76%	0.21%	0.00%	0.00%	0.11%	34.00%

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	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Platinum	Off Exchange	Platinum Plan C	-0.54%	12.54%	3.26	8.00	6.16	-	-	38.86	56.29	0.92	-	(2.38)	0.47	55.30
Gold	Off Exchange	Gold Plan C	-0.54%	12.54%	2.79	6.86	5.28	-	-	33.33	48.27	0.79	-	(2.04)	0.41	47.42
Gold	Off Exchange	Gold Plan D	-0.54%	12.54%	2.72	6.68	5.14	-	-	32.45	46.99	0.77	-	(1.99)	0.40	46.17
Gold	Off Exchange	Gold Plan E	-0.54%	12.54%	3.03	7.44	5.73	-	-	36.12	52.31	0.86	-	(2.21)	0.44	51.39
Gold	Off Exchange	Gold Plan F	-0.54%	12.54%	5.90	14.50	11.16	-	-	70.40	101.96	1.67	-	(4.32)	0.86	100.17
Gold	Off Exchange	Gold Plan G	-0.54%	12.54%	2.62	6.44	4.96	-	-	31.26	45.27	0.74	-	(1.92)	0.38	44.48
Gold	Off Exchange	Gold Plan H	-0.54%	12.54%	2.65	6.52	5.01	-	-	31.63	45.81	0.75	-	(1.94)	0.39	45.00
Silver	Off Exchange	Silver Plan C	-0.54%	12.54%	2.36	5.81	4.47	-	-	28.21	40.86	0.67	-	(1.73)	0.34	40.14
Silver	Off Exchange	Silver Plan E	-0.54%	12.54%	2.65	6.53	5.02	-	-	31.69	45.89	0.75	-	(1.94)	0.39	45.09
Silver	Off Exchange	Silver Plan F	-0.54%	12.54%	5.37	13.20	10.16	-	-	64.08	92.81	1.52	-	(3.93)	0.78	91.18
Silver	Off Exchange	Silver Plan G	-0.54%	12.54%	2.34	5.75	4.43	-	-	27.92	40.43	0.66	-	(1.71)	0.34	39.72
Silver	Off Exchange	Silver Plan H	-0.54%	12.54%	2.38	5.86	4.51	-	-	28.43	41.17	0.67	-	(1.74)	0.35	40.45
Silver	Off Exchange	Silver Plan I	-0.54%	12.54%	2.46	6.06	4.66	-	-	29.41	42.59	0.70	-	(1.80)	0.36	41.84
Bronze	Off Exchange	Bronze Plan B	-0.54%	12.54%	1.93	4.75	3.66	-	-	23.06	33.40	0.55	-	(1.41)	0.28	32.81
Bronze	Off Exchange	Bronze Plan C	-0.54%	12.54%	1.97	4.84	3.73	-	-	23.51	34.05	0.56	-	(1.44)	0.29	33.45
Bronze	Off Exchange	Bronze Plan D	-0.54%	12.54%	2.01	4.94	3.80	-	-	24.00	34.76	0.57	-	(1.47)	0.29	34.15
Bronze	Off Exchange	Bronze Plan E	-0.54%	12.54%	2.28	5.61	4.32	-	-	27.25	39.46	0.65	-	(1.67)	0.33	38.77
Bronze	Off Exchange	Bronze Plan F	-0.54%	12.54%	4.81	11.82	9.10	-	-	57.38	83.10	1.36	-	(3.52)	0.70	81.64

Independent Health Benefits Corporation

Small Group Off-Exchange Plans

2014 Premium Rates

Prepared for:
Independent Health Benefits Corporation

Prepared by:

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May 8, 2013

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ATTACHMENTS

Attachment A	Proposed rates for Independent Health's small group plans
Attachment B	Development of conversion factor
Attachment C	Printouts of AV Calculator calculation pages
Attachment D	List of terminated products
Attachment E	Description of quality improvement/cost containment programs [Provided by Independent Health]
Attachment F	Description of the development of the Standardized Premium in Exhibit 7 [Provided by Independent Health]

GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

Company legal name: Independent Health Benefits Corporation

State: New York

HIOS Issuer ID: 18029

Market: Small Group

Effective Date: Quarterly rates effective January 1, 2014; April 1, 2014; July 1, 2014; October 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 value 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 Benefits Corporation's (IHBC's) small group plans to be offered for sale outside of the New York State Small Business Health Options Programs (SHOP) Exchange are presented in Attachment A.

While all the plans shown in Attachment A are new plans to be offered for sale outside of the New York SHOP Exchange effective January 1, 2014, the rates are based on IHBC's current block of small group products. These products will be terminated in 2014. The rate development for these products is consistent with the approach used for IHBC's small group 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.

- Historical Experience: We used the incurred claims for January 1, 2012 through December 31, 2102, paid through March, 2013, for Independent Health's Article 43 (IHBC) as the experience basis for our projections. The incurred claims amount includes an estimate for incurred but not reported (IBNR) claims.

- Morbidity: We did not adjust the 2012 experience for morbidity as the new market rules do not impact small groups in New York (i.e., we did not adjust the experience period data for guarantee issue, take-up rate of the uninsured, health status of

newly insured, pent-up demand of newly insured, etc.). We expect that the population covered in the experience period to have similar morbidity to the population covered in the projection period.

- Other/Merger of Risk Pools: We adjusted the 2012 experience to include the experience from IHA, IHBC's Article 44 sister company. IHA will not sell small group in 2014 with the exception of the mandated off exchange Healthy New York Product. IHA's groups will be cross-walked into IHBC. The IHA claims data was adjusted for the difference in provider contracted rates between IHA and IHBC.

- Trend: We applied utilization and cost trends to the underlying claims to reflect the expected claim levels in 2014.

- Risk Adjustment: We adjusted the projected claims to reflect payments to or from the small group risk adjustment pool as a result of the ACA risk adjustment effective in 2014.

- Benefit Adjustment: The projected claims were adjusted to reflect the benefits that will be offered for each of the products outside of the New York SHOP 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 small group blocks of business.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

Exhibit 7 show's IHBC's earned premium and incurred and paid claims for the period of January 1 through December 31, 2012, with run-out through March 2013. The results shown in Exhibit 7 are consistent with Worksheet 1, Section 1 of the Part 1 Unified Rate Review Template and the Experience Period section of Exhibit 8.

Paid through date: We used claims for calendar year 2012, paid through March, 2013. We included an adjustment for IBNR claims.

Premiums (net of MLR rebate) in the experience period: The premium for the calendar year 2012 experience period is based on detailed member-level premium information. The development is described in detail in Attachment F.

Based on preliminary information for calendar year 2012, no MLR rebates are anticipated to be refunded to enrollees. Therefore we did not include an adjustment for MLR rebates in the 2012 premium.

Allowed and incurred claims incurred during the experience period: Worksheet 1 Section 1 shows our best estimates of the amount of claims incurred during the 12–month experience period. The estimate includes:

- The amount of claims which were processed through IHBC's claims system, summarized from IHBC's detailed claim level historical data,
- Claims processed outside of the claims system, and
- Our best estimate of IBNR

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.

BENEFIT CATEGORIES

Independent Health's claims experience is allocated into benefit categories using the Milliman's Health Cost Guidelines 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

We used the following factors in the projection of the 2014 rates.

MORBIDITY ADJUSTMENTS

We did not adjust the experience period data for changes in morbidity of the population expected to be covered in 2014.

OTHER ADJUSTMENTS

Independent Health made the following other adjustments to project the experience period to the projection period:

- Included the 2012 small group experience from IHA, IHBC's Article 44 sister company. IHA will not sell small group in 2014 with the exception of the one mandated product off exchange. IHA's groups will be cross-walked into IHBC. The IHA claims data was adjusted for the difference in provider contracted rates between IHA and IHBC.

- Identified small groups that Independent Health believes have the biggest incentive to drop coverage in 2014 and allow their employees to purchase insurance through New York's individual Exchange. IHBC removed the experience of these groups from the claims experience.

- Removed Healthy New York individual and sole proprietor experience as these members will transition into the Individual Exchanges in 2014.

Independent Health believes this new claims pool experience reflects the expected demographic mix of its small group population in Region 2 (Buffalo Area) in 2014.

CHANGES IN BENEFITS

All of the benefits provided in IHBC's current small group products would be considered essential health benefits for 2014. The claims experience does not include any non-essential health benefits. However, IHBC's small group products did not cover all New York essential health benefits prior to 2014. The claims experience was adjusted for 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 or nutrition benefit)

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 Group PPO filing: SERFF # DDPA-128974006).

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 benefits 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.

- Nutrition: This benefit provides members with a produce debit card, up to a maximum of $500 per member or $1,000 per family contract, for every $2.00 spent on produce. Members will also have to fill out a health risk assessment to qualify for the benefit. We estimated the value of the nutrition benefit by analyzing historical experience on produce spending and the percentage of members who will fill out a health risk assessment, which we assumed to be 80%.

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 for IHA and IHBC combined; 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 the prescription drug data for IHA and IHBC small group combined 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 the 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
SMALL GROUP

SERVICE CATEGORY	UTILIZATION	ALLOWED CHARGE	PMPM
Hospital Inpatient	2.1%	6.6%	8.9%
Hospital Outpatient	2.3%	4.0%	6.4%
Physician	2.4%	3.7%	6.2%
Prescription Drugs	3.2%	7.7%	11.2%
Other	5.4%	-0.8%	4.5%
Other Medical Expenses*			-4.5%
Total Trend			7.0%

* "Other Medical Expenses" includes BD&C taxes, GME, provider incentives, medical management savings initiatives, and other items related to managing the medical expense trend.

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:

INDUCED DEMAND ADJUSTMENT USED FOR EACH METAL TIER IN THE PAYMENT TRANSFER FORMULA	
Metal Level	**Induced Demand Adjustment**
Catastrophic	1.00
Bronze	1.00
Silver	1.03
Gold	1.08
Platinum	1.15

We used the same induced demand adjustment for each plan within each metal level tier. Prior to using the factors we renormalized them to the average tier of the experience data, which is a gold plan.

CONVERSION AND TIER FACTOR

Independent Health small group conversion factor is 1.23. This factor is based on the members and subscribers enrolled in Independent Health's current small group plans utilized in the rating. IHBC does not expect the overall subscriber/member distribution to change significantly in 2014. Attachment B shows the detail underlying the calculation of the small group 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 MANUAL RATE DEVELOPMENT

Not applicable. IHBC's historical experience is fully credible for the purpose of rate projections.

CREDIBILITY OF EXPERIENCE

Not applicable. IHBC's historical experience is fully credible for the purpose of rate projections.

PAID TO ALLOWED RATIO

The *Paid to Allowed Average Factor in the Projection Period* for the market is shown on Worksheet 1, Section III.

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 PMPM

For IHBC's risk adjustment we relied on the results of the risk simulation performed by Deloitte for New York State. Independent Health believes that the risk profile of New York's small group market will not change significantly in 2014 and any changes that do occur at the State level will have a similar impact on Independent Health's service area. Therefore, we assume that Independent Health's current relationship to the overall state risk score, as shown in the risk simulation, will remain the same. All of Independent Health's small group business in 2014 will be sold through IHBC, therefore we used a weighted average, based on members months, of the "implied normalized risk factor" for IHA and IHBC as the assumed factor for IHBC in 2014.

We calculated the expected risk pool transfer as a percent of the statewide average premium. The result was an estimated payment from the pool of 1.7% of premium. We divided IHBC's projected 2014 net claims costs by 1 plus 1.7% to determine the expected net claims costs after risk adjustment.

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 IHBC as follows:

ADMINISTRATIVE EXPENSE LOAD

Independent Health is using a 13% administrative 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 0.21% as a risk/profit margin. This load was applied to all products and plans. All of IHBC's investment income applicable to the individual and small group products both on and off the Exchange was applied to pricing of the premiums. This practice is consistent with prior years. IHBC's investment portfolios primarily consist of tax exempt fixed income securities with an expected return of approximately 2.5%.

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.

QUARTERLY TREND

We calculated premium rates, as described above, for the first quarter 2014 and then applied a quarterly trend to develop rates for each of the remaining three quarters of 2014. The trend rates are as follows:

2014 QUATERLY TREND RATES

	2nd Qtr.	3rd Qtr.	4th Qtr.
Claim Trend	2.25%	2.25%	2.25%
Exchange User Fee*	0.85%	0.85%	0.85%
Quarterly Premium Trend	3.10%	3.10%	3.10%

*We assume an exchange user fee of 3.5% of premium in 2015, consistent with the Federally Facilitated Exchange user fee.

PROJECTED LOSS RATIO

Under section 4308(c)(3)(A) of New York Insurance Law[1], the expected minimum loss ratio for a small group contract form cannot be less than 82%. Target pricing loss ratios for each of the proposed four quarters in 2014 are presented below. Note that rate increases between quarters are intended to reflect anticipated trend from quarter to quarter, thus preserving target loss ratios.

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

2014 TARGET PRICING LOSS RATIOS	
1st Quarter	87%
2nd Quarter	87%
3rd Quarter	87%
4th Quarter	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 program or for Exchange user fees.

The Index Rate shown in Worksheet 1, Section I of the Unified Rate Review Template was developed by IHBC based on actual claims experience for non-grandfathered plans for essential health benefits only.

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), with appropriate adjustments made to the actuarial value for plan design features that deviate substantially from the parameters in the AV Calculator.

Each of IHBC's non-Standard plans, on and off the Exchange, includes a wellness benefit. The member has the choice of an exercise facility reimbursement benefit or a nutrition benefit as described above. We adjusted the actuarial value produced by the AV Calculator by adding the cost of the wellness benefit PMPM ($4.87) to both the numerator and the denominator (i.e., the paid and allowed PMPMs from the AV Calculator continuance tables, by metal tier.)

The table below shows the results of our actuarial value analysis for IHBC's proposed Off-Exchange plans.

PLAN MARKETING NAME	AVC METAL TIER	WELLNESS BENEFIT	ADJUSTED AV	AV METAL VALUE	COUNTY
Option 2 - Platinum Plan C	89.6%	$4.87	89.7%	Platinum	8 counties
Option 2 - Gold Plan C	80.5%	$4.87	80.7%	Gold	8 counties
Option 3 - Gold Plan D	78.2%	$4.87	78.4%	Gold	8 counties
Option 4 IHPA – Gold Plan E	78.2%	$4.87	78.4%	Gold	3 southern counties
Option 5 Choice Plus – Gold Plan G	78.2%	$4.87	78.4%	Gold	Erie & Niagara
Option 7 Prime Access – Gold Plan H	77.9%	$4.87	78.1%	Gold	Erie & Niagara
Option 15 First Health – Gold Plan F	78.2%	$4.87	78.4%	Gold	8 counties
Option 2 – Silver Plan C	69.3%	$4.87	69.7%	Silver	8 counties
Option 4 IHPA – Silver Plan E	69.3%	$4.87	69.7%	Silver	3 southern counties
Option 7 Choice Plus – Silver Plan G	69.6%	$4.87	69.9%	Silver	Erie & Niagara
Option 12 Prime Access – Silver Plan H	69.7%	$4.87	70.0%	Silver	Erie & Niagara
Option 13 – Silver Plan I	70.0%	$4.87	70.4%	Silver	8 counties
Option 15 First Health – Silver Plan F	69.3%	$4.87	69.7%	Silver	8 counties
Option 1 Choice Plus – Bronze Plan B	60.4%	$4.87	60.8%	Bronze	Erie & Niagara
Option 2 Prime Access - Bronze Plan C	60.5%	$4.87	61.0%	Bronze	Erie & Niagara
Option 3 – Bronze Plan D	61.5%	$4.87	61.9%	Bronze	8 counties
Option 16 IHPA – Bronze Plan E	61.5%	$4.87	61.9%	Bronze	3 southern counties
Option 17 First Health – Bronze Plan F	61.5%	$4.87	61.9%	Bronze	8 counties

Based on the adjusted AV's listed above all the plans fall within the de minimus range for their metallic tiers.

Copies of the AV Calculator pages are provided as Attachment C to this actuarial memorandum.

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 IHBC 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 for the reference plan. Every plan is compared to the reference plan.

MEMBERSHIP PROJECTIONS

Independent Health is combining its small group Article 44 HMO and Article 43 products into one pool all positioned on the Article 43 platform. It projects 37,543 members in its small group products by year end 2014 and 86% of these members are estimated to be off-exchange.

Independent Health is projecting the following distribution of these members across the metal tiers:

IHBC SMALL GROUP OFF-EXCHANGE PLANS ASSUMED 2014 MEMBER DISTRIBUTION BY TIER

Metal Level	Members
Platinum	7,123
Gold	9,486
Silver	12,234
Bronze	3,445
Total	32,288

TERMINATED PRODUCTS

A list of the products that will be terminated prior to the January 1, 2014 effective date is provided in Attachment D.

WARNING ALERTS

Not applicable.

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

I have used the Actuarial Value Calculator to determine the actuarial value of the plan provisions that fit within the calculator parameters and made appropriate adjustments to the actuarial values identified by the calculator, for plan design features that deviate substantially from the parameters of the Actuarial Value Calculator. To the best of my knowledge, these actuarial values are calculated in compliance with the Department of Health and Human Services and New York insurance law.

I certify that the adjustments made to the actuarial value as identified by the Actuarial Value Calculator are appropriate and in accordance with generally accepted actuarial principles and methodologies.

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: [redacted]

Title: Principal and Consulting Actuary

Date: May 8, 2013

Attachment A

Independent Health Benefits Corporation

Small Group off Exchange Premium Rates Effective January 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
Platinum Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1170017-00	IHBC-C1027	IHBC-SBP005-3				Platinum Plan C	Base	$542.58	$1,085.16	$922.39	$1,546.35
18029NY1170019-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, 29, FP	$547.36	$1,094.72	$930.51	$1,559.98
18029NY1170020-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064		IHBC-R1065	Platinum Plan C	DP, 29	$544.57	$1,089.14	$925.77	$1,552.02
18029NY1170021-00	IHBC-C1027	IHBC-SBP005-3			IHBC-R1065	Platinum Plan C	DP	$542.58	$1,085.16	$922.39	$1,546.35
18029NY1170024-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, FP	$545.36	$1,090.72	$927.11	$1,554.28
18029NY1170027-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066		Platinum Plan C	29, FP	$547.36	$1,094.72	$930.51	$1,559.98
18029NY1170029-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064			Platinum Plan C	29	$544.57	$1,089.14	$925.77	$1,552.02
18029NY1170030-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066		Platinum Plan C	FP	$545.36	$1,090.72	$927.11	$1,554.28
Gold Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1200017-00	IHBC-C1027	IHBC-SBG005-3				Gold Plan C	Base	$465.27	$930.54	$790.96	$1,326.02
18029NY1200019-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan C	DP, 29, FP	$469.37	$938.74	$797.93	$1,337.70
18029NY1200020-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064		IHBC-R1065	Gold Plan C	DP, 29	$466.98	$933.96	$793.87	$1,330.89
18029NY1200021-00	IHBC-C1027	IHBC-SBG005-3			IHBC-R1065	Gold Plan C	DP	$465.27	$930.54	$790.96	$1,326.02
18029NY1200024-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066	IHBC-R1065	Gold Plan C	DP, FP	$467.66	$935.32	$795.02	$1,332.83
18029NY1200027-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066		Gold Plan C	29, FP	$469.37	$938.74	$797.93	$1,337.70
18029NY1200029-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064			Gold Plan C	29	$466.98	$933.96	$793.87	$1,330.89
18029NY1200030-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066		Gold Plan C	FP	$467.66	$935.32	$795.02	$1,332.83
18029NY1200049-00	IHBC-C1027	IHBC-SBG006-3				Gold Plan D	Base	$452.98	$905.96	$770.07	$1,290.99
18029NY1200051-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan D	DP, 29, FP	$456.97	$913.94	$776.85	$1,302.36
18029NY1200052-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064		IHBC-R1065	Gold Plan D	DP, 29	$454.64	$909.28	$772.89	$1,295.72
18029NY1200053-00	IHBC-C1027	IHBC-SBG006-3			IHBC-R1065	Gold Plan D	DP	$452.98	$905.96	$770.07	$1,290.99
18029NY1200056-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066	IHBC-R1065	Gold Plan D	DP, FP	$455.31	$910.62	$774.03	$1,297.63
18029NY1200059-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066		Gold Plan D	29, FP	$456.97	$913.94	$776.85	$1,302.36
18029NY1200061-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064			Gold Plan D	29	$454.64	$909.28	$772.89	$1,295.72
18029NY1200062-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066		Gold Plan D	FP	$455.31	$910.62	$774.03	$1,297.63
18029NY1210001-00	IHBC-C1027	IHBC-SBG007-3				Gold Plan E	Base	$504.24	$1,008.48	$857.21	$1,437.08
18029NY1210003-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan E	DP, 29, FP	$508.68	$1,017.36	$864.76	$1,449.74
18029NY1210004-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064		IHBC-R1065	Gold Plan E	DP, 29	$506.08	$1,012.16	$860.34	$1,442.33
18029NY1210005-00	IHBC-C1027	IHBC-SBG007-3			IHBC-R1065	Gold Plan E	DP	$504.24	$1,008.48	$857.21	$1,437.08
18029NY1210008-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066	IHBC-R1065	Gold Plan E	DP, FP	$506.82	$1,013.64	$861.59	$1,444.44
18029NY1210011-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066		Gold Plan E	29, FP	$508.68	$1,017.36	$864.76	$1,449.74
18029NY1210013-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064			Gold Plan E	29	$506.08	$1,012.16	$860.34	$1,442.33
18029NY1210014-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066		Gold Plan E	FP	$506.82	$1,013.64	$861.59	$1,444.44
18029NY1200065-00	IHBC-C1027	IHBC-SBG009-3				Gold Plan G	Base	$436.39	$872.78	$741.86	$1,243.71

Independent Health Benefits Corporation

Small Group off Exchange Premium Rates Effective January 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
18029NY1200067-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan G	DP, 29, FP	$440.23	$880.46	$748.39	$1,254.66
18029NY1200068-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064		IHBC-R1065	Gold Plan G	DP, 29	$437.99	$875.98	$744.58	$1,248.27
18029NY1200069-00	IHBC-C1027	IHBC-SBG009-3			IHBC-R1065	Gold Plan G	DP	$436.39	$872.78	$741.86	$1,243.71
18029NY1200072-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066	IHBC-R1065	Gold Plan G	DP, FP	$438.63	$877.26	$745.67	$1,250.10
18029NY1200075-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066		Gold Plan G	29, FP	$440.23	$880.46	$748.39	$1,254.66
18029NY1200077-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064			Gold Plan G	29	$437.99	$875.98	$744.58	$1,248.27
18029NY1200078-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066		Gold Plan G	FP	$438.63	$877.26	$745.67	$1,250.10
18029NY1200097-00	IHBC-C1027	IHBC-SBG011-3				Gold Plan H	Base	$441.59	$883.18	$750.70	$1,258.53
18029NY1200099-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan H	DP, 29, FP	$445.47	$890.94	$757.30	$1,269.59
18029NY1200100-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064		IHBC-R1065	Gold Plan H	DP, 29	$443.21	$886.42	$753.46	$1,263.15
18029NY1200101-00	IHBC-C1027	IHBC-SBG011-3			IHBC-R1065	Gold Plan H	DP	$441.59	$883.18	$750.70	$1,258.53
18029NY1200104-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066	IHBC-R1065	Gold Plan H	DP, FP	$443.84	$887.68	$754.53	$1,264.94
18029NY1200107-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066		Gold Plan H	29, FP	$445.47	$890.94	$757.30	$1,269.59
18029NY1200109-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064			Gold Plan H	29	$443.21	$886.42	$753.46	$1,263.15
18029NY1200110-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066		Gold Plan H	FP	$443.84	$887.68	$754.53	$1,264.94
18029NY1210057-00	IHBC-C1027	IHBC-SBG008-3				Gold Plan F	Base	$982.83	$1,965.66	$1,670.81	$2,801.07
18029NY1210058-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan F	DP, 29, FP	$991.54	$1,983.08	$1,685.62	$2,825.89
18029NY1210059-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064		IHBC-R1065	Gold Plan F	DP, 29	$986.44	$1,972.88	$1,676.95	$2,811.35
18029NY1210060-00	IHBC-C1027	IHBC-SBG008-3			IHBC-R1065	Gold Plan F	DP	$982.83	$1,965.66	$1,670.81	$2,801.07
18029NY1210061-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066	IHBC-R1065	Gold Plan F	DP, FP	$987.90	$1,975.80	$1,679.43	$2,815.52
18029NY1210062-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066		Gold Plan F	29, FP	$991.54	$1,983.08	$1,685.62	$2,825.89
18029NY1210063-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064			Gold Plan F	29	$986.44	$1,972.88	$1,676.95	$2,811.35
18029NY1210064-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066		Gold Plan F	FP	$987.90	$1,975.80	$1,679.43	$2,815.52

Silver Plans

29 = Child Definition Extension to Age 29
FP = Family Planning Rider
DP = Domestic Partner Rider

18029NY1240033-00	IHBC-C1027	IHBC-SBS009-3				Silver Plan C	Base	$393.88	$787.76	$669.60	$1,122.56
18029NY1240035-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan C	DP, 29, FP	$397.34	$794.68	$675.48	$1,132.42
18029NY1240036-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064		IHBC-R1065	Silver Plan C	DP, 29	$395.32	$790.64	$672.04	$1,126.66
18029NY1240037-00	IHBC-C1027	IHBC-SBS009-3			IHBC-R1065	Silver Plan C	DP	$393.88	$787.76	$669.60	$1,122.56
18029NY1240040-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066	IHBC-R1065	Silver Plan C	DP, FP	$395.90	$791.80	$673.03	$1,128.32
18029NY1240043-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066		Silver Plan C	29, FP	$397.34	$794.68	$675.48	$1,132.42
18029NY1240045-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064			Silver Plan C	29	$395.32	$790.64	$672.04	$1,126.66
18029NY1240046-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066		Silver Plan C	FP	$395.90	$791.80	$673.03	$1,128.32
18029NY1250001-00	IHBC-C1027	IHBC-SBS013-3				Silver Plan E	Base	$442.38	$884.76	$752.05	$1,260.78
18029NY1250003-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan E	DP, 29, FP	$446.27	$892.54	$758.66	$1,271.87
18029NY1250004-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064		IHBC-R1065	Silver Plan E	DP, 29	$444.00	$888.00	$754.80	$1,265.40
18029NY1250005-00	IHBC-C1027	IHBC-SBS013-3			IHBC-R1065	Silver Plan E	DP	$442.38	$884.76	$752.05	$1,260.78
18029NY1250008-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066	IHBC-R1065	Silver Plan E	DP, FP	$444.65	$889.30	$755.91	$1,267.25
18029NY1250011-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066		Silver Plan E	29, FP	$446.27	$892.54	$758.66	$1,271.87
18029NY1250013-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064			Silver Plan E	29	$444.00	$888.00	$754.80	$1,265.40

Independent Health Benefits Corporation

Small Group off Exchange Premium Rates Effective January 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
18029NY1250014-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066		Silver Plan E	FP	$444.65	$889.30	$755.91	$1,267.25
18029NY1240049-00	IHBC-C1027	IHBC-SBS015-3				Silver Plan G	Base	$389.76	$779.52	$662.59	$1,110.82
18029NY1240051-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan G	DP, 29, FP	$393.18	$786.36	$668.41	$1,120.56
18029NY1240052-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064		IHBC-R1065	Silver Plan G	DP, 29	$391.19	$782.38	$665.02	$1,114.89
18029NY1240053-00	IHBC-C1027	IHBC-SBS015-3			IHBC-R1065	Silver Plan G	DP	$389.76	$779.52	$662.59	$1,110.82
18029NY1240056-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066	IHBC-R1065	Silver Plan G	DP, FP	$391.75	$783.50	$665.98	$1,116.49
18029NY1240059-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066		Silver Plan G	29, FP	$393.18	$786.36	$668.41	$1,120.56
18029NY1240061-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064			Silver Plan G	29	$391.19	$782.38	$665.02	$1,114.89
18029NY1240062-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066		Silver Plan G	FP	$391.75	$783.50	$665.98	$1,116.49
18029NY1240081-00	IHBC-C1027	IHBC-SBS016-3				Silver Plan H	Base	$396.91	$793.82	$674.75	$1,131.19
18029NY1240083-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan H	DP, 29, FP	$400.39	$800.78	$680.66	$1,141.11
18029NY1240084-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064		IHBC-R1065	Silver Plan H	DP, 29	$398.35	$796.70	$677.20	$1,135.30
18029NY1240085-00	IHBC-C1027	IHBC-SBS016-3			IHBC-R1065	Silver Plan H	DP	$396.91	$793.82	$674.75	$1,131.19
18029NY1240088-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066	IHBC-R1065	Silver Plan H	DP, FP	$398.94	$797.88	$678.20	$1,136.98
18029NY1240091-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066		Silver Plan H	29, FP	$400.39	$800.78	$680.66	$1,141.11
18029NY1240093-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064			Silver Plan H	29	$398.35	$796.70	$677.20	$1,135.30
18029NY1240094-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066		Silver Plan H	FP	$398.94	$797.88	$678.20	$1,136.98
18029NY1240113-00	IHBC-C1027	IHBC-SBS017-3				Silver Plan I	Base	$410.58	$821.16	$697.99	$1,170.15
18029NY1240115-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan I	DP, 29, FP	$414.19	$828.38	$704.12	$1,180.44
18029NY1240116-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064		IHBC-R1065	Silver Plan I	DP, 29	$412.09	$824.18	$700.55	$1,174.46
18029NY1240117-00	IHBC-C1027	IHBC-SBS017-3			IHBC-R1065	Silver Plan I	DP	$410.58	$821.16	$697.99	$1,170.15
18029NY1240120-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066	IHBC-R1065	Silver Plan I	DP, FP	$412.68	$825.36	$701.56	$1,176.14
18029NY1240123-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066		Silver Plan I	29, FP	$414.19	$828.38	$704.12	$1,180.44
18029NY1240125-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064			Silver Plan I	29	$412.09	$824.18	$700.55	$1,174.46
18029NY1240126-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066		Silver Plan I	FP	$412.68	$825.36	$701.56	$1,176.14
18029NY1250033-00	IHBC-C1027	IHBC-SBS014-3				Silver Plan F	Base	$894.68	$1,789.36	$1,520.96	$2,549.84
18029NY1250035-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan F	DP, 29, FP	$902.60	$1,805.20	$1,534.42	$2,572.41
18029NY1250036-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064		IHBC-R1065	Silver Plan F	DP, 29	$897.97	$1,795.94	$1,526.55	$2,559.21
18029NY1250037-00	IHBC-C1027	IHBC-SBS014-3			IHBC-R1065	Silver Plan F	DP	$894.68	$1,789.36	$1,520.96	$2,549.84
18029NY1250040-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066	IHBC-R1065	Silver Plan F	DP, FP	$899.29	$1,798.58	$1,528.79	$2,562.98
18029NY1250043-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066		Silver Plan F	29, FP	$902.60	$1,805.20	$1,534.42	$2,572.41
18029NY1250045-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064			Silver Plan F	29	$897.97	$1,795.94	$1,526.55	$2,559.21
18029NY1250046-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066		Silver Plan F	FP	$899.29	$1,798.58	$1,528.79	$2,562.98

Bronze Plans

29 = Child Definition Extension to Age 29
FP = Family Planning Rider
DP = Domestic Partner Rider

18029NY1300017-00	IHBC-C1027	IHBC-SBB005-3				Bronze Plan B	Base	$321.97	$643.94	$547.35	$917.61
18029NY1300019-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, 29, FP	$324.79	$649.58	$552.14	$925.65
18029NY1300020-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064		IHBC-R1065	Bronze Plan B	DP, 29	$323.14	$646.28	$549.34	$920.95
18029NY1300021-00	IHBC-C1027	IHBC-SBB005-3			IHBC-R1065	Bronze Plan B	DP	$321.97	$643.94	$547.35	$917.61
18029NY1300024-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, FP	$323.60	$647.20	$550.12	$922.26

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Small Group off Exchange Premium Rates Effective January 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
18029NY1300027-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066		Bronze Plan B	29, FP	$324.79	$649.58	$552.14	$925.65
18029NY1300029-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064			Bronze Plan B	29	$323.14	$646.28	$549.34	$920.95
18029NY1300030-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066		Bronze Plan B	FP	$323.60	$647.20	$550.12	$922.26
18029NY1300033-00	IHBC-C1027	IHBC-SBB006-3				Bronze Plan C	Base	$328.20	$656.40	$557.94	$935.37
18029NY1300035-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, 29, FP	$331.06	$662.12	$562.80	$943.52
18029NY1300036-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064		IHBC-R1065	Bronze Plan C	DP, 29	$329.38	$658.76	$559.95	$938.73
18029NY1300037-00	IHBC-C1027	IHBC-SBB006-3			IHBC-R1065	Bronze Plan C	DP	$328.20	$656.40	$557.94	$935.37
18029NY1300040-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, FP	$329.86	$659.72	$560.76	$940.10
18029NY1300043-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066		Bronze Plan C	29, FP	$331.06	$662.12	$562.80	$943.52
18029NY1300045-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064			Bronze Plan C	29	$329.38	$658.76	$559.95	$938.73
18029NY1300046-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066		Bronze Plan C	FP	$329.86	$659.72	$560.76	$940.10
18029NY1300049-00	IHBC-C1027	IHBC-SBB007-3				Bronze Plan D	Base	$335.11	$670.22	$569.69	$955.06
18029NY1300051-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, 29, FP	$338.05	$676.10	$574.69	$963.44
18029NY1300052-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064		IHBC-R1065	Bronze Plan D	DP, 29	$336.33	$672.66	$571.76	$958.54
18029NY1300053-00	IHBC-C1027	IHBC-SBB007-3			IHBC-R1065	Bronze Plan D	DP	$335.11	$670.22	$569.69	$955.06
18029NY1300056-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, FP	$336.82	$673.64	$572.59	$959.94
18029NY1300059-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066		Bronze Plan D	29, FP	$338.05	$676.10	$574.69	$963.44
18029NY1300061-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064			Bronze Plan D	29	$336.33	$672.66	$571.76	$958.54
18029NY1300062-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066		Bronze Plan D	FP	$336.82	$673.64	$572.59	$959.94
18029NY1270001-00	IHBC-C1027	IHBC-SBB008-3				Bronze Plan E	Base	$380.40	$760.80	$646.68	$1,084.14
18029NY1270003-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, 29, FP	$383.74	$767.48	$652.36	$1,093.66
18029NY1270004-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064		IHBC-R1065	Bronze Plan E	DP, 29	$381.79	$763.58	$649.04	$1,088.10
18029NY1270005-00	IHBC-C1027	IHBC-SBB008-3			IHBC-R1065	Bronze Plan E	DP	$380.40	$760.80	$646.68	$1,084.14
18029NY1270008-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, FP	$382.35	$764.70	$650.00	$1,089.70
18029NY1270011-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066		Bronze Plan E	29, FP	$383.74	$767.48	$652.36	$1,093.66
18029NY1270013-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064			Bronze Plan E	29	$381.79	$763.58	$649.04	$1,088.10
18029NY1270014-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066		Bronze Plan E	FP	$382.35	$764.70	$650.00	$1,089.70
18029NY1270033-00	IHBC-C1027	IHBC-SBB009-3				Bronze Plan F	Base	$801.09	$1,602.18	$1,361.85	$2,283.11
18029NY1270035-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, 29, FP	$808.18	$1,616.36	$1,373.91	$2,303.31
18029NY1270036-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064		IHBC-R1065	Bronze Plan F	DP, 29	$804.03	$1,608.06	$1,366.85	$2,291.49
18029NY1270037-00	IHBC-C1027	IHBC-SBB009-3			IHBC-R1065	Bronze Plan F	DP	$801.09	$1,602.18	$1,361.85	$2,283.11
18029NY1270040-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, FP	$805.22	$1,610.44	$1,368.87	$2,294.88
18029NY1270043-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066		Bronze Plan F	29, FP	$808.18	$1,616.36	$1,373.91	$2,303.31
18029NY1270045-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064			Bronze Plan F	29	$804.03	$1,608.06	$1,366.85	$2,291.49
18029NY1270046-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066		Bronze Plan F	FP	$805.22	$1,610.44	$1,368.87	$2,294.88

Independent Health Benefits Corporation

Small Group off Exchange Premium Rates Effective April 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
Platinum Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1170017-00	IHBC-C1027	IHBC-SBP005-3				Platinum Plan C	Base	$559.18	$1,118.36	$950.61	$1,593.66
18029NY1170019-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, 29, FP	$564.11	$1,128.22	$958.99	$1,607.71
18029NY1170020-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064		IHBC-R1065	Platinum Plan C	DP, 29	$561.23	$1,122.46	$954.09	$1,599.51
18029NY1170021-00	IHBC-C1027	IHBC-SBP005-3			IHBC-R1065	Platinum Plan C	DP	$559.18	$1,118.36	$950.61	$1,593.66
18029NY1170024-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, FP	$562.06	$1,124.12	$955.50	$1,601.87
18029NY1170027-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066		Platinum Plan C	29, FP	$564.11	$1,128.22	$958.99	$1,607.71
18029NY1170029-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064			Platinum Plan C	29	$561.23	$1,122.46	$954.09	$1,599.51
18029NY1170030-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066		Platinum Plan C	FP	$562.06	$1,124.12	$955.50	$1,601.87
Gold Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1200017-00	IHBC-C1027	IHBC-SBG005-3				Gold Plan C	Base	$479.48	$958.96	$815.12	$1,366.52
18029NY1200019-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan C	DP, 29, FP	$483.71	$967.42	$822.31	$1,378.57
18029NY1200020-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064		IHBC-R1065	Gold Plan C	DP, 29	$481.24	$962.48	$818.11	$1,371.53
18029NY1200021-00	IHBC-C1027	IHBC-SBG005-3			IHBC-R1065	Gold Plan C	DP	$479.48	$958.96	$815.12	$1,366.52
18029NY1200024-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066	IHBC-R1065	Gold Plan C	DP, FP	$481.94	$963.88	$819.30	$1,373.53
18029NY1200027-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066		Gold Plan C	29, FP	$483.71	$967.42	$822.31	$1,378.57
18029NY1200029-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064			Gold Plan C	29	$481.24	$962.48	$818.11	$1,371.53
18029NY1200030-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066		Gold Plan C	FP	$481.94	$963.88	$819.30	$1,373.53
18029NY1200049-00	IHBC-C1027	IHBC-SBG006-3				Gold Plan D	Base	$466.82	$933.64	$793.59	$1,330.44
18029NY1200051-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan D	DP, 29, FP	$470.92	$941.84	$800.56	$1,342.12
18029NY1200052-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064		IHBC-R1065	Gold Plan D	DP, 29	$468.52	$937.04	$796.48	$1,335.28
18029NY1200053-00	IHBC-C1027	IHBC-SBG006-3			IHBC-R1065	Gold Plan D	DP	$466.82	$933.64	$793.59	$1,330.44
18029NY1200056-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066	IHBC-R1065	Gold Plan D	DP, FP	$469.22	$938.44	$797.67	$1,337.28
18029NY1200059-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066		Gold Plan D	29, FP	$470.92	$941.84	$800.56	$1,342.12
18029NY1200061-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064			Gold Plan D	29	$468.52	$937.04	$796.48	$1,335.28
18029NY1200062-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066		Gold Plan D	FP	$469.22	$938.44	$797.67	$1,337.28
18029NY1210001-00	IHBC-C1027	IHBC-SBG007-3				Gold Plan E	Base	$519.66	$1,039.32	$883.42	$1,481.03
18029NY1210003-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan E	DP, 29, FP	$524.24	$1,048.48	$891.21	$1,494.08
18029NY1210004-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064		IHBC-R1065	Gold Plan E	DP, 29	$521.56	$1,043.12	$886.65	$1,486.45
18029NY1210005-00	IHBC-C1027	IHBC-SBG007-3			IHBC-R1065	Gold Plan E	DP	$519.66	$1,039.32	$883.42	$1,481.03
18029NY1210008-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066	IHBC-R1065	Gold Plan E	DP, FP	$522.32	$1,044.64	$887.94	$1,488.61
18029NY1210011-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066		Gold Plan E	29, FP	$524.24	$1,048.48	$891.21	$1,494.08
18029NY1210013-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064			Gold Plan E	29	$521.56	$1,043.12	$886.65	$1,486.45
18029NY1210014-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066		Gold Plan E	FP	$522.32	$1,044.64	$887.94	$1,488.61
18029NY1200065-00	IHBC-C1027	IHBC-SBG009-3				Gold Plan G	Base	$449.71	$899.42	$764.51	$1,281.67
18029NY1200067-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan G	DP, 29, FP	$453.66	$907.32	$771.22	$1,292.93
18029NY1200068-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064		IHBC-R1065	Gold Plan G	DP, 29	$451.37	$902.74	$767.33	$1,286.40
18029NY1200069-00	IHBC-C1027	IHBC-SBG009-3			IHBC-R1065	Gold Plan G	DP	$449.71	$899.42	$764.51	$1,281.67
18029NY1200072-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066	IHBC-R1065	Gold Plan G	DP, FP	$452.02	$904.04	$768.43	$1,288.26

Independent Health Benefits Corporation

Small Group off Exchange Premium Rates Effective April 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
18029NY1200075-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066		Gold Plan G	29, FP	$453.66	$907.32	$771.22	$1,292.93
18029NY1200077-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064			Gold Plan G	29	$451.37	$902.74	$767.33	$1,286.40
18029NY1200078-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066		Gold Plan G	FP	$452.02	$904.04	$768.43	$1,288.26
18029NY1200097-00	IHBC-C1027	IHBC-SBG011-3				Gold Plan H	Base	$455.06	$910.12	$773.60	$1,296.92
18029NY1200099-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan H	DP, 29, FP	$459.08	$918.16	$780.44	$1,308.38
18029NY1200100-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064		IHBC-R1065	Gold Plan H	DP, 29	$456.74	$913.48	$776.46	$1,301.71
18029NY1200101-00	IHBC-C1027	IHBC-SBG011-3			IHBC-R1065	Gold Plan H	DP	$455.06	$910.12	$773.60	$1,296.92
18029NY1200104-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066	IHBC-R1065	Gold Plan H	DP, FP	$457.39	$914.78	$777.56	$1,303.56
18029NY1200107-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066		Gold Plan H	29, FP	$459.08	$918.16	$780.44	$1,308.38
18029NY1200109-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064			Gold Plan H	29	$456.74	$913.48	$776.46	$1,301.71
18029NY1200110-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066		Gold Plan H	FP	$457.39	$914.78	$777.56	$1,303.56
18029NY1210057-00	IHBC-C1027	IHBC-SBG008-3				Gold Plan F	Base	$1,013.09	$2,026.18	$1,722.25	$2,887.31
18029NY1210058-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan F	DP, 29, FP	$1,022.07	$2,044.14	$1,737.52	$2,912.90
18029NY1210059-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064		IHBC-R1065	Gold Plan F	DP, 29	$1,016.81	$2,033.62	$1,728.58	$2,897.91
18029NY1210060-00	IHBC-C1027	IHBC-SBG008-3			IHBC-R1065	Gold Plan F	DP	$1,013.09	$2,026.18	$1,722.25	$2,887.31
18029NY1210061-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066	IHBC-R1065	Gold Plan F	DP, FP	$1,018.31	$2,036.62	$1,731.13	$2,902.18
18029NY1210062-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066		Gold Plan F	29, FP	$1,022.07	$2,044.14	$1,737.52	$2,912.90
18029NY1210063-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064			Gold Plan F	29	$1,016.81	$2,033.62	$1,728.58	$2,897.91
18029NY1210064-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066		Gold Plan F	FP	$1,018.31	$2,036.62	$1,731.13	$2,902.18
Silver Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1240033-00	IHBC-C1027	IHBC-SBS009-3				Silver Plan C	Base	$405.88	$811.76	$690.00	$1,156.76
18029NY1240035-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan C	DP, 29, FP	$409.44	$818.88	$696.05	$1,166.90
18029NY1240036-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064		IHBC-R1065	Silver Plan C	DP, 29	$407.36	$814.72	$692.51	$1,160.98
18029NY1240037-00	IHBC-C1027	IHBC-SBS009-3			IHBC-R1065	Silver Plan C	DP	$405.88	$811.76	$690.00	$1,156.76
18029NY1240040-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066	IHBC-R1065	Silver Plan C	DP, FP	$407.96	$815.92	$693.53	$1,162.69
18029NY1240043-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066		Silver Plan C	29, FP	$409.44	$818.88	$696.05	$1,166.90
18029NY1240045-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064			Silver Plan C	29	$407.36	$814.72	$692.51	$1,160.98
18029NY1240046-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066		Silver Plan C	FP	$407.96	$815.92	$693.53	$1,162.69
18029NY1250001-00	IHBC-C1027	IHBC-SBS013-3				Silver Plan E	Base	$455.89	$911.78	$775.01	$1,299.29
18029NY1250003-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan E	DP, 29, FP	$459.89	$919.78	$781.81	$1,310.69
18029NY1250004-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064		IHBC-R1065	Silver Plan E	DP, 29	$457.56	$915.12	$777.85	$1,304.05
18029NY1250005-00	IHBC-C1027	IHBC-SBS013-3			IHBC-R1065	Silver Plan E	DP	$455.89	$911.78	$775.01	$1,299.29
18029NY1250008-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066	IHBC-R1065	Silver Plan E	DP, FP	$458.23	$916.46	$778.99	$1,305.96
18029NY1250011-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066		Silver Plan E	29, FP	$459.89	$919.78	$781.81	$1,310.69
18029NY1250013-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064			Silver Plan E	29	$457.56	$915.12	$777.85	$1,304.05
18029NY1250014-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066		Silver Plan E	FP	$458.23	$916.46	$778.99	$1,305.96
18029NY1240049-00	IHBC-C1027	IHBC-SBS015-3				Silver Plan G	Base	$401.63	$803.26	$682.77	$1,144.65
18029NY1240051-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan G	DP, 29, FP	$405.15	$810.30	$688.76	$1,154.68
18029NY1240052-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064		IHBC-R1065	Silver Plan G	DP, 29	$403.10	$806.20	$685.27	$1,148.84
18029NY1240053-00	IHBC-C1027	IHBC-SBS015-3			IHBC-R1065	Silver Plan G	DP	$401.63	$803.26	$682.77	$1,144.65
18029NY1240056-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066	IHBC-R1065	Silver Plan G	DP, FP	$403.68	$807.36	$686.26	$1,150.49
18029NY1240059-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066		Silver Plan G	29, FP	$405.15	$810.30	$688.76	$1,154.68
18029NY1240061-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064			Silver Plan G	29	$403.10	$806.20	$685.27	$1,148.84

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HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
18029NY1240062-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066		Silver Plan G	FP	$403.68	$807.36	$686.26	$1,150.49
18029NY1240081-00	IHBC-C1027	IHBC-SBS016-3				Silver Plan H	Base	$409.00	$818.00	$695.30	$1,165.65
18029NY1240083-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan H	DP, 29, FP	$412.59	$825.18	$701.40	$1,175.88
18029NY1240084-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064		IHBC-R1065	Silver Plan H	DP, 29	$410.50	$821.00	$697.85	$1,169.93
18029NY1240085-00	IHBC-C1027	IHBC-SBS016-3			IHBC-R1065	Silver Plan H	DP	$409.00	$818.00	$695.30	$1,165.65
18029NY1240088-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066	IHBC-R1065	Silver Plan H	DP, FP	$411.10	$822.20	$698.87	$1,171.64
18029NY1240091-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066		Silver Plan H	29, FP	$412.59	$825.18	$701.40	$1,175.88
18029NY1240093-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064			Silver Plan H	29	$410.50	$821.00	$697.85	$1,169.93
18029NY1240094-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066		Silver Plan H	FP	$411.10	$822.20	$698.87	$1,171.64
18029NY1240113-00	IHBC-C1027	IHBC-SBS017-3				Silver Plan I	Base	$423.10	$846.20	$719.27	$1,205.84
18029NY1240115-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan I	DP, 29, FP	$426.83	$853.66	$725.61	$1,216.47
18029NY1240116-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064		IHBC-R1065	Silver Plan I	DP, 29	$424.65	$849.30	$721.91	$1,210.25
18029NY1240117-00	IHBC-C1027	IHBC-SBS017-3			IHBC-R1065	Silver Plan I	DP	$423.10	$846.20	$719.27	$1,205.84
18029NY1240120-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066	IHBC-R1065	Silver Plan I	DP, FP	$425.26	$850.52	$722.94	$1,211.99
18029NY1240123-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066		Silver Plan I	29, FP	$426.83	$853.66	$725.61	$1,216.47
18029NY1240125-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064			Silver Plan I	29	$424.65	$849.30	$721.91	$1,210.25
18029NY1240126-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066		Silver Plan I	FP	$425.26	$850.52	$722.94	$1,211.99
18029NY1250033-00	IHBC-C1027	IHBC-SBS014-3				Silver Plan F	Base	$922.21	$1,844.42	$1,567.76	$2,628.30
18029NY1250035-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan F	DP, 29, FP	$930.37	$1,860.74	$1,581.63	$2,651.55
18029NY1250036-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064		IHBC-R1065	Silver Plan F	DP, 29	$925.60	$1,851.20	$1,573.52	$2,637.96
18029NY1250037-00	IHBC-C1027	IHBC-SBS014-3			IHBC-R1065	Silver Plan F	DP	$922.21	$1,844.42	$1,567.76	$2,628.30
18029NY1250040-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066	IHBC-R1065	Silver Plan F	DP, FP	$926.96	$1,853.92	$1,575.83	$2,641.84
18029NY1250043-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066		Silver Plan F	29, FP	$930.37	$1,860.74	$1,581.63	$2,651.55
18029NY1250045-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064			Silver Plan F	29	$925.60	$1,851.20	$1,573.52	$2,637.96
18029NY1250046-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066		Silver Plan F	FP	$926.96	$1,853.92	$1,575.83	$2,641.84
Bronze Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1300017-00	IHBC-C1027	IHBC-SBB005-3				Bronze Plan B	Base	$331.75	$663.50	$563.98	$945.49
18029NY1300019-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, 29, FP	$334.65	$669.30	$568.91	$953.75
18029NY1300020-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064		IHBC-R1065	Bronze Plan B	DP, 29	$332.95	$665.90	$566.02	$948.91
18029NY1300021-00	IHBC-C1027	IHBC-SBB005-3			IHBC-R1065	Bronze Plan B	DP	$331.75	$663.50	$563.98	$945.49
18029NY1300024-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, FP	$333.42	$666.84	$566.81	$950.25
18029NY1300027-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066		Bronze Plan B	29, FP	$334.65	$669.30	$568.91	$953.75
18029NY1300029-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064			Bronze Plan B	29	$332.95	$665.90	$566.02	$948.91
18029NY1300030-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066		Bronze Plan B	FP	$333.42	$666.84	$566.81	$950.25
18029NY1300033-00	IHBC-C1027	IHBC-SBB006-3				Bronze Plan C	Base	$338.16	$676.32	$574.87	$963.76
18029NY1300035-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, 29, FP	$341.11	$682.22	$579.89	$972.16
18029NY1300036-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064		IHBC-R1065	Bronze Plan C	DP, 29	$339.39	$678.78	$576.96	$967.26
18029NY1300037-00	IHBC-C1027	IHBC-SBB006-3			IHBC-R1065	Bronze Plan C	DP	$338.16	$676.32	$574.87	$963.76
18029NY1300040-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, FP	$339.88	$679.76	$577.80	$968.66
18029NY1300043-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066		Bronze Plan C	29, FP	$341.11	$682.22	$579.89	$972.16
18029NY1300045-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064			Bronze Plan C	29	$339.39	$678.78	$576.96	$967.26
18029NY1300046-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066		Bronze Plan C	FP	$339.88	$679.76	$577.80	$968.66
18029NY1300049-00	IHBC-C1027	IHBC-SBB007-3				Bronze Plan D	Base	$345.30	$690.60	$587.01	$984.11

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18029NY1300051-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, 29, FP	$348.31	$696.62	$592.13	$992.68
18029NY1300052-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064		IHBC-R1065	Bronze Plan D	DP, 29	$346.54	$693.08	$589.12	$987.64
18029NY1300053-00	IHBC-C1027	IHBC-SBB007-3			IHBC-R1065	Bronze Plan D	DP	$345.30	$690.60	$587.01	$984.11
18029NY1300056-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, FP	$347.06	$694.12	$590.00	$989.12
18029NY1300059-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066		Bronze Plan D	29, FP	$348.31	$696.62	$592.13	$992.68
18029NY1300061-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064			Bronze Plan D	29	$346.54	$693.08	$589.12	$987.64
18029NY1300062-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066		Bronze Plan D	FP	$347.06	$694.12	$590.00	$989.12
18029NY1270001-00	IHBC-C1027	IHBC-SBB008-3				Bronze Plan E	Base	$391.98	$783.96	$666.37	$1,117.14
18029NY1270003-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, 29, FP	$395.42	$790.84	$672.21	$1,126.95
18029NY1270004-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064		IHBC-R1065	Bronze Plan E	DP, 29	$393.41	$786.82	$668.80	$1,121.22
18029NY1270005-00	IHBC-C1027	IHBC-SBB008-3			IHBC-R1065	Bronze Plan E	DP	$391.98	$783.96	$666.37	$1,117.14
18029NY1270008-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, FP	$393.99	$787.98	$669.78	$1,122.87
18029NY1270011-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066		Bronze Plan E	29, FP	$395.42	$790.84	$672.21	$1,126.95
18029NY1270013-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064			Bronze Plan E	29	$393.41	$786.82	$668.80	$1,121.22
18029NY1270014-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066		Bronze Plan E	FP	$393.99	$787.98	$669.78	$1,122.87
18029NY1270033-00	IHBC-C1027	IHBC-SBB009-3				Bronze Plan F	Base	$825.71	$1,651.42	$1,403.71	$2,353.27
18029NY1270035-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, 29, FP	$833.02	$1,666.04	$1,416.13	$2,374.11
18029NY1270036-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064		IHBC-R1065	Bronze Plan F	DP, 29	$828.74	$1,657.48	$1,408.86	$2,361.91
18029NY1270037-00	IHBC-C1027	IHBC-SBB009-3			IHBC-R1065	Bronze Plan F	DP	$825.71	$1,651.42	$1,403.71	$2,353.27
18029NY1270040-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, FP	$829.97	$1,659.94	$1,410.95	$2,365.41
18029NY1270043-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066		Bronze Plan F	29, FP	$833.02	$1,666.04	$1,416.13	$2,374.11
18029NY1270045-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064			Bronze Plan F	29	$828.74	$1,657.48	$1,408.86	$2,361.91
18029NY1270046-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066		Bronze Plan F	FP	$829.97	$1,659.94	$1,410.95	$2,365.41

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HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
Platinum Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1170017-00	IHBC-C1027	IHBC-SBP005-3				Platinum Plan C	Base	$576.31	$1,152.62	$979.73	$1,642.48
18029NY1170019-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, 29, FP	$581.39	$1,162.78	$988.36	$1,656.96
18029NY1170020-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064		IHBC-R1065	Platinum Plan C	DP, 29	$578.43	$1,156.86	$983.33	$1,648.53
18029NY1170021-00	IHBC-C1027	IHBC-SBP005-3			IHBC-R1065	Platinum Plan C	DP	$576.31	$1,152.62	$979.73	$1,642.48
18029NY1170024-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, FP	$579.27	$1,158.54	$984.76	$1,650.92
18029NY1170027-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066		Platinum Plan C	29, FP	$581.39	$1,162.78	$988.36	$1,656.96
18029NY1170029-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064			Platinum Plan C	29	$578.43	$1,156.86	$983.33	$1,648.53
18029NY1170030-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066		Platinum Plan C	FP	$579.27	$1,158.54	$984.76	$1,650.92
Gold Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1200017-00	IHBC-C1027	IHBC-SBG005-3				Gold Plan C	Base	$494.14	$988.28	$840.04	$1,408.30
18029NY1200019-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan C	DP, 29, FP	$498.50	$997.00	$847.45	$1,420.73
18029NY1200020-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064		IHBC-R1065	Gold Plan C	DP, 29	$495.95	$991.90	$843.12	$1,413.46
18029NY1200021-00	IHBC-C1027	IHBC-SBG005-3			IHBC-R1065	Gold Plan C	DP	$494.14	$988.28	$840.04	$1,408.30
18029NY1200024-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066	IHBC-R1065	Gold Plan C	DP, FP	$496.67	$993.34	$844.34	$1,415.51
18029NY1200027-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066		Gold Plan C	29, FP	$498.50	$997.00	$847.45	$1,420.73
18029NY1200029-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064			Gold Plan C	29	$495.95	$991.90	$843.12	$1,413.46
18029NY1200030-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066		Gold Plan C	FP	$496.67	$993.34	$844.34	$1,415.51
18029NY1200049-00	IHBC-C1027	IHBC-SBG006-3				Gold Plan D	Base	$481.07	$962.14	$817.82	$1,371.05
18029NY1200051-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan D	DP, 29, FP	$485.32	$970.64	$825.04	$1,383.16
18029NY1200052-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064		IHBC-R1065	Gold Plan D	DP, 29	$482.85	$965.70	$820.85	$1,376.12
18029NY1200053-00	IHBC-C1027	IHBC-SBG006-3			IHBC-R1065	Gold Plan D	DP	$481.07	$962.14	$817.82	$1,371.05
18029NY1200056-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066	IHBC-R1065	Gold Plan D	DP, FP	$483.56	$967.12	$822.05	$1,378.15
18029NY1200059-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066		Gold Plan D	29, FP	$485.32	$970.64	$825.04	$1,383.16
18029NY1200061-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064			Gold Plan D	29	$482.85	$965.70	$820.85	$1,376.12
18029NY1200062-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066		Gold Plan D	FP	$483.56	$967.12	$822.05	$1,378.15
18029NY1210001-00	IHBC-C1027	IHBC-SBG007-3				Gold Plan E	Base	$535.56	$1,071.12	$910.45	$1,526.35
18029NY1210003-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan E	DP, 29, FP	$540.28	$1,080.56	$918.48	$1,539.80
18029NY1210004-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064		IHBC-R1065	Gold Plan E	DP, 29	$537.52	$1,075.04	$913.78	$1,531.93
18029NY1210005-00	IHBC-C1027	IHBC-SBG007-3			IHBC-R1065	Gold Plan E	DP	$535.56	$1,071.12	$910.45	$1,526.35
18029NY1210008-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066	IHBC-R1065	Gold Plan E	DP, FP	$538.30	$1,076.60	$915.11	$1,534.16
18029NY1210011-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066		Gold Plan E	29, FP	$540.28	$1,080.56	$918.48	$1,539.80
18029NY1210013-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064			Gold Plan E	29	$537.52	$1,075.04	$913.78	$1,531.93
18029NY1210014-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066		Gold Plan E	FP	$538.30	$1,076.60	$915.11	$1,534.16
18029NY1200065-00	IHBC-C1027	IHBC-SBG009-3				Gold Plan G	Base	$463.44	$926.88	$787.85	$1,320.80
18029NY1200067-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan G	DP, 29, FP	$467.53	$935.06	$794.80	$1,332.46
18029NY1200068-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064		IHBC-R1065	Gold Plan G	DP, 29	$465.14	$930.28	$790.74	$1,325.65
18029NY1200069-00	IHBC-C1027	IHBC-SBG009-3			IHBC-R1065	Gold Plan G	DP	$463.44	$926.88	$787.85	$1,320.80
18029NY1200072-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066	IHBC-R1065	Gold Plan G	DP, FP	$465.82	$931.64	$791.89	$1,327.59

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18029NY1200075-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066		Gold Plan G	29, FP	$467.53	$935.06	$794.80	$1,332.46
18029NY1200077-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064			Gold Plan G	29	$465.14	$930.28	$790.74	$1,325.65
18029NY1200078-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066		Gold Plan G	FP	$465.82	$931.64	$791.89	$1,327.59
18029NY1200097-00	IHBC-C1027	IHBC-SBG011-3				Gold Plan H	Base	$468.97	$937.94	$797.25	$1,336.56
18029NY1200099-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan H	DP, 29, FP	$473.10	$946.20	$804.27	$1,348.34
18029NY1200100-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064		IHBC-R1065	Gold Plan H	DP, 29	$470.69	$941.38	$800.17	$1,341.47
18029NY1200101-00	IHBC-C1027	IHBC-SBG011-3			IHBC-R1065	Gold Plan H	DP	$468.97	$937.94	$797.25	$1,336.56
18029NY1200104-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066	IHBC-R1065	Gold Plan H	DP, FP	$471.37	$942.74	$801.33	$1,343.40
18029NY1200107-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066		Gold Plan H	29, FP	$473.10	$946.20	$804.27	$1,348.34
18029NY1200109-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064			Gold Plan H	29	$470.69	$941.38	$800.17	$1,341.47
18029NY1200110-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066		Gold Plan H	FP	$471.37	$942.74	$801.33	$1,343.40
18029NY1210057-00	IHBC-C1027	IHBC-SBG008-3				Gold Plan F	Base	$1,044.28	$2,088.56	$1,775.28	$2,976.20
18029NY1210058-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan F	DP, 29, FP	$1,053.54	$2,107.08	$1,791.02	$3,002.59
18029NY1210059-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064		IHBC-R1065	Gold Plan F	DP, 29	$1,048.12	$2,096.24	$1,781.80	$2,987.14
18029NY1210060-00	IHBC-C1027	IHBC-SBG008-3			IHBC-R1065	Gold Plan F	DP	$1,044.28	$2,088.56	$1,775.28	$2,976.20
18029NY1210061-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066	IHBC-R1065	Gold Plan F	DP, FP	$1,049.68	$2,099.36	$1,784.46	$2,991.59
18029NY1210062-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066		Gold Plan F	29, FP	$1,053.54	$2,107.08	$1,791.02	$3,002.59
18029NY1210063-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064			Gold Plan F	29	$1,048.12	$2,096.24	$1,781.80	$2,987.14
18029NY1210064-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066		Gold Plan F	FP	$1,049.68	$2,099.36	$1,784.46	$2,991.59
Silver Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1240033-00	IHBC-C1027	IHBC-SBS009-3				Silver Plan C	Base	$418.25	$836.50	$711.03	$1,192.01
18029NY1240035-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan C	DP, 29, FP	$421.93	$843.86	$717.28	$1,202.50
18029NY1240036-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064		IHBC-R1065	Silver Plan C	DP, 29	$419.78	$839.56	$713.63	$1,196.37
18029NY1240037-00	IHBC-C1027	IHBC-SBS009-3			IHBC-R1065	Silver Plan C	DP	$418.25	$836.50	$711.03	$1,192.01
18029NY1240040-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066	IHBC-R1065	Silver Plan C	DP, FP	$420.40	$840.80	$714.68	$1,198.14
18029NY1240043-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066		Silver Plan C	29, FP	$421.93	$843.86	$717.28	$1,202.50
18029NY1240045-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064			Silver Plan C	29	$419.78	$839.56	$713.63	$1,196.37
18029NY1240046-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066		Silver Plan C	FP	$420.40	$840.80	$714.68	$1,198.14
18029NY1250001-00	IHBC-C1027	IHBC-SBS013-3				Silver Plan E	Base	$469.81	$939.62	$798.68	$1,338.96
18029NY1250003-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan E	DP, 29, FP	$473.94	$947.88	$805.70	$1,350.73
18029NY1250004-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064		IHBC-R1065	Silver Plan E	DP, 29	$471.53	$943.06	$801.60	$1,343.86
18029NY1250005-00	IHBC-C1027	IHBC-SBS013-3			IHBC-R1065	Silver Plan E	DP	$469.81	$939.62	$798.68	$1,338.96
18029NY1250008-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066	IHBC-R1065	Silver Plan E	DP, FP	$472.22	$944.44	$802.77	$1,345.83
18029NY1250011-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066		Silver Plan E	29, FP	$473.94	$947.88	$805.70	$1,350.73
18029NY1250013-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064			Silver Plan E	29	$471.53	$943.06	$801.60	$1,343.86
18029NY1250014-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066		Silver Plan E	FP	$472.22	$944.44	$802.77	$1,345.83
18029NY1240049-00	IHBC-C1027	IHBC-SBS015-3				Silver Plan G	Base	$413.88	$827.76	$703.60	$1,179.56
18029NY1240051-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan G	DP, 29, FP	$417.52	$835.04	$709.78	$1,189.93
18029NY1240052-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064		IHBC-R1065	Silver Plan G	DP, 29	$415.39	$830.78	$706.16	$1,183.86
18029NY1240053-00	IHBC-C1027	IHBC-SBS015-3			IHBC-R1065	Silver Plan G	DP	$413.88	$827.76	$703.60	$1,179.56
18029NY1240056-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066	IHBC-R1065	Silver Plan G	DP, FP	$415.99	$831.98	$707.18	$1,185.57
18029NY1240059-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066		Silver Plan G	29, FP	$417.52	$835.04	$709.78	$1,189.93
18029NY1240061-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064			Silver Plan G	29	$415.39	$830.78	$706.16	$1,183.86

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18029NY1240062-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066		Silver Plan G	FP	$415.99	$831.98	$707.18	$1,185.57
18029NY1240081-00	IHBC-C1027	IHBC-SBS016-3				Silver Plan H	Base	$421.47	$842.94	$716.50	$1,201.19
18029NY1240083-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan H	DP, 29, FP	$425.17	$850.34	$722.79	$1,211.73
18029NY1240084-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064		IHBC-R1065	Silver Plan H	DP, 29	$423.00	$846.00	$719.10	$1,205.55
18029NY1240085-00	IHBC-C1027	IHBC-SBS016-3			IHBC-R1065	Silver Plan H	DP	$421.47	$842.94	$716.50	$1,201.19
18029NY1240088-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066	IHBC-R1065	Silver Plan H	DP, FP	$423.64	$847.28	$720.19	$1,207.37
18029NY1240091-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066		Silver Plan H	29, FP	$425.17	$850.34	$722.79	$1,211.73
18029NY1240093-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064			Silver Plan H	29	$423.00	$846.00	$719.10	$1,205.55
18029NY1240094-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066		Silver Plan H	FP	$423.64	$847.28	$720.19	$1,207.37
18029NY1240113-00	IHBC-C1027	IHBC-SBS017-3				Silver Plan I	Base	$436.02	$872.04	$741.23	$1,242.66
18029NY1240115-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan I	DP, 29, FP	$439.84	$879.68	$747.73	$1,253.54
18029NY1240116-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064		IHBC-R1065	Silver Plan I	DP, 29	$437.60	$875.20	$743.92	$1,247.16
18029NY1240117-00	IHBC-C1027	IHBC-SBS017-3			IHBC-R1065	Silver Plan I	DP	$436.02	$872.04	$741.23	$1,242.66
18029NY1240120-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066	IHBC-R1065	Silver Plan I	DP, FP	$438.24	$876.48	$745.01	$1,248.98
18029NY1240123-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066		Silver Plan I	29, FP	$439.84	$879.68	$747.73	$1,253.54
18029NY1240125-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064			Silver Plan I	29	$437.60	$875.20	$743.92	$1,247.16
18029NY1240126-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066		Silver Plan I	FP	$438.24	$876.48	$745.01	$1,248.98
18029NY1250033-00	IHBC-C1027	IHBC-SBS014-3				Silver Plan F	Base	$950.58	$1,901.16	$1,615.99	$2,709.15
18029NY1250035-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan F	DP, 29, FP	$959.00	$1,918.00	$1,630.30	$2,733.15
18029NY1250036-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064		IHBC-R1065	Silver Plan F	DP, 29	$954.09	$1,908.18	$1,621.95	$2,719.16
18029NY1250037-00	IHBC-C1027	IHBC-SBS014-3			IHBC-R1065	Silver Plan F	DP	$950.58	$1,901.16	$1,615.99	$2,709.15
18029NY1250040-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066	IHBC-R1065	Silver Plan F	DP, FP	$955.48	$1,910.96	$1,624.32	$2,723.12
18029NY1250043-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066		Silver Plan F	29, FP	$959.00	$1,918.00	$1,630.30	$2,733.15
18029NY1250045-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064			Silver Plan F	29	$954.09	$1,908.18	$1,621.95	$2,719.16
18029NY1250046-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066		Silver Plan F	FP	$955.48	$1,910.96	$1,624.32	$2,723.12
Bronze Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1300017-00	IHBC-C1027	IHBC-SBB005-3				Bronze Plan B	Base	$341.82	$683.64	$581.09	$974.19
18029NY1300019-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, 29, FP	$344.82	$689.64	$586.19	$982.74
18029NY1300020-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064		IHBC-R1065	Bronze Plan B	DP, 29	$343.06	$686.12	$583.20	$977.72
18029NY1300021-00	IHBC-C1027	IHBC-SBB005-3			IHBC-R1065	Bronze Plan B	DP	$341.82	$683.64	$581.09	$974.19
18029NY1300024-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, FP	$343.55	$687.10	$584.04	$979.12
18029NY1300027-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066		Bronze Plan B	29, FP	$344.82	$689.64	$586.19	$982.74
18029NY1300029-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064			Bronze Plan B	29	$343.06	$686.12	$583.20	$977.72
18029NY1300030-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066		Bronze Plan B	FP	$343.55	$687.10	$584.04	$979.12
18029NY1300033-00	IHBC-C1027	IHBC-SBB006-3				Bronze Plan C	Base	$348.43	$696.86	$592.33	$993.03
18029NY1300035-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, 29, FP	$351.48	$702.96	$597.52	$1,001.72
18029NY1300036-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064		IHBC-R1065	Bronze Plan C	DP, 29	$349.70	$699.40	$594.49	$996.65
18029NY1300037-00	IHBC-C1027	IHBC-SBB006-3			IHBC-R1065	Bronze Plan C	DP	$348.43	$696.86	$592.33	$993.03
18029NY1300040-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, FP	$350.21	$700.42	$595.36	$998.10
18029NY1300043-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066		Bronze Plan C	29, FP	$351.48	$702.96	$597.52	$1,001.72
18029NY1300045-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064			Bronze Plan C	29	$349.70	$699.40	$594.49	$996.65
18029NY1300046-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066		Bronze Plan C	FP	$350.21	$700.42	$595.36	$998.10
18029NY1300049-00	IHBC-C1027	IHBC-SBB007-3				Bronze Plan D	Base	$355.79	$711.58	$604.84	$1,014.00

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18029NY1300051-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, 29, FP	$358.90	$717.80	$610.13	$1,022.87
18029NY1300052-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064		IHBC-R1065	Bronze Plan D	DP, 29	$357.08	$714.16	$607.04	$1,017.68
18029NY1300053-00	IHBC-C1027	IHBC-SBB007-3			IHBC-R1065	Bronze Plan D	DP	$355.79	$711.58	$604.84	$1,014.00
18029NY1300056-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, FP	$357.60	$715.20	$607.92	$1,019.16
18029NY1300059-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066		Bronze Plan D	29, FP	$358.90	$717.80	$610.13	$1,022.87
18029NY1300061-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064			Bronze Plan D	29	$357.08	$714.16	$607.04	$1,017.68
18029NY1300062-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066		Bronze Plan D	FP	$357.60	$715.20	$607.92	$1,019.16
18029NY1270001-00	IHBC-C1027	IHBC-SBB008-3				Bronze Plan E	Base	$403.93	$807.86	$686.68	$1,151.20
18029NY1270003-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, 29, FP	$407.48	$814.96	$692.72	$1,161.32
18029NY1270004-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064		IHBC-R1065	Bronze Plan E	DP, 29	$405.40	$810.80	$689.18	$1,155.39
18029NY1270005-00	IHBC-C1027	IHBC-SBB008-3			IHBC-R1065	Bronze Plan E	DP	$403.93	$807.86	$686.68	$1,151.20
18029NY1270008-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, FP	$405.99	$811.98	$690.18	$1,157.07
18029NY1270011-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066		Bronze Plan E	29, FP	$407.48	$814.96	$692.72	$1,161.32
18029NY1270013-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064			Bronze Plan E	29	$405.40	$810.80	$689.18	$1,155.39
18029NY1270014-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066		Bronze Plan E	FP	$405.99	$811.98	$690.18	$1,157.07
18029NY1270033-00	IHBC-C1027	IHBC-SBB009-3				Bronze Plan F	Base	$851.10	$1,702.20	$1,446.87	$2,425.64
18029NY1270035-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, 29, FP	$858.64	$1,717.28	$1,459.69	$2,447.12
18029NY1270036-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064		IHBC-R1065	Bronze Plan F	DP, 29	$854.23	$1,708.46	$1,452.19	$2,434.56
18029NY1270037-00	IHBC-C1027	IHBC-SBB009-3			IHBC-R1065	Bronze Plan F	DP	$851.10	$1,702.20	$1,446.87	$2,425.64
18029NY1270040-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, FP	$855.49	$1,710.98	$1,454.33	$2,438.15
18029NY1270043-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066		Bronze Plan F	29, FP	$858.64	$1,717.28	$1,459.69	$2,447.12
18029NY1270045-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064			Bronze Plan F	29	$854.23	$1,708.46	$1,452.19	$2,434.56
18029NY1270046-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066		Bronze Plan F	FP	$855.49	$1,710.98	$1,454.33	$2,438.15

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HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
Platinum Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1170017-00	IHBC-C1027	IHBC-SBP005-3				Platinum Plan C	Base	$593.97	$1,187.94	$1,009.75	$1,692.81
18029NY1170019-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, 29, FP	$599.20	$1,198.40	$1,018.64	$1,707.72
18029NY1170020-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064		IHBC-R1065	Platinum Plan C	DP, 29	$596.15	$1,192.30	$1,013.46	$1,699.03
18029NY1170021-00	IHBC-C1027	IHBC-SBP005-3			IHBC-R1065	Platinum Plan C	DP	$593.97	$1,187.94	$1,009.75	$1,692.81
18029NY1170024-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066	IHBC-R1065	Platinum Plan C	DP, FP	$597.02	$1,194.04	$1,014.93	$1,701.51
18029NY1170027-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064	IHBC-R1066		Platinum Plan C	29, FP	$599.20	$1,198.40	$1,018.64	$1,707.72
18029NY1170029-00	IHBC-C1027	IHBC-SBP005-3	IHBC-R1064			Platinum Plan C	29	$596.15	$1,192.30	$1,013.46	$1,699.03
18029NY1170030-00	IHBC-C1027	IHBC-SBP005-3		IHBC-R1066		Platinum Plan C	FP	$597.02	$1,194.04	$1,014.93	$1,701.51
Gold Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1200017-00	IHBC-C1027	IHBC-SBG005-3				Gold Plan C	Base	$509.25	$1,018.50	$865.73	$1,451.36
18029NY1200019-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan C	DP, 29, FP	$513.74	$1,027.48	$873.36	$1,464.16
18029NY1200020-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064		IHBC-R1065	Gold Plan C	DP, 29	$511.12	$1,022.24	$868.90	$1,456.69
18029NY1200021-00	IHBC-C1027	IHBC-SBG005-3			IHBC-R1065	Gold Plan C	DP	$509.25	$1,018.50	$865.73	$1,451.36
18029NY1200024-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066	IHBC-R1065	Gold Plan C	DP, FP	$511.86	$1,023.72	$870.16	$1,458.80
18029NY1200027-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064	IHBC-R1066		Gold Plan C	29, FP	$513.74	$1,027.48	$873.36	$1,464.16
18029NY1200029-00	IHBC-C1027	IHBC-SBG005-3	IHBC-R1064			Gold Plan C	29	$511.12	$1,022.24	$868.90	$1,456.69
18029NY1200030-00	IHBC-C1027	IHBC-SBG005-3		IHBC-R1066		Gold Plan C	FP	$511.86	$1,023.72	$870.16	$1,458.80
18029NY1200049-00	IHBC-C1027	IHBC-SBG006-3				Gold Plan D	Base	$495.79	$991.58	$842.84	$1,413.00
18029NY1200051-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan D	DP, 29, FP	$500.15	$1,000.30	$850.26	$1,425.43
18029NY1200052-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064		IHBC-R1065	Gold Plan D	DP, 29	$497.61	$995.22	$845.94	$1,418.19
18029NY1200053-00	IHBC-C1027	IHBC-SBG006-3			IHBC-R1065	Gold Plan D	DP	$495.79	$991.58	$842.84	$1,413.00
18029NY1200056-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066	IHBC-R1065	Gold Plan D	DP, FP	$498.33	$996.66	$847.16	$1,420.24
18029NY1200059-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064	IHBC-R1066		Gold Plan D	29, FP	$500.15	$1,000.30	$850.26	$1,425.43
18029NY1200061-00	IHBC-C1027	IHBC-SBG006-3	IHBC-R1064			Gold Plan D	29	$497.61	$995.22	$845.94	$1,418.19
18029NY1200062-00	IHBC-C1027	IHBC-SBG006-3		IHBC-R1066		Gold Plan D	FP	$498.33	$996.66	$847.16	$1,420.24
18029NY1210001-00	IHBC-C1027	IHBC-SBG007-3				Gold Plan E	Base	$551.95	$1,103.90	$938.32	$1,573.06
18029NY1210003-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan E	DP, 29, FP	$556.83	$1,113.66	$946.61	$1,586.97
18029NY1210004-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064		IHBC-R1065	Gold Plan E	DP, 29	$553.97	$1,107.94	$941.75	$1,578.81
18029NY1210005-00	IHBC-C1027	IHBC-SBG007-3			IHBC-R1065	Gold Plan E	DP	$551.95	$1,103.90	$938.32	$1,573.06
18029NY1210008-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066	IHBC-R1065	Gold Plan E	DP, FP	$554.78	$1,109.56	$943.13	$1,581.12
18029NY1210011-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064	IHBC-R1066		Gold Plan E	29, FP	$556.83	$1,113.66	$946.61	$1,586.97
18029NY1210013-00	IHBC-C1027	IHBC-SBG007-3	IHBC-R1064			Gold Plan E	29	$553.97	$1,107.94	$941.75	$1,578.81
18029NY1210014-00	IHBC-C1027	IHBC-SBG007-3		IHBC-R1066		Gold Plan E	FP	$554.78	$1,109.56	$943.13	$1,581.12
18029NY1200065-00	IHBC-C1027	IHBC-SBG009-3				Gold Plan G	Base	$477.59	$955.18	$811.90	$1,361.13
18029NY1200067-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan G	DP, 29, FP	$481.81	$963.62	$819.08	$1,373.16
18029NY1200068-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064		IHBC-R1065	Gold Plan G	DP, 29	$479.35	$958.70	$814.90	$1,366.15
18029NY1200069-00	IHBC-C1027	IHBC-SBG009-3			IHBC-R1065	Gold Plan G	DP	$477.59	$955.18	$811.90	$1,361.13
18029NY1200072-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066	IHBC-R1065	Gold Plan G	DP, FP	$480.05	$960.10	$816.09	$1,368.14

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18029NY1200075-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064	IHBC-R1066		Gold Plan G	29, FP	$481.81	$963.62	$819.08	$1,373.16
18029NY1200077-00	IHBC-C1027	IHBC-SBG009-3	IHBC-R1064			Gold Plan G	29	$479.35	$958.70	$814.90	$1,366.15
18029NY1200078-00	IHBC-C1027	IHBC-SBG009-3		IHBC-R1066		Gold Plan G	FP	$480.05	$960.10	$816.09	$1,368.14
18029NY1200097-00	IHBC-C1027	IHBC-SBG011-3				Gold Plan H	Base	$483.30	$966.60	$821.61	$1,377.41
18029NY1200099-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan H	DP, 29, FP	$487.56	$975.12	$828.85	$1,389.55
18029NY1200100-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064		IHBC-R1065	Gold Plan H	DP, 29	$485.07	$970.14	$824.62	$1,382.45
18029NY1200101-00	IHBC-C1027	IHBC-SBG011-3			IHBC-R1065	Gold Plan H	DP	$483.30	$966.60	$821.61	$1,377.41
18029NY1200104-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066	IHBC-R1065	Gold Plan H	DP, FP	$485.77	$971.54	$825.81	$1,384.44
18029NY1200107-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064	IHBC-R1066		Gold Plan H	29, FP	$487.56	$975.12	$828.85	$1,389.55
18029NY1200109-00	IHBC-C1027	IHBC-SBG011-3	IHBC-R1064			Gold Plan H	29	$485.07	$970.14	$824.62	$1,382.45
18029NY1200110-00	IHBC-C1027	IHBC-SBG011-3		IHBC-R1066		Gold Plan H	FP	$485.77	$971.54	$825.81	$1,384.44
18029NY1210057-00	IHBC-C1027	IHBC-SBG008-3				Gold Plan F	Base	$1,076.45	$2,152.90	$1,829.97	$3,067.88
18029NY1210058-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Gold Plan F	DP, 29, FP	$1,085.98	$2,171.96	$1,846.17	$3,095.04
18029NY1210059-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064		IHBC-R1065	Gold Plan F	DP, 29	$1,080.41	$2,160.82	$1,836.70	$3,079.17
18029NY1210060-00	IHBC-C1027	IHBC-SBG008-3			IHBC-R1065	Gold Plan F	DP	$1,076.45	$2,152.90	$1,829.97	$3,067.88
18029NY1210061-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066	IHBC-R1065	Gold Plan F	DP, FP	$1,082.00	$2,164.00	$1,839.40	$3,083.70
18029NY1210062-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064	IHBC-R1066		Gold Plan F	29, FP	$1,085.98	$2,171.96	$1,846.17	$3,095.04
18029NY1210063-00	IHBC-C1027	IHBC-SBG008-3	IHBC-R1064			Gold Plan F	29	$1,080.41	$2,160.82	$1,836.70	$3,079.17
18029NY1210064-00	IHBC-C1027	IHBC-SBG008-3		IHBC-R1066		Gold Plan F	FP	$1,082.00	$2,164.00	$1,839.40	$3,083.70
Silver Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1240033-00	IHBC-C1027	IHBC-SBS009-3				Silver Plan C	Base	$431.00	$862.00	$732.70	$1,228.35
18029NY1240035-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan C	DP, 29, FP	$434.80	$869.60	$739.16	$1,239.18
18029NY1240036-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064		IHBC-R1065	Silver Plan C	DP, 29	$432.59	$865.18	$735.40	$1,232.88
18029NY1240037-00	IHBC-C1027	IHBC-SBS009-3			IHBC-R1065	Silver Plan C	DP	$431.00	$862.00	$732.70	$1,228.35
18029NY1240040-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066	IHBC-R1065	Silver Plan C	DP, FP	$433.21	$866.42	$736.46	$1,234.65
18029NY1240043-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064	IHBC-R1066		Silver Plan C	29, FP	$434.80	$869.60	$739.16	$1,239.18
18029NY1240045-00	IHBC-C1027	IHBC-SBS009-3	IHBC-R1064			Silver Plan C	29	$432.59	$865.18	$735.40	$1,232.88
18029NY1240046-00	IHBC-C1027	IHBC-SBS009-3		IHBC-R1066		Silver Plan C	FP	$433.21	$866.42	$736.46	$1,234.65
18029NY1250001-00	IHBC-C1027	IHBC-SBS013-3				Silver Plan E	Base	$484.16	$968.32	$823.07	$1,379.86
18029NY1250003-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan E	DP, 29, FP	$488.42	$976.84	$830.31	$1,392.00
18029NY1250004-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064		IHBC-R1065	Silver Plan E	DP, 29	$485.94	$971.88	$826.10	$1,384.93
18029NY1250005-00	IHBC-C1027	IHBC-SBS013-3			IHBC-R1065	Silver Plan E	DP	$484.16	$968.32	$823.07	$1,379.86
18029NY1250008-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066	IHBC-R1065	Silver Plan E	DP, FP	$486.65	$973.30	$827.31	$1,386.95
18029NY1250011-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064	IHBC-R1066		Silver Plan E	29, FP	$488.42	$976.84	$830.31	$1,392.00
18029NY1250013-00	IHBC-C1027	IHBC-SBS013-3	IHBC-R1064			Silver Plan E	29	$485.94	$971.88	$826.10	$1,384.93
18029NY1250014-00	IHBC-C1027	IHBC-SBS013-3		IHBC-R1066		Silver Plan E	FP	$486.65	$973.30	$827.31	$1,386.95
18029NY1240049-00	IHBC-C1027	IHBC-SBS015-3				Silver Plan G	Base	$426.50	$853.00	$725.05	$1,215.53
18029NY1240051-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan G	DP, 29, FP	$430.24	$860.48	$731.41	$1,226.18
18029NY1240052-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064		IHBC-R1065	Silver Plan G	DP, 29	$428.06	$856.12	$727.70	$1,219.97
18029NY1240053-00	IHBC-C1027	IHBC-SBS015-3			IHBC-R1065	Silver Plan G	DP	$426.50	$853.00	$725.05	$1,215.53
18029NY1240056-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066	IHBC-R1065	Silver Plan G	DP, FP	$428.68	$857.36	$728.76	$1,221.74
18029NY1240059-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064	IHBC-R1066		Silver Plan G	29, FP	$430.24	$860.48	$731.41	$1,226.18
18029NY1240061-00	IHBC-C1027	IHBC-SBS015-3	IHBC-R1064			Silver Plan G	29	$428.06	$856.12	$727.70	$1,219.97

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18029NY1240062-00	IHBC-C1027	IHBC-SBS015-3		IHBC-R1066		Silver Plan G	FP	$428.68	$857.36	$728.76	$1,221.74
18029NY1240081-00	IHBC-C1027	IHBC-SBS016-3				Silver Plan H	Base	$434.33	$868.66	$738.36	$1,237.84
18029NY1240083-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan H	DP, 29, FP	$438.14	$876.28	$744.84	$1,248.70
18029NY1240084-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064		IHBC-R1065	Silver Plan H	DP, 29	$435.91	$871.82	$741.05	$1,242.34
18029NY1240085-00	IHBC-C1027	IHBC-SBS016-3			IHBC-R1065	Silver Plan H	DP	$434.33	$868.66	$738.36	$1,237.84
18029NY1240088-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066	IHBC-R1065	Silver Plan H	DP, FP	$436.56	$873.12	$742.15	$1,244.20
18029NY1240091-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064	IHBC-R1066		Silver Plan H	29, FP	$438.14	$876.28	$744.84	$1,248.70
18029NY1240093-00	IHBC-C1027	IHBC-SBS016-3	IHBC-R1064			Silver Plan H	29	$435.91	$871.82	$741.05	$1,242.34
18029NY1240094-00	IHBC-C1027	IHBC-SBS016-3		IHBC-R1066		Silver Plan H	FP	$436.56	$873.12	$742.15	$1,244.20
18029NY1240113-00	IHBC-C1027	IHBC-SBS017-3				Silver Plan I	Base	$449.32	$898.64	$763.84	$1,280.56
18029NY1240115-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan I	DP, 29, FP	$453.27	$906.54	$770.56	$1,291.82
18029NY1240116-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064		IHBC-R1065	Silver Plan I	DP, 29	$450.96	$901.92	$766.63	$1,285.24
18029NY1240117-00	IHBC-C1027	IHBC-SBS017-3			IHBC-R1065	Silver Plan I	DP	$449.32	$898.64	$763.84	$1,280.56
18029NY1240120-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066	IHBC-R1065	Silver Plan I	DP, FP	$451.61	$903.22	$767.74	$1,287.09
18029NY1240123-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064	IHBC-R1066		Silver Plan I	29, FP	$453.27	$906.54	$770.56	$1,291.82
18029NY1240125-00	IHBC-C1027	IHBC-SBS017-3	IHBC-R1064			Silver Plan I	29	$450.96	$901.92	$766.63	$1,285.24
18029NY1240126-00	IHBC-C1027	IHBC-SBS017-3		IHBC-R1066		Silver Plan I	FP	$451.61	$903.22	$767.74	$1,287.09
18029NY1250033-00	IHBC-C1027	IHBC-SBS014-3				Silver Plan F	Base	$979.84	$1,959.68	$1,665.73	$2,792.54
18029NY1250035-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Silver Plan F	DP, 29, FP	$988.52	$1,977.04	$1,680.48	$2,817.28
18029NY1250036-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064		IHBC-R1065	Silver Plan F	DP, 29	$983.45	$1,966.90	$1,671.87	$2,802.83
18029NY1250037-00	IHBC-C1027	IHBC-SBS014-3			IHBC-R1065	Silver Plan F	DP	$979.84	$1,959.68	$1,665.73	$2,792.54
18029NY1250040-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066	IHBC-R1065	Silver Plan F	DP, FP	$984.90	$1,969.80	$1,674.33	$2,806.97
18029NY1250043-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064	IHBC-R1066		Silver Plan F	29, FP	$988.52	$1,977.04	$1,680.48	$2,817.28
18029NY1250045-00	IHBC-C1027	IHBC-SBS014-3	IHBC-R1064			Silver Plan F	29	$983.45	$1,966.90	$1,671.87	$2,802.83
18029NY1250046-00	IHBC-C1027	IHBC-SBS014-3		IHBC-R1066		Silver Plan F	FP	$984.90	$1,969.80	$1,674.33	$2,806.97
Bronze Plans						**29 = Child Definition Extension to Age 29 FP = Family Planning Rider DP = Domestic Partner Rider**					
18029NY1300017-00	IHBC-C1027	IHBC-SBB005-3				Bronze Plan B	Base	$352.20	$704.40	$598.74	$1,003.77
18029NY1300019-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, 29, FP	$355.29	$710.58	$603.99	$1,012.58
18029NY1300020-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064		IHBC-R1065	Bronze Plan B	DP, 29	$353.48	$706.96	$600.92	$1,007.42
18029NY1300021-00	IHBC-C1027	IHBC-SBB005-3			IHBC-R1065	Bronze Plan B	DP	$352.20	$704.40	$598.74	$1,003.77
18029NY1300024-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066	IHBC-R1065	Bronze Plan B	DP, FP	$353.99	$707.98	$601.78	$1,008.87
18029NY1300027-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064	IHBC-R1066		Bronze Plan B	29, FP	$355.29	$710.58	$603.99	$1,012.58
18029NY1300029-00	IHBC-C1027	IHBC-SBB005-3	IHBC-R1064			Bronze Plan B	29	$353.48	$706.96	$600.92	$1,007.42
18029NY1300030-00	IHBC-C1027	IHBC-SBB005-3		IHBC-R1066		Bronze Plan B	FP	$353.99	$707.98	$601.78	$1,008.87
18029NY1300033-00	IHBC-C1027	IHBC-SBB006-3				Bronze Plan C	Base	$359.03	$718.06	$610.35	$1,023.24
18029NY1300035-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, 29, FP	$362.16	$724.32	$615.67	$1,032.16
18029NY1300036-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064		IHBC-R1065	Bronze Plan C	DP, 29	$360.33	$720.66	$612.56	$1,026.94
18029NY1300037-00	IHBC-C1027	IHBC-SBB006-3			IHBC-R1065	Bronze Plan C	DP	$359.03	$718.06	$610.35	$1,023.24
18029NY1300040-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066	IHBC-R1065	Bronze Plan C	DP, FP	$360.85	$721.70	$613.45	$1,028.42
18029NY1300043-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064	IHBC-R1066		Bronze Plan C	29, FP	$362.16	$724.32	$615.67	$1,032.16
18029NY1300045-00	IHBC-C1027	IHBC-SBB006-3	IHBC-R1064			Bronze Plan C	29	$360.33	$720.66	$612.56	$1,026.94
18029NY1300046-00	IHBC-C1027	IHBC-SBB006-3		IHBC-R1066		Bronze Plan C	FP	$360.85	$721.70	$613.45	$1,028.42
18029NY1300049-00	IHBC-C1027	IHBC-SBB007-3				Bronze Plan D	Base	$366.61	$733.22	$623.24	$1,044.84

''

Independent Health Benefits Corporation

Small Group off Exchange Premium Rates Effective October 1, 2014

HIOS Plan ID	Form Numbers					Product Name	Product Description	Single	Double	Employee / Child(ren)	Family
18029NY1300051-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, 29, FP	$369.82	$739.64	$628.69	$1,053.99
18029NY1300052-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064		IHBC-R1065	Bronze Plan D	DP, 29	$367.94	$735.88	$625.50	$1,048.63
18029NY1300053-00	IHBC-C1027	IHBC-SBB007-3			IHBC-R1065	Bronze Plan D	DP	$366.61	$733.22	$623.24	$1,044.84
18029NY1300056-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066	IHBC-R1065	Bronze Plan D	DP, FP	$368.47	$736.94	$626.40	$1,050.14
18029NY1300059-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064	IHBC-R1066		Bronze Plan D	29, FP	$369.82	$739.64	$628.69	$1,053.99
18029NY1300061-00	IHBC-C1027	IHBC-SBB007-3	IHBC-R1064			Bronze Plan D	29	$367.94	$735.88	$625.50	$1,048.63
18029NY1300062-00	IHBC-C1027	IHBC-SBB007-3		IHBC-R1066		Bronze Plan D	FP	$368.47	$736.94	$626.40	$1,050.14
18029NY1270001-00	IHBC-C1027	IHBC-SBB008-3				Bronze Plan E	Base	$416.25	$832.50	$707.63	$1,186.31
18029NY1270003-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, 29, FP	$419.90	$839.80	$713.83	$1,196.72
18029NY1270004-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064		IHBC-R1065	Bronze Plan E	DP, 29	$417.76	$835.52	$710.19	$1,190.62
18029NY1270005-00	IHBC-C1027	IHBC-SBB008-3			IHBC-R1065	Bronze Plan E	DP	$416.25	$832.50	$707.63	$1,186.31
18029NY1270008-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066	IHBC-R1065	Bronze Plan E	DP, FP	$418.37	$836.74	$711.23	$1,192.35
18029NY1270011-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064	IHBC-R1066		Bronze Plan E	29, FP	$419.90	$839.80	$713.83	$1,196.72
18029NY1270013-00	IHBC-C1027	IHBC-SBB008-3	IHBC-R1064			Bronze Plan E	29	$417.76	$835.52	$710.19	$1,190.62
18029NY1270014-00	IHBC-C1027	IHBC-SBB008-3		IHBC-R1066		Bronze Plan E	FP	$418.37	$836.74	$711.23	$1,192.35
18029NY1270033-00	IHBC-C1027	IHBC-SBB009-3				Bronze Plan F	Base	$877.28	$1,754.56	$1,491.38	$2,500.25
18029NY1270035-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, 29, FP	$885.05	$1,770.10	$1,504.59	$2,522.39
18029NY1270036-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064		IHBC-R1065	Bronze Plan F	DP, 29	$880.50	$1,761.00	$1,496.85	$2,509.43
18029NY1270037-00	IHBC-C1027	IHBC-SBB009-3			IHBC-R1065	Bronze Plan F	DP	$877.28	$1,754.56	$1,491.38	$2,500.25
18029NY1270040-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066	IHBC-R1065	Bronze Plan F	DP, FP	$881.80	$1,763.60	$1,499.06	$2,513.13
18029NY1270043-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064	IHBC-R1066		Bronze Plan F	29, FP	$885.05	$1,770.10	$1,504.59	$2,522.39
18029NY1270045-00	IHBC-C1027	IHBC-SBB009-3	IHBC-R1064			Bronze Plan F	29	$880.50	$1,761.00	$1,496.85	$2,509.43
18029NY1270046-00	IHBC-C1027	IHBC-SBB009-3		IHBC-R1066		Bronze Plan F	FP	$881.80	$1,763.60	$1,499.06	$2,513.13

Attachment B

Independent Health Benefits Corporation
Development of Conversion Factor for Small Group Rating Pool

Pre 2014 Small Group	Total Paid	Member Months	Child Months	Subscriber Months	Avg Size	PSPM	PMPM	Actual Tier Ratio
Single	$ 52,978,427	159,052	-	159,052	1.00	333.09	333.09	1.000
Single + Spouse	$ 18,713,678	48,713	-	24,357	2.00	768.31	384.16	2.307
Single + Child(ren)	$ 4,936,778	30,444	19,094	11,348	2.68	435.04	162.16	1.306
Single + Spouse + Child(ren)	$ 54,464,221	281,496	144,123	68,686	4.10	792.95	193.48	2.381
Total	$ 131,093,103	519,705	163,217	263,443	1.97	497.61	252.25	1.494

	2014 NYS Tier Factors	Conversion Factor [1]
	1.00	
	2.00	
	1.70	
	2.85	
Weighted Avg (by subscribers)	1.60	**1.23**

Current Tier Factors	Conversion Factor [1]
1.00	
2.55	
1.80	
2.80	
1.65	**1.20**

[1] Average Family Size divided by weighted average of tier factors

Attachment C

User Inputs for Plan Parameters

Platinum Plan C

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐		
Specialist Visit	☐	☐		$30.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐		
X-rays and Diagnostic Imaging	☐	☐		$30.00	☐	☐		
Skilled Nursing Facility	☐	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	94%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☐	☑	98%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	89.6%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Gold Plan C

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☐	☐		
Specialist Visit	☑	☐		$45.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$45.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$45.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$45.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	97%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.5%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan D

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

	Gold Plan E
Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan F

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan G

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00		$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		60.00%	100.00%	
OOP Maximum ($)	$5,000.00			$6,350.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑	60%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☐		$30.00
Specialist Visit	☑	☐		$50.00	☑	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☐		$100.00
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☐		$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☐		$50.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☐		$30.00
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☐		$50.00
Skilled Nursing Facility	☑	☐		$500.00	☑	☑	60%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	97%		☑	☑	60%	
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☑	50%		☐	☑	50%	
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☑	50%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold Plan H

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$63.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	97%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	77.9%
Metal Tier:	

User Inputs for Plan Parameters

	Silver Plan C
Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan E

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan F

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan G

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			$2,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%			60.00%
OOP Maximum ($)			$5,000.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		$200.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑	60%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☐		$30.00
Specialist Visit	☑	☐		$50.00	☑	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☐		$100.00
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☐		$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☐		$50.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☐		$30.00
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☐		$50.00
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑	60%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☑	☑	60%	
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☑	☐		$4.00
Preferred Brand Drugs	☑	☐		$30.00	☑	☐		$30.00
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.6%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver Plan H

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$63.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.7%
Metal Tier:	Silver

User Inputs for Plan Parameters

	Silver Plan I
Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$750.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$63.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$750.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	93%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

User Inputs for Plan Parameters

Bronze Plan B

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			$5,500.00
Coinsurance (%, Insurer's Cost Share)			80.00%			60.00%
OOP Maximum ($)			$6,350.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑	80%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑	60%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑	80%	
Specialist Visit	☑	☑	80%		☑	☑	80%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑	80%	
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑	80%	
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑	80%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑	80%	
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑	80%	
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑	80%	
Skilled Nursing Facility	☑	☑	70%		☑	☑	60%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑	60%	
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☑	☑	50%	
Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.4%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan C

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑	64%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.5%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan D

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan E

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze Plan F

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze

Attachment D

Base Plans

Plan	Form No.	Description	Notes	Size
EncPlus	IHBC-POSC-001	Encompass D3 - OoN - 25% Coins, $500 Ded, $2500 OoP	Enc D	S
EncPlus	IHBC-POSC-001	Encompass D4 - OoN - 30% Coins, $500 Ded, $2500 OoP	Enc D	S
EncPlus	IHBC-POSC-001	Encompass D5 - OoN - 30% Coins, $1000 Ded, $5000 OoP	Enc D	S
EncPlus	IHBC-C1005	FlexFit Select - Active	FFS	S
EncPlus	IHBC-C1005	FlexFit Select - Family	FFS	S
EncPlus	IHBC-C1009	Encompass Essential - Version 1 (Base 1)	Ess	S
EncPlus	IHBC-C1009	Encompass Essential - Version 2 (E)	Ess	S
EncPlus	IHBC-C1009	Essential - Version 3	Ess	S
Passport Plan Select	500103-43	Select - Option #3 - $20 Copay, $1000 Ded, $3000 Out of Pocket	Option(s): 3	S
Passport Plan Select	500103-43	Select - Option #5 - $25 Copay, $1000 Ded, $3000 Out of Pocket	Option(s): 5	S
Passport Plan Select	500103-43	Select - Option #7 - $35 Copay, $1000 Ded, $3000 Out of Pocket	Option(s): 7	S
Passport Plan Select	500103-43	Select - Option #8 - $35 Copay, $2000 Ded, $6000 Out of Pocket	Option(s): 8	S
Passport Plan Select	500103-43 / 550	Select - Option #10 - $25/$40 Copay, $500 In-Net/$2,000 OoN Ded, $5000 OoP	Option(s): 10	S
Passport Plan Select	500103-43 / IHBC-R1006	Select - Option #11 - $20 Copay, $250 Ded, $2000 Out of Pocket	Option(s): 11	S
Passport Plan Select	500103-43 / IHBC-R1006	Select - Option #12 - $20 Copay, $500 Ded, $3000 Out of Pocket	Option(s): 12	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - B Plan - 1 Series B	1500	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - B Plan - 1 Series B	2000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - B Plan - 1 Series B	2500	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - B Plan - 1 Series B	3000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - B Plan - 1 Series B	4000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - B Plan - 1 Series B	5000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - C Plan - 1 Series C	1500	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - C Plan - 1 Series C	2000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - C Plan - 1 Series C	2500	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - C Plan - 1 Series C	3000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - C Plan - 1 Series C	4000	S
iDirect	IHBC-HSAQE-C-001	iDirect 1 Series - C Plan - 1 Series C	5000	S
iDirect	IHBC-HSAQP-C-001	iDirect 2 Series ($25) - 2 Series	1500	S
iDirect	IHBC-HSAQP-C-001	iDirect 2 Series ($25) - 2 Series	2000	S
iDirect	IHBC-HSAQP-C-001	iDirect 2 Series ($25) - 2 Series	2500	S
iDirect	IHBC-HSAQP-C-001	iDirect 2 Series ($25) - 2 Series	3000	S
iDirect	IHBC-HSAQP-C-001	iDirect 2 Series ($25) - 2 Series	4000	S
iDirect	IHBC-HSAQP-C-001	iDirect 2 Series ($25) - 2 Series	5000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 20% OoN - 3 Series	2500	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 20% OoN - 3 Series	3000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 25% OoN - 3 Series	2500	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 25% OoN - 3 Series	3000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 30% OoN - 3 Series	2500	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 30% OoN - 3 Series	3000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 30% OoN - 3 Series	4000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 30% OoN - 3 Series	5000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 40% OoN - 3 Series	2500	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 40% OoN - 3 Series	3000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 40% OoN - 3 Series	4000	S
iDirect	IHBC-HSAQ-C-003	iDirect 3 Series - 40% OoN - 3 Series	5000	S
iDirect	IHBC-HSAQ-C-004	iDirect 4 Series - 20% - 4 Series	1500	S
iDirect	IHBC-HSAQ-C-004	iDirect 4 Series - 20% - 4 Series	2000	S
iDirect	IHBC-HSAQ-C-004	iDirect 4 Series - 20% - 4 Series	2500	S
iDirect	IHBC-HSAQ-C-004	iDirect 4 Series - 20% - 4 Series	3000	S
iDirect	IHBC-HSAQ-C-004	iDirect 4 Series - 20% - 4 Series	4000	S
iDirect	IHBC-HSAQ-C-004	iDirect 4 Series - 20% - 4 Series	5000	S
iDirect	IHBC-C1001	iDirect 5 Series - No OoN - 5 Series	1500	S
iDirect	IHBC-C1001	iDirect 5 Series - No OoN - 5 Series	3000	S
iDirect	IHBC-C1001	iDirect 5 Series - No OoN - 5 Series	5000	S
iDirect	IHBC-C1008	Evolve	1500	S
iDirect	IHBC-C1021	Empower HDHP Enhanced Option 4	1500	S
iDirect	IHBC-C1021	Empower HDHP Standard Option 4	2500	S
iDirect	IHBC-C1021	Empower HDHP Enhanced Option 6	2500	S
iDirect	IHBC-C1021	Empower HDHP Standard Option 6	3500	S
iDirect	IHBC-C1022	Prime Access Option 1: Enhanced	1500	S
iDirect	IHBC-C1022	Prime Access Option 1: Standard	2500	S
iDirect	IHBC-C1022	Prime Access Option 2: Enhanced	2500	S

Base Plans

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-C1022	Prime Access Option 2: Standard	3500	S
iDirect	IHBC-C1023	Choice Plus Option 1	1500/2500	S
iDirect	IHBC-C1023	Choice Plus Option 2	2000/3000	S
iDirect	IHBC-HRAE-C-001B	iDirect 1 Series - B Plan - 1 Series B	1500	S
iDirect	IHBC-HRAE-C-001B	iDirect 1 Series - B Plan - 1 Series B	2000	S
iDirect	IHBC-HRAE-C-001B	iDirect 1 Series - B Plan - 1 Series B	2500	S
iDirect	IHBC-HRAE-C-001B	iDirect 1 Series - B Plan - 1 Series B	3000	S
iDirect	IHBC-HRAE-C-001B	iDirect 1 Series - B Plan - 1 Series B	4000	S
iDirect	IHBC-HRAE-C-001B	iDirect 1 Series - B Plan - 1 Series B	5000	S
iDirect	IHBC-HRAE-C-001C	iDirect 1 Series - C Plan - 1 Series C	1500	S
iDirect	IHBC-HRAE-C-001C	iDirect 1 Series - C Plan - 1 Series C	2000	S
iDirect	IHBC-HRAE-C-001C	iDirect 1 Series - C Plan - 1 Series C	2500	S
iDirect	IHBC-HRAE-C-001C	iDirect 1 Series - C Plan - 1 Series C	3000	S
iDirect	IHBC-HRAE-C-001C	iDirect 1 Series - C Plan - 1 Series C	4000	S
iDirect	IHBC-HRAE-C-001C	iDirect 1 Series - C Plan - 1 Series C	5000	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($25) - 2 Series	1500	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($25) - 2 Series	2000	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($25) - 2 Series	2500	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($25) - 2 Series	3000	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($25) - 2 Series	4000	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($25) - 2 Series	5000	S
iDirect	IHBC-HRAP-C-001	iDirect 2 Series ($15/$40) - 2 Series	1000	S
iDirect	IHBC-C1008	Evolve	1500	S
iDirect	IHBC-C1008	Evolve Option 3	1000	S
iDirect	IHBC-C1021	Empower HDHP Enhanced Option 5	1500	S
iDirect	IHBC-C1021	Empower HDHP Standard Option 5	2500	S
iDirect	IHBC-C1021	Empower HDHP Enhanced Option 7	2500	S
iDirect	IHBC-C1021	Empower HDHP Standard Option 7	3500	S
Passport Plan Select Out of Area	IHBC-C1019	Select - Option #7 - $35 Copay, $1000 Ded, $3000 Out of Pocket	Option(s): 7	S
Passport Plan Select Out of Area	IHBC-C1019	Select - Option #11 - $20 Copay, $250 Ded, $2000 Out of Pocket	Option(s): 11	S
Passport Plan Select Out of Area	IHBC-C1019	Select - Option #12 - $20 Copay, $500 Ded, $3000 Out of Pocket	Option(s): 12	S
iDirect Out of Area	IHBC-C1014	iDirect 1 Series - B Plan - 1 Series B	1500	S
iDirect Out of Area	IHBC-C1015	iDirect 1 Series - C Plan - 1 Series C	1500	S
iDirect Out of Area	IHBC-C1015	iDirect 1 Series - C Plan - 1 Series C	2000	S

Prescription Drug Riders

Plan	Form No.	Description	Notes	Size
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$7/ $25 / $40 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10/ $20/ $35 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	30% ($1 min / $100 max) Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx w/ $200 Ded on Tiers 2 & 3	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx w/ $200 Ded on Tier 2 & 3	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $50 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 Tier 3)	All	S
EncPlus	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 Tier 3)	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx	All	S
EncPlus	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / 50% Rx	All	S
EncPlus	IHBC-PR1001	Contraceptive Removal - Religious Groups	All	S
EncPlus	IHBC-PR1002	Direct Pay Contraceptive Benefit	All	S
EncPlus	IHBC-PA1003	Contraceptive Coverage Only Rx Rider	All	S
EncPlus	IHBC-POSR-036	$0 Tier 1 Rx for Kids - w/ $3 Tier 1 Rx	All	S
EncPlus	IHBC-POSR-036	$0 Tier 1 Rx for Kids - w/ $4 Tier 1 Rx	All	S
EncPlus	IHBC-POSR-036	$0 Tier 1 Rx for Kids - w/ $5 Tier 1 Rx	All	S
EncPlus	IHBC-POSR-036	$0 Tier 1 Rx for Kids - w/ $7 Tier 1 Rx	All	S
EncPlus	IHBC-POSR-036	$0 Tier 1 Rx for Kids - w/ $10 Tier 1 Rx	All	S
EncPlus	IHBC-POSR-036	$0 Tier 1 Rx for Kids - w/ $15 Tier 1 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1007	$7 / $25 / $40 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1007	$10 / $20 / $35 Rx Triple Option	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1007	$10 / $50 / $100 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-E-001	$10 / $30 / $100 Rx w/ $200 Ded on Tiers 2 & 3	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-E-002	$10 / $50 / $100 Rx w/ $200 Ded on Tiers 2 & 3	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-E-004	$10 / $30 / $100 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3)	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3)	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx	All	S
Passport Plan Select	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / 50% Rx	All	S
Passport Plan Select	IHBC-POSR-036	$0 Tier 1 Rx for Kids w/ $3 Tier 1	All	S
Passport Plan Select	IHBC-POSR-036	$0 Tier 1 Rx for Kids w/ $4 Tier 1	All	S
Passport Plan Select	IHBC-POSR-036	$0 Tier 1 Rx for Kids w/ $5 Tier 1	All	S
Passport Plan Select	IHBC-POSR-036	$0 Tier 1 Rx for Kids w/ $7 Tier 1	All	S
Passport Plan Select	IHBC-POSR-036	$0 Tier 1 Rx for Kids w/ $10 Tier 1	All	S
Passport Plan Select	IHBC-POSR-036	$0 Tier 1 Rx for Kids w/ $15 Tier 1	All	S
Passport Plan Select	IHBC-PR1001	Removal of Contraceptives – Religious Groups	All	S
Passport Plan Select	IHBC-PR1002	Direct Pay Contraceptive - Religious Group Employees	All	S
Passport Plan Select	IHBC-PA1003	Contraceptive Coverage Only Rx Rider	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All Series	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All Series	2000	S

Prescription Drug Riders

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All Series	2000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All Series	2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All Series	3000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All Series	4000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All Series	5000	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - Empower Opt 4	1500 / 2500	S

Prescription Drug Riders

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$4 / 35% / 50% - PriAcc Opt 1	1500 / 2500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$4 / 35% / 50% - PriAcc Opt 2	2500 / 3500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$4 / 35% / 50% - CP 1	1500	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$4 / 35% / 50% - CP 2	2000	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $3) - All Series	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $4) - All Series	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $5) - All Series	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $7) - All Series	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $10) - All Series	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $15) - All Series	All	S
iDirect	IHBC-PR1001	Removal of Contraceptives – Religious Groups	All	S
iDirect	IHBC-PR1002	Direct Pay Contraceptive - Religious Group Employees	All	S
iDirect	IHBC-PA1003	Contraceptive Coverage Only Rx Rider	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$7 / $25 / $40 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $20 / $35 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $30 / $100 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 / $50 / $100 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	30% Rx ($1 Min /$100 Max) on Tiers 1 & 2 - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1001	$10 Tier 1 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-003	$4 / $25 / 50% Rx (min $40 copay Tier 3) - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-004	$4 / 100% / 100% Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-RX-OPTE-005	$10 / $30 / 50% Rx (min $45 copay Tier 3) - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $15 / $75 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$4 / $30 / $75 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1000	$10 / $30 / $75 Rx - All	All	S
iDirect	IHBC-RX-R-001 / IHBC-PE1006	$10 / $50 / $50% Rx - All	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $3) - All	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $4) - All	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $5) - All	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $7) - All	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $10) - All	All	S
iDirect	IHBC-HSAQR-661E	$0 Tier 1 Child Copay (from $15) - All	All	S
iDirect	IHBC-PR1001	Removal of Oral Contr & Devices – Religious Groups	All	S
iDirect	IHBC-PR1002	Opt-In Rider for Religious Group Employers	All	S
iDirect	IHBC-PA1003	Contraceptive Coverage Only Rx Rider	All	S
Passport Plan Select Out of Area	IHBC-RX-R-001 / IHBC-PE1007	$7 / $25 / $40 Rx	All	S
Passport Plan Select Out of Area	IHBC-RX-R-001 / IHBC-PE1007	$10 / $50 / $100 Rx	All	S
Passport Plan Select Out of Area	IHBC-RX-R-001 / IHBC-RX-E-005	$10 / $30 / $50 Rx	All	S
Passport Plan Select Out of Area	IHBC-PR1001	Removal of Contraceptives – Religious Groups	All	S
Passport Plan Select Out of Area	IHBC-PR1002	Direct Pay Contraceptive - Religious Group Employees	All	S
Passport Plan Select Out of Area	IHBC-PA1003	Contraceptive Coverage Only Rx Rider	All	S
iDirect Out of Area	$7 / $25 / $40 Rx	1500		S
iDirect Out of Area	$10 / $50 / $100 Rx	1500		S
iDirect Out of Area	$10 / $30 / $50 Rx	1500		S
iDirect Out of Area	$7 / $25 / $40 Rx	2000		S
iDirect Out of Area	$10 / $50 / $100 Rx	2000		S
iDirect Out of Area	$10 / $30 / $50 Rx	2000		S
iDirect Out of Area	Removal of Contraceptives – Religious Groups	All		S
iDirect Out of Area	Direct Pay Contraceptive - Religious Group Employees	All		S

Prescription Drug Riders

Plan	Form No.	Description	Notes	Size
iDirect Out of Area	Contraceptive Coverage Only Rx Rider	All		S

Other Riders

Plan	Form No.	Description	Notes	Size
EncPlus	IHBC-POSR-023	$250 IP	Enc D	S
EncPlus	IHBC-POSR-027	IP Rehab	Enc D, FFS	S
EncPlus	IHBC-POSR-033	Unlimited Skilled Nursing Facility	Enc D, FFS	S
EncPlus	IHBC-POSR-034	EyeMed Premier Vision	All	S
EncPlus	IHBC-POSR-035	$0 OV Copay for Children - w/ $20 OV Copay	Enc D	S
EncPlus	IHBC-POSR-035	$0 OV Copay for Children - w/ $35 OV Copay	Enc D	S
EncPlus	IHBC-POSR-037	Right to Life	All	S
EncPlus	IHBC-POSR-038	No Sterilization	All	S
EncPlus	IHBC-POSR-049	$20 PCP / $35 SCP	Enc D	S
EncPlus	IHBC-POSR-049	$25 PCP / $40 SCP	Enc D	S
EncPlus	IHBC-POSR-049	$30 PCP / $50 SCP	Enc D	S
EncPlus	IHBC-R-209	$250 IP	FFS	S
EncPlus	IHBC-R-219	Essential Additional Benefits	Ess 1, E	S
EncPlus	IHBC-R-219	Essential Additional Benefits	Ess 2	S
EncPlus	IHBC-R-220	Essential Family Benefits	Ess E	S
EncPlus	IHBC-R-220	Essential Family Benefits	Ess 1	S
EncPlus	IHBC-R-221	Essential POS w/o Add'l Benefits	Ess	S
EncPlus	IHBC-R-221	Essential POS w/ Add'l Benefits	Ess	S
EncPlus	IHBC-R-223	Unlimited Skilled Nursing Facility	Ess	S
EncPlus	IHBC-R-224	PT / OT in a Hospital	Ess	S
EncPlus	IHBC-R-014	NYS Mental Health Rider - Small Groups	Enc D	S
EncPlus	IHBC-R-014	NYS Mental Health Rider - Small Groups	FFS	S
EncPlus	IHBC-R-014	NYS Mental Health Rider - Small Groups	Ess Base 1	S
EncPlus	IHBC-R-014	NYS Mental Health Rider - Small Groups	Ess Base 2	S
EncPlus	IHBC-R-014	NYS Mental Health Rider - Small Groups	Ess Base E	S
EncPlus	IHBC-R-017	personalBest Fitness	All	S
EncPlus	IHBC-R-032	IP Rehab for Substance Abuse - Contract Year	Ess	S
EncPlus	IHBC-R-032	IP Rehab for Substance Abuse - Calendar Year	Ess	S
EncPlus	IHBC-R-036	PT/OT/ST Increase visit limits to 30	All	S
EncPlus	IHBC-R-036	PT/OT/ST Increase visit limits to 45	All	S
EncPlus	IHBC-OPTR-001	IP Substance Abuse - Calendar Year Benefits	All	S
EncPlus	IHBC-R1002	Federal MHP Opt-Out for Unions	D	S
EncPlus	IHBC-R1002	Federal MHP Opt-Out for Unions	FFS	S
EncPlus	IHBC-R1002	Federal MHP Opt-Out for Unions	Ess 1	S
EncPlus	IHBC-R1002	Federal MHP Opt-Out for Unions	Ess 2	S
EncPlus	IHBC-R1002	Federal MHP Opt-Out for Unions	Ess E	S
EncPlus	IHBC-R1005	Federal MHP Rider for Small Groups	Enc D	S
EncPlus	IHBC-R1005	Federal MHP Rider for Small Groups	FFS	S
EncPlus	IHBC-R1005	Federal MHP Rider for Small Groups	Ess Base 1	S
EncPlus	IHBC-R1005	Federal MHP Rider for Small Groups	Ess Base 2	S
EncPlus	IHBC-R1005	Federal MHP Rider for Small Groups	Ess Base E	S
EncPlus	IHBC-MHP-A-001	Federal MHP Amendment	Enc A-D	S
EncPlus	IHBC-MHP-A-001	Federal MHP Amendment	FFS	S
EncPlus	IHBC-MHP-A-001	Federal MHP Amendment	Ess Base 1	S
EncPlus	IHBC-MHP-A-001	Federal MHP Amendment	Ess Base 2	S
EncPlus	IHBC-MHP-A-001	Federal MHP Amendment	Ess Base E	S
EncPlus	IHBC-R1020	FitWorks w/ Incentive	All	S
EncPlus	IHBC-R1022	FitWorks without Incentive	All	S
EncPlus	IHBC-R1025	$500 IP Copay	FFS	S
EncPlus	IHBC-R1029	$35 OV Copay	Enc D	S
EncPlus	IHBC-POSR-505	Small Group Domestic Partner Rider	All	S
Passport Plan Select	5220103-43	IP Rehabilitation for Substance Abuse - Contract Year	All	S
Passport Plan Select	5220103-43	IP Rehabilitation for Substance Abuse - Calendar Year	All	S
Passport Plan Select	5260103-43	Eyemed Premier Vision Rider	All	S
Passport Plan Select	5300103-43	Unlimited Skilled Nursing Facility	All	S
Passport Plan Select	IHBC-R-014	Mental Health - Small Groups	Option(s): 1-8, 11, 12	S
Passport Plan Select	IHBC-R-014	Mental Health - Small Groups	Option(s): 10	S
Passport Plan Select	IHBC-R-017	personalBest Fitness	All	S
Passport Plan Select	IHBC-POSR-037	Right to Life	All	S
Passport Plan Select	IHBC-POSR-038	Sterilization Exclusion	All	S
Passport Plan Select	IHBC-R-036	PT/OT/ST Increase visit limits to 30 Any Opt w/ PP Select	All	S
Passport Plan Select	IHBC-R-036	PT/OT/ST Increase visit limits to 45 Any Opt w/ PP Select	All	S
Passport Plan Select	IHBC-R1002	Federal MHP Opt-Out for Unions	Option(s): 1-8, 11, 12	S
Passport Plan Select	IHBC-R1002	Federal MHP Opt-Out for Unions	Option(s): 9	S

Other Riders

Plan	Form No.	Description	Notes	Size
Passport Plan Select	IHBC-R1002	Federal MHP Opt-Out for Unions	Option(s): 10	S
Passport Plan Select	IHBC-R1005	Federal MHP for Small Groups	Option(s): 1-8, 11, 12	S
Passport Plan Select	IHBC-R1005	Federal MHP for Small Groups	Option(s): 10	S
Passport Plan Select	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify	Option(s): 1-8, 11, 12	S
Passport Plan Select	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify	Option(s): 10	S
Passport Plan Select	IHBC-R1020	FitWorks with Incentive	All	S
Passport Plan Select	IHBC-R1022	FitWorks without Incentive	All	S
Passport Plan Select	IHBC-POSR-505	Small Group Domestic Partner Rider	All	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	1500	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	2000	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	2500	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	3000	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	4000	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	5000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C, 5 Series	1500	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	2000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	2500	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C, 5 Series	3000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	4000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C, 5 Series	5000	S
iDirect	IHBC-HSAQR-668E	IP Rehab for Substance Abuse - 1 Series	All	S
iDirect	IHBC-HSAQR-668E	IP Rehab for Substance Abuse - Cal Year - 1 Series	All	S
iDirect	IHBC-HSAQR-602P	IP Rehab for Substance Abuse - 2 Series, Evolve	All	S
iDirect	IHBC-HSAQR-602P	IP Rehab for Substance Abuse - 3 Series	All	S
iDirect	IHBC-HSAQR-602P	IP Rehab for Substance Abuse (20%) - 4 Series	All	S
iDirect	IHBC-HSAQR-602P	IP Rehab for Substance Abuse - Cal Year - 2-4 Series, Evolve	All	S
iDirect	IHBC-R1058	IP Rehab for Substance Abuse - Empower	All	S
iDirect	IHBC-R1058	IP Rehab for Substance Abuse - Cal Year - Empower	All	S
iDirect	IHBC-R1062	IP Rehab for Substance Abuse - CP 1	1500	S
iDirect	IHBC-R1062	IP Rehab for Substance Abuse - CP 2	2000	S
iDirect	IHBC-R1062	IP Rehab for Substance Abuse - Cal Year - CP 1	1500	S
iDirect	IHBC-R1062	IP Rehab for Substance Abuse - Cal Year - CP 2	2000	S
iDirect	IHBC-HSAQR-669E	Right to Life - All Series	All	S
iDirect	IHBC-HSAQR-670E	Sterilization Exclusion - All Series	All	S
iDirect	IHBC-HSAQR-675E	EyeMed Premier Vision - All Series	All	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	1500	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	2000	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	2500	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	3000	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	4000	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	5000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	1500	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	2000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	2500	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	3000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	4000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	5000	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - 1 Series	All	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - 2 Series, Evolve	All	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - 3 Series	All	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - 4 Series	All	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - Empower 4	All	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - CP 1	1500	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - CP 2	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	5000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	3000	S

Other Riders

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	5000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	5000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	5000	S
iDirect	IHBC-R1014	$0 Child OV - 5 Series	1500	S
iDirect	IHBC-R1014	$0 Child OV - 5 Series	3000	S
iDirect	IHBC-R1014	$0 Child OV - 5 Series	5000	S
iDirect	IHBC-R1014	$0 Child & $15 OV - 5 Series	1500	S
iDirect	IHBC-R1014	$0 Child & $15 OV - 5 Series	3000	S
iDirect	IHBC-R1014	$0 Child & $15 OV - 5 Series	5000	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - 1 Series B	All	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - 1 Series C	All	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - 2 Series	All	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - 3 Series	All	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - 20% - 4 Series	All	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - 5 Series	All	S
iDirect	IHBC-R-014	NYS Mental Health Rider - Small Groups - Evolve	All	S
iDirect	IHBC-R1028	NYS Mental Health Rider - Small Groups - Empower	All	S
iDirect	IHBC-R1028	NYS Mental Health Rider - Small Groups - PriAcc	All	S
iDirect	IHBC-R1060	NYS Mental Health Rider - Small Groups - CP 1	1500	S
iDirect	IHBC-R1060	NYS Mental Health Rider - Small Groups - CP 2	2000	S
iDirect	IHBC-R-017	personalBest Fitness	All	S
iDirect	IHBC-R-036	PT/OT/ST Increase visit limits to 30 - 1-4 Series, Evolve	All	S
iDirect	IHBC-R-036	PT/OT/ST Increase visit limits to 45 - 1-4 Series, Evolve	All	S
iDirect	IHBC-R-036	PT/OT/ST Increase visit limits to 30 - 5 Series	All	S
iDirect	IHBC-R-036	PT/OT/ST Increase visit limits to 45 - 5 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 1 Series B	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 1 Series C	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 2 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 3 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 10% - 4 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 20% - 4 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 20% - 5 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - Evolve	All	S
iDirect	IHBC-R1056	Federal MHP Opt-Out for Unions - Empower	All	S
iDirect	IHBC-R1056	Federal MHP Opt-Out for Unions - PriAcc	All	S
iDirect	IHBC-R1056	Federal MHP Opt-Out for Unions - CP 1	1500	S
iDirect	IHBC-R1056	Federal MHP Opt-Out for Unions - CP 2	2000	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 1 Series B	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 1 Seriec C	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 2 Series	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 3 Series	All	S
iDirect	IHBC-R1005	Federal MHP Riderfor Small Groups - 20% - 4 Series	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 20% - 5 Series	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - Evolve	All	S
iDirect	IHBC-R1057	Federal MHP Rider for Small Groups - Empower	All	S
iDirect	IHBC-R1057	Federal MHP Rider for Small Groups - PCiP	All	S
iDirect	IHBC-R1061	Federal MHP Rider for Small Groups - CMP 1	1500	S
iDirect	IHBC-R1061	Federal MHP Rider for Small Groups - CMP 2	2000	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 1 Series B	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 1 Series C	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 2 Series	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 3 series	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 20% - 4 Series	All	S

Other Riders

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 20% - 5 Series	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - Evolve	All	S
iDirect	IHBC-A1047	Federal MHP Benefit for Small Groups that Qualify - Empower	All	S
iDirect	IHBC-A1047	Federal MHP Benefit for Small Groups that Qualify - PriAcc	All	S
iDirect	IHBC-A1049	Federal MHP Benefit for Small Groups that Qualify - CP 1	1500	S
iDirect	IHBC-A1049	Federal MHP Benefit for Small Groups that Qualify - CP 2	2000	S
iDirect	IHBC-R1001	$15 OV - 5 Series	1500	S
iDirect	IHBC-R1001	$15 OV - 5 Series	3000	S
iDirect	IHBC-R1001	$15 OV - 5 Series	5000	S
iDirect	IHBC-R1013	IP Rehab for Substance Abuse - 5 Series	All	S
iDirect	IHBC-R1013	IP Rehab for Substance Abuse - Cal Year - 5 Series	All	S
iDirect	IHBC-R1021	$0 Child OV - Evolve	1500	S
iDirect	IHBC-R1021	$0 Child OV - Empower Opt 4	1500 / 2500	S
iDirect	IHBC-R1021	$0 Child OV - Empower Opt 6	2500 / 3500	S
iDirect	IHBC-R1020	FitWorks with Incentive	All	S
iDirect	IHBC-R1022	FitWorks without Incentive - 1-5 Series	All	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	1500	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	2000	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	2500	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	3000	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	4000	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	5000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	1500	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	2000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	2500	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	3000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	4000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	5000	S
iDirect	IHBC-HSAQR-674E	Small Group Domestic Partner Rider	All	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	1500	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	2000	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	2500	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	3000	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	4000	S
iDirect	IHBC-HSAQR-665E	$0 IP Copay - 1 Series B	5000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	1500	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	2000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	2500	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	3000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	4000	S
iDirect	IHBC-HSAQR-666C	$250 IP Copay - 1 Series C	5000	S
iDirect	IHBC-HSAQR-668E	IP Rehabilitation for Substance Abuse - Contract Year - 1 Series	All	S
iDirect	IHBC-HSAQR-668E	IP Rehabilitation for Substance Abuse - Calendar Year - 1 Series	All	S
iDirect	IHBC-HSAQR-602P	IP Rehabilitation for Substance Abuse - Contract Year - 2 Series, Evolve	All	S
iDirect	IHBC-HSAQR-602P	IP Rehabilitation for Substance Abuse - Calendar Year - 2 Series, Evolve	All	S
iDirect	IHBC-R1058	IP Rehabilitation for Substance Abuse - Contract Year - Empower	All	S
iDirect	IHBC-R1058	IP Rehabilitation for Substance Abuse - Calendar Year - Empower	All	S
iDirect	IHBC-HSAQR-669E	Right to Life - All	All	S
iDirect	IHBC-HSAQR-670E	Sterilization Exclusion - All	All	S
iDirect	IHBC-HSAQR-675E	EyeMed Premier Vision - All	All	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	1500	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	2000	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	2500	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	3000	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	4000	S
iDirect	IHBC-HSAQR-673C	OV $20 Copay - 1 Series C	5000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	1500	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	2000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	2500	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	3000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	4000	S
iDirect	IHBC-HSAQR-673C	OV $25 Copay - 1 Series C	5000	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - 1 Series	All	S
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - 2 Series, Evolve	All	S

Other Riders

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-HSAQR-676E	Skilled Nursing Facility - Unlimited Benefit - Empower	All	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series B	5000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV - 1 Series C	5000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $20 OV - 1 Series C	5000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	1500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	2000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	2500	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	3000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	4000	S
iDirect	IHBC-HSAQR-677E	$0 Child OV & $25 OV - 1 Series C	5000	S
iDirect	IHBC-R-014	Small Group Mental Health - 1 Series B	All	S
iDirect	IHBC-R-014	Small Group Mental Health - 1 Series C	All	S
iDirect	IHBC-R-014	Small Group Mental Health - 2 Series	All	S
iDirect	IHBC-R-014	Small Group Mental Health - Evolve	All	S
iDirect	IHBC-R1028	NYS Mental Health Rider - Small Groups - Empower	All	S
iDirect	IHBC-R-017	personalBest Fitness - 1, 2 Series	All	S
iDirect	IHBC-R-036	PT/OT/ST Increase visit limits to 30 - All	All	S
iDirect	IHBC-R-036	PT/OT/ST Increase visit limits to 45 - All	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 1 Series B	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 1 Series C	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - 2 Series	All	S
iDirect	IHBC-R1002	Federal MHP Opt-Out for Unions - Evolve	All	S
iDirect	IHBC-R1056	Federal MHP Opt-Out for Unions - Empower	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 1 Series B	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 1 Series C	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - 2 Series	All	S
iDirect	IHBC-R1005	Federal MHP Rider for Small Groups - Evolve	All	S
iDirect	IHBC-R1057	Federal MHP Rider for Small Groups - Empower	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 1 Series B	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 1 Series C	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - 2 Series	All	S
iDirect	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify - Evolve	All	S
iDirect	IHBC-A1047	Federal MHP Benefit for Small Groups that Qualify - Empower	All	S
iDirect	IHBC-R1021	$0 Child OV - Evolve	1500	S
iDirect	IHBC-R1021	$0 Child OV with Evolve Option 3	1000	S
iDirect	IHBC-R1021	$0 Child OV - Empower Opt 5	1500 / 2500	S
iDirect	IHBC-R1021	$0 Child OV - Empower Opt 7	2500 / 3500	S
iDirect	IHBC-R1020	FitWorks with Incentive - 1-2 Series	All	S
iDirect	IHBC-R1022	FitWorks without Incentive - 1-2 Series	All	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	1500	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	2000	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	2500	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	3000	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	4000	S
iDirect	IHBC-R1024	$500 IP Copay - 1 Series C	5000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	1500	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	2000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	2500	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	3000	S

Other Riders

Plan	Form No.	Description	Notes	Size
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	4000	S
iDirect	IHBC-R1027	$25 / $40 Split OV Copay - 1 Series C	5000	S
iDirect	IHBC-R1033	$25 / $40 Split Office Visit No Deductible - Evolve Opt 1	1500	S
iDirect	IHBC-R1033	$25 / $40 Split Office Visit No Deductible - Evolve Opt 3	1000	S
iDirect	IHBC-R1038	$30 / $50 Split Office Visit No Deductible - Evolve Opt 1	1500	S
iDirect	IHBC-R1038	$30 / $50 Split Office Visit No Deductible - Evolve Opt 3	1000	S
iDirect	IHBC-R1038	$30 / $50 Split Office Visit No Deductible - Empower Opt 5	1500 / 2500	S
iDirect	IHBC-R1038	$30 / $50 Split Office Visit No Deductible - Empower Opt 7	2500 / 3500	S
iDirect	IHBC-HSAQR-674E	Small Group Domestic Partner Rider	All	S
Passport Plan Select Out of Area	5220103-43	Inpatient Rehabilitation for Substance Abuse - Contract Year	All	S
Passport Plan Select Out of Area	5220103-43	IP Rehabilitation for Substance Abuse - Calendar Year	All	S
Passport Plan Select Out of Area	5260103-43	Eyemed Premier Vision Rider	All	S
Passport Plan Select Out of Area	5300103-43	Unlimited Skilled Nursing Facility	All	S
Passport Plan Select Out of Area	IHBC-R-014	Mental Health Rider - Small Groups	All	S
Passport Plan Select Out of Area	IHBC-POSR-037	Right to Life	All	S
Passport Plan Select Out of Area	IHBC-POSR-038	Sterilization Exclusion	All	S
Passport Plan Select Out of Area	IHBC-R1002	Federal MHP Opt-Out for Unions	Option(s): 1-8, 11, 12	S
Passport Plan Select Out of Area	IHBC-R1005	Federal MHP Rider for Small Groups	All	S
Passport Plan Select Out of Area	IHBC-MHP-A-001	Federal MHP Benefit for Small Groups that Qualify	All	S
Passport Plan Select Out of Area	IHBC-R1028	Out of Area	Option(s): 7	S
Passport Plan Select Out of Area	IHBC-R1028	Out of Area	Option(s): 11	S
Passport Plan Select Out of Area	IHBC-R1028	Out of Area	Option(s): 12	S
Passport Plan Select Out of Area	IHBC-POSR-505	Small Group Domestic Partner Rider	All	S
iDirect Out of Area	IHBC-HSAQR-666C	$0 Inpatient Copay - 1 Series B	1500	S
iDirect Out of Area	IHBC-HSAQR-666C	$250 Inpatient Copay - 1 Series C	1500	S
iDirect Out of Area	IHBC-HSAQR-666C	$250 Inpatient Copay - 1 Series C	2000	S
iDirect Out of Area	IHBC-HSAQR-668E	Inpatient Rehab for Substance Abuse - 1 Series	All	S
iDirect Out of Area	IHBC-HSAQR-668E	IP Rehab for Substance Abuse - Cal Year - 1 Series	All	S
iDirect Out of Area	IHBC-HSAQR-669E	Right to Life - All Series	All	S
iDirect Out of Area	IHBC-HSAQR-670E	Sterilization Exclusion - All Series	All	S
iDirect Out of Area	IHBC-HSAQR-676E	Unlimited Skilled Nursing Facility - 1 Series	All	S
iDirect Out of Area	IHBC-R-014	Mental Health Rider - Small Groups - 1 Series B	All	S
iDirect Out of Area	IHBC-R-014	Mental Health Rider - Small Groups - 1 Series C	All	S
iDirect Out of Area	IHBC-R1002	Federal MHP Opt-Out for Unions - 1 Series B	All	S
iDirect Out of Area	IHBC-R1002	Federal MHP Opt-Out for Unions - 1 Series C	All	S
iDirect Out of Area	IHBC-R1005	Federal MHP Rider for Small Groups - 1 Series B	All	S
iDirect Out of Area	IHBC-R1005	Federal MHP Rider for Small Groups - 1 Series C	All	S
iDirect Out of Area	IHBC-MHP-A-001	Federal MHP Rider for Small Groups that Qualify - 1 Series B	All	S
iDirect Out of Area	IHBC-MHP-A-001	Federal MHP Rider for Small Groups that Qualify - 1 Series C	All	S
iDirect Out of Area	IHBC-R1028	Out of Area	1500	S
iDirect Out of Area	IHBC-R1028	Out of Area	1500	S
iDirect Out of Area	IHBC-R1028	Out of Area	2000	S
iDirect Out of Area	IHBC-HSAQR-674E	Small Group Domestic Partner Rider	All	S

Multiplier Riders

Plan	Form No.	Description	Notes	Size
EncPlus	IHBC-R1004	Age through 29 Make Available	Enc, Ess	S
EncPlus	IHBC-R1004	Age through 29 Make Available	FFS	S
Passport Plan Select	IHBC-R1004	Age through 29 Make Available	All	S
iDirect	IHBC-R1004	Age through 29 Make Available - All Series	All	S
Passport Plan Select Out of Area	IHBC-R1004	Age through 29 Make Available	All	S
iDirect Out of Area	IHBC-R1004	Age through 29 Make Available - All Series	All	S

Attachment E

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.

Attachment F

Standardized Premium Calculation
Rolling Rate Example

To calculate the standardized premium in Exhibit 7 for a rolling rate structure, the actual earned premium for each earned month for every combination of employer group and product is reduced back to a January level by removing the impact of the quarterly rolling rate trend,where applicable. This January premium is then adjusted to 2013 by applying the product rate changes implemented from the premium year to January 2013. The premium is then converted to a 4th quarter 2013 rate by applying the three 2013 quarterly rolling rate trends.

A1	2009 1Q single rate file & use rate	$	290.78
A2	2009 2Q single rate file & use rate	$	300.96
A3	2009 3Q single rate file & use rate	$	311.49
A4	2009 4Q single rate file & use rate	$	322.39
B1	Premium change (before benefit & conversion factor chg) (2009-2010)		12 55%
B2	Premium change (after benefit & conversion factor chg) (2009-2010)		8.13%
C1	2010 1Q single rate file & use rate	$	314.43
C2	2010 2Q single rate file & use rate	$	323.86
C3	2010 3Q single rate file & use rate	$	333.57
C4	2010 4Q single rate file & use rate	$	352.40
D1	Premium change (before benefit & conversion factor chg) (2010-2011)		13 38%
D2	Premium change (after benefit & conversion factor chg) (2010-2011)		14.11%
E1	2011 1Q single rate file & use rate	$	362.86
E2	2011 2Q single rate file & use rate	$	373.75
E3	2011 3Q single rate file & use rate	$	384.97
E4	2011 4Q single rate file & use rate	$	396.50
F1	Premium change (before benefit & conversion factor chg) (2011-2012)		8 90%
F2	Premium change (after benefit & conversion factor chg) (2011-2012)		8 90%
G1	2012 1Q single rate file & use rate	$	390.74
G2	2012 2Q single rate file & use rate	$	400.52
G3	2012 3Q single rate file & use rate	$	410.52
G4	2012 4Q single rate file & use rate	$	420.78
H1	Premium change (before benefit & conversion factor chg) (2012-2013)		3 82%
H2	Premium change (after benefit & conversion factor chg) (2012-2013)		3 82%
I1	2009 Quarterly Premium Trend		3 50%
I2	2010 Quarterly Premium Trend		3 00%
I3	2011 Quarterly Premium Trend		2 50%
I4	2012 Quarterly Premium Trend		2 50%
I5	2013 Quarterly Premium Trend		1.75%

	Group	Single Contracts	Renewal Month	2012 Annualized Actual Earned Premiums
J1	A- 1Q renewal group renew January	1	January	$ 4,688 88
J2	B- 2Q renewal group renew April	1	April	$ 4,725 93
J3	C- 3Q renewal group renew July	1	July	$ 4,772 94
J4	D- 4Q renewal group renew October	1	October	$ 4,830 84

Step 1 Calculate 2011 and 2012 January Single Premium Rate

		2011 Contract Premium	2011 Premium Rate Paid in 2012	2011 Premium Rate Paid in 2012 Adjusted to 1Q11 Level
K1	Group A	=N/A	N/A	N/A
K2	Group B	=E2/(1+I3)	$ 373.75	$ 364 63
K3	Group C	=E3/((1+I3)^2)	$ 384.97	$ 366.42
K4	Group D	=E4/((1+I3)^3)	$ 396.50	$ 368.19

		2012 Contract Premium	2012 Premium Rate Paid in 2012	2012 Premium Rate Paid in 2012 Adjusted to 1Q12 Level
L1	Group A	=G1	$ 390.74	$ 390.74
L2	Group B	=G2/(1+I4)	$ 400.52	$ 390.75
L3	Group C	=G3/((1+I4)^2)	$ 410.52	$ 390.74
L4	Group D	=G4/((1+I4)^3)	$ 420.78	$ 390.74

Standardized Premium Calculation
Non-Rolling Rate Example

Premium rates for non-rolling rate products are annual. The standardized premium in Exhibit 7 is calculated by trending the member's premium for each year to 2013 using the annual rate increase for each year.

2009 1Q single rate file & use rate	$	215 63
2009 2Q single rate file & use rate	$	215 63
2009 3Q single rate file & use rate	$	215 63
2009 4Q single rate file & use rate	$	215 63
Premium change (before benefit & conversion factor chg) (2009-2010)		-9 52%
Premium change (after benefit & conversion factor chg) (2009-2010)		-9 52%
2010 1Q single rate file & use rate	$	195.11
2010 2Q single rate file & use rate	$	195.11
2010 3Q single rate file & use rate	$	195.11
2010 4Q single rate file & use rate	$	195.11
Premium change (before benefit & conversion factor chg) (2010-2011)		-2 87%
Premium change (after benefit & conversion factor chg) (2010-2011)		-2 87%
2011 1Q single rate file & use rate	$	189 51
2011 2Q single rate file & use rate	$	189 51
2011 3Q single rate file & use rate	$	189 51
2011 4Q single rate file & use rate	$	189 51
Premium change (before benefit & conversion factor chg) (2011-2012)		15 00%
Premium change (after benefit & conversion factor chg) (2011-2012)		15 00%
2012 1Q single rate file & use rate	$	220.74
2012 2Q single rate file & use rate	$	220.74
2012 3Q single rate file & use rate	$	220.74
2012 4Q single rate file & use rate	$	220.74
Premium change (before benefit & conversion factor chg) (2012-2013)		12.47%
Premium change (after benefit & conversion factor chg) (2012-2013)		12.47%
2009 Quarterly Premium Trend		0 00%
2010 Quarterly Premium Trend		0 00%
2011 Quarterly Premium Trend		0 00%
2012 Quarterly Premium Trend		0 00%
2013 Quarterly Premium Trend		0 00%

Group	Single Contracts	Renewal Month	2011 Annualized Actual Earned Premiums
A- 1Q renewal group renew January	1	January	$ 2,648.88
B- 2Q renewal group renew April	1	April	N/A*
C- 3Q renewal group renew July	1	July	N/A*
D- 4Q renewal group renew October	1	October	N/A*

Step 1 Calculate 2011 and 2012 January Single Premium Rate

	2011 Contract Premium	2011 Premium Rate Paid in 2012	2011 Premium Rate Paid in 2012 Adjusted to 1Q11 Level
Group A	=N/A	N/A	N/A
Group B	=E2/(1+I4)	N/A*	N/A*
Group C	=E3/((1+I3)^2)	N/A*	N/A*
Group D	=E4/((1+I3)^3)	N/A*	N/A*

	2012 Contract Premium	2012 Premium Rate Paid in 2012	2012 Premium Rate Paid in 2012 Adjusted to 1Q12 Level
Group A	=G1	$ 220.74	$ 220.74
Group B	=G2/(1+I4)	N/A*	N/A*
Group C	=G3/((1+I4)^2)	N/A*	N/A*
Group D	=G4/((1+I4)^3)	N/A*	N/A*

Step 2 Calculate the total of 2011/2012 contract premiums from Step1

		2011 Contract Total Premium	# of months in 2012 at 2011 premium rate	Total Premium Paid prior to 2012 renewal adjusted to 1Q 2011 Level
M1	Group A	=N/A	0	N/A
M2	Group B	=K2 * 3	3	$ 1,093 90
M3	Group C	=K3 * 6	6	$ 2,198 52
M4	Group D	=K4 * 9	9	$ 3,313.71

		2012 Contract Total Premium	# of months in 2012 at 2012 premium rate	Total Premium Paid after 2012 renewal adjusted to 1Q 2012 Level
N1	Group A	=L1 * 12	12	$ 4,688 88
N2	Group B	=L2 * 9	9	$ 3,516.76
N3	Group C	=L3 * 6	6	$ 2,344.43
N4	Group D	=L4 * 3	3	$ 1,172 21

Step 3 Calculate the Standardized Premium (2013 1Q) Single Premium

		2012 Premium Adjusted to 1Q 2013 Level	Annual Premium adjusted to 1Q 2013 level
O1	Group A	=(M1*(1+F1) +N1)*(1+H1)	$ 4,868 04
O2	Group B	=(M2*(1+F1) +N2)*(1+H1)	$ 4,887 93
O3	Group C	=(M3*(1+F1) +N3)*(1+H1)	$ 4,919.73
O4	Group D	=(M4*(1+F1) +N4)*(1+H1)	$ 4 963 57

Step 4 % change from 2012 Calculate the Standardized Premium (2013 4Q)

		Adjusts 1Q 2013 to 4Q 2013 Level	Annual Premium adjusted to 4Q 2013 level	% Change from Earned Premium
P1	Group A	=O1*((1+I5)^3)	$5,128.11	9 37%
P2	Group B	=O2*((1+I5)^3)	$5,149.07	8 95%
P3	Group C	=O3*((1+I5)^3)	$5,182.56	8 58%
P4	Group D	=O4*((1+I5)^3)	$5,228.75	8 24%

Step 2 Calculate the total of 2011/2012 contract premiums from Step1

	2011 Contract Total Premium	# of months in 2012 at 2011 premium rate	Total Premium Paid prior to 2012 renewal adjusted to 1Q 2011 Level
Group A	=N/A	0	N/A
Group B	=K2 * 3	3	N/A*
Group C	=K3 * 6	6	N/A*
Group D	=K4 * 9	9	N/A*

	2012 Contract Total Premium	# of months in 2012 at 2012 premium rate	Total Premium Paid after 2012 renewal adjusted to 1Q 2012 Level
Group A	=L1 * 12	12	$ 2,648.88
Group B	=L2 * 9	9	N/A*
Group C	=L3 * 6	6	N/A*
Group D	=L4 * 3	3	N/A*

Step 3 Calculate the Standardized Premium (2013 1Q) Single Premium

	2012 Premium Adjusted to 1Q 2013 Level	Annual Premium adjusted to 1Q 2013 level
Group A	=(M1*(1+F1) +N1)*(1+H1)	$ 2,979.12
Group B	=(M2*(1+F1) +N2)*(1+H1)	N/A*
Group C	=(M3*(1+F1) +N3)*(1+H1)	N/A*
Group D	=(M4*(1+F1) +N4)*(1+H1)	N/A*

Step 4 % change from 2012 Calculate the Standardized Premium (2013 4Q)

	Adjusts 1Q 2013 to 4Q 2013 Level	Annual Premium adjusted to 4Q 2013 level	% Change from Earned Premium
Group A	=O1*((1+I5)^3)	########	12.47%
Group B	=O2*((1+I5)^3)	N/A*	N/A*
Group C	=O3*((1+I5)^3)	N/A*	N/A*
Group D	=O4*((1+I5)^3)	N/A*	N/A*

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code
Independent Health Benefits Corporation	Not-For-Profit - 43	Not-for-Profit	47034

Company mailing address: 511 Farber Lakes Drive, Buffalo NY 14221

B. Contact Person:

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

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address
[redacted]	[redacted]	[redacted]

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

New rate applicability period	New rate effective date	SERFF Tracking Number
1/1/2014 - 2/28/2015 (Rolling 1st Qtr) 4/1/2014 - 5/31/2015 (Rolling 2nd Qtr) 7/1/2014 - 8/31/2015 (Rolling 3rd Qtr) 10/1/2014 - 11/30/2015 (Rolling 4th Qtr)	1/1/2014 (1st Qtr) 4/1/2014 (2nd Qtr) 7/1/2014 (3rd Qtr) 10/1/2014 (4th Qtr)	NDPD-129001076

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

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	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 exh bit 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:	**Small Group**
Effective Date of Rate Change(s):	**1/1/2014**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

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

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$173,200,765	$323.67	100.00%
Incurred Claims in Experience Period	$152,118,017	284.27	87.83%
Allowed Claims:	$195,637,977	365.60	112.95%
Index Rate of Experience Period		$365.35	
Experience Period Member Months	535,110		

Section II: Allowed Claims, PMPM basis

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

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	61.96	$14,156.66	$73.10	1.000	1.072	1.066	1.021	64.60	$17,249.99	$92.86	0.00	$0.00	$0.00
Outpatient Hospital	Services	8,123.15	87.37	59.14	1.000	1.072	1.040	1.023	8,508.41	101.28	71.81	0.00	0.00	0.00
Professional	Services	12,751.58	95.75	101.74	1.000	1.072	1.037	1.024	13,379.15	110.37	123.06	0.00	0.00	0.00
Other Medical	Services	12,458.26	45.38	47.12	1.000	1.072	1.000	1.054	13,842.50	48.65	56.12	0.00	0.00	0.00
Capitation	Benefit Period	1.00	0.01	0.00	1.000	1.072	1.000	1.000	1.00	0.01	0.00	0.00	0.00	0.00
Prescription Drug	Prescriptions	10,768.97	94.16	84.50	1.000	1.072	1.077	1.032	11,476.69	117.02	111.92	0.00	0.00	0.00
Total				$365.60							$455.77			$0.00

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$455.77	$115,403,243
Paid to Allowed Average Factor in Projection Period			0.787	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$358.49	$90,770,810
Projected Risk Adjustments PMPM			5.99	1,517,310
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$352.50	$89,253,501
Projected ACA reinsurance recoveries, net of rein prem, PMPM				
Projected Incurred Claims			$352.50	$89,253,501
Administrative Expense Load		12.79%	53.64	13,580,865
Profit & Risk Load		0.21%	0.88	222,985
Taxes & Fees		2.94%	12.35	3,126,115
Single Risk Pool Gross Premium Avg. Rate, PMPM			$419.36	$106,183,466
Index Rate for Projection Period			$454.81	
% increase over Experience Period			29.56%	
% Increase, annualized:			13.83%	
Projected Member Months				253,205

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:	**Independent Health Benefits Corporation**	State:
HIOS Issuer ID:	**18029**	Market:
Effective Date of Rate Change(s):	**1/1/2014**	

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		Terminated Product	Platinum									
Product ID:		18029NY999	18029NY117									
Metal:		Catastrophic	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold
AV Metal Value		0.000	0.897	0.897	0.897	0.897	0.897	0.897	0.897	0.897	0.807
AV Pricing Value		0.000	0.990	0.999	0.994	0.990	0.995	0.999	0.994	0.995	0.847
Plan Type:		POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name		Terminated Products	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Platinum Plan C	Option 2 Gold Plan C
Plan ID (Standard Component ID):		18029NY9999999	18029NY1170017	18029NY1170019	18029NY1170020	18029NY1170021	18029NY1170024	18029NY1170027	18029NY1170029	18029NY1170030	18029NY1200017
Exchange Plan?		No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		0.00%	0.00%								
Historical Rate Increase - Calendar Year - 1		0.00%	0.00%								
Historical Rate Increase - Calendar Year 0		0.00%	0.00%								
Effective Date of Proposed Rates		1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)		0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %		0.00%	0.00%								

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

Plan ID (Standard Component ID):	Total	18029NY9999999	18029NY1170017	18029NY1170019	18029NY1170020	18029NY1170021	18029NY1170024	18029NY1170027	18029NY1170029	18029NY1170030	18029NY1200017
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$419.36	$323.67	$441.12	$445.01	$442.73	$441.12	$443.38	$445.01	$442.73	$443.38	$378.28
Projected Member Months	253,205	0	6,649	6,649	6,649	6,649	6,649	6,649	6,649	6,649	1,740

Section III: Experience Period Information

	Plan ID (Standard Component ID):	Total	18029NY9999999	18029NY1170017	18029NY1170019	18029NY1170020	18029NY1170021	18029NY1170024	18029NY1170027	18029NY1170029	18029NY1170030	18029NY1200017
remium Information	Average Rate PMPM	$323.67	$323.67	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	535,110	535,110	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$173,200,765	$173,200,765	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	99.93%	99.93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.07%	0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$195,637,977	$195,637,977	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	99.93%	99.93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.07%	0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation:	$43,519,960	$43,519,960	$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
	Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$152,118,017	$152,118,017	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Incurred Claims PMPM	$284.27	$284.27	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Allowed Claims PMPM	$365.60	$365.60	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	EHB portion of Allowed Claims, PMPM	$365.35	$365.35	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date)

	Plan ID (Standard Component ID):	Total	18029NY9999999	18029NY1170017	18029NY1170019	18029NY1170020	18029NY1170021	18029NY1170024	18029NY1170027	18029NY1170029	18029NY1170030	18029NY1200017
Premium Information	Average Rate PMPM	$419.36	$323.67	$441.12	$445.01	$442.73	$441.12	$443.38	$445.01	$442.73	$443.38	$378.28
	Member Months	253,205	-	6,649	6,649	6,649	6,649	6,649	6,649	6,649	6,649	1,740
	Total Premium (TP)	$106,183,466	$0	$2,932,831	$2,958,679	$2,943,572	$2,932,831	$2,947,882	$2,958,679	$2,943,572	$2,947,882	$658,381
	EHB basis or full portion of TP, [see instructions]	99.79%	0.00%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.21%	0.00%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%
	Other benefits portion of TP	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$113,886,732	$0	$2,807,317	$2,832,372	$2,817,729	$2,807,317	$2,821,906	$2,832,372	$2,817,729	$2,821,906	$691,083
	EHB basis or full portion of TAC, [see instructions]	99.79%	0.00%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.21%	0.00%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%
	Other benefits portion of TAC	0.00%	100.00%	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	$24,633,231	$0	$340,483	$343,521	$341,745	$340,483	$342,252	$343,521	$341,745	$342,252	$138,473
	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
	insured person, as %	0.00%	#DIV/0!	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	$89,253,501	$0	$2,466,834	$2,488,850	$2,475,983	$2,466,834	$2,479,654	$2,488,850	$2,475,983	$2,479,654	$552,610
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$1,517,310	$0	-$41,936	-$42,310	-$42,092	-$41,936	-$42,154	-$42,310	-$42,092	-$42,154	-$9,394
	Incurred Claims PMPM	$352.50	#DIV/0!	$371.03	$374.34	$372.41	$371.03	$372.96	$374.34	$372.41	$372.96	$317.50
	Allowed Claims PMPM	$449.78	#DIV/0!	$422.24	$426.01	$423.81	$422.24	$424.43	$426.01	$423.81	$424.43	$397.06
	EHB portion of Allowed Claims, PMPM	$448.82	#DIV/0!	$422.24	$424.17	$422.24	$422.24	$424.17	$424.17	$422.24	$424.17	$397.06

Product-Plan Data Collection

Company Legal Name: **NY**
HIOS Issuer ID: **Small Group**
Effective Date of Rate Change(s):

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product											
Product ID:											
Metal:	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
AV Metal Value	0.807	0.807	0.807	0.807	0.807	0.807	0.807	0.784	0.784	0.784	0.784
AV Pricing Value	0.855	0.850	0.847	0.852	0.855	0.850	0.852	0.824	0.832	0.828	0.824
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	Option 2 Gold Plan C	Option 2 Gold Plan C	Option 2 Gold Plan C	Option 2 Gold Plan C	Option 2 Gold Plan C	Option 2 Gold Plan C	Option 2 Gold Plan C	Option 3 Gold Plan D	Option 3 Gold Plan D	Option 3 Gold Plan D	Option 3 Gold Plan D
Plan ID (Standard Component ID):	18029NY1200019	18029NY1200020	18029NY1200021	18029NY1200024	18029NY1200027	18029NY1200029	18029NY1200030	18029NY1200049	18029NY1200051	18029NY1200052	18029NY1200053
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2											
Historical Rate Increase - Calendar Year - 1											
Historical Rate Increase - Calendar Year 0											
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %											

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1200019	18029NY1200020	18029NY1200021	18029NY1200024	18029NY1200027	18029NY1200029	18029NY1200030	18029NY1200049	18029NY1200051	18029NY1200052	18029NY1200053
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$381.60	$379.66	$378.28	$380.21	$381.60	$379.66	$380.21	$368.28	$371.52	$369.63	$368.28
Projected Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1200019	18029NY1200020	18029NY1200021	18029NY1200024	18029NY1200027	18029NY1200029	18029NY1200030	18029NY1200049	18029NY1200051	18029NY1200052	18029NY1200053
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

Company Legal Name: **NY**
HIOS Issuer ID: **Small Group**
Effective Date of Rate Change(s):

	Product/Plan Level Calculations											
Pl	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1200019	18029NY1200020	18029NY1200021	18029NY1200024	18029NY1200027	18029NY1200029	18029NY1200030	18029NY1200049	18029NY1200051	18029NY1200052	18029NY1200053
Premium Information	Average Rate PMPM	$381.60	$379.66	$378.28	$380.21	$381.60	$379.66	$380.21	$368.28	$371.52	$369.63	$368.28
	Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740
	Total Premium (TP)	$664,172	$660,787	$658,381	$661,753	$664,172	$660,787	$661,753	$640,991	$646,626	$643,332	$640,991
	EHB basis or full portion of TP, [see instructions]	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%
	Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$697,250	$693,646	$691,083	$694,674	$697,250	$693,646	$694,674	$691,335	$697,505	$693,899	$691,335
	EHB basis or full portion of TAC, [see instructions]	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%
	Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	$139,709	$138,987	$138,473	$139,193	$139,709	$138,987	$139,193	$153,537	$154,907	$154,106	$153,537
	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
	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%
	Total Incurred claims, payable with issuer funds	$557,542	$554,659	$552,610	$555,482	$557,542	$554,659	$555,482	$537,798	$542,597	$539,792	$537,798
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$9,478	-$9,429	-$9,394	-$9,443	-$9,478	-$9,429	-$9,443	-$9,143	-$9,224	-$9,176	-$9,143

	Incurred Claims PMPM	$320.34	$318.68	$317.50	$319.15	$320.34	$318.68	$319.15	$308.99	$311.75	$310.14	$308.99
	Allowed Claims PMPM	$400.61	$398.54	$397.06	$399.13	$400.61	$398.54	$399.13	$397.21	$400.75	$398.68	$397.21
	EHB portion of Allowed Claims, PMPM	$398.88	$397.06	$397.06	$398.88	$398.88	$397.06	$398.88	$397.21	$399.02	$397.21	$397.21

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	Gold										
Product ID:	18029NY120										
Metal:	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
AV Metal Value	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784
AV Pricing Value	0.829	0.832	0.828	0.829	0.794	0.801	0.797	0.794	0.798	0.801	0.797
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	Option 3 Gold Plan D	Option 3 Gold Plan D	Option 3 Gold Plan D	Option 3 Gold Plan D	Choice Plus Gold Plan G	Choice Plus Gold Plan G	Choice Plus Gold Plan G	Choice Plus Gold Plan G	Choice Plus Gold Plan G	Choice Plus Gold Plan G	Choice Plus Gold Plan G
Plan ID (Standard Component ID):	18029NY1200056	18029NY1200059	18029NY1200061	18029NY1200062	18029NY1200065	18029NY1200067	18029NY1200068	18029NY1200069	18029NY1200072	18029NY1200075	18029NY1200077
Exchange Plan?	No	No	No	No	No	No	No	No	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	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%										

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1200056	18029NY1200059	18029NY1200061	18029NY1200062	18029NY1200065	18029NY1200067	18029NY1200068	18029NY1200069	18029NY1200072	18029NY1200075	18029NY1200077
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$370.17	$371.52	$369.63	$370.17	$354.79	$357.91	$356.09	$354.79	$356.61	$357.91	$356.09
Projected Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1200056	18029NY1200059	18029NY1200061	18029NY1200062	18029NY1200065	18029NY1200067	18029NY1200068	18029NY1200069	18029NY1200072	18029NY1200075	18029NY1200077
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1200056	18029NY1200059	18029NY1200061	18029NY1200062	18029NY1200065	18029NY1200067	18029NY1200068	18029NY1200069	18029NY1200072	18029NY1200075	18029NY1200077
Premium Information	Average Rate PMPM	$370.17	$371.52	$369.63	$370.17	$354.79	$357.91	$356.09	$354.79	$356.61	$357.91	$356.09
	Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740
	Total Premium (TP)	$644,272	$646,626	$643,332	$644,272	$617,508	$622,934	$619,763	$617,508	$620,668	$622,934	$619,763
	EHB basis or full portion of TP, [see instructions]	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%
	state mandated benefits portion of TP that are other than EHB	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%
	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%
Claims Information	Total Allowed Claims (TAC)	$694,927	$697,505	$693,899	$694,927	$667,725	$673,685	$670,202	$667,725	$671,195	$673,685	$670,202
	EHB basis or full portion of TAC, [see instructions]	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%
	state mandated benefits portion of TAC that are other than EHB	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%
	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%
	Allowed Claims which are not the issuer's obligation	$154,335	$154,907	$154,106	$154,335	$149,928	$151,266	$150,484	$149,928	$150,707	$151,266	$150,484
	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
	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%
	Total Incurred claims, payable with issuer funds	$540,592	$542,597	$539,792	$540,592	$517,797	$522,418	$519,717	$517,797	$520,488	$522,418	$519,717
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$9,190	-$9,224	-$9,176	-$9,190	-$8,803	-$8,881	-$8,835	-$8,803	-$8,848	-$8,881	-$8,835

	Incurred Claims PMPM	$310.60	$311.75	$310.14	$310.60	$297.50	$300.16	$298.61	$297.50	$299.05	$300.16	$298.61
	Allowed Claims PMPM	$399.27	$400.75	$398.68	$399.27	$383.64	$387.07	$385.07	$383.64	$385.64	$387.07	$385.07
	EHB portion of Allowed Claims, PMPM	$399.02	$399.02	$397.21	$399.02	$383.64	$385.39	$383.64	$383.64	$385.39	$385.39	$383.64

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											
Product ID:											
Metal:	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
AV Metal Value	0.784	0.781	0.781	0.781	0.781	0.781	0.781	0.781	0.781	0.784	0.784
AV Pricing Value	0.798	0.803	0.811	0.806	0.803	0.808	0.811	0.806	0.808	0.919	0.927
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	PPO	PPO
Plan Name	Choice Plus Gold Plan G	Prime Access	Prime Access	Prime Access	Prime Access	Prime Access	Prime Access	Prime Access	Prime Access	IHPA Gold Plan E	IHPA Gold Plan E
Plan ID (Standard Component ID):	18029NY1200078	18029NY1200097	18029NY1200099	18029NY1200100	18029NY1200101	18029NY1200104	18029NY1200107	18029NY1200109	18029NY1200110	18029NY1210001	18029NY1210003
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2											
Historical Rate Increase - Calendar Year - 1											
Historical Rate Increase - Calendar Year 0											
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %											

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1200078	18029NY1200097	18029NY1200099	18029NY1200100	18029NY1200101	18029NY1200104	18029NY1200107	18029NY1200109	18029NY1200110	18029NY1210001	18029NY1210003
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$356.61	$359.02	$362.17	$360.33	$359.02	$360.85	$362.17	$360.33	$360.85	$409.95	$413.56
Projected Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1200078	18029NY1200097	18029NY1200099	18029NY1200100	18029NY1200101	18029NY1200104	18029NY1200107	18029NY1200109	18029NY1200110	18029NY1210001	18029NY1210003
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1200078	18029NY1200097	18029NY1200099	18029NY1200100	18029NY1200101	18029NY1200104	18029NY1200107	18029NY1200109	18029NY1200110	18029NY1210001	18029NY1210003
Premium Information	Average Rate PMPM	$356.61	$359.02	$362.17	$360.33	$359.02	$360.85	$362.17	$360.33	$360.85	$409.95	$413.56
	Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740
	Total Premium (TP)	$620,668	$624,859	$630,351	$627,141	$624,859	$628,057	$630,351	$627,141	$628,057	$713,511	$719,794
	EHB basis or full portion of TP, [see instructions]	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%
	state mandated benefits portion of TP that are other than EHB	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%
	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%
Claims Information	Total Allowed Claims (TAC)	$671,195	$675,992	$682,025	$678,499	$675,992	$679,505	$682,025	$678,499	$679,505	$758,756	$765,527
	EHB basis or full portion of TAC, [see instructions]	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%
	state mandated benefits portion of TAC that are other than EHB	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%
	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%
	Allowed Claims which are not the issuer's obligation	$150,707	$151,934	$153,290	$152,497	$151,934	$152,723	$153,290	$152,497	$152,723	$159,190	$160,611
	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
	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%
	Total Incurred claims, payable with issuer funds	$520,488	$524,058	$528,735	$526,002	$524,058	$526,782	$528,735	$526,002	$526,782	$599,566	$604,917
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$8,848	-$8,909	-$8,988	-$8,942	-$8,909	-$8,955	-$8,988	-$8,942	-$8,955	-$10,193	-$10,284

	Incurred Claims PMPM	$299.05	$301.10	$303.79	$302.22	$301.10	$302.66	$303.79	$302.22	$302.66	$344.48	$347.56
	Allowed Claims PMPM	$385.64	$388.39	$391.86	$389.83	$388.39	$390.41	$391.86	$389.83	$390.41	$435.95	$439.84
	EHB portion of Allowed Claims, PMPM	$385.39	$388.39	$390.16	$388.39	$388.39	$390.16	$390.16	$388.39	$390.16	$435.95	$437.96

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	Gold										
Product ID:	18029NY121										
Metal:	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
AV Metal Value	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784	0.784
AV Pricing Value	0.923	0.919	0.924	0.927	0.923	0.924	1.803	1.820	1.810	1.803	1.813
Plan Type:	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name	IHPA Gold Plan E	IHPA Gold Plan E	IHPA Gold Plan E	IHPA Gold Plan E	IHPA Gold Plan E	IHPA Gold Plan E	First Health	First Health	First Health	First Health	First Health
Plan ID (Standard Component ID):	18029NY1210004	18029NY1210005	18029NY1210008	18029NY1210011	18029NY1210013	18029NY1210014	18029NY1210057	18029NY1210058	18029NY1210059	18029NY1210060	18029NY1210061
Exchange Plan?	No	No	No	No	No	No	No	No	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	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%										

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1210004	18029NY1210005	18029NY1210008	18029NY1210011	18029NY1210013	18029NY1210014	18029NY1210057	18029NY1210058	18029NY1210059	18029NY1210060	18029NY1210061
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$411.45	$409.95	$412.05	$413.56	$411.45	$412.05	$799.05	$806.13	$801.99	$799.05	$803.17
Projected Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1210004	18029NY1210005	18029NY1210008	18029NY1210011	18029NY1210013	18029NY1210014	18029NY1210057	18029NY1210058	18029NY1210059	18029NY1210060	18029NY1210061
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1210004	18029NY1210005	18029NY1210008	18029NY1210011	18029NY1210013	18029NY1210014	18029NY1210057	18029NY1210058	18029NY1210059	18029NY1210060	18029NY1210061
Premium Information	Average Rate PMPM	$411.45	$409.95	$412.05	$413.56	$411.45	$412.05	$799.05	$806.13	$801.99	$799.05	$803.17
	Member Months	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740	1,740
	Total Premium (TP)	$716,122	$713,511	$717,170	$719,794	$716,122	$717,170	$1,390,725	$1,403,051	$1,395,847	$1,390,725	$1,397,902
	EHB basis or full portion of TP, [see instructions]	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.60%	99.63%	100.00%	99.97%
	state mandated benefits portion of TP that are other than EHB	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.40%	0.37%	0.00%	0.03%
	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%
Claims Information	Total Allowed Claims (TAC)	$761,570	$758,756	$762,699	$765,527	$761,570	$762,699	$1,390,400	$1,402,809	$1,395,557	$1,390,400	$1,397,626
	EHB basis or full portion of TAC, [see instructions]	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.60%	99.63%	100.00%	99.97%
	state mandated benefits portion of TAC that are other than EHB	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.40%	0.37%	0.00%	0.03%
	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%
	Allowed Claims which are not the issuer's obligation	$159,780	$159,190	$160,017	$160,611	$159,780	$160,017	$214,031	$215,942	$214,825	$214,031	$215,144
	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
	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%
	Total Incurred claims, payable with issuer funds	$601,789	$599,566	$602,682	$604,917	$601,789	$602,682	$1,176,369	$1,186,867	$1,180,731	$1,176,369	$1,182,482
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$10,230	-$10,193	-$10,246	-$10,284	-$10,230	-$10,246	-$19,998	-$20,177	-$20,072	-$19,998	-$20,102

	Incurred Claims PMPM	$345.76	$344.48	$346.27	$347.56	$345.76	$346.27	$675.89	$681.92	$678.39	$675.89	$679.40
	Allowed Claims PMPM	$437.56	$435.95	$438.21	$439.84	$437.56	$438.21	$798.86	$805.99	$801.82	$798.86	$803.01
	EHB portion of Allowed Claims, PMPM	$435.95	$435.95	$437.96	$437.96	$435.95	$437.96	$798.86	$802.76	$798.86	$798.86	$802.76

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											
Product ID:											
Metal:	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
AV Metal Value	0.784	0.784	0.784	0.697	0.697	0.697	0.697	0.697	0.697	0.697	0.697
AV Pricing Value	1.820	1.810	1.813	0.715	0.722	0.718	0.715	0.719	0.722	0.718	0.719
Plan Type:	PPO	PPO	PPO	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	First Health	First Health	First Health	Option 2 Silver Plan C	Option 2 Silver Plan C	Option 2 Silver Plan C	Option 2 Silver Plan C	Option 2 Silver Plan C	Option 2 Silver Plan C	Option 2 Silver Plan C	Option 2 Silver Plan C
Plan ID (Standard Component ID):	18029NY1210062	18029NY1210063	18029NY1210064	18029NY1240033	18029NY1240035	18029NY1240036	18029NY1240037	18029NY1240040	18029NY1240043	18029NY1240045	18029NY1240046
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2											
Historical Rate Increase - Calendar Year - 1											
Historical Rate Increase - Calendar Year 0											
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %											

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1210062	18029NY1210063	18029NY1210064	18029NY1240033	18029NY1240035	18029NY1240036	18029NY1240037	18029NY1240040	18029NY1240043	18029NY1240045	18029NY1240046
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$806.13	$801.99	$803.17	$320.23	$323.04	$321.40	$320.23	$321.86	$323.04	$321.40	$321.86
Projected Member Months	1,740	1,740	1,740	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1210062	18029NY1210063	18029NY1210064	18029NY1240033	18029NY1240035	18029NY1240036	18029NY1240037	18029NY1240040	18029NY1240043	18029NY1240045	18029NY1240046
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pl	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1210062	18029NY1210063	18029NY1210064	18029NY1240033	18029NY1240035	18029NY1240036	18029NY1240037	18029NY1240040	18029NY1240043	18029NY1240045	18029NY1240046
Premium Information	Average Rate PMPM	$806.13	$801.99	$803.17	$320.23	$323.04	$321.40	$320.23	$321.86	$323.04	$321.40	$321.86
	Member Months	1,740	1,740	1,740	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899
	Total Premium (TP)	$1,403,051	$1,395,847	$1,397,902	$608,120	$613,454	$610,337	$608,120	$611,226	$613,454	$610,337	$611,226
	EHB basis or full portion of TP, [see instructions]	99.60%	99.63%	99.97%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%
	state mandated benefits portion of TP that are other than EHB	0.40%	0.37%	0.03%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%
	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%
Claims Information	Total Allowed Claims (TAC)	$1,402,809	$1,395,557	$1,397,626	$720,247	$726,675	$722,918	$720,247	$723,990	$726,675	$722,918	$723,990
	EHB basis or full portion of TAC, [see instructions]	99.60%	99.63%	99.97%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%
	state mandated benefits portion of TAC that are other than EHB	0.40%	0.37%	0.03%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%
	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%
	Allowed Claims which are not the issuer's obligation	$215,942	$214,825	$215,144	$211,189	$213,073	$211,972	$211,189	$212,286	$213,073	$211,972	$212,286
	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
	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%
	Total Incurred claims, payable with issuer funds	$1,186,867	$1,180,731	$1,182,482	$509,058	$513,601	$510,946	$509,058	$511,703	$513,601	$510,946	$511,703
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$20,177	-$20,072	-$20,102	-$8,654	-$8,731	-$8,686	-$8,654	-$8,699	-$8,731	-$8,686	-$8,699

	Incurred Claims PMPM	$681.92	$678.39	$679.40	$268.06	$270.46	$269.06	$268.06	$269.46	$270.46	$269.06	$269.46
	Allowed Claims PMPM	$805.99	$801.82	$803.01	$379.27	$382.66	$380.68	$379.27	$381.24	$382.66	$380.68	$381.24
	EHB portion of Allowed Claims, PMPM	$802.76	$798.86	$802.76	$379.27	$381.01	$379.27	$379.27	$381.01	$381.01	$379.27	$381.01

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	Silver										
Product ID:	18029NY124										
Metal:	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
AV Metal Value	0.699	0.699	0.699	0.699	0.699	0.699	0.699	0.699	0.700	0.700	0.700
AV Pricing Value	0.708	0.714	0.711	0.708	0.712	0.714	0.711	0.712	0.721	0.727	0.724
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Prime Acess	Prime Acess	Prime Acess
Plan ID (Standard Component ID):	18029NY1240049	18029NY1240051	18029NY1240052	18029NY1240053	18029NY1240056	18029NY1240059	18029NY1240061	18029NY1240062	18029NY1240081	18029NY1240083	18029NY1240084
Exchange Plan?	No	No	No	No	No	No	No	No	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	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%										

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1240049	18029NY1240051	18029NY1240052	18029NY1240053	18029NY1240056	18029NY1240059	18029NY1240061	18029NY1240062	18029NY1240081	18029NY1240083	18029NY1240084
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$316.88	$319.66	$318.04	$316.88	$318.50	$319.66	$318.04	$318.50	$322.69	$325.52	$323.87
Projected Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1240049	18029NY1240051	18029NY1240052	18029NY1240053	18029NY1240056	18029NY1240059	18029NY1240061	18029NY1240062	18029NY1240081	18029NY1240083	18029NY1240084
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1240049	18029NY1240051	18029NY1240052	18029NY1240053	18029NY1240056	18029NY1240059	18029NY1240061	18029NY1240062	18029NY1240081	18029NY1240083	18029NY1240084
Premium Information	Average Rate PMPM	$316.88	$319.66	$318.04	$316.88	$318.50	$319.66	$318.04	$318.50	$322.69	$325.52	$323.87
	Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899
	Total Premium (TP)	$601,762	$607,040	$603,955	$601,762	$604,835	$607,040	$603,955	$604,835	$612,800	$618,176	$615,034
	EHB basis or full portion of TP, [see instructions]	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%
	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%
Claims Information	Total Allowed Claims (TAC)	$695,418	$701,624	$697,997	$695,418	$699,032	$701,624	$697,997	$699,032	$703,971	$710,253	$706,581
	EHB basis or full portion of TAC, [see instructions]	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%
	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%
	Allowed Claims which are not the issuer's obligation	$191,775	$193,486	$192,486	$191,775	$192,771	$193,486	$192,486	$192,771	$190,926	$192,630	$191,635
	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
	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%
	Total Incurred claims, payable with issuer funds	$503,643	$508,138	$505,511	$503,643	$506,260	$508,138	$505,511	$506,260	$513,044	$517,623	$514,947
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$8,562	-$8,638	-$8,594	-$8,562	-$8,606	-$8,638	-$8,594	-$8,606	-$8,722	-$8,800	-$8,754

	Incurred Claims PMPM	$265.21	$267.58	$266.20	$265.21	$266.59	$267.58	$266.20	$266.59	$270.16	$272.57	$271.16
	Allowed Claims PMPM	$366.20	$369.47	$367.56	$366.20	$368.10	$369.47	$367.56	$368.10	$370.70	$374.01	$372.08
	EHB portion of Allowed Claims, PMPM	$366.20	$367.86	$366.20	$366.20	$367.86	$367.86	$366.20	$367.86	$370.70	$372.39	$370.70

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											
Product ID:											
Metal:	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
AV Metal Value	0.700	0.700	0.700	0.700	0.700	0.704	0.704	0.704	0.704	0.704	0.704
AV Pricing Value	0.721	0.725	0.727	0.724	0.725	0.746	0.753	0.749	0.746	0.750	0.753
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	Prime Acess	Prime Acess	Prime Acess	Prime Acess	Prime Acess	Option 13 Silver Plan I	Option 13 Silver Plan I	Option 13 Silver Plan I	Option 13 Silver Plan I	Option 13 Silver Plan I	Option 13 Silver Plan I
Plan ID (Standard Component ID):	18029NY1240085	18029NY1240088	18029NY1240091	18029NY1240093	18029NY1240094	18029NY1240113	18029NY1240115	18029NY1240116	18029NY1240117	18029NY1240120	18029NY1240123
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2											
Historical Rate Increase - Calendar Year - 1											
Historical Rate Increase - Calendar Year 0											
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %											

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1240085	18029NY1240088	18029NY1240091	18029NY1240093	18029NY1240094	18029NY1240113	18029NY1240115	18029NY1240116	18029NY1240117	18029NY1240120	18029NY1240123
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$322.69	$324.34	$325.52	$323.87	$324.34	$333.81	$336.74	$335.03	$333.81	$335.52	$336.74
Projected Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1240085	18029NY1240088	18029NY1240091	18029NY1240093	18029NY1240094	18029NY1240113	18029NY1240115	18029NY1240116	18029NY1240117	18029NY1240120	18029NY1240123
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1240085	18029NY1240088	18029NY1240091	18029NY1240093	18029NY1240094	18029NY1240113	18029NY1240115	18029NY1240116	18029NY1240117	18029NY1240120	18029NY1240123
Premium Information	Average Rate PMPM	$322.69	$324.34	$325.52	$323.87	$324.34	$333.81	$336.74	$335.03	$333.81	$335.52	$336.74
	Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899
	Total Premium (TP)	$612,800	$615,930	$618,176	$615,034	$615,930	$633,912	$639,477	$636,225	$633,912	$637,152	$639,477
	EHB basis or full portion of TP, [see instructions]	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%
	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%
Claims Information	Total Allowed Claims (TAC)	$703,971	$707,629	$710,253	$706,581	$707,629	$719,873	$726,298	$722,543	$719,873	$723,614	$726,298
	EHB basis or full portion of TAC, [see instructions]	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%
	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%
	Allowed Claims which are not the issuer's obligation	$190,926	$191,919	$192,630	$191,635	$191,919	$188,847	$190,532	$189,547	$188,847	$189,828	$190,532
	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
	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%
	Total Incurred claims, payable with issuer funds	$513,044	$515,710	$517,623	$514,947	$515,710	$531,026	$535,765	$532,996	$531,026	$533,786	$535,765
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$8,722	-$8,767	-$8,800	-$8,754	-$8,767	-$9,027	-$9,108	-$9,061	-$9,027	-$9,074	-$9,108

	Incurred Claims PMPM	$270.16	$271.57	$272.57	$271.16	$271.57	$279.63	$282.13	$280.67	$279.63	$281.08	$282.13
	Allowed Claims PMPM	$370.70	$372.63	$374.01	$372.08	$372.63	$379.08	$382.46	$380.48	$379.08	$381.05	$382.46
	EHB portion of Allowed Claims, PMPM	$370.70	$372.39	$372.39	$370.70	$372.39	$379.08	$380.81	$379.08	$379.08	$380.81	$380.81

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			Silver								
Product ID:			18029NY125								
Metal:	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
AV Metal Value	0.704	0.704	0.697	0.697	0.697	0.697	0.697	0.697	0.697	0.697	0.697
AV Pricing Value	0.749	0.750	0.805	0.812	0.808	0.805	0.809	0.812	0.808	0.809	1.641
Plan Type:	POS	POS	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name	Option 13 Silver Plan I	Option 13 Silver Plan I	IHPA	IHPA	IHPA	IHPA	IHPA	IHPA	IHPA	IHPA	First Health
Plan ID (Standard Component ID):	18029NY1240125	18029NY1240126	18029NY1250001	18029NY1250003	18029NY1250004	18029NY1250005	18029NY1250008	18029NY1250011	18029NY1250013	18029NY1250014	18029NY1250033
Exchange Plan?	No	No	No	No	No	No	No	No	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	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %			0.00%								

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1240125	18029NY1240126	18029NY1250001	18029NY1250003	18029NY1250004	18029NY1250005	18029NY1250008	18029NY1250011	18029NY1250013	18029NY1250014	18029NY1250033
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$335.03	$335.52	$359.66	$362.82	$360.97	$359.66	$361.50	$362.82	$360.97	$361.50	$727.38
Projected Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1240125	18029NY1240126	18029NY1250001	18029NY1250003	18029NY1250004	18029NY1250005	18029NY1250008	18029NY1250011	18029NY1250013	18029NY1250014	18029NY1250033
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1240125	18029NY1240126	18029NY1250001	18029NY1250003	18029NY1250004	18029NY1250005	18029NY1250008	18029NY1250011	18029NY1250013	18029NY1250014	18029NY1250033
Premium Information	Average Rate PMPM	$335.03	$335.52	$359.66	$362.82	$360.97	$359.66	$361.50	$362.82	$360.97	$361.50	$727.38
	Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899	1,899
	Total Premium (TP)	$636,225	$637,152	$683,001	$689,003	$685,495	$683,001	$686,496	$689,003	$685,495	$686,496	$1,381,308
	EHB basis or full portion of TP, [see instructions]	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%
	Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$722,543	$723,614	$790,412	$797,466	$793,343	$790,412	$794,519	$797,466	$793,343	$794,519	$1,447,779
	EHB basis or full portion of TAC, [see instructions]	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%
	Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	$189,547	$189,828	$217,575	$219,517	$218,382	$217,575	$218,706	$219,517	$218,382	$218,706	$280,174
	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
	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%
	Total Incurred claims, payable with issuer funds	$532,996	$533,786	$572,836	$577,949	$574,961	$572,836	$575,813	$577,949	$574,961	$575,813	$1,167,605
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$9,061	-$9,074	-$9,738	-$9,825	-$9,774	-$9,738	-$9,789	-$9,825	-$9,774	-$9,789	-$19,849

	Incurred Claims PMPM	$280.67	$281.08	$301.65	$304.34	$302.77	$301.65	$303.22	$304.34	$302.77	$303.22	$614.85
	Allowed Claims PMPM	$380.48	$381.05	$416.22	$419.94	$417.76	$416.22	$418.38	$419.94	$417.76	$418.38	$762.38
	EHB portion of Allowed Claims, PMPM	$379.08	$380.81	$416.22	$418.15	$416.22	$416.22	$418.15	$418.15	$416.22	$418.15	$762.38

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											
Product ID:											
Metal:	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze
AV Metal Value	0.697	0.697	0.697	0.697	0.697	0.697	0.697	0.619	0.619	0.619	0.619
AV Pricing Value	1.655	1.647	1.641	1.649	1.655	1.647	1.649	0.690	0.697	0.693	0.690
Plan Type:	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name	First Health	First Health	First Health	First Health	First Health	First Health	First Health	IHPA	IHPA	IHPA	IHPA
Plan ID (Standard Component ID):	18029NY1250035	18029NY1250036	18029NY1250037	18029NY1250040	18029NY1250043	18029NY1250045	18029NY1250046	18029NY1270001	18029NY1270003	18029NY1270004	18029NY1270005
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2											
Historical Rate Increase - Calendar Year - 1											
Historical Rate Increase - Calendar Year 0											
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %											

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1250035	18029NY1250036	18029NY1250037	18029NY1250040	18029NY1250043	18029NY1250045	18029NY1250046	18029NY1270001	18029NY1270003	18029NY1270004	18029NY1270005
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$733.82	$730.06	$727.38	$731.13	$733.82	$730.06	$731.13	$309.27	$311.99	$310.40	$309.27
Projected Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	633	633	633	633

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1250035	18029NY1250036	18029NY1250037	18029NY1250040	18029NY1250043	18029NY1250045	18029NY1250046	18029NY1270001	18029NY1270003	18029NY1270004	18029NY1270005
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pl	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1250035	18029NY1250036	18029NY1250037	18029NY1250040	18029NY1250043	18029NY1250045	18029NY1250046	18029NY1270001	18029NY1270003	18029NY1270004	18029NY1270005
Premium Information	Average Rate PMPM	$733.82	$730.06	$727.38	$731.13	$733.82	$730.06	$731.13	$309.27	$311.99	$310.40	$309.27
	Member Months	1,899	1,899	1,899	1,899	1,899	1,899	1,899	633	633	633	633
	Total Premium (TP)	$1,393,543	$1,386,392	$1,381,308	$1,388,432	$1,393,543	$1,386,392	$1,388,432	$195,771	$197,487	$196,484	$195,771
	EHB basis or full portion of TP, [see instructions]	99.60%	99.63%	100.00%	99.97%	99.60%	99.63%	99.97%	100.00%	99.57%	99.63%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.40%	0.37%	0.00%	0.03%	0.40%	0.37%	0.03%	0.00%	0.43%	0.37%	0.00%
	Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$1,460,700	$1,453,149	$1,447,779	$1,455,303	$1,460,700	$1,453,149	$1,455,303	$256,161	$258,447	$257,111	$256,161
	EHB basis or full portion of TAC, [see instructions]	99.60%	99.63%	100.00%	99.97%	99.60%	99.63%	99.97%	100.00%	99.57%	99.63%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.40%	0.37%	0.00%	0.03%	0.40%	0.37%	0.03%	0.00%	0.43%	0.37%	0.00%
	Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	$282,674	$281,213	$280,174	$281,630	$282,674	$281,213	$281,630	$92,382	$93,207	$92,725	$92,382
	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
	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%
	Total Incurred claims, payable with issuer funds	$1,178,026	$1,171,936	$1,167,605	$1,173,673	$1,178,026	$1,171,936	$1,173,673	$163,779	$165,240	$164,386	$163,779
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$20,026	-$19,923	-$19,849	-$19,952	-$20,026	-$19,923	-$19,952	-$2,784	-$2,809	-$2,795	-$2,784

	Incurred Claims PMPM	$620.33	$617.13	$614.85	$618.04	$620.33	$617.13	$618.04	$258.73	$261.04	$259.69	$258.73
	Allowed Claims PMPM	$769.19	$765.21	$762.38	$766.34	$769.19	$765.21	$766.34	$404.68	$408.29	$406.18	$404.68
	EHB portion of Allowed Claims, PMPM	$766.11	$762.38	$762.38	$766.11	$766.11	$762.38	$766.11	$404.68	$406.55	$404.68	$404.68

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:	18029NY127										
Metal:	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
AV Metal Value	0.619	0.619	0.619	0.619	0.619	0.619	0.619	0.619	0.619	0.619	0.619
AV Pricing Value	0.694	0.697	0.693	0.694	1.468	1.481	1.473	1.468	1.475	1.481	1.473
Plan Type:	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name	IHPA	IHPA	IHPA	IHPA	First Health	First Health	First Health	First Health	First Health	First Health	First Health
Plan ID (Standard Component ID):	18029NY1270008	18029NY1270011	18029NY1270013	18029NY1270014	18029NY1270033	18029NY1270035	18029NY1270036	18029NY1270037	18029NY1270040	18029NY1270043	18029NY1270045
Exchange Plan?	No	No	No	No	No	No	No	No	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	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%										

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1270008	18029NY1270011	18029NY1270013	18029NY1270014	18029NY1270033	18029NY1270035	18029NY1270036	18029NY1270037	18029NY1270040	18029NY1270043	18029NY1270045
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$310.85	$311.99	$310.40	$310.85	$651.29	$657.05	$653.68	$651.29	$654.65	$657.05	$653.68
Projected Member Months	633	633	633	633	633	633	633	633	633	633	633

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1270008	18029NY1270011	18029NY1270013	18029NY1270014	18029NY1270033	18029NY1270035	18029NY1270036	18029NY1270037	18029NY1270040	18029NY1270043	18029NY1270045
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pl	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1270008	18029NY1270011	18029NY1270013	18029NY1270014	18029NY1270033	18029NY1270035	18029NY1270036	18029NY1270037	18029NY1270040	18029NY1270043	18029NY1270045
Premium Information	Average Rate PMPM	$310.85	$311.99	$310.40	$310.85	$651.29	$657.05	$653.68	$651.29	$654.65	$657.05	$653.68
	Member Months	633	633	633	633	633	633	633	633	633	633	633
	Total Premium (TP)	$196,770	$197,487	$196,484	$196,770	$412,267	$415,915	$413,783	$412,267	$414,391	$415,915	$413,783
	EHB basis or full portion of TP, [see instructions]	99.94%	99.57%	99.63%	99.94%	100.00%	99.60%	99.63%	100.00%	99.97%	99.60%	99.63%
	state mandated benefits portion of TP that are other than EHB	0.06%	0.43%	0.37%	0.06%	0.00%	0.40%	0.37%	0.00%	0.03%	0.40%	0.37%
	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%
Claims Information	Total Allowed Claims (TAC)	$257,492	$258,447	$257,111	$257,492	$469,037	$473,223	$470,776	$469,037	$471,474	$473,223	$470,776
	EHB basis or full portion of TAC, [see instructions]	99.94%	99.57%	99.63%	99.94%	100.00%	99.60%	99.63%	100.00%	99.97%	99.60%	99.63%
	state mandated benefits portion of TAC that are other than EHB	0.06%	0.43%	0.37%	0.06%	0.00%	0.40%	0.37%	0.00%	0.03%	0.40%	0.37%
	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%
	Allowed Claims which are not the issuer's obligation	$92,863	$93,207	$92,725	$92,863	$120,862	$121,941	$121,310	$120,862	$121,490	$121,941	$121,310
	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
	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%
	Total Incurred claims, payable with issuer funds	$164,630	$165,240	$164,386	$164,630	$348,174	$351,282	$349,466	$348,174	$349,984	$351,282	$349,466
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$2,799	-$2,809	-$2,795	-$2,799	-$5,919	-$5,972	-$5,941	-$5,919	-$5,950	-$5,972	-$5,941

	Incurred Claims PMPM	$260.08	$261.04	$259.69	$260.08	$550.04	$554.95	$552.08	$550.04	$552.90	$554.95	$552.08
	Allowed Claims PMPM	$406.78	$408.29	$406.18	$406.78	$740.97	$747.59	$743.72	$740.97	$744.82	$747.59	$743.72
	EHB portion of Allowed Claims, PMPM	$406.55	$406.55	$404.68	$406.55	$740.97	$744.59	$740.97	$740.97	$744.59	$744.59	$740.97

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											
Product ID:											
Metal:	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
AV Metal Value	0.619	0.608	0.608	0.608	0.608	0.608	0.608	0.608	0.608	0.610	0.610
AV Pricing Value	1.475	0.582	0.587	0.584	0.582	0.585	0.587	0.584	0.585	0.594	0.599
Plan Type:	PPO	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	First Health	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Prime Acess	Prime Acess
Plan ID (Standard Component ID):	18029NY1270046	18029NY1300017	18029NY1300019	18029NY1300020	18029NY1300021	18029NY1300024	18029NY1300027	18029NY1300029	18029NY1300030	18029NY1300033	18029NY1300035
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2											
Historical Rate Increase - Calendar Year - 1											
Historical Rate Increase - Calendar Year 0											
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %											

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1270046	18029NY1300017	18029NY1300019	18029NY1300020	18029NY1300021	18029NY1300024	18029NY1300027	18029NY1300029	18029NY1300030	18029NY1300033	18029NY1300035
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$654.65	$261.76	$264.05	$262.72	$261.76	$263.10	$264.05	$262.72	$263.10	$266.82	$269.16
Projected Member Months	633	633	633	633	633	633	633	633	633	633	633

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1270046	18029NY1300017	18029NY1300019	18029NY1300020	18029NY1300021	18029NY1300024	18029NY1300027	18029NY1300029	18029NY1300030	18029NY1300033	18029NY1300035
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1270046	18029NY1300017	18029NY1300019	18029NY1300020	18029NY1300021	18029NY1300024	18029NY1300027	18029NY1300029	18029NY1300030	18029NY1300033	18029NY1300035
Premium Information	Average Rate PMPM	$654.65	$261.76	$264.05	$262.72	$261.76	$263.10	$264.05	$262.72	$263.10	$266.82	$269.16
	Member Months	633	633	633	633	633	633	633	633	633	633	633
	Total Premium (TP)	$414,391	$165,697	$167,145	$166,299	$165,697	$166,540	$167,145	$166,299	$166,540	$168,899	$170,375
	EHB basis or full portion of TP, [see instructions]	99.97%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%
	state mandated benefits portion of TP that are other than EHB	0.03%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%
	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%
Claims Information	Total Allowed Claims (TAC)	$471,474	$225,474	$227,486	$226,310	$225,474	$226,646	$227,486	$226,310	$226,646	$228,247	$230,284
	EHB basis or full portion of TAC, [see instructions]	99.97%	100.00%	99.57%	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%
	state mandated benefits portion of TAC that are other than EHB	0.03%	0.00%	0.43%	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%
	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%
	Allowed Claims which are not the issuer's obligation	$121,490	$87,310	$88,089	$87,634	$87,310	$87,764	$88,089	$87,634	$87,764	$87,356	$88,136
	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
	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%
	Total Incurred claims, payable with issuer funds	$349,984	$138,164	$139,397	$138,676	$138,164	$138,882	$139,397	$138,676	$138,882	$140,891	$142,149
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$5,950	-$2,349	-$2,370	-$2,357	-$2,349	-$2,361	-$2,370	-$2,357	-$2,361	-$2,395	-$2,417

	Incurred Claims PMPM	$552.90	$218.27	$220.22	$219.08	$218.27	$219.40	$220.22	$219.08	$219.40	$222.58	$224.56
	Allowed Claims PMPM	$744.82	$356.20	$359.38	$357.52	$356.20	$358.05	$359.38	$357.52	$358.05	$360.58	$363.80
	EHB portion of Allowed Claims, PMPM	$744.59	$356.20	$357.82	$356.20	$356.20	$357.82	$357.82	$356.20	$357.82	$360.58	$362.22

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:	18029NY130										
Metal:	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
AV Metal Value	0.610	0.610	0.610	0.610	0.610	0.610	0.619	0.619	0.619	0.619	0.619
AV Pricing Value	0.596	0.594	0.597	0.599	0.596	0.597	0.607	0.612	0.609	0.607	0.610
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	Prime Acess	Prime Acess	Prime Acess	Prime Acess	Prime Acess	Prime Acess	Option 3 Bronze Plan D	Option 3 Bronze Plan D	Option 3 Bronze Plan D	Option 3 Bronze Plan D	Option 3 Bronze Plan D
Plan ID (Standard Component ID):	18029NY1300036	18029NY1300037	18029NY1300040	18029NY1300043	18029NY1300045	18029NY1300046	18029NY1300049	18029NY1300051	18029NY1300052	18029NY1300053	18029NY1300056
Exchange Plan?	No	No	No	No	No	No	No	No	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	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%										

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1300036	18029NY1300037	18029NY1300040	18029NY1300043	18029NY1300045	18029NY1300046	18029NY1300049	18029NY1300051	18029NY1300052	18029NY1300053	18029NY1300056
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$267.79	$266.82	$268.18	$269.16	$267.79	$268.18	$272.45	$274.83	$273.44	$272.45	$273.84
Projected Member Months	633	633	633	633	633	633	633	633	633	633	633

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1300036	18029NY1300037	18029NY1300040	18029NY1300043	18029NY1300045	18029NY1300046	18029NY1300049	18029NY1300051	18029NY1300052	18029NY1300053	18029NY1300056
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	0	0	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

	Product/Plan Level Calculations											
Pr	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%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	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%
	Allowed Claims which are not the issuer's obligation:	$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
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1300036	18029NY1300037	18029NY1300040	18029NY1300043	18029NY1300045	18029NY1300046	18029NY1300049	18029NY1300051	18029NY1300052	18029NY1300053	18029NY1300056
Premium Information	Average Rate PMPM	$267.79	$266.82	$268.18	$269.16	$267.79	$268.18	$272.45	$274.83	$273.44	$272.45	$273.84
	Member Months	633	633	633	633	633	633	633	633	633	633	633
	Total Premium (TP)	$169,513	$168,899	$169,759	$170,375	$169,513	$169,759	$172,460	$173,968	$173,087	$172,460	$173,338
	EHB basis or full portion of TP, [see instructions]	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%
	state mandated benefits portion of TP that are other than EHB	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%
	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%
Claims Information	Total Allowed Claims (TAC)	$229,094	$228,247	$229,433	$230,284	$229,094	$229,433	$233,441	$235,524	$234,307	$233,441	$234,654
	EHB basis or full portion of TAC, [see instructions]	99.63%	100.00%	99.94%	99.57%	99.63%	99.94%	100.00%	99.57%	99.63%	100.00%	99.94%
	state mandated benefits portion of TAC that are other than EHB	0.37%	0.00%	0.06%	0.43%	0.37%	0.06%	0.00%	0.43%	0.37%	0.00%	0.06%
	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%
	Allowed Claims which are not the issuer's obligation	$87,680	$87,356	$87,810	$88,136	$87,680	$87,810	$89,517	$90,316	$89,849	$89,517	$89,982
	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
	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%
	Total Incurred claims, payable with issuer funds	$141,414	$140,891	$141,623	$142,149	$141,414	$141,623	$143,924	$145,209	$144,458	$143,924	$144,672
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$2,404	-$2,395	-$2,408	-$2,417	-$2,404	-$2,408	-$2,447	-$2,469	-$2,456	-$2,447	-$2,459

	Incurred Claims PMPM	$223.40	$222.58	$223.73	$224.56	$223.40	$223.73	$227.37	$229.40	$228.21	$227.37	$228.55
	Allowed Claims PMPM	$361.92	$360.58	$362.45	$363.80	$361.92	$362.45	$368.78	$372.08	$370.15	$368.78	$370.70
	EHB portion of Allowed Claims, PMPM	$360.58	$360.58	$362.22	$362.22	$360.58	$362.22	$368.78	$370.47	$368.78	$368.78	$370.47

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			
Product ID:			
Metal:	Bronze	Bronze	Bronze
AV Metal Value	0.619	0.619	0.619
AV Pricing Value	0.612	0.609	0.610
Plan Type:	POS	POS	POS
Plan Name	Option 3 Bronze Plan D	Option 3 Bronze Plan D	Option 3 Bronze Plan D
Plan ID (Standard Component ID):	18029NY1300059	18029NY1300061	18029NY1300062
Exchange Plan?	No	No	No
Historical Rate Increase - Calendar Year - 2			
Historical Rate Increase - Calendar Year - 1			
Historical Rate Increase - Calendar Year 0			
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)	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %			

Section II: Components of Premium Increase (PMPM

Plan ID (Standard Component ID):	18029NY1300059	18029NY1300061	18029NY1300062
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	$274.83	$273.44	$273.84
Projected Member Months	633	633	633

Section III: Experience Period Information

	Plan ID (Standard Component ID):	18029NY1300059	18029NY1300061	18029NY1300062
remium Information	Average Rate PMPM	$0.00	$0.00	$0.00
	Member Months	0	0	0
	Total Premium (TP)	$0	$0	$0
	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%

Product-Plan Data Collection

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

	Product/Plan Level Calculations			
Pl	Other benefits portion of TP	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$0	$0	$0
	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%
	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	$0	$0	$0
	Net Amt of Rein	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00

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

Section IV: Projected (12 months following effective dat

	Plan ID (Standard Component ID):	18029NY1300059	18029NY1300061	18029NY1300062
Premium Information	Average Rate PMPM	$274.83	$273.44	$273.84
	Member Months	633	633	633
	Total Premium (TP)	$173,968	$173,087	$173,338
	EHB basis or full portion of TP, [see instructions]	99.57%	99.63%	99.94%
	state mandated benefits portion of TP that are other than EHB	0.43%	0.37%	0.06%
	Other benefits portion of TP	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$235,524	$234,307	$234,654
	EHB basis or full portion of TAC, [see instructions]	99.57%	99.63%	99.94%
	state mandated benefits portion of TAC that are other than EHB	0.43%	0.37%	0.06%
	Other benefits portion of TAC	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation	$90,316	$89,849	$89,982
	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	$145,209	$144,458	$144,672
	Net Amt of Rein	$0	$0	$0
	Net Amt of Risk Adj	-$2,469	-$2,456	-$2,459

	Incurred Claims PMPM	$229.40	$228.21	$228.55
	Allowed Claims PMPM	$372.08	$370.15	$370.70
	EHB portion of Allowed Claims, PMPM	$370.47	$368.78	$370.47