

State: New York **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

Filing at a Glance

Company: MVP Health Plan, Inc.
Product Name: MVP Individual - Off Exchange
State: New York
TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI: HOrg02I.005D Individual - HMO
Filing Type: Off Exchange NG Forms & Rates
Date Submitted: 05/15/2013
SERFF Tr Num: MVPH-129027223
SERFF Status: Pending Industry Response
State Tr Num: 2013050127
State Status: CR Awaiting Company Response
Co Tr Num: 13-02 (B)

Implementation: 01/01/2014
Date Requested:
Author(s): 
Reviewer(s): 
Disposition Date:
Disposition Status:
Implementation Date:

State Filing Description:
Legal objection letter sent on 6/10/13.

State: New York **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

General Information

Project Name: MVP Individual - Off Exchange	Status of Filing in Domicile:
Project Number: 13-02 (B)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual, Non Employer Group - Individual
Overall Rate Impact:	Filing Status Changed: 06/10/2013
	State Status Changed: 06/10/2013
Deemer Date:	Created By: Karin Weis
Submitted By: Karin Weis	Corresponding Filing Tracking Number:
	PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms
PPACA Notes: null	
Include Exchange Intentions:	No

Filing Description:

MVP Health Plan, Inc. individual products to be sold off-exchange. For its off-exchange small group products in 2014, MVP will satisfy its obligation to offer the pediatric essential health benefit by bundling the medical products contained in this filing with the dental products of Delta Dental. A Letter of Agreement evidencing this partnership is included as supporting documentation. Pursuant to DFS guidance, the dental benefits and premium rates are not included in this filing and will be separately submitted by Delta. MVP expects that members will be informed of this partnership at the time of sale.

Company and Contact

Filing Contact Information

[Redacted]	[Redacted]
[Redacted]	[Redacted]
[Redacted]	[Redacted]

Filing Company Information

MVP Health Plan, Inc.	CoCode: 95521	State of Domicile: New York
625 State Street	Group Code: 1198	Company Type: Health
Schenectady, NY 12305	Group Name:	Maintenance Organization
(518) 388-2469 ext. [Phone]	FEIN Number: 14-1640868	State ID Number:

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

State: New York **Filing Company:** MVP Health Plan, Inc.
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1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): Yes: MVPH-129027250, MVPH-129027208
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
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.): Only the out of network rider will be used for statutory individual HMO
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

SERFF Tracking #:

MVPH-129027223

State Tracking #:

2013050127

Company Tracking #:

13-02 (B)

State: New York **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing: N/A initial submission

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):
MVP Health Plan, Inc.	New Product	%	%				%	%
Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

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Rate Review Detail

COMPANY:

Company Name: MVP Health Plan, Inc.
 HHS Issuer Id: 56184
 Product Names: [NY STD INDV COC], [NY NSTD INDV COC]
 Trend Factors:

FORMS:

New Policy Forms: NY STD INDV COC, NY NSTD INDV COC
 Affected Forms:
 Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
 Member Months: 730,025
 Benefit Change:
 Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

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

REQUESTED RATE:

Projected Earned Premium: 287,089,880.00
 Projected Incurred Claims: 235,987,882.00
 Annual \$: Min: 196.88 Max: 795.16 Avg: 394.77

SERFF Tracking #:

MVPH-129027223

State Tracking #:

2013050127

Company Tracking #:

13-02 (B)

State: New York

Filing Company: MVP Health Plan, Inc.

TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO

Product Name: MVP Individual - Off Exchange

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Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		2014 Individual Off Exchange Rate Manual v1		New		2014 Individual Off Exchange Rate Manual v1.pdf,

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for
Individual Off Exchange**

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MVP Health Plan, Inc.
Benefit Descriptions
Effective January 1, 2014
Version 5/15/2013

MVP Form ID	Form Description	Plan Type	Small vs Individual	Standard vs Non-Standard	Metal Level	Form Applies to: On vs Off Exchange	Available to "Child Only"
NY-HMO-DB-001-S (2014)	Standard Bronze	HMO	Individual	Standard	Bronze	Off	No
NY-HMO-DS-001-S (2014)	Standard Silver	HMO	Individual	Standard	Silver	Off	No
NY-HMO-DG-001-S (2014)	Standard Gold	HMO	Individual	Standard	Gold	Off	No
NY-HMO-DP-001-S (2014)	Standard Platinum	HMO	Individual	Standard	Platinum	Off	No
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	HMO	Individual	Non-Standard	Bronze	Off	No
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	HMO	Individual	Non-Standard	Bronze	Off	No
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	HD HMO	Individual	Non-Standard	Bronze	Off	No
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	HMO	Individual	Non-Standard	Silver	Off	No
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	HMO	Individual	Non-Standard	Silver	Off	No
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	HD HMO	Individual	Non-Standard	Silver	Off	No
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	HMO	Individual	Non-Standard	Gold	Off	No
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	HD HMO	Individual	Non-Standard	Gold	Off	No
NY-POS-DP-001-S (2014)	CompCare POS Replacement	POS	Individual	Non-Standard	Platinum	Off	No

NOTE:
All cost sharing after Deductible unless otherwise noted by "no DD"

MVP Health Plan, Inc.
Benefit Descriptions
Effective January 1, 2014
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MVP Form ID	Single Deductible Medical	Family Deductible Medical	Single OOP Maximum	Family OOP Maximum	Emergency Room	Inpatient Stay/SNF	Outpatient Facility	Physician Surgery
NY-HMO-DB-001-S (2014)	\$3,000	\$6,000	\$6,350	\$12,700	50%	50%	50%	50%
NY-HMO-DS-001-S (2014)	\$2,000	\$4,000	\$5,500	\$11,000	\$150	\$1,500	\$100	\$100
NY-HMO-DG-001-S (2014)	\$600	\$1,200	\$4,000	\$8,000	\$150	\$1,000	\$100	\$100
NY-HMO-DP-001-S (2014)	\$0	\$0	\$2,000	\$4,000	\$100	\$500	\$100	\$100
NY-HMO-DB-001-N (2014)	\$3,500	\$7,000	\$6,350	\$12,700	50%	50%	\$300	\$300
NY-HMO-DB-002-N (2014)	\$4,000	\$8,000	\$6,350	\$12,700	\$350 no DD	30%	\$300	\$300
NY-HMOH-DB-003-N (2014)	\$4,000	\$8,000	\$6,350	\$12,700	\$300	30%	\$100	\$100
NY-HMO-DS-001-N (2014)	\$1,900	\$3,800	\$6,350	\$12,700	\$350	20%	\$300	\$200
NY-HMO-DS-002-N (2014)	\$1,500	\$3,000	\$6,350	\$12,700	\$350 no DD	20%	\$200	\$200
NY-HMOH-DS-003-N (2014)	\$1,500	\$3,000	\$6,350	\$12,700	\$300	\$500	\$200	\$100
NY-HMO-DG-001-N (2014)	\$850	\$1,700	\$6,350	\$12,700	\$300 no DD	\$500	\$200	\$100
NY-HMOH-DG-002-N (2014)	\$1,400	\$2,800	\$6,350	\$12,700	\$75	\$200	\$100	\$25
NY-POS-DP-001-S (2014)	\$0	\$0	\$2,000	\$4,000	\$100	\$500	\$100	\$100

NOTE:
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MVP Health Plan, Inc.
Benefit Descriptions
Effective January 1, 2014
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MVP Form ID	Primary Care Office	Specialist Office	Mental Health Office	High Tech Imaging	Diagnostic Imaging	PT/OT/ST	Lab
NY-HMO-DB-001-S (2014)	50%	50%	50%	50%	50%	50%	50%
NY-HMO-DS-001-S (2014)	\$30	\$50	\$30	\$50	\$50	\$30	\$50
NY-HMO-DG-001-S (2014)	\$25	\$40	\$25	\$40	\$40	\$30	\$40
NY-HMO-DP-001-S (2014)	\$15	\$35	\$15	\$35	\$35	\$25	\$35
NY-HMO-DB-001-N (2014)	\$35	\$80	\$80	\$300	\$100	\$80	\$80
NY-HMO-DB-002-N (2014)	3 visits at \$0, then \$35 no DD	\$60	\$60	\$300	\$100	\$60	\$60
NY-HMOH-DB-003-N (2014)	\$30	\$50	\$50	\$200	\$100	\$50	\$50
NY-HMO-DS-001-N (2014)	\$30 no DD	\$50	\$50	\$350	\$100	\$50	\$50
NY-HMO-DS-002-N (2014)	3 visits at \$0, then \$35 no DD	\$60	\$60	\$350	\$100	\$60	\$60
NY-HMOH-DS-003-N (2014)	\$25	\$50	\$50	\$200	\$50	\$50	\$50
NY-HMO-DG-001-N (2014)	3 visits at \$0, then \$15 no DD	\$45	\$45	\$100	\$60	\$45	\$45
NY-HMOH-DG-002-N (2014)	\$5	\$15	\$15	\$75	\$15	\$15	\$15
NY-POS-DP-001-S (2014)	\$15	\$35	\$15	\$35	\$35	\$25	\$35

NOTE:
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MVP Health Plan, Inc.
Benefit Descriptions
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MVP Form ID	Tier 1 Prescription	Tier 2 Prescription	Tier 3 Prescription	Prescription Deductible	IRS Qualified Plan
NY-HMO-DB-001-S (2014)		\$10	\$35	\$70	Integrated with Med No
NY-HMO-DS-001-S (2014)		\$10	\$35	\$70	\$0 No
NY-HMO-DG-001-S (2014)		\$10	\$35	\$70	\$0 No
NY-HMO-DP-001-S (2014)		\$10	\$30	\$60	\$0 No
NY-HMO-DB-001-N (2014)	\$0 Generic to age 10, otherwise \$10 after Deductible	\$40	50%	\$200	No
NY-HMO-DB-002-N (2014)	\$0 Generic to age 10, otherwise \$8	\$40	\$60	Integrated with Med	No
NY-HMOH-DB-003-N (2014)	\$5	\$40	\$60	Integrated with Med	Yes
NY-HMO-DS-001-N (2014)	\$0 Generic to age 10, otherwise \$8 no DD	\$35	\$70	\$100 Tier 2 & 3 Only	No
NY-HMO-DS-002-N (2014)	\$0 Generic to age 10, otherwise \$8	\$35	\$70	Integrated with Med	No
NY-HMOH-DS-003-N (2014)	\$10	\$40	\$60	Integrated with Med	Yes
NY-HMO-DG-001-N (2014)	\$0 Generic to age 10, otherwise \$5 No DD	\$35	\$70	\$100 Tier 2 & 3 Only	No
NY-HMOH-DG-002-N (2014)	\$5	\$15	\$25	Integrated with Med	Yes
NY-POS-DP-001-S (2014)	\$10	\$30	\$60	\$0	No

NOTE:
All cost sharing after Deductible t

MVP Health Plan, Inc.
 Benefit Descriptions
 Effective January 1, 2014
 Version 5/15/2013

Exhibit A

MVP Form ID	Out of Network				
	Single Deductible	Family Deductible	Coinsurance	Single Out of Pocket Max	Family Out of Pocket Max
NY-HMO-DB-001-S (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	N/A	N/A	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	\$1,000	\$2,000	20%	\$3,000	\$5,000

NOTE:

All cost sharing after Deductible t

MVP Health Plan, Inc.
 Rider Descriptions
 Effective January 1, 2014
 Version 5/15/2013

MVP Form ID	MVP Form for Rate Distinction	Benefit Description	Small vs Individual	Standard vs Non-Standard	Metal Level	Available to Child Only Policies	Form Applies to: On vs Off Exchange
NY-X-100	NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	No	Off

MVP Health Plan, Inc.

Exhibit B

Area Factor

Effective January 1, 2014

Version 5/15/2013

County	2014 Rate Region by DFS	Off Exchange: Individual		2014 MVP Rate Relativites - Individual
		Standard (AR44)	Non-Standard (AR44)	
ALBANY	1 Albany	X	X	0.902
COLUMBIA	1 Albany	X	X	0.902
FULTON	1 Albany	X	No	0.902
GREENE	1 Albany	X	X	0.902
MONTGOMERY	1 Albany	X	X	0.902
RENSSELAER	1 Albany	X	X	0.902
SARATOGA	1 Albany	X	X	0.902
SCHENECTADY	1 Albany	X	X	0.902
SCHOHARIE	1 Albany	X	No	0.902
WARREN	1 Albany	X	X	0.902
WASHINGTON	1 Albany	X	X	0.902
ALLEGANY	2 Buffalo	No	No	0.801
CATTARAUGUS	2 Buffalo	No	No	0.801
CHAUTAUQUA	2 Buffalo	No	No	0.801
ERIE	2 Buffalo	No	No	0.801
GENESEE	2 Buffalo	X	No	0.801
NIAGARA	2 Buffalo	No	No	0.801
ORLEANS	2 Buffalo	X	X	0.801
WYOMING	2 Buffalo	X	X	0.801
DELAWARE	3 Mid-Hudson	X	No	1.105
DUTCHESS	3 Mid-Hudson	X	X	1.105
ORANGE	3 Mid-Hudson	X	X	1.105
PUTNAM	3 Mid-Hudson	X	X	1.105
SULLIVAN	3 Mid-Hudson	X	X	1.105
ULSTER	3 Mid-Hudson	X	X	1.105
BRONX	4 NYC	No	No	1.436
KINGS	4 NYC	No	No	1.436
NEW YORK	4 NYC	No	No	1.436
QUEENS	4 NYC	No	No	1.436
RICHMOND	4 NYC	No	No	1.436
ROCKLAND	4 NYC	X	X	1.436
WESTCHESTER	4 NYC	No	No	1.436
LIVINGSTON	5 Rochester	X	X	0.792
MONROE	5 Rochester	X	X	0.792
ONTARIO	5 Rochester	X	X	0.792
SENECA	5 Rochester	X	X	0.792
WAYNE	5 Rochester	X	X	0.792
YATES	5 Rochester	X	X	0.792
BROOME	6 Syracuse	X	X	1.031
CAYUGA	6 Syracuse	X	X	1.031
CHEMUNG	6 Syracuse	No	No	1.031
CORTLAND	6 Syracuse	X	X	1.031
ONONDAGA	6 Syracuse	X	X	1.031
SCHUYLER	6 Syracuse	No	No	1.031
STEUBEN	6 Syracuse	X	No	1.031
TIOGA	6 Syracuse	X	No	1.031
TOMPKINS	6 Syracuse	X	X	1.031
CHENANGO	7 Utica/Watertown	X	X	0.875
CLINTON	7 Utica/Watertown	X	No	0.875
ESSEX	7 Utica/Watertown	X	No	0.875
FRANKLIN	7 Utica/Watertown	X	No	0.875
HAMILTON	7 Utica/Watertown	X	No	0.875
HERKIMER	7 Utica/Watertown	X	No	0.875
JEFFERSON	7 Utica/Watertown	X	No	0.875
LEWIS	7 Utica/Watertown	X	X	0.875

MVP Health Plan, Inc.
 Area Factor
 Effective January 1, 2014
 Version 5/15/2013

Exhibit B

County	2014 Rate Region by DFS	Off Exchange: Individual		2014 MVP Rate Relativites - Individual
		Standard (AR44)	Non-Standard (AR44)	
MADISON	7 Utica/Watertown	X	X	0.875
ONEIDA	7 Utica/Watertown	X	X	0.875
OSWEGO	7 Utica/Watertown	X	X	0.875
OTSEGO	7 Utica/Watertown	X	No	0.875
SAINT LAWRENCE	7 Utica/Watertown	X	No	0.875
NASSAU	8 Long Island	No	No	1.293
SUFFOLK	8 Long Island	No	No	1.293

* "8 Long Island" premiums are are Statewide Associations only.

MVP Health Plan, Inc.
Premiums
Effective January 1, 2014
Version 5/15/2013

MVP Form ID	Benefit Description	Small vs Individual	Standard vs Non-Standard	Metal Level	Rate Region	2014 Premium Rates						
						Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only (1 Child)	Child Only (2 Children)	Child Only (3+ Children)
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	0 Base	\$319.33	\$638.66	\$542.86	\$910.09	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	0 Base	\$415.25	\$830.50	\$705.93	\$1,183.46	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	0 Base	\$499.86	\$999.72	\$849.76	\$1,424.60	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	0 Base	\$589.47	\$1,178.94	\$1,002.10	\$1,679.99	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	0 Base	\$321.15	\$642.30	\$545.96	\$915.28	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	0 Base	\$324.32	\$648.64	\$551.34	\$924.31	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	0 Base	\$308.98	\$617.96	\$525.27	\$880.59	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	0 Base	\$387.73	\$775.46	\$659.14	\$1,105.03	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	0 Base	\$400.26	\$800.52	\$680.44	\$1,140.74	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	0 Base	\$402.44	\$804.88	\$684.15	\$1,146.95	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	0 Base	\$478.12	\$956.24	\$812.80	\$1,362.64	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	0 Base	\$454.70	\$909.40	\$772.99	\$1,295.90	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	0 Base	\$688.29	\$1,376.58	\$1,170.09	\$1,961.63	N/A	N/A	N/A
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	1 Albany	\$288.04	\$576.08	\$489.67	\$820.91	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	1 Albany	\$374.55	\$749.10	\$636.74	\$1,067.47	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	1 Albany	\$450.87	\$901.74	\$766.48	\$1,284.98	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	1 Albany	\$531.71	\$1,063.42	\$903.91	\$1,515.37	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	1 Albany	\$289.68	\$579.36	\$492.46	\$825.59	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	1 Albany	\$292.54	\$585.08	\$497.32	\$833.74	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	1 Albany	\$278.70	\$557.40	\$473.79	\$794.30	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	1 Albany	\$349.73	\$699.46	\$594.54	\$996.73	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	1 Albany	\$361.04	\$722.08	\$613.77	\$1,028.96	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	1 Albany	\$363.00	\$726.00	\$617.10	\$1,034.55	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	1 Albany	\$431.26	\$862.52	\$733.14	\$1,229.09	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	1 Albany	\$410.14	\$820.28	\$697.24	\$1,168.90	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	1 Albany	\$620.84	\$1,241.68	\$1,055.43	\$1,769.39	N/A	N/A	N/A
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	2 Buffalo	\$255.78	\$511.56	\$434.83	\$728.97	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	2 Buffalo	\$332.61	\$665.22	\$565.44	\$947.94	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	2 Buffalo	\$400.38	\$800.76	\$680.65	\$1,141.08	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	2 Buffalo	\$472.17	\$944.34	\$802.69	\$1,345.68	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	2 Buffalo	\$257.24	\$514.48	\$437.31	\$733.13	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	2 Buffalo	\$259.78	\$519.56	\$441.63	\$740.37	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	2 Buffalo	\$247.50	\$495.00	\$420.75	\$705.38	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	2 Buffalo	\$310.57	\$621.14	\$527.97	\$885.12	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	2 Buffalo	\$320.61	\$641.22	\$545.04	\$913.74	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	2 Buffalo	\$322.36	\$644.72	\$548.01	\$918.73	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	2 Buffalo	\$382.97	\$765.94	\$651.05	\$1,091.46	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	2 Buffalo	\$364.21	\$728.42	\$619.16	\$1,038.00	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	2 Buffalo	\$551.32	\$1,102.64	\$937.24	\$1,571.26	N/A	N/A	N/A
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	3 Mid-Hudson	\$352.86	\$705.72	\$599.86	\$1,005.65	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	3 Mid-Hudson	\$458.85	\$917.70	\$780.05	\$1,307.72	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	3 Mid-Hudson	\$552.34	\$1,104.68	\$938.98	\$1,574.17	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	3 Mid-Hudson	\$651.37	\$1,302.74	\$1,107.33	\$1,856.40	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	3 Mid-Hudson	\$354.87	\$709.74	\$603.28	\$1,011.38	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	3 Mid-Hudson	\$358.38	\$716.76	\$609.25	\$1,021.38	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	3 Mid-Hudson	\$341.43	\$682.86	\$580.43	\$973.08	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	3 Mid-Hudson	\$428.44	\$856.88	\$728.35	\$1,221.05	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	3 Mid-Hudson	\$442.29	\$884.58	\$751.89	\$1,260.53	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	3 Mid-Hudson	\$444.70	\$889.40	\$755.99	\$1,267.40	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	3 Mid-Hudson	\$528.32	\$1,056.64	\$898.14	\$1,505.71	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	3 Mid-Hudson	\$502.44	\$1,004.88	\$854.15	\$1,431.95	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	3 Mid-Hudson	\$760.56	\$1,521.12	\$1,292.95	\$2,167.60	N/A	N/A	N/A

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MVP Form ID	Benefit Description	Small vs Individual	Standard vs Non-Standard	Metal Level	Rate Region	2014 Premium Rates						
						Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only (1 Child)	Child Only (2 Children)	Child Only (3+ Children)
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	4 NYC	\$458.56	\$917.12	\$779.55	\$1,306.90	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	4 NYC	\$596.30	\$1,192.60	\$1,013.71	\$1,699.46	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	4 NYC	\$717.79	\$1,435.58	\$1,220.24	\$2,045.70	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	4 NYC	\$846.49	\$1,692.98	\$1,439.03	\$2,412.50	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	4 NYC	\$461.17	\$922.34	\$783.99	\$1,314.33	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	4 NYC	\$465.73	\$931.46	\$791.74	\$1,327.33	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	4 NYC	\$443.70	\$887.40	\$754.29	\$1,264.55	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	4 NYC	\$556.78	\$1,113.56	\$946.53	\$1,586.82	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	4 NYC	\$574.78	\$1,149.56	\$977.13	\$1,638.12	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	4 NYC	\$577.91	\$1,155.82	\$982.45	\$1,647.04	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	4 NYC	\$686.58	\$1,373.16	\$1,167.19	\$1,956.75	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	4 NYC	\$652.94	\$1,305.88	\$1,110.00	\$1,860.88	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	4 NYC	\$988.39	\$1,976.78	\$1,680.26	\$2,816.91	N/A	N/A	N/A
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	5 Rochester	\$252.91	\$505.82	\$429.95	\$720.79	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	5 Rochester	\$328.88	\$657.76	\$559.10	\$937.31	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	5 Rochester	\$395.89	\$791.78	\$673.01	\$1,128.29	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	5 Rochester	\$466.86	\$933.72	\$793.66	\$1,330.55	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	5 Rochester	\$254.35	\$508.70	\$432.40	\$724.90	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	5 Rochester	\$256.86	\$513.72	\$436.66	\$732.05	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	5 Rochester	\$244.72	\$489.44	\$416.02	\$697.45	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	5 Rochester	\$307.08	\$614.16	\$522.04	\$875.18	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	5 Rochester	\$317.01	\$634.02	\$538.92	\$903.48	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	5 Rochester	\$318.73	\$637.46	\$541.84	\$908.38	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	5 Rochester	\$378.67	\$757.34	\$643.74	\$1,079.21	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	5 Rochester	\$360.12	\$720.24	\$612.20	\$1,026.34	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	5 Rochester	\$545.13	\$1,090.26	\$926.72	\$1,553.62	N/A	N/A	N/A
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	6 Syracuse	\$329.23	\$658.46	\$559.69	\$938.31	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	6 Syracuse	\$428.12	\$856.24	\$727.80	\$1,220.14	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	6 Syracuse	\$515.35	\$1,030.70	\$876.10	\$1,468.75	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	6 Syracuse	\$607.75	\$1,215.50	\$1,033.18	\$1,732.09	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	6 Syracuse	\$331.11	\$662.22	\$562.89	\$943.66	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	6 Syracuse	\$334.38	\$668.76	\$568.45	\$952.98	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	6 Syracuse	\$318.56	\$637.12	\$541.55	\$907.90	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	6 Syracuse	\$399.75	\$799.50	\$679.58	\$1,139.29	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	6 Syracuse	\$412.67	\$825.34	\$701.54	\$1,176.11	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	6 Syracuse	\$414.92	\$829.84	\$705.36	\$1,182.52	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	6 Syracuse	\$492.94	\$985.88	\$838.00	\$1,404.88	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	6 Syracuse	\$468.79	\$937.58	\$796.94	\$1,336.05	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	6 Syracuse	\$709.63	\$1,419.26	\$1,206.37	\$2,022.45	N/A	N/A	N/A
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	7 Utica/Watertown	\$279.41	\$558.82	\$475.00	\$796.32	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	7 Utica/Watertown	\$363.34	\$726.68	\$617.68	\$1,035.52	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	7 Utica/Watertown	\$437.37	\$874.74	\$743.53	\$1,246.50	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	7 Utica/Watertown	\$515.79	\$1,031.58	\$876.84	\$1,470.00	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	7 Utica/Watertown	\$281.01	\$562.02	\$477.72	\$800.88	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	7 Utica/Watertown	\$283.78	\$567.56	\$482.43	\$808.77	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	7 Utica/Watertown	\$270.36	\$540.72	\$459.61	\$770.53	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	7 Utica/Watertown	\$339.27	\$678.54	\$576.76	\$966.92	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	7 Utica/Watertown	\$350.23	\$700.46	\$595.39	\$998.16	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	7 Utica/Watertown	\$352.14	\$704.28	\$598.64	\$1,003.60	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	7 Utica/Watertown	\$418.35	\$836.70	\$711.20	\$1,192.30	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	7 Utica/Watertown	\$397.86	\$795.72	\$676.36	\$1,133.90	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	7 Utica/Watertown	\$602.26	\$1,204.52	\$1,023.84	\$1,716.44	N/A	N/A	N/A

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MVP Form ID	Benefit Description	Small vs Individual	Standard vs Non-Standard	Metal Level	Rate Region	2014 Premium Rates						
						Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only (1 Child)	Child Only (2 Children)	Child Only (3+ Children)
NY-HMO-DB-001-S (2014)	Standard Bronze	Individual	Standard	Bronze	8 Long Island	\$412.89	\$825.78	\$701.91	\$1,176.74	N/A	N/A	N/A
NY-HMO-DS-001-S (2014)	Standard Silver	Individual	Standard	Silver	8 Long Island	\$536.92	\$1,073.84	\$912.76	\$1,530.22	N/A	N/A	N/A
NY-HMO-DG-001-S (2014)	Standard Gold	Individual	Standard	Gold	8 Long Island	\$646.31	\$1,292.62	\$1,098.73	\$1,841.98	N/A	N/A	N/A
NY-HMO-DP-001-S (2014)	Standard Platinum	Individual	Standard	Platinum	8 Long Island	\$762.19	\$1,524.38	\$1,295.72	\$2,172.24	N/A	N/A	N/A
NY-HMO-DB-001-N (2014)	Non-Standard Bronze 1	Individual	Non-Standard	Bronze	8 Long Island	\$415.25	\$830.50	\$705.93	\$1,183.46	N/A	N/A	N/A
NY-HMO-DB-002-N (2014)	Non-Standard Bronze 2	Individual	Non-Standard	Bronze	8 Long Island	\$419.35	\$838.70	\$712.90	\$1,195.15	N/A	N/A	N/A
NY-HMOH-DB-003-N (2014)	Non-Standard Bronze 3	Individual	Non-Standard	Bronze	8 Long Island	\$399.52	\$799.04	\$679.18	\$1,138.63	N/A	N/A	N/A
NY-HMO-DS-001-N (2014)	Non-Standard Silver 1	Individual	Non-Standard	Silver	8 Long Island	\$501.34	\$1,002.68	\$852.28	\$1,428.82	N/A	N/A	N/A
NY-HMO-DS-002-N (2014)	Non-Standard Silver 2	Individual	Non-Standard	Silver	8 Long Island	\$517.54	\$1,035.08	\$879.82	\$1,474.99	N/A	N/A	N/A
NY-HMOH-DS-003-N (2014)	Non-Standard Silver 3	Individual	Non-Standard	Silver	8 Long Island	\$520.36	\$1,040.72	\$884.61	\$1,483.03	N/A	N/A	N/A
NY-HMO-DG-001-N (2014)	Non-Standard Gold 1	Individual	Non-Standard	Gold	8 Long Island	\$618.20	\$1,236.40	\$1,050.94	\$1,761.87	N/A	N/A	N/A
NY-HMOH-DG-002-N (2014)	Non-Standard Gold 2	Individual	Non-Standard	Gold	8 Long Island	\$587.92	\$1,175.84	\$999.46	\$1,675.57	N/A	N/A	N/A
NY-POS-DP-001-S (2014)	CompCare POS Replacement	Individual	Non-Standard	Platinum	8 Long Island	\$889.96	\$1,779.92	\$1,512.93	\$2,536.39	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	0 Base	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	1 Albany	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	2 Buffalo	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	3 Mid-Hudson	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	4 NYC	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	5 Rochester	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	6 Syracuse	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	7 Utica/Watertown	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A
NY-X-100	Dependent Through Age 29	Individual	Standard	All Metal Levels	8 Long Island	1.00%	1.00%	1.00%	1.00%	N/A	N/A	N/A

MVP Health Plan, Inc.**Exhibit D**

Example of Rate Calculation

Effective January 1, 2014

Version 5/15/2013

MVP Form ID			NY-HMO-DS-001-S
Benefit Description			(2014)
Small vs Individual			Standard Silver
Standard vs Non-Standard			Individual
On vs Off Exchange			Standard
Available to "Child Only"			Off
Metal Level			No
Final Plan Specific Net Index PMPM claim rate		\$	273.28
Non Claim Expenses for Taxes/Administration/Risk Charge			
	Federal Taxes PMPM	\$5.50 \$	5.50
	Federal Taxes (Premium Based)	2.0% \$	6.68
	State Premium Taxes (Premium Based)	0.0% \$	-
	State 332 Assessment Taxes (Premium Based)	0.7% \$	2.34
	General Plan Administration (Premium Based)	9.7% \$	32.40
	Administration Expense due to Quality Improvement (Premium Based)	0.8% \$	2.67
	Broker Expense (Premium Based)	1.2% \$	4.01
	Bad Debt Expense	0.15% \$	0.50
	Profit/Contribution to surplus margins (Premium Based)	2.0% \$	6.68
Final Plan Specific Gross Index PMPM claim rate		\$	334.07
Rate Region			1 Albany
Regional Factor			0.902
Final Plan Specific Regional Gross PMPM		\$	301.33
Conversion Factor			1.243
Single	1.000	\$	374.55
Single + Spouse	2.000	\$	749.10
Single + Child(ren)	1.700	\$	636.74
Single + Spouse + Child(ren)	2.850	\$	1,067.47
Child Only (1 Child)	0.412		N/A
Child Only (2 Children)	2x		N/A
Child Only (3+ Children)	3x		N/A

2014 Broker Commission Schedule
Effective January 1, 2014

NY OFF-EXCHANGE COMMISSION

SMALL GROUP (2-50)	4% of premium
INDIVIDUAL/SOLE PROPRIETORS	3% of premium

GENERAL PROVISIONS

- All groups must meet MVP's eligibility and participation requirements as filed with the Department of Financial Services.
- Brokers are paid commission based on the amount of monthly premium received by MVP for each of the broker's accounts.
- Commissions are paid monthly.
- MVP reserves the right, in its sole discretion, to alter or void the compensation programs at any time in response to issues and conditions that affect the corporation, business, marketplace or economy. Entitlement to commission is subject to terms and conditions contained in the Broker Agreement. MVP reserves the right to make the final determination of eligibility for case (group/member) credit, premium credit and commission. The forgoing commission rates may be changed at MVP's option on thirty (30) days notice to brokers.

- Only eligible subscribers who live in MVP's service area are eligible to join.

State: New York **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	See attached A&H Product Checklist
Attachment(s):	Individual Checklist.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	<p>see attached Flesch Score Certification.</p> <p>Please note: No Flesch scores have been provided for the enclosed schedules, as Section 3102(F)(i) of the Insurance Laws of New York State excepts schedules from the definition of text and they are therefore not subject to readability requirements.</p> <p>Also, The Flesch score for most of the policy forms falls short of the required score of 45; however, MVP feels that the lower score should be permitted under §3102(d)(3) of the Insurance Law, as the lower score is caused by certain language which is drafted to conform to the requirements of state or federal law and utilizes model language.</p>
Attachment(s):	INDIVIDUAL FLESH (SIGNED).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability
Comments:	See attached explanation of variability.
Attachment(s):	Explanation of Variable Material Individual.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Black-lined Copy of Model Language
Comments:	<p>See attached redlined copies showing areas where MVP varied from Model Language.</p> <p>The variations are the same as what was noted for our on-exchange products.</p>
Attachment(s):	compcare POS transition Rider RL from model language.pdf

State: New York
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

Filing Company: MVP Health Plan, Inc.

Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Memorandum
Comments:	Please see attached.
Attachment(s):	Actuarial Memorandum - 2014 Individual OFF Exchange.pdf Appendix B-MVP NY EHB Benefit Substitutions Indiv.pdf Appendix C-2012 Detail description of QI expense Indiv.pdf Appendix D-MVP NY EHB Benefits Pricing Indiv.pdf Appendix E1-Standard AVC Summary - OFF HIX Indiv.pdf Appendix E2-Non-Standard AVC Summary - OFF HIX Indiv.pdf Appendix F-Development of Index PMPM claim rate Indiv Off v1.pdf Appendix G Development of Gross PMPM by Plan Indiv Off v1.pdf Appendix H-Numerical SP Example Indiv.pdf
Item Status:	
Status Date:	
Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	The Unified Rate Review template is not due on 5/15/2013. It will be submitted by the June deadline via an amendment to this filing. The accompanying actuarial memorandum will be submitted at that time.
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Value Calculations
Comments:	Please see Appendix E of the Actuarial Memorandum.
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 7-Historical Data
Comments:	Please see attached.

State: New York **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

Attachment(s):	Standard Exhibit 7 - Individual v2.pdf Standard Exhibit 7 - Individual v2.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	Please see attached.
Attachment(s):	Standard Exhibit 8 - Individual Off v1.pdf Standard Exhibit 8 - Individual Off v1.xls Standard Exhibit 8 - Individual Off (small group version) v1.pdf Standard Exhibit 8 - Individual Off (small group version) v1.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	Please see attached.
Attachment(s):	Standard Exhibit 9 - Individual Off HIX.pdf Standard Exhibit 9 - Individual Off HIX.xls
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Documents for Web Posting-NG Off Exchange
Comments:	Please see attached.
Attachment(s):	Standard Exhibit 1 - Individual Off Redacted.pdf Actuarial Memorandum - 2014 Individual OFF Exchange Redacted.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	The Unified Rate Review template is not due on 5/15/2013. It will be submitted by the June deadline via an amendment to this filing.
Attachment(s):	

State: New York **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
Product Name: MVP Individual - Off Exchange
Project Name/Number: MVP Individual - Off Exchange/13-02 (B)

Item Status:	
Status Date:	
Satisfied - Item:	Initial Certification of Rates
Comments:	Please see attached.
Attachment(s):	HMO Initial Premium Rates Certification MAF.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Letter of Agreement
Comments:	See signed letter of agreement with Delta Dental.
Attachment(s):	Signed LOA Delta NY (all off exchange).pdf
Item Status:	
Status Date:	
Satisfied - Item:	Black-lined copy - standard
Comments:	See attached redlined copies showing areas where MVP varied from Model Language. The variations are the same as what was noted for our on-exchange products.
Attachment(s):	Off Exchange Standard INDIV COC RL from Model Language.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Blacklined copy - non-standard
Comments:	See attached redlined copies showing areas where MVP varied from Model Language. The variations are the same as what was noted for our on-exchange products.
Attachment(s):	Off Exchange Nstd Individual COC RL from model language.pdf
Item Status:	
Status Date:	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

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LINE OF BUSINESS: **Individual Exchange**

	<u>TOI</u>	<u>LINE(S)</u>	<u>OF INSURANCE</u>	<u>Sub-TOI</u>
HOrg021		Indi Heal	vidual Health Organization HO th Maintenance (HMO) HO	rg021.005B Individual POS rg021.005D Individual HMO
Individual Health		Maj H16	or Medical H16	1.005A Individual PPO 1.005C Individual Other
Individual Health		Ho	spital Surgical Medical Expense H15	I.001 Health
H06		H	ealth Conversion H	06.000 Conversion

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

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

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

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APPLICATION FORMS	Model Language		Form/Page/Para Reference
Model Application Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	N/A
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	True
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	True
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	1
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	1
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	True
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	True
Table of Contents	§ 3102(c)(1)(G) Model Language	A table of contents is required.	2-3; Pediatric Dental was removed from TOC
Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
DEFINITIONS	§ 3217 Model Language	<i>Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.</i>	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

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Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	12
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	12
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	Policy does not require designation of PCP
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	\$500.00, whichever is less, is permissible.	10 (E)
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	10 (G)
Contact Information Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(16) §4324(a)(16) PHL §4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	11
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	MVP does not require referrals
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured’s medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	MVP does not require designated of PCP and does nor require referrals
Standing Referrals Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	MVP does not require designation of PCP and does not require referrals
Specialty Care Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	MVP does not require designation of PCP and does not require referrals
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>PHL §4403(6)(e) Model Language</p>	<p>provider’s contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer’s contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured’s care and adhere to the insurer’s policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.</p>	
<p>Transitional Care For A New Member in a Course of Treatment</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language</p>	<p>If an insured is in an ongoing course of treatment with a non-participating provider when the insured’s coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured’s coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer’s fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured’s care and to adhere to the insurer’s policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.</p>	<p>12 (A)</p>
<p>COST-SHARING EXPENSES AND ALLOWED AMOUNT.</p>			
<p>Cost of Service</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3201(c)(3) 11 NYCRR 52.1(c) Model Language</p>	<p>If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.</p>	<p>13 (B)</p>
<p>Reimbursement of Providers</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language</p>	<p>This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.</p>	<p>13 (E)</p>
<p>Non-Participating Providers and Non-Authorized Services</p>	<p>§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language</p>	<p>This policy or contract form includes a description of the insured’s financial responsibility for payment when services are provided by a health care provider who is not part of the insurer’s network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.</p>	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			No benefits for out of network
ELIGIBILITY	Model Language	For each of the following eligibility provisions model language <u>must</u> be used.	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	14
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	14
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. <i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i>	14-15
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. <i>Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the</i>	16

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		<i>insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 60 days of the day of birth to make coverage effective from the moment of birth.</i>	
Adopted Children and Step-Children	11NYCRR52.17(a)(30) , (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	14
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	17
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	15-16
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	<i>The following benefits <u>must</u> be included in the policy or contract form.</i> Standard Products: Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

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		<p>All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.</p> <p><u>Non-Standard Products:</u> Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	18-20
Federally Mandated Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	18-20

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<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>19</p>
<p>Mammography Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>19-20</p>
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>20 (6)</p>
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for 	<p>20-21 (7)</p>

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		<p>osteoporosis.</p> <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance</p>	
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	21 (8)
EMERGENCY SERVICES AND URGENT CARE			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>§4328 §3216(i)(24) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p>	

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		<ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting. 	
<p>Emergency Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. <p><i>Note the following definitions must be used:</i></p> <p><i>Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph” to stabilize” means, with respect to an emergency condition, to provide such medical treatment of the condition as may be</i></p>	<p>22-24 Policy contains variation regarding payment for emergency services</p>

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		<i>necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).</i>	
Urgent Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	24
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	25 (1)
Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	25 (2)
Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	25 (3)
Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	25 (4)
Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	25 (5)

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		<p>amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment.</p> <p><i>Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.</p>	<p>25 (6)</p>
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the</i></p>	<p>§4328 §3216(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>26 (7)</p>

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<p><i>addition of benefits to EHB categories are only permissible in Non-Standard Products.</i></p> <p>Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>		<p><i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.</i></p>	
<p><u>Non-Standard Benefit explanation:</u></p>			
<p>Home Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(6) §4303(a)(3) Model Language</p>	<p>This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p>	<p>26 (8)</p>

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		<i>Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.</i>	
Interruption of Pregnancy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. <i>Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.</i>	26 (9)
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form. 	26-27 910)
Infusion Therapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	27 (11)
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	27 (12)
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) Model Language	injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	28 (14)
Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	28 (15)
Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	28 (16)
Outpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i> Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more</i>	28 (17)

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this substitution or addition differs from the Standard benefit in the space provided.		<i>visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.</i>	
<u>Non-Standard Benefit explanation:</u>			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. <ul style="list-style-type: none">• This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist.• This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	28-29 (18)
Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	29 (18)
Mandatory Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	29
Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	29
Surgical Services	45 CFR § 156.100 §4328	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed	29 919)

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) 11 NYCRR § 52.6 Model Language</p>	<p>reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician’s assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Oral Surgery</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language</p>	<p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures:</p> <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>29 (20)</p>
<p>Mastectomy Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §3216(i)(20) §4328 §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>30 (21)</p>
<p>Post Mastectomy Reconstruction</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(20) §4328 §4303(x) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.</p>	<p>30 (21)</p>
<p>Transplants</p>	<p>45 CFR § 156.100 §3215(l)</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart,</p>	<p>30 (23)</p>

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(25) Model Language 11 NYCRR 440	<p>This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p> <p>The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.</p> <p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p>	30-32(1)

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		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. <i>Note: For Standard Products, the medical benefit cost-sharing must apply. For Non-Standard Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.</i> <i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i>	32-34
Durable Medical Equipment and Braces Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	34 (3)
Hearing Aids Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. <i>{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i> Bone anchored hearing aids must be covered only if an insured has either of the following: <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. <i>{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i>	35 (4)

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		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	<p>This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member’s immediate family cope with the emotional and social issues related to the Member’s death.</p> <p>Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.</i></p>	35 (5)
Prosthetics Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	<p>External Prosthetic Devices: This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown.</p> <p><i>Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.</i></p> <p>Internal Prosthetic Devices: This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	35-36 (7)

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<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>36-37</p>
<p>Maternity Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(10) §4328 4303(c) Model Language</p>	<p>This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951.</p> <p>Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.</p>	<p>37</p>

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		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	37 (6)
Inpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. <i>Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the “per condition” and/or “per lifetime” limit.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>For the purposes of this benefit, “per condition” means the disease or injury causing the need for the therapy.</i>	37-38 (7)
<u>Non-Standard Benefit explanation:</u>			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(d) 45 CFR § 156.100 Model Language</p>	<p>including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered.</p> <p><i>Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>38 (8)</p>
<p>End of Life Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.</p>	<p>38 (9)</p>
<p>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES</p>			
<p>Inpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>39 (G) (1) (a)</p>
<p>Outpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.</p>	<p>This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p>	<p>39 (G) (1) (b)</p>

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	<p>20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>40 (1) (a)</p>
<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to</p>	<p>This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of</p>	<p>40 (1) (b)</p>

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	<p>Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the</p>	<p>40 (H) (1)</p>

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		<p>same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	41 (H) (1)
<p>Off-Label Cancer Drug Usage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(12) §4328 §4303(q) Model Language</p>	<p>This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard’s Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.</p>	41 (H) (1)
<p>Usual and Customary Cost of Prescribed Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language</p>	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	42 (3)
<p>Prohibition for Tier IV Drugs</p>	<p>§4328 §3216(l) §4303(gg) PHL §4406-c(7)</p>	<p>The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).</p>	complies
<p>Eye Drops</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(hh) Model Language</p>	<p>The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not</p>	41-42 (2)

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		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(12-a)(A) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	41
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§4328 §3216(l) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	No mail order in Individual Plans
Contraceptive Drugs and Devices Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. Contraceptive coverage must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	41
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of \$200.00 for the subscriber and \$100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. <i>Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.</i>	48-49 (l)

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<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p><i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.</i></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>			
<p><u>Non-Standard Benefit explanation:</u></p>			
<p>Other Wellness Benefits</p> <p>Is this a Standard Exchange Plan? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, Additional Wellness Benefits may not be offered.</p>	<p>45 CFR § 156.100 §3239 §4328 §3216(l)</p>	<p>Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits <u>must</u> comply with § 3239 of Insurance Law.</p>	<p>Not offered</p>
<p>VISION CARE</p>			
<p>Pediatric Vision Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l)</p> <p>Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>49 (J)</p>
<p>DENTAL CARE</p>			
<p>Pediatric Dental Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is dental coverage being</p>	<p>45 CFR § 156.100 §4328 §3216(l)</p> <p>Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>provided in separate rider</p>

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provided by this QHP filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<u>Explanation:</u>			
ADDITIONAL BENEFITS		Additional benefits may be covered in the non-standard Exchange plans only.	
Family Vision Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	N/A
Orthotics Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	N/A
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	N/A
<u>Explanation:</u>			
Acupuncture		This policy or contract form provides coverage for acupuncture.	N/A
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	50 (A)
Convalescent and Custodial Care	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Necessary.	50 (B)
Cosmetic Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(5)) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	50 (C)
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	50 (D)
Dental Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(9)) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	50 (E)
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	51 (F)
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	51 (G)
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(6)) Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	51 (H)
Government Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	51 (K)
Medically Necessary Model Language Used?	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent	

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		certified by the State.	51 (J)
Medicare or Other Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	51 (K)
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4) (i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	51 (L)
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	51 (M)
Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	51 (N)
Services Provided by a Family Member Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	52 (O)
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	52 (P)
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	52 (Q)
Vision Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	52 (R)
Workers' Compensation	11NYCRR52.16(c)(8))	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		52 (S)
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	52 (T)
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	52 (B)
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	52 (C)
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 	55-56
Utilization Review Policies and Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; 	56 (2) (A)

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	Model Language	<ul style="list-style-type: none"> the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; the right to designate a representative; a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and further appeal rights, if any. 	
External Appeal Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: <ul style="list-style-type: none"> Instructions on how to request an external appeal; The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and The timeframe for submitting an external appeal. 	60-61
TERMINATION OF COVERAGE Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language §4306(c) §4304(c)	<i>The following are the only termination provisions permissible under the Insurance Law.</i> <i>The model language must be used for each of the following termination provisions.</i>	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	64
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	64 (3) (A)
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	70 (18)
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	64 (3) (A)

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Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	65 (D)
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	65 (E)
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	65 (B)
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	64 (1) (B)
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	64 (1) (A)
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.	64 (2)
Rescission Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	64-65
Renewal	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	69 (17)
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	64 (3) (A)
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits	11 NYCRR	This policy or contract form provides that when coverage under this policy or contract form ends,	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§2.17(a)(15) Model Language</p>	<p>benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.</p> <p>If the covered persons' coverage terminates, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.</p>	<p>65-66</p>
<p>Suspension of Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension. 	<p>67</p>
<p>Conversion - Right to a New Contract After Termination</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306(i) §3216(c)(5)</p>	<p>This policy or contract form provides that (a) if an individual is no longer covered under a “family policy or contract” because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e. bronze, silver, gold, or platinum) that covers all benefits required by state and federal law.</p> <p>Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the “family policy or contract” or whose young adult coverage terminates.</p> <p>Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.</p>	<p>66</p>
<p>GENERAL PROVISIONS</p>			<p>Form/Page/Para Reference</p>
<p>Incontestability</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306 §3216(d)(1)(B)(1) Model Language</p>	<p>The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.</p>	<p>68 (10)</p>

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Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	71 (28)
Action in Law or Equity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	71 (24)
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	70-71 (23)
Unilateral Modification Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11 NYCRR52.17(a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	67 (3)
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	71 (25)
SCHEDULE OF BENEFITS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Standard Benefit Design Description Chart Model Language	This policy or contract <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization <u>must</u> be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	see various schedules
Limitations on Annual Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose “restricted” annual dollar limits for essential health benefits.	see various schedules

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	Model Language		
Insured's Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	see various schedules
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input type="checkbox"/>	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	plan does not provide option for out of network coverage.
Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	FRNY-X-100
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF. <i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i>	

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		<i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 82.2 %.	See actuarial memorandum
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	See actuarial memorandum
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 82.2 %.	
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

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

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

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

A. Scoring Option *(select one)*

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

B. Scope of Test *(select one)*

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

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

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

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 with this filing:

Form #	Words	Sentences	Syllables	Flesch Score
NY STD INDV COC	28,901	1147	5.2	34.0
NY NSTD INDV COC	29,501	1160	5.2	34.1
NY-X-POS	1,457	59	5.3	32.4
NY-X-100	227	10	4.8	53.7

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

Name of Officer

Acting General Counsel & VP, Legal Affairs

Title

MVP Health Plan, Inc.

Name of Insurer

(To list more forms, complete and submit the 'Additional Sheet(s)' attached to the requirement for Readability Certification. If submitting multiple sheets complete and attach them individually.)

Reset Form

Explanation of Variable Material (ALL INDIVIDUAL)

- 1. Cover Page: Group name or individual name will be filled in as applicable.**
- 2. Cover Page: Marketing name to be decided.**
- 3. Cover Page: Signature of President/CEO bracketed to accommodate future changes in person holding position.**
- 4. Definitions of Participating Provider and Non-Participating Provider: Bracketed “or another plan” to allow for future additions of dental or vision partners.**
- 5. Definition of Service Area: Bracketed all counties to allow for changes in service area. Counties listed could be removed if MVP Health Plan, Inc. were to obtain a license in those counties.**
- 6. References to other sections within Certificate have been bracketed to accommodate changes in section number if new sections were added or existing sections were deleted.**
- 7. MVP’s website has been bracketed in all instances to allow for a change in website address.**
- 8. Important phone numbers have been bracketed to allow for changes in contact information.**
- 9. Open Enrollment Section is bracketed. Per model language this section will no longer be necessary after 3/31/14.**

Applicable only to Non-Standard Individual COC’s:

- 1. Both versions of the model language for the description of deductible have been provided and marked variable in Section IV. Depending on which schedule is purchased by the group either the aggregate or embedded language will be used.**

Except as expressly modified by this Rider, all of the exclusions of the Contract apply to the benefits covered by this Rider. In addition, none of the following services are covered under this Rider:

1. Primary Care Physician Office Visits
2. Preventive
3. Well Child Care
4. Prescription Drugs

12. Controlling Contract

All of the terms, conditions, limitations, and exclusions of Your Contract; to which this Rider is attached shall also apply to this Rider except where specifically changed by this Rider.

MVP Health Plan, Inc.
Schenectady, New York





Actuarial Memorandum
MVP Health Plan, Inc.
2014 New York Individual OFF Exchange Rate Filing
(With Appendices B-H)

Scope and Purpose

This memorandum details the methods and assumptions underlying the proposed 2014 premium rates for the Individual Market outside the Exchange. These products will be issued by MVP Health Plan, Inc., a subsidiary of MVP Health Care, Inc. All of the products and premium rates proposed comply with the requirements of the Federal ACA. These are all new products and therefore are being filed as normal pre approval filings subject to Section 4308(b) of the New York Insurance law.

The Individual Market premium rates are effective between 1/1/2014 and 12/31/2014. Rates and benefits will be reset on 1/1/15.

The product portfolio and proposed premium rates included herein are the same as those offered on the Individual Exchange with the following exceptions:

1. The Non Standard Platinum 1 and Non Standard Platinum 2 plans offered on the Exchange will not be available off exchange and therefore are not included in this rate filing.
2. The Catastrophic Plan and all of the Silver Plan and American Indian/Native American subsidy plan variations are not included. These are only available on Exchange per Federal ACA Regulation.
3. One additional plan, the CompCare POS Replacement Plan, is new and offered only OFF exchange, per New York State requirements.

Market/Benefits

A summary description of benefit plans and riders being offered is included in the Rate Manual. All Essential Health Benefits (EHB) are covered. For the Non Standard Plan offerings two actuarial equivalent EHB substitutions were made, one for the Standard Gym reimbursement benefit and the other for the PT/OT/ST benefit. MVP contracted Milliman, Inc. to determine the actuarial equivalence of the benefit substitutions. The supporting memorandum is included as Appendix B. There are no additional benefits included in these proposed plans in excess of the EHB.

The Pediatric Dental EHB is being satisfied by a partnership with Delta Dental. MVP has signed a letter of intent to partner with Delta Dental to satisfy the EHB requirement relating to Pediatric Dental. The dental benefits and premium rates are not included in this rate filing. These benefits will be issued by Delta dental. The benefits and premium rates for these benefits will be the same benefits and rates Delta dental will offer for direct sale members. Members will be informed at the time of sale of this partnership. Members are not required to purchase Delta dental through MVP. The letter of intent is included in the supporting documentation included with the SERFF submission.

Experience Period Claims

MVP Health Plan, Inc. and MVP Health Insurance Company's existing small employer group market historical claim data was the starting basis of the premium rate development as directed by DFS. MVP Health Plan data comprised the commercial employer group market as well as the Healthy New York employer group market. All Sole Proprietor data was removed and excluded from this experience basis. Per New York State requirements, these covered members will be required to purchase in the Individual Market upon renewal in 2014. All grandfathered and non grandfathered membership was included. There were no products excluded. No adjustments were made to the experience period claims for the impact of Regulation 146 or for Stop Loss reimbursement pools.

MVP combined the experience of these two companies to form a more credible experience base. The claim data is assumed to be fully credible. The experience period for the historical claims is incurred dates of service beginning 10/1/11 through 9/30/12, paid through 3/31/13. The experience period data complies with the single risk pool requirement of the Federal ACA.

An allowance for incurred but not reported (IBNR) paid claims was added to the experience period claims. The IBNR factors were supplied directly from MVP's reserving actuary. MVP uses a combination PMPM and completion factor method to develop IBNR estimates. New York specific data for the experience period was used to develop the factors and they are consistent with the IBNR factors used in MVP's monthly financial statements.

The experience period claim data includes claims from our fee for service claim warehouse along with additional medical expenses like capitations and other non fee for service medical expenses like medical home, physician incentive payments, wellness incentives, New York State HCRA and Covered lives assessments and net reinsurance expenses.

The experience period claims were reconciled with the IBNR lag triangles to ensure accuracy.

Appendix F illustrates the development of the "Index" PMPM claim rate starting with the experience period claim data shown separately for the MVP Health Plan, Inc. and MVP Health Insurance Company small group membership so to illustrate the market wide adjustments made to each pool prior to combining for the single risk pool Index Rate.

Market Wide Adjustments to Experience Period Claims

Several adjustments to the experience period claim data were necessary to adjust for the benefit changes included in the EHB Benchmark plan for New York State as well as for current benefit mandates not yet reflected in the experience period. Most of the adjustments were made prior to trend. Some were made on the basis of the 2014 projection period as these adjustments were provided by Milliman, Inc. on a 2014 cost basis. The adjustments are explained below.

Benefit costs removed from Experience Period Claims

The following benefits were covered in one or more of the products included in the experience period risk pool either as a standard covered benefit or as an optional rider: pediatric dental, vision exams and hardware, acupuncture and wellness rewards. All expenses associated with these benefits were removed from the experience period data.

Benefit costs added to Experience Period Claims

The following benefits were not standard covered benefits in one or more of the products included in the experience period risk pool but are New York State EHB benchmark requirements: Mental Health and Substance Abuse, Chiropractic care and full Pharmacy coverage. Estimated expenses associated with these benefits were added to the experience period data.

In addition to new benefit cost adjustments, the cost sharing associated with preventative services covered under the Grandfathered Healthy New York products were added to the experience period as well as the cost sharing associated

with the Federal mandate to cover contraceptive drugs in full under the woman's preventative mandate. The costs associated with this mandate are not yet reflected in the experience period.

The net impact of the claim cost adjustments to the experience period claim costs are illustrated on Lines 4 and 5 in Appendix F.

Market Wide Projection Period Adjustments to Experience Period Claims

New Benefits

Several other new covered benefits need to be accounted for as adjustments to the Index PMPM claim rate. They are as follows: Skilled Nursing Facility, Pediatric Vision, Disposable Medical Supplies, Hearing Aids, Wigs and the benchmark Gym membership benefit. The SNF benefit cost adjustment was only needed for the portion of the experience period associated with Healthy New York membership. The rest of the adjustments were added based on all of the membership. The cost estimates for these additional benefits were provided by Milliman, Inc. on a 2014 cost basis and therefore no additional trend was added.

Trend Factors

Trend factors were applied to the adjusted experience period incurred claims to project costs to the 2014 rating period. Annual unit cost and utilization trends were estimated for medical and pharmacy claim expenses for 2013 and 2014. The total projection period was 27 months from the midpoint of the experience period to the midpoint of the rating period (4/1/12 to 7/1/14).

For medical expenses, unit cost trends reflect known and anticipated changes to contracted provider reimbursement rates. The unit cost trend factors vary by region but have been weighted together based on the experience period membership mix across MVP's service area. Utilization trend did not vary by region and reflects modest expected increase in utilization. Recent trend studies have illustrated little to no utilization trend and therefore an uptick is expected in the underwriting cycle.

For Pharmacy expenses, the assumed unit cost and utilization trend factors used in the projection reflect trend factors provided by MVP's Pharmacy vendor, Express Scripts. Projected increases in MVP's non fee for service medical expenses (i.e. Capitations, HCRA charges, Medical home, etc.) reflect the anticipated increases for each of these items separately. Total trend rates were adjusted for leveraging impact that fixed member copay and deductible amounts have on the actual increase passed on to MVP as claim liability.

The total combined trend projection factor used to project the experience period claims to the rating period was 15.3% or 6.53% annualized. This is illustrated in Line 6 of Appendix F.

The average annual unit cost trend was 3.9% for the fee for service medical claims and 2.1% for pharmacy claims. The average annual utilization trend was 1.9% for fee for service medical and 1.9% for pharmacy. The combined unit cost and utilization increases represents the expected increase in the Allowed claim cost but not the final trend realized by the Health Insurer due to the impact that fixed deductibles and copayments have on the Health Plan's liability. Therefore, an additional trend factor is applied to reflect the impact of cost share leveraging on realized trends. The average annual leverage factor added was 0.70% for the medical claims and 0.67% for the pharmacy claims.

These factors were computed by trending the allowed claims from the experience period by the total trend, the copay cost sharing by only the utilization trends and the deductible cost sharing by the utilization trend and only a portion of the unit cost trend to reflect that some members have not yet met their deductible. The net paid claim trend is then computed by subtracting the projected cost sharing amounts from the projected allowed amounts. The excess trend above the allowed trend is the leveraging component of trend.

Network Changes

MVP Health Insurance Company small employer group data, which is part of the single risk pool experience base used as the basis for this rate setting, reflects a national network product portfolio. MVP partners with CIGNA to offer this

national network on this product portfolio. The products rated in this filing are HMO products with a network limited to MVP Health Plan Inc.'s service area. A 2% reduction to the MVP Health Insurance Company small employer group data was applied to reflect the anticipated cost of this national network on the experience claim base. This factor was derived based on an analysis of claims covered by CIGNA providers outside of MVP's service area compared to claims covered by MVP providers. The analysis was done on a regional basis taking into consideration case mix intensity of services and aggregated across all the regions. The 2% reduction is reflected on line 9 of Appendix F.

Fee Schedule Changes

MVP's network management staff contracted with the hospitals and physicians in MVP's network for lower reimbursement rates for the Individual Market relative to the existing commercial contracts wherever they were able to. Some parts of our service area were agreeable to this while others were not. Collectively across the entire service area, the individual reimbursement rates are expected to be 3.7% less than the current commercial group rates. This savings is reflected in line 10 of Appendix F.

Utilization Management Changes

Using contracted vendor software, MVP identified specific inefficient providers in our current commercial network. The providers were identified as having practice patterns of care that exceeded the mean efficiency of their peers. These providers were not re-contracted with for the Individual Market. A 0.46% reduction to the combined small group experience period data was applied to reflect the anticipated cost savings associated with removing these providers from the Individual Market network. This savings is reflected in line 11 of Appendix F.

Ratio of Individual Risk Pool to Small Group Risk Pool Adjustment

This adjustment is intended to reflect the expected relative morbidity difference in the 2014 rating period between the Individual Market and the Small Employer Group Market. The 1.151 factor illustrated on line 13 of Appendix F comes directly from the Deloitte published paper titled Impact of the Affordable Care Act on the New York Small Group and Non-Group Markets. The factor adjustment is calculated using the Adjusted Baseline relative morbidity factors from Table 2B: Morbidity as a factor of Average Monthly Small Group Health Insurance. The factor adjustment equals Post ACA (2014) Non Group factor = 1.119 divided by Post ACA (2014) Small Group factor = 0.972.

Federal Risk Adjustment

The basis for this experience period adjustment was the DFS commissioned Transfer Payment Risk Simulation project conducted by Deloitte using membership and claim detail from all of the current health insurers operating in the small group market in New York. The simulation was done by licensed legal entity by market (group vs. individual) to simulate the actual HHS risk adjustment that will take place for the first time in the spring of 2015. MVP used only the simulation results for small group markets to correspond to the experience period data being used to rate both the small group and individual market products in 2014. The actual PMPM transfer amounts for MVP's two legal entities were the starting point for the adjustment and are shown on line 16 of Appendix F. Two adjustments were made to these PMPM results prior to applying as an adjustment to the Index rate.

First the PMPM amounts were adjusted to reflect the projected changes in the underlying experience period data between the experience period and the projection period due to the collective impact of medical inflation, network changes, fee schedule changes and utilization management changes.

This adjusted PMPM amount was then reduced by 25% to account for the likelihood for the margin of error in the simulation results. MVP felt the simulation was reasonable in its methods and assumptions and therefore should be directionally reliable. However, there were many areas where less than perfect data was relied upon in the calculations. An example of this is the calculated actuarial values for the in-force benefit plans which are relied upon in the risk transfer formula. The final Federal Calculator was not available for this simulation and therefore a draft version was relied upon. Calculated AV's between the old and new calculator are significantly different in some cases. In addition to the draft use of the AV calculator, Deloitte and DFS were forced to rely on the integrity of all of the data submissions without any measurable audit capabilities.

MVP did not feel it would be actuarially justified to rely upon the full amount of the projected payment given the nature of the simulation exercise.

The final adjustment to the Index rate to account for the expected payment from the Federal Risk Adjustment program is reflected in line 19 of Appendix F.

Federal Transitional Reinsurance Program Recovery

The basis for this experience period adjustment was the DFS commissioned Transfer Payment Risk Simulation project which included in it expected reinsurance amounts for MVP’s small group experience block. MVP used only the simulation reinsurance results for small group markets to correspond to the experience period data being used to rate both the small group and individual market products in 2014. The actual PMPM reinsurance recovery amounts for MVP’s two legal entities for the 6% annual trend rate scenario were used which is close to the 6.5% average annual trend assumed in MVP’s projection. The PMPM amounts were averaged together based on experience period member months to arrive the assumed reinsurance recovery adjustment to the Individual Market Index rate and is reflected on line 20 of Appendix F.

Exchange User Fees

No adjustment was applied per DFS instructions.

Impact of anticipated changes in membership distribution by standard rating regions

No adjustment was made for anticipated membership changes.

Actuarial Values

The AV Metal Level for each plan was determined using the Federal prescribed Actuarial Value Calculator. Benefit Plans with copay cost sharing for Outpatient Facility and Outpatient Surgery services were valued consistently with the methodology employed by DFS for the Standard plans. The coinsurance equivalents for MVP’s Non Standard plans for copays other than \$100 were linearly interpolated from the coinsurance equivalents of the \$100 copay plans. For the MVP non Standard Bronze plans, MVP relied on Milliman, Inc. to compute a similar \$100 copay coinsurance equivalent. No adjustments were made to the calculator results.

The AV Pricing Value for each plan was determined using MVP’s in house benefit pricing tools. The pricing tools value the expected net paid claim cost associated with unique benefit plan designs from a starting single risk pool allowed amount. The AV is the ratio of the expected paid to allowed amount for each plan design. MVP did not reflect any induced demand in the projection of the net paid amounts for each unique benefit plan. The induced demand factors used to develop the Final AV Pricing Values are equal to those included in the HHS Notice of Benefits and Payment Parameters for 2014 (Platinum = 1.15, Gold = 1.08, Silver = 1.03, Bronze = 1.0).

The AV Metal Level and the AV Pricing Value were determined for all of the inforce benefit plans reflected in the experience period data. Using the AV Metal level values and the prescribed mapping by DFS, MVP mapped all of the inforce membership by Metal level and then computed the weighted average Induced Demand factor using the factors prescribed in Notice of Benefits and Payment Parameters for 2014 and the member months by plan as weights. The computed average induced demand factor for the experience period inforce block is 1.094. The weighted average AV Pricing Value for the experience period inforce block was also computed using the member months as weights. The computed average AV Pricing Value was 0.808.

The following table reflects the distribution of membership by AV Metal Level for the experience period inforce block of business:

EP Membership by Metal Level - Fed AVC AV (Final)	Total Small Group	Induced Demand Factor
Platinum	36%	1.150

Gold	44%	1.080
Silver	18%	1.030
Bronze	2%	1.000
Total	100%	1.094

The product of the average Induced Demand factor and the average AV Pricing value equals the Total AV Pricing Value reflected in the Index PMPM claim rate and used as the basis for the Plan level adjustments and resulting premium rates.

No adjustments were made to the calculated AV from the HHS Calculator for the Inforce block of business. Given the large range for mapping the plans to metal levels it was determined to be immaterial to the final distribution of plans by metal level.

Appendix E1 and E2 include the AVC screenshots for all of the Plans included in this rate filing.

Plan Level Adjustments / Plan Specific Net and Gross Index PMPM rates

The Final Index PMPM rate from Appendix F is the starting basis for the development of the Plan Specific Final Net and Gross Index PMPM rates calculated in Appendix G. The Plan Specific Index PMPM rate for each plan is computed as follows:

- Final Index PMPM rate / (Avg Inforce Pricing AV x Avg Inforce Induced Demand Factor)
- Multiplied by
- The plan specific AV Pricing Value x Metal Level Induced Demand Factor)
- Multiplied by
- The product of all of the plan specific adjustment factors
- Plus
- The plan specific PMPM adjustments

These collective adjustments arrive at the Final Plan Specific Net Index PMPM claim rate before non claim expense loads get added to the rate.

Next the Final Plan Specific Gross Index PMPM rate for each plan is derived based on adding the plan level adjustments for PMPM expense loads and percent of premium expense loads to the Plan Specific Net Index PMPM claim rate for each plan.

Each plan level adjustment is explained below:

Claim expense plan level adjustments

Impact of provider network characteristics

The provider network associated with the Non Standard plans is a reduced network relative to the provider network associated with the Standard Plans. The Hospitals and Physicians removed from the Standard network reflect some of the higher cost providers in MVP's Standard Network and as a result this plan specific adjustment applies to all of the Non Standard plans only. The specific adjustment factor equal to 0.969 reflects the anticipated savings associated with this smaller provider network.

Impact of delivery system characteristics

No plan specific adjustments were made.

Impact of utilization management practices

No plan specific adjustments were made.

Benefits in addition to EHB (greater than 1.00)

No plan specific adjustments were made. There are no benefits added in addition to the EHBs.

Impact of eligibility categories (catastrophic plans only)

There is no catastrophic plan off exchange.

Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)

As required by New York State, a single POS plan offering is available exclusively for MVP's current CompCare members enrolled in the CompCare POS product. This plan is identical to the Standard Platinum Plan but with an out of network benefit included. The out of network benefit is equal to the current CompCare out of network benefit. The plan level adjustment factor equal to 1.17 accounts for this out of network benefit. This adjustment factor is based on the out of network loads included in MVP's current small group PPO portfolio and is slightly lower than the current out of network load included in MVP's POS CompCare product. This plan will sunset if no eligible individuals buy it.

Other (non standard Gym benefit above the standard Gym benefit)

The Gym benefit included in the Standard Plans was part of the EHB Benchmark plan for New York. The cost associated with this benefit is included in the Final Index PMPM claim rate developed in Appendix F so there is no plan level adjustment needed for the Standard Plans. For the Non Standard plans MVP contracted Milliman, Inc. to determine the dollar amount of an actuarially equivalent EHB substitution for this Gym benefit reflecting MVP's desired Wellness Reward benefit. The actuarially equivalent benefit is a \$100 per contract reimbursement allowance for subscribers based on a choice of three wellness activities: gym membership, youth sports/fitness or healthy weight support. The actuarial certification is included as Appendix B to this Memorandum. MVP's actual Wellness Reward benefit included in the Non Standard Plans is for a reimbursement amount equal to \$125 per contract. The additional cost associated with the extra \$25 dollars above the actuarially equivalent benefit is added as a plan level adjustment to the Non Standard Plans.

Non Claim Expense plan level adjustments

Non claim expenses include both percent of premium loads and PMPM loads. The loads do not vary by plan. Each Standard and Non Standard plan is being loaded with the same PMPM and Percent of Premium loads. The loads are outlined below.

Federal Taxes PMPM based

A total of \$5.50 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis and includes the following 3 taxes: \$5.25 reinsurance contribution rate, \$0.08 HHS risk adjustment user fee and \$0.17 Patient Centered Outcome Research Fee.

Federal Taxes Premium based

This is referred to as the ACA Insurer Tax and will be assessed as a premium based tax applicable to all health insurance carriers. The fee collected by HHS will vary each year beginning with \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017 and \$14.3 billion in 2018. Estimates provided to MVP by Optum Insight estimate the fee to be approximately 2% of premium in 2014 and rising in later years.

State Taxes Premium based – Premium Tax

MVP Health Plan, Inc. is a tax exempt company and therefore exempt from State Premium Taxes.

State Taxes Premium based – 332 Assessment

New York State funds its insurance department budget with an industry assessment attributable to premium market share. The 332 assessment reflected in MVP Health Plan's 2012 Statutory filings is 0.7% of assessable premium. This amount was added as a plan level adjustment.

In last year's prior approval rate applications it was assumed, in error, that this expense was covered in the general administrative load and as a result was in effect not built into the premium rates since the administrative load was needed to fund just the administrative expenses. The Standard Exhibit 2 from 2013 prior approval rate filings identified the 332 Assessment load as 0.9%. This was based on the 2011 assessment as a percent of premium.

General Administrative Expense Load (including QI)

The total administrative expense load included as a plan level adjustment is equal to 10.5% of premium. This reflects a higher expected administrative expense burden for the Individual market compared to the group market. This is consistent with the administrative load included in the 2013 Healthy New York prior approval rate application (assuming the load for the 332 assessment was 0%). The 2013 prior approval administrative load for the Individual Direct Pay product was 4.5% but on a premium base that was about 3 times higher than the 2014 rates.

Included in this load is 0.8% allocated to Quality Improvement/Cost Containment Programs based on the 2012 Statutory SHCE filing for the Individual lines of business.

MVP is currently working towards improving administrative efficiencies to reduce its operating expenses to align with pricing loads and assuming membership growth in 2014. The following table summarizes the administrative expenses for small group and individual lines of business from the 2012 Statutory SHCE's.

Administrative Cost Summary from SHCE's for 2012 Statutory Filings

MVP Health Insurance Company								
SHCE NY only:	Premium	SHCE QI expenses	SHCE Broker Fees	SHCE All Other Admin Expenses	SHCE QI expenses	SHCE Broker Fees	All other Admin / Premium	Total Admin
Comprehensive Individual								
Comprehensive Small Group	213,205,297	2,450,445	9,044,376	19,979,322	1.1%	4.2%	9.4%	14.8%

MVP Health Plan								
SHCE NY only:	Premium	SHCE QI expenses	SHCE Broker Fees	SHCE All Other Admin Expenses	SHCE QI expenses	SHCE Broker Fees	All other Admin/Premium	Total Admin
Comprehensive Individual	14,904,312	117,109	165,317	1,716,588	0.8%	1.1%	11.5%	13.4%
Comprehensive Small Group	49,712,310	621,360	835,913	7,100,102	1.2%	1.7%	14.3%	17.2%

Combined								
SHCE NY only:	Premium	SHCE QI expenses	SHCE Broker Fees	SHCE All Other Admin Expenses	SHCE QI expenses	SHCE Broker Fees	All other Admin/Premium	Total Admin
Comprehensive Individual	14,904,312	117,109	165,317	1,716,588	0.8%	1.1%	11.5%	13.4%
Comprehensive Small Group	262,917,607	3,071,805	9,880,289	27,079,424	1.2%	3.8%	10.3%	15.2%
Total Individual/Small Group	277,821,919	3,188,914	10,045,605	28,796,012	1.1%	3.6%	10.4%	15.1%

Broker Expense

MVP's broker distribution channel has a strong presence in today's small group and sole proprietor market. In 2012 83% of MVP Health Insurance Company's small group and sole proprietor premium revenue was commissioned and 61% of MVP Health Plan, Inc.'s small group and sole proprietor premium revenue was commissioned for a total average small group broker penetration rate equal to 81% of premiums.

For the Individual Market, the 2014 Broker commission rate will be 3% of premiums. Because sole proprietors and some individual Healthy New York members are accustomed to relying on broker services we expect brokers to have a presence in the Individual Market sales as well. How much is yet to be determined however and many of the new entrants may rely solely on the Exchange funded Navigators. As a result, MVP is assuming a lower Broker penetration rate (40%) in the Individual Market and therefore the plan level adjustment for the broker expense is 1.2%.

Profit/Risk Charge

A 2% profit/risk charge is added to premium rates as an expected contribution to reserves or protection against adverse experience relative to pricing assumptions. Surplus for MVP Health Plan, Inc. was 17.6% of premium for the year ending December 31, 2012. We have assumed a 2% profit margin which translates to a targeted 11.4% return on surplus. We believe this to be in line with the industry.

Bad Debt Expense

A plan level adjustment equal to 0.15% of premium was added to account for non payment of premium risk. This is in line with the actual cost of bad debt for MVP's current book of business.

Per Contract Premium Rates

The Plan Specific Gross PMPM Index Claim Rates computed in the Appendix G are converted to per contract premium rates in the Rate Manual using the computed single conversion factor and the prescribed standard load ratios.

The Rate Manual includes the Base Rate for each plan as well as the regional rate for each plan along with the rates for the mandatory make available riders.

The single conversion factor (SCF) was calculated using subscriber and member exposure months by contract type from the experience period used to develop the Index rate. The SCF = weighted average contract size/ weighted average load ratio. The table below illustrates the data used to compute the SCF.

In the Individual Market, Child Only policies are required to be offered at 41.2% of the single rate. As a result, it is likely that Single Parent contracts with only one child will purchase separate policies, and pay the single and child only rate vs. paying for the Parent +1 contract type which would be more expensive. The same result is likely for 2 parent families with only one child. MVP accounted for this in the calculation of the SCF.

Contract Type	Actual Contract Mix	Average Contract Size	Weighted Contract Size	Desired Load Factors	Weighted Loading Factors
4T-Single	56.7%	1.000	0.567	1.000	0.567
4T-Double	13.8%	2.000	0.276	2.000	0.276
4T-Parent (1 Child)	2.4%	2.000	0.048	1.412	0.034
4T-Parent (2+ Children)	1.8%	3.336	0.060	1.700	0.031
4T-Family (1 Children)	7.3%	3.000	0.219	2.412	0.176
4T-Family (2+ Children)	18.1%	4.521	0.818	2.850	0.516
Total	100%		1.988		1.600

Single Conversion Factor (SCF)	1.243
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Mandatory Make Available Riders

Dependent Thru Age 29 Add on Rider

This is an optional add on rider for the Standard Plans only. For the Non Standard Plans, coverage to age 29 is included in the base.

The premium rate for the rider is a 1% load to each contract rate. The factor load was derived based on the current riders on file for this benefit for MVP's inforce business which charge a 1% load to the Family Contracts only.

Beginning in 2014, standard contract load ratios apply. However for this benefit add on, no single and double contract holders will choose the Standard Plans that include the dependent thru age 29 benefit. Therefore, it is still appropriate to charge the current 1% load and apply it to all contract tier types.

As claim experience for these dependents to age 29 emerges under these products the cost associated with this expanded coverage will be removed from the single risk pool index rate through a market wide adjustment and added back through as a plan level adjustment for the Non standard plans so not to include these costs in the Standard Plans without the rider.

Pediatric Dental Add on Rider

This is an optional rider available for all Standard and Non Standard Plans. MVP contracted Milliman, Inc. to derive the cost associated with this benefit. The cost was developed on a PMPM basis by Metal level by Standard and Non Standard dental benefit. The Net PMPM rider costs are outlined in the Appendix D attached. The per contract rider rates were derived by loading the same percent of premium retention loads included in the base rate development and the same single conversion factors and load ratios.

Standardized Rating Regions and Area Factors

MVP has established area factors for the 7 rate regions in which we are licensed to service plus an area factor for region 8 Long Island. The Region 8 Long Island area factor is included, along with filed premium rates for Region 8 for the sole use by Associations acting as brokers for their members. MVP is not licensed to sell directly to individuals and sole proprietors in Region 8.

The area factors were derived based an analysis of the relative cost differences of providing care across our service due to varying provider reimbursement rates and practice patterns. Cost differences were evaluated separately for Facility costs and Physician costs in each of the regions and then blended together to derive the total relative cost differences. Book of business claim weightings for Facility spend, Physician spend, Pharmacy Spend and other non fee for service expense were used to generate the total relative spend for each region. Pharmacy spend and non fee for service medical spend was assumed to not vary by rating region.

The area factors were derived without regard to differences in health status, age, sex, occupation among enrollees in each rating region and are in compliance with HHS regulations on rate review. The area factors established for the Individual Market premium rates for 2014 are as follows:

Rating Region Premium Factors	2014 MVP Area Rating Factors - Individual
1 Albany	0.902
2 Buffalo	0.801
3 Mid-Hudson	1.105
4 NYC	1.436
5 Rochester	0.792
6 Syracuse	1.031
7 Utica/Watertown	0.875
8 Long Island	1.293

Loss Ratios

The target pricing loss ratios included in these proposed premium rates comply with Federal and State requirements. The projected Traditional MLR and Federal MLR for each plan rider combination are illustrated at the bottom of Appendix G. The expected book of business average loss ratios are illustrated in the shaded column of Appendix G.

These were computed using the premium rate developed assuming the market wide final index PMPM rate used to derive all of the plan specific premiums.

Required Standard Exhibit 7

Exhibit 7 includes historical paid claims, incurred claims, earned premiums and standardized premiums for the prior 3 12 month experience periods. MVP Health Plan, Inc. as well as MVP Health Insurance Company's pre ACA individual and employer group policy forms are listed here. For the small employer group policy forms the data was shown separately for sole proprietor versus non sole proprietor per DFS request. Incurred and Paid claims reported in this exhibit were extracted from MVP's claim warehouse. Earned premium data was extracted from MVP's premium warehouse. Incurred claims for the most recent experience period included claim run out through 3/31/13. Claim run out for the prior 2 experience periods was through 12/31/12.

Standardized Premiums were developed for each reported earned premium in Exhibit 7. The Standardized Premiums were computed using a database of membership and earned premium data for every benefit plan in force in each of the 3 historical periods. The data was grouped by benefit plan, renewal month and rate region in order to apply the appropriate standardized premium adjustment factors to the earned premium. The premium data was split between pre renewal months and post renewal months. Standardized premium factors by benefit plan by rate region were calculated for every possible cumulative projection period and applied to the earned premium detail. For example, for the data included in the 2nd prior experience period, some of the earned premium reflected 4Q 2008 rate levels (ie. the pre renewal premium for the November and December 2009 renewal months). These premiums were multiplied by a standardized premium adjustment factor that reflected the product of all of the quarterly rate increases starting with 1Q09/4Q08 through the 4Q13/3Q13. The earned and computed standardized premiums were rolled up to the policy form level for reporting in Exhibit 7. A numerical example is included as Appendix H.

Reliance

I relied upon the Actuarial Certifications from Howard Kahn of Milliman, Inc. for the EHB substitutions included in the Non Standard Plan offerings as well as the benefit pricing for the new benefit expansions included in the EHB benchmark plan for New York.

Actuarial Certification

I, [REDACTED] am a Member of the American Academy of Actuaries. The projected Index Rate used in the development of these proposed premium rates is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)) and developed in compliance with the applicable Actuarial Standards of Practice. I have examined the assumptions and methods used in determining MVP's requested rates. Based on my review and examination, it is my opinion that the proposed premium rates are reasonable in relation to the benefits provided and that they are neither excessive, inadequate, nor unfairly discriminatory. They are developed using only the permitted rating classifications. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The Standard AV Calculator was used to determine the Metal AV Value to be shown in Worksheet 2 of the Part I Unified Rate Review template for all the plans.

I certify that I am knowledgeable as to the New York state rating laws and regulations that apply to this filing and that, to the best of my knowledge and belief, this filing is in compliance with such laws and regulations and provides all required benefits. I am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the PPACA and the HCERA of 2010.

I certify that each rate filing has been prepared in accordance with the following Actuarial Standards of Practice; ASOP #5, ASOP#8, ASOP #12, ASOP #23, ASOP # 25, ASOP#26,and ASOP#41.

[Redacted]

[Redacted] FSA, MAAA
Director of Actuarial Services
MVP Health Care, Inc.

Date 5/15/2013



MEMO

April 26, 2013

One Pennsylvania Plaza,
38th Floor
New York, NY 10119
Tel +1 646 473.3000
Fax +1 646 473.3199
www.milliman.com

To [REDACTED] (MVP Health Care)
From [REDACTED] (Milliman)
Subject NY EHB Actuarial Equivalent Benefit Substitutions

MVP Health Care (MVP) would like to substitute actuarial equivalent benefits for the current gym reimbursement and the outpatient physical, occupational and speech therapy benefits in the New York State Essential Health Benefits (EHB) package:

- The NY EHB includes a gym reimbursement benefit equal to up to \$400 per year for subscribers and up to \$200 per year for spouses/partners. The benefit is reimbursable for every 6 month period in which the member completes 50 visits to the gym.

MVP would like to replace this benefit with their Non Standard Plan Wellness Benefit, which includes the same benefits from three existing wellness riders:

- Lifestyle Riders 361 (Gym/Fitness Club)
 - Lifestyle Rider 362 (Youth Sports and Fitness)
 - Lifestyle Rider 363 (Healthy Weight Support)
- The NY EHB covers up to 60 outpatient physical therapy (PT)/ occupational therapy (OT)/speech therapy (ST) visits per condition per lifetime per member for both rehabilitation and habilitation.

MVP would like to cover 12 acupuncture visits per member per year. It wishes to do this by reducing the PT/OT/ST visit limit by an actuarially equivalent amount.

This memo presents our actuarial equivalent estimates for these substitutions.

Results

Exhibit 1 shows our pricing development of the EHB gym benefit and MVP's Non Standard Plan Wellness Benefit.. Under MVP's proposal, any contract that takes advantage of the wellness benefit will receive a lump sum of money to spend on any of the wellness covered services. We estimate that a \$100 wellness benefit per contract per year would cost \$0.49 per member per month (PMPM), the same cost of the EHB gym benefit, resulting in an actuarially equivalent benefit. In addition, at the request of MVP, we show the PMPM cost of offering a \$125 benefit.

Exhibit 2 shows our pricing for the development for the 12 visit per year acupuncture benefit. Our estimate of the gross claims costs for the acupuncture benefit suggests a reduction of the PT/OT/ST maximum to 54 visits per condition per lifetime.



Methodology

EHB Gym Benefit Substitution

Using Milliman's Health Cost Guidelines (HCGs)¹ standard demographics, we estimated the cost of NY's EHB gym benefit and MVP's Non Standard Plan Wellness Benefit.

For the EHB gym reimbursement benefit we assumed a maximum annual benefit per contract of \$400 (\$200 limit per 6 months) for the Employee only and Employee & Child(ren) tiers. We assumed a \$600 per contract per year max for the Employee & Spouse and Family tiers, due to the presence of a spouse/partner (an additional \$100 limit per 6 months).

We assume a low uptake rate of 2.5% for this benefit because the member must document each gym visit and go up to 50 times every 6 months in order to be reimbursed.

For MVP's current Healthy Lifestyle Riders and proposed Non Standard Plan Wellness Benefit, there is no requirement for reimbursement and we assume higher starting uptake rates which were used in the development of the premium rates for the Healthy Lifestyle Riders that are currently on file with the New York Department of Financial Services (DFS):

- 26% for Riders 361 and 362 (Rider 362 covers children only)
- 5% for Rider 363

However, the reimbursement levels with the filed wellness riders are higher than the proposed Non Standard Plan Wellness Benefit; therefore, we adjust the above uptake rates downward to reflect that members are less likely to submit for reimbursement.

PT/OT/ST Substitution

We estimated, using online resources as described in the data reliance section, the estimated gross claim cost PMPM of adding a 12 visit per year acupuncture benefit.

We estimated the utilization rates for outpatient facility and office PT/OT/ST services under different visit limits using utilization from Milliman's 2013 HCGs (representing a standard large group), adjusted for each region, and MVP's 2011 member distribution:

- 13% Central NY
- 26% East NY
- 25% Mid-Hudson
- 36% Rochester

¹ The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually. The HCGs provide a flexible but consistent basis for the determination of health claim costs and premium rates for a wide variety of health plans. The HCGs are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as they are used in measuring the experience or evaluating the rates of health plans, and as they are compared to other data sources.



MVP provided us with estimates of PT/OT/ST reimbursement separately for their East and West NY regions. We calculated a member-weighted average reimbursement rate of \$53.81 per case using the above distribution.

Using both the utilization rates and averaged allowed charge for MVP's service area, we estimate that the visits limit would need to be reduced to 54 visits from the current 60 visit limit in order to add an actuarially equivalent acupuncture benefit.

Data Reliance

We relied on the following files provided by MVP:

- DOC001.PDF
- 361 Gym rider legal approved.pdf
- 362 Youth Sport rider legal approved.pdf
- 363 Weight Support legal approved.pdf
- Actuarial Memo Lifestyle Riders v1.doc
- Attachment A - Essential Health Benefits.xls
- 3/29/13 email titled "Contracted Rates for PT/OT/ST" from Kathleen Fish

Sources for acupuncture utilization and cost assumptions:

- <http://www.sciencebasedmedicine.org/index.php/how-popular-is-acupuncture/>. Accessed on March 29, 2013.
- <http://health.costhelper.com/acupuncture.html>. Accessed on March 29, 2013.



Additional Notes and Caveats

Our models are based on the assumptions listed above and the data you have provided to us. If you believe any of our assumptions are incorrect, please let us know and we will amend our models accordingly.

This memorandum was prepared for the internal use of MVP Health Care and statutory provisions in the State of New York protect its confidentiality. This report may be provided to insurance regulators in New York for their internal use in accordance with established regulatory procedures. This memorandum may not be shown or distributed to any other party without the prior written consent of Milliman, Inc. Furthermore, any distribution of this report must be in its entirety.

I, [REDACTED] is employed by Milliman, Inc. and I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion in this report.

[REDACTED]

[REDACTED] FSA, MAAA
Consulting Actuary
April 26, 2013

**Exhibit 1
NYS EHB Gym Benefit Substitution**

Standard Demographics from Milliman's HCGs			NYS EHB Gym Benefit Pricing		MVP - Non Standard Plan Wellness Benefit <i>Lump Sum - Per Contract</i>	
<u>Four Tier</u>	<u>Total Contracts</u>	<u>Total Members</u>	<u>Modeled Benefit</u>	<u>Total Cost</u>	<u>Benefit</u>	<u>Total Cost</u>
Single	5,325	5,325	\$400.00	\$2,130,000	\$100.00	\$532,500
Individual & Spouse	1,276	2,552	\$600.00	\$765,600	\$100.00	\$127,600
Individual & Child(ren)	916	2,428	\$400.00	\$366,400	\$100.00	\$91,600
Family	2,483	10,008	\$600.00	\$1,489,800	\$100.00	\$248,300
Total	10,000	20,313	\$475.18	\$4,751,800	\$100.00	\$1,000,000
Assumed Uptake Rate (Single and Individual & Spouse):				2.5%	10.0%	
Assumed Uptake Rate (Individual & Child(ren) and Family):				2.5%	15.0%	
Estimated PMPM:			EHB Gym PMPM	\$0.49	MVP Total PMPM	\$0.48

Assuming \$125 Benefit

Standard Demographics from Milliman's HCGs			MVP - Non Standard Plan Wellness Benefit <i>Lump Sum - Per Contract</i>	
<u>Four Tier</u>	<u>Total Contracts</u>	<u>Total Members</u>	<u>Benefit</u>	<u>Total Cost</u>
Single	5,325	5,325	\$125.00	\$665,625
Individual & Spouse	1,276	2,552	\$125.00	\$159,500
Individual & Child(ren)	916	2,428	\$125.00	\$114,500
Family	2,483	10,008	\$125.00	\$310,375
Total	10,000	20,313	\$125.00	\$1,250,000
Assumed Uptake Rate (Single and Individual & Spouse):				11.0%
Assumed Uptake Rate (Individual & Child(ren) and Family):				20.0%
Estimated PMPM:			MVP Total PMPM	\$0.72

**Exhibit 2
PT/OT/ST Substitution**

PT/OT/ST

	2014 Cases per 1,000 Members	2014 Avg. Allowed Charge	2014 Allowed PMPM
60 visit limit			
Outpatient Facility	220	\$53.81	\$0.99
Office Setting	1,053	\$53.81	\$4.72
Total			\$5.71
54 visit limit			
Outpatient Facility	211	\$53.81	\$0.95
Office Setting	1,009	\$53.81	\$4.52
Total			\$5.47

2014 PMPM Differential

\$0.24

Acupuncture

% of Population	Number of Annual Visits	Average Annual Vists	2014 Allowed Charge per Visit	2014 Allowed PMPM
98.57%	0	0.0	\$0.00	\$0.00
0.4%	1	1.0	\$70.00	\$0.02
1.0%	2-5	3.5	\$70.00	\$0.20
0.1%	6-12	9.0	\$70.00	\$0.04

Estimated 2014 PMPM

\$0.26

ACTUARIAL CERTIFICATION

for

MVP HEALTH CARE

NEW YORK STATE

**ACTUARIAL EQUIVALENT EHB SUBSTITUTIONS FOR
GYM REIMBURSEMENT BENEFIT
AND
OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY BENEFIT
EFFECTIVE JANUARY 1, 2014**

I, [REDACTED] Consulting Actuary, 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, and I have reviewed MVP Health Care's Non Standard Plan Wellness Benefit and MVP Health Care's Non Standard PT/OT/ST Benefit that will be effective January 1, 2014.

I certify, that to the best of my knowledge, MVP Health Care's Non Standard Plan Wellness and Non Standard PT/OT/ST Essential Health Benefits (EHB) substitutions are actuarially equivalent and are:

- Made only within the same EHB category,
- Based on a standardized plan population,
- Determined regardless of cost-sharing,
- In accordance with generally accepted actuarial principles and methodologies, and
- In compliance with the Department of Health and Human Services (HHS) and New York State Insurance Law.

[REDACTED]

[REDACTED] FSA, MAAA

Consulting Actuary

April 26, 2013

Appendix C- Detailed Description of QI Program Expense

Improve Health Outcomes

1.0001	All	Effective Case Management, Disease Management, Care Coordination. Oversight of these activities Quality activities such as physician profiling, performance review, clinical reporting, chart review, member and provider focused outreach.
1.0002	All	Oversight of these activities
1.0003	All	Behavioral Health vendor fees; Case Management, clinical reporting, referrals Medical Management support on case review to prevent avoidable hospital admissions, encourage evidence based medicine. Oversight of
1.0004	All	medical home model.
1.0005	All	ICD-10 Implementation
1.0006	All	Medical Affairs admin allocation, support of QI activities.
1.0007	All	Medical Informatics allocation, support of QI activities.
1.0008	All	Chiro & Acupuncture vendor fees; outreach encouraging appropriate patient treatment

Improve Patient

3.0001	All	Prospective Utilization Management; Medical & Pharmacy
3.0002	All	Radiology vendor fees; prospective utilization review
3.0003	All	Medical Affairs admin allocation, support of QI activities.
3.0004	All	Medical Informatics allocation, support of QI activities.

Wellness & Health Promotion

4.0001	All	Worksite Health Promotions that support the deployment of the "Work Well Live Well" program to employer groups and Wellness Assessments
4.0002	All	Health Promotional Communications
4.0003	All	Medical Affairs admin allocation, support of QI activities.
4.0004	All	Medical Informatics allocation, support of QI activities.

HIT Expenses for Health Care Quality Improvements

5.0001	All	Amortization & Maintenance of Medical Management Software & Hardware; Technology that improve quality of care and provide the infrastructure to enhance current QI or make new QI initiatives possible.
5.0002	All	Quality department costs associated with reporting & analysis to maintain HEDIS & NCQA accreditation. Oversight of these activities
5.0003	All	Lab vendor fees; quality reporting
5.0004	All	Medical Affairs admin allocation, support of QI activities.
5.0005	All	Medical Informatics allocation, support of QI activities.



MEMO

April 26, 2013

One Pennsylvania Plaza,
38th Floor
New York, NY 10119
Tel +1 646 473.3000
Fax +1 646 473.3199
www.milliman.com

To [REDACTED] (MVP)
From [REDACTED] (Milliman)
Subject New York State EHB Pricing

As requested, we have estimated the cost of the following benefits included by New York State in its Essential Health Benefits (EHB) package:

- Pediatric dental
- Pediatric vision
- Disposable medical supplies
- Bariatric surgery
- Cardiac rehabilitation
- Hearing aids
- Wigs
- Prosthetics
- Wellness reimbursement benefit

MVP Health Care (MVP) does not currently offer these benefits or offer the benefits at lower contractual limits than the EHB package for New York State.

Results

Our estimates for the incremental 2014 Per Member Per Month (PMPM) costs, assuming a standard population, for each of the additional benefits are outlined below. Please note, all PMPM costs are on an allowed basis, except for pediatric dental, which is shown on a net of member cost sharing basis.



BENEFIT	ESTIMATED 2014 PAID PMPM – INDIVIDUAL	ESTIMATED 2014 PAID PMPM – SMALL GROUP
Pediatric Dental (standard cost-sharing)		
Catastrophic	\$2.91	N/A
Bronze	\$7.62	\$6.96
Silver	\$8.44	\$7.71
Gold	\$9.53	\$8.70
Platinum	\$10.61	\$9.69
Pediatric Dental (MVP non-standard)		
Catastrophic	\$5.01	N/A
Bronze	\$7.77	\$7.10
Silver	\$7.90	\$7.21
Gold	\$8.56	\$7.81
Platinum	\$9.11	\$8.32

BENEFIT	ESTIMATED 2014 ALLOWED PMPM – INDIVIDUAL	ESTIMATED 2014 ALLOWED PMPM – SMALL GROUP
Pediatric Vision	\$1.20	\$1.09
Disposable Medical Supplies	\$0.14	\$0.13
Bariatric Surgery	\$0.00 ¹	\$0.00 ¹
Cardiac Rehabilitation	\$0.00 ²	\$0.00 ²
Hearing Aids	\$0.08	\$0.07
Wigs	\$0.02	\$0.02
Prosthetics	\$0.00 ³	\$0.00 ³

¹MVP currently offers one per lifetime. We do not believe there is a material incremental cost to extend this benefit to unlimited.

²MVP currently offers 36 visits per year. We do not believe there is a material incremental cost to extend this benefit to unlimited.

³MVP currently offers prosthetics when medically necessary. We do not believe there is a material incremental cost to offer one external prosthetic device per limb per lifetime.



Methodology

In the process of estimating the incremental costs for each service listed above, we use Milliman's Health Cost Guidelines (HCGs)¹ and Truven Health Analytics MarketScan Commercial Database (MarketScan)². The underlying experience of each of these tools is primarily representative of large group. We have therefore increased our estimates by 5% to reflect utilization differences between the current large group market and the small group market post-2014 and 15% to reflect utilization differences between the current large group market and the individual market post-2014.

The 15% adjustment factor considers utilization differences separately between current large group and small group post-2014 and small group post-2014 to the individual market post-2014. While we believe eventually the small group market will approach the large group market in terms of utilization rates, we do not believe in the first year under Affordable Care Act (ACA) this will be the case so we assume a small differential of 5% between small and large group. Using Tables 2A and 2B in Deloitte's paper "Impact of the Affordable Care Act on the New York Small Group and Non-Group Markets" we believe that a 10% utilization adjustment from small group to the individual market post-2014 is appropriate.

Below, we describe in more detail the methodology for each benefit.

Pediatric Dental

Using Milliman's 2011 Dental HCGs, we estimated New York State's standard pediatric dental benefit and MVP's non-standard benefit. MVP's member cost-sharing for the non-standard benefit is:

- Preventative: 100%, not subject to any deductible
- Routine Dental Care: 80%, subject to any deductible
- Endodontics: 50%, subject to any deductible
- Prosthodontics: 50%, subject to any deductible
- Orthodontics: 50%, subject to any deductible

Our estimates are by each metal tier and represent net claims costs after member cost sharing. Our assumptions include:

- Area adjusting the HCGs to represent MVP's service area in NY.

¹ The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually. The HCGs provide a flexible but consistent basis for the determination of health claim costs and premium rates for a wide variety of health plans. The HCGs are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as they are used in measuring the experience or evaluating the rates of health plans, and as they are compared to other data sources.

² This database contains all paid claims generated by approximately 35 million commercially insured lives. The MarketScan database represents the inpatient and outpatient healthcare service use of individuals nationwide who are covered by the benefit plans of large employers, health plans, government, and public organizations. The MarketScan database links paid claims and encounter data to detailed patient information across sites and types of providers, and over time. The annual medical database includes private sector health data from approximately 100 payers.



- Based on Milliman experience and judgment, including reasonable dental discounts to derive unit costs.
- Trending unit cost by 3% annually and utilization by 1% annually to develop 2014 PMPMs. These trend assumptions are developed from Milliman’s secular dental trend rates.
- Applying 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 to reflect in utilization for each metal tier:

INDUCED DEMAND ADJUSTMENTS	
Metal Level	Induced Demand Adjustment
Catastrophic	1.00
Bronze	1.00
Silver	1.03
Gold	1.08
Platinum	1.15

- Re-normalizing the induced demand adjustments to reflect that the underlying HCG data which is a silver plan.
- The catastrophic tier limits our standard demographics to under the age of 30.

Pediatric Vision

New York State is including the following pediatric vision (to age 18) benefits in its EHB package:

- 1 vision exam per year
- Vision hardware

We estimated the additional allowed PMPM cost for these benefits by calibrating our 2013 HCGs to MVP’s New York State service area and assuming 120% of Medicare’s Resource Based Relative Value fee schedule for provider reimbursement in this same service area. We trended the resulting per member amount by 6% per annum which is Milliman’s HCGs secular trend for professional services.

Disposable Medical Supplies

Using the 2010 Truven Health Analytics MarketScan Commercial Database (MarketScan) for the upstate New York region we identified all claims for the codes listed in Appendix A provided by MVP.

We trended the resulting per member amount by 6% per annum for 4 years.



Bariatric Surgery, Cardiac Rehabilitation, and Prosthetics

Currently, MVP offers:

- One bariatric surgery per lifetime
- 36 cardiac rehabilitation visits per year
- Prosthetics when medically necessary

The New York State EHB package has the following limits for these benefits:

- Unlimited bariatric surgeries
- Unlimited cardiac rehabilitation visits
- One external prosthetic device per limb per lifetimes

Using Milliman’s HCGs and actuarial judgment, we do not believe there is a material incremental cost for offering the EHB package coverage instead of MVP’s current benefits.

Hearing Aids

Using 2010 MarketScan for New York State, we identified all claims for hearing aids, as defined by Milliman’s HCGs.

We trended the resulting per member amount by 6% per annum for 4 years.

Wigs

New York State is including wigs in its EHB package when hair loss is due to disease or chemotherapy. Since wigs are not a commonly offered benefit, we are unable to derive credible utilization rates from the MarketScan database. Instead, we refer to published literature to estimate the incremental cost for wigs due to chemotherapy, assuming no additional cost for other diseases:

2014 ALLOWED WIG PMPM DEVELOPMENT		SOURCE
Cancer Incidence (Under 65)	0.22%	http://seer.cancer.gov/statfacts/html/all.html Accessed on March 18, 2013
Probability of Losing Hair Under Chemo	65%	http://www.derma-haarcenter.ch/files/Directory/Publikationen/Chemotherapy.pdf Accessed on March 18, 2013
Percent Female	48%	http://seer.cancer.gov/statfacts/html/all.html Accessed on March 18, 2013
2014 Unit Cost for Wigs	\$379.31	2010 Nationwide MarketScan (HCPCS A9282, trended annually at 6%)
2014 PMPY(Per Member Per Year)	\$0.26	
2014 PMPM	\$0.02	



Data Reliance

We relied on the following files provided by MVP:

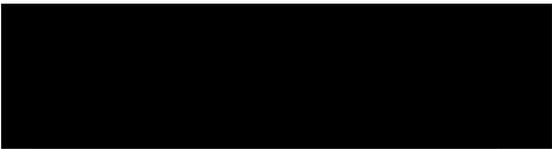
- HCPCS codes that require Disposable Coverage8 2011 (NOT AN ALL INCLUSIVE LIST).xlsx
- E-mail dated April 11, 2013 from Kathleen Fish
- E-mail dated March 25, 2013 from Kathleen Fish

Additional Notes and Caveats

Our models are based on the assumptions listed above and the data you have provided to us. If you believe any of our assumptions are incorrect, please let us know and we will amend our models accordingly. Actual experience will vary from expected.

This memorandum was prepared for the internal use of MVP Health Care and statutory provisions in the State of New York protect its confidentiality. This report may be provided to insurance regulators in New York for their internal use in accordance with established regulatory procedures. This memorandum may not be shown or distributed to any other party without the prior written consent of Milliman, Inc. Furthermore, any distribution of this report must be in its entirety.

██████████ is employed by Milliman, Inc. and is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion in this report.



██████████ FSA, MAAA
Consulting Actuary
April 26, 2013

Appendix A

HCPCS Used For Identifying Disposable Medical Supplies

A4206	A4284	A4365	A4611	A4772	A6214	A6259	A7008
A4208	A4305	A4396	A4611	A4773	A6216	A6260	A7009
A4209	A4306	A4402	A4612	A4802	A6218	A6261	A7010
A4210	A4310	A4450	A4612	A4927	A6219	A6262	A7011
A4212	A4311	A4450	A4613	A4929	A6220	A6266	A7012
A4213	A4312	A4450	A4613	A4930	A6222	A6402	A7013
A4216	A4313	A4452	A4614	A5102	A6223	A6403	A7014
A4217	A4314	A4452	A4615	A5105	A6224	A6404	A7015
A4217	A4315	A4452	A4616	A5112	A6228	A6407	A7016
A4221	A4316	A4455	A4617	A5113	A6229	A6410	A7018
A4222	A4320	A4456	A4618	A5114	A6230	A6412	A7501
A4233	A4322	A4461	A4618	A5200	A6231	A6441	A7502
A4234	A4326	A4463	A4619	A6010	A6232	A6442	A7503
A4235	A4327	A4465	A4620	A6011	A6233	A6443	A7504
A4236	A4328	A4470	A4623	A6021	A6234	A6444	A7505
A4244	A4330	A4480	A4624	A6022	A6235	A6445	A7506
A4245	A4331	A4481	A4625	A6023	A6236	A6446	A7507
A4246	A4332	A4490	A4626	A6024	A6237	A6447	A7508
A4247	A4333	A4495	A4627	A6025	A6238	A6448	A7509
A4250	A4334	A4500	A4628	A6154	A6240	A6449	A7523
A4253	A4338	A4510	A4629	A6196	A6241	A6452	A7524
A4255	A4340	A4550	A4630	A6197	A6242	A6453	A7525
A4256	A4344	A4554	A4633	A6199	A6243	A6454	A7526
A4256	A4346	A4556	A4635	A6200	A6244	A6455	A7527
A4257	A4349	A4557	A4635	A6201	A6245	A6456	B4034
A4258	A4351	A4558	A4636	A6202	A6246	A6457	B4035
A4258	A4352	A4559	A4636	A6203	A6247	A6531	B4036
A4259	A4353	A4561	A4637	A6204	A6248	A6532	L8621
A4259	A4354	A4562	A4637	A6206	A6251	A6545	L8622
A4262	A4355	A4565	A4639	A6207	A6252	A6550	L8623
A4263	A4356	A4570	A4640	A6209	A6253	A7000	L8624
A4265	A4357	A4590	A4640	A6210	A6254	A7001	
A4267	A4358	A4595	A4680	A6211	A6255	A7002	
A4269	A4360	A4605	A4690	A6212	A6257	A7004	
A4280	A4364	A4608	A4750	A6213	A6258	A7007	

User Inputs for Plan Parameters

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

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

Desired Metal Tier

Platinum

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

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			
Coinsurance (% Insurer's Cost Share)			
OOP Maximum (\$)			
OOP Maximum if Separate (\$)			

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

Options for Additional Benefit Design Limits:

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

Output

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

User Inputs for Plan Parameters

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

Desired Metal Tier: Gold

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$600.00	\$0.00				
Coinsurance (% Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum (\$)	\$4,000.00					
OOP Maximum if Separate (\$)						

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

Options for Additional Benefit Design Limits:

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

Output

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

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$2,000.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	100.00%	100.00%
OOP Maximum (\$)	\$5,500.00	
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	96%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	92%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$3,000.00
Coinsurance (%; Insurer's Cost Share)			50.00%
OOP Maximum (\$)			\$6,350.00
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			
Coinsurance (%; Insurer's Cost Share)			
OOP Maximum (\$)			
OOP Maximum if Separate (\$)			

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

Options for Additional Benefit Design Limits:

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

Output

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

User Inputs for Plan Parameters

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

Non-Standard Gold 1

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

Desired Metal Tier Gold

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$850.00	\$100.00	
Coinsurance (% , Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$45.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$45.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$45.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$45.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$45.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	92.24%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	93.22%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$5.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input type="checkbox"/>
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input checked="" type="checkbox"/>
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

78.2%

Metal Tier:

Gold

User Inputs for Plan Parameters

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

Non-Standard Gold 2

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$1,400.00
Coinsurance (% , Insurer's Cost Share)		100.00%
OOP Maximum (\$)		\$6,350.00
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$5.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	96.12%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	98.31%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$5.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input type="checkbox"/>	100
Specialty Rx Coinsurance Maximum: <input type="text"/>	25
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10): <input type="text"/>	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10): <input type="text"/>	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10): <input type="text"/>	

Output

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

User Inputs for Plan Parameters

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

Non-Standard Silver 1

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

Desired Metal Tier Silver

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,900.00	\$100.00	
Coinsurance (% , Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$350.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>	80%		<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$350.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	80%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	86.71%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	84.68%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$8.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:
 Actuarial Value:
 Metal Tier:

Calculation Successful.
 69.2%
 Silver

User Inputs for Plan Parameters

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

Non-Standard Silver 2

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

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

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$350.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>	80%		<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$350.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	80%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	91.14%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	84.68%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$8.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input type="checkbox"/>	Specialty Rx Coinsurance Maximum:
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	# Days (1-10):
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input checked="" type="checkbox"/>	# Visits (1-10): 3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	# Copays (1-10):

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 68.3%
 Metal Tier: Silver

User Inputs for Plan Parameters

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

Non-Standard silver 3

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

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

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

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible? <input checked="" type="checkbox"/> All	Subject to Coinsurance? <input type="checkbox"/> All	Coinsurance, if different	Copay, if separate	Subject to Deductible? <input type="checkbox"/> All	Subject to Coinsurance? <input type="checkbox"/> All	Coinsurance, if different	Copay, if separate
Medical								
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	91.14%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	92.34%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs								
Generics	<input type="checkbox"/> All	<input type="checkbox"/> All		\$10.00	<input type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input type="checkbox"/>	200
Specialty Rx Coinsurance Maximum: <input type="checkbox"/>	100
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 68.0%
 Metal Tier: Silver

User Inputs for Plan Parameters

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

Non-standard Bronze 1

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$3,500.00	\$200.00	
Coinsurance (% Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>	50%		<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>	50%		<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$80.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$80.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$80.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$80.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$80.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	50%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	85.51%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	74.56%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful.
60.9%
Bronze

User Inputs for Plan Parameters

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

Non-Standard Bronze 2

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$4,000.00
Coinsurance (% , Insurer's Cost Share)		100.00%
OOP Maximum (\$)		\$6,350.00
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$350.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>	70%		<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	70%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	85.51%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	74.56%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$8.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input type="checkbox"/>	Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>	# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input checked="" type="checkbox"/>	# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>	# Copays (1-10):	

Output

Status/Error Messages:
 Actuarial Value:
 Metal Tier:

Calculation Successful.
 61.7%
 Bronze

User Inputs for Plan Parameters

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

Non-Standard Bronze 3

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$4,000.00
Coinsurance (% , Insurer's Cost Share)		100.00%
OOP Maximum (\$)		\$6,350.00
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input type="checkbox"/>	<input type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>	70%		<input type="checkbox"/>	<input type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	70%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input type="checkbox"/>	95.17%		<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input type="checkbox"/>	91.52%		<input type="checkbox"/>	<input type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$5.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful.
58.7%
Bronze

Appendix F - Development of "Index" PMPM Claim Rate Individual Market

Line Reference	Info Only	Info only	Total Combined Single Risk Pool Group Data
	MVP Health Plan Group	MVP Health Insurance Company Group	
1 Incurred Net Claims (DOS 10/1/11 - 9/30/12)	40,082,875	193,077,572	233,160,447
2 Membermonths	121,668	608,357	730,025
3 Experience Period Incurred Claims PMPM	\$329.44	\$317.38	\$319.39
4 EHB Adjustments to Experience Period Incurred Medical Claims	\$2.16	(\$1.06)	(\$0.52)
5 EHB Adjustments to Experience Period Incurred Rx Claims	\$4.82	\$5.56	\$5.44
6 Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.149	1.161	1.153
7 EHB Adjustments to the Projection Period Incurred Claims	\$2.01	\$1.60	\$1.67
8 Total Projected Incurred Claims after EHB adjustments (sum lines 3-5 X line 6 + line 7)	\$388.55	\$375.36	\$375.58
9 Market wide adjustment for changes in provider network (Adjust for no CIGNA)	\$0.00	(\$7.51)	(\$6.26)
10 Market wide adjustment for fee schedule changes	\$0.00	\$0.00	(\$13.90)
11 Market wide adjustment for utilization management changes	\$0.00	\$0.00	(\$1.74)
12 Impact on risk pool of changes in expected covered membership risk characteristics	\$0.00	\$0.00	\$0.00
13 Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only] *			1.151
14 Total Projected Incurred Claims after Network and Risk Pool adjustments (sum lines 8-12 X line 13)	\$388.55	\$367.85	\$407.18
15 Adjustment for changes in distribution of risk pool membership by rating regions	\$0.00	\$0.00	\$0.00
16 Experience Period Federal Risk Adjustment Program Results from DFS Simulation	(\$68.91)	(\$56.29)	(\$58.39)
17 Projection Period Federal Risk Adjustment Program Results from DFS Simulation	(\$79.17)	(\$64.05)	(\$63.18)
18 Adjustment Factor to account for DFS Simulation Margin of Error	0.75	0.75	0.75
19 Final Projection Period Federal Risk Adjustment Program Impact Adjustment	(\$59.38)	(\$48.04)	(\$47.38)
20 Federal Transitional Reinsurance Program Recovery [Indiv. Only]	(\$29.53)	(\$37.10)	(\$35.84)
21 Impact of adjustments due to experience period claim data not being sufficiently credible	\$0.00	\$0.00	\$0.00
22 Final Index PMPM Claim Rate (line 14 - line 19 - line 20)			\$323.96

Appendix G - Development of Gross PMPM by Plan Individual Market

Plan Name	Avg Loss Ratio for Inforce Mix	Standard Bronze 56184NY0140010 NY-HMO-DB-001-S (2014)	Standard Silver 56184NY0140012 NY-HMO-DS-001-S (2014)	Standard Gold 56184NY0140014 NY-HMO-DG-001-S (2014)	Standard Platinum 56184NY0140016 NY-HMO-DP-001-S (2014)	Non-Standard Bronze 2 56184NY0150008 NY-HMO-DB-002-N (2014)	Non-Standard Silver 2 56184NY0150009 NY-HMO-DS-002-N (2014)	Non-Standard Gold 1 56184NY0150010 NY-HMO-DG-001-N (2014)	
HOIS Plan ID									
MVP Form ID (Off Exchange)									
Final Index PMPM claim rate	\$323.96	\$323.96	\$323.96	\$323.96	\$323.96	\$323.96	\$323.96	\$323.96	
Average Experience Period AV Pricing Value	0.808	0.808	0.808	0.808	0.808	0.808	0.808	0.808	
Average Experience Period Induced Demand Factor	1.094	1.094	1.094	1.094	1.094	1.094	1.094	1.094	
Average Experience Period Total AV Pricing Value	0.884	0.884	0.884	0.884	0.884	0.884	0.884	0.884	
Plan Level Adjustments									
Pricing actuarial value (without induced demand factor)	0.808	0.570	0.724	0.834	0.926	0.597	0.719	0.822	
Pricing actuarial value (only the induced demand factor)	1.094	1.000	1.030	1.080	1.150	1.000	1.030	1.080	
Impact of provider network characteristics (non Standard Individual Only)	1.000	1.000	1.000	1.000	1.000	0.969	0.969	0.969	
Impact of delivery system characteristics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Other (non standard Gym benefit above the standard Gym benefit)	-	\$0.00	\$0.00	\$0.00	\$0.00	\$0.24	\$0.24	\$0.24	
Final Plan Specific Net Index PMPM claim rate (before non claim expense loads)	\$323.94	\$208.89	\$273.28	\$330.08	\$390.25	\$212.24	\$263.22	\$315.49	
Non Claim Expenses for Taxes/Administration/Risk Charge									
Federal Taxes PMPM*	\$5.50	\$5.50	\$5.50	\$5.50	\$5.50	\$5.50	\$5.50	\$5.50	
Federal Taxes (Premium Based)	2.0%	\$7.90	\$5.14	\$6.68	\$8.04	\$9.48	\$5.22	\$6.44	
State Premium Taxes (Premium Based)	0.0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
State 332 Assessment Taxes (Premium Based)	0.7%	\$2.76	\$1.80	\$2.34	\$2.81	\$3.32	\$1.83	\$2.25	
General Plan Administration(Premium Based)	9.7%	\$38.29	\$24.92	\$32.40	\$39.01	\$46.00	\$25.31	\$31.24	
Administration Expense due to Quality Improvement (Premium Based)	0.8%	\$3.16	\$2.06	\$2.67	\$3.22	\$3.79	\$2.09	\$2.58	
Broker Expense (Premium Based)	1.2%	\$4.74	\$3.08	\$4.01	\$4.83	\$5.69	\$3.13	\$3.86	
Bad Debt Expense	0.15%	\$0.59	\$0.39	\$0.50	\$0.60	\$0.71	\$0.39	\$0.48	
Profit/Contribution to surplus margins (Premium Based)	2.0%	\$7.90	\$5.14	\$6.68	\$8.04	\$9.48	\$5.22	\$6.44	
Final Plan Specific Gross Index PMPM claim rate	\$394.77	\$256.90	\$334.07	\$402.14	\$474.24	\$260.92	\$322.01	\$384.65	
Expected Earned Gross PMPM Premium net bad debt expense	\$394.18	\$256.52	\$333.57	\$401.53	\$473.52	\$260.53	\$321.53	\$384.07	
NYS Target Loss Ratio	82.2%	81.4%	81.9%	82.2%	82.4%	81.5%	81.9%	82.1%	
Federal Target Loss Ratio	86.5%	86.4%	86.5%	86.5%	86.6%	86.4%	86.5%	86.5%	

Appendix G - Development of Gross PMPM by Plan Individual Market

Plan Name	Non-Standard Bronze 1	Non-Standard Silver 1	Non-Standard Bronze 3	Non-Standard Silver 3	Non-Standard Gold 2	Compcare POS replacement
HOIS Plan ID	56184NY0150012	56184NY0150013	56184NY0200004	56184NY0200005	56184NY0200006	56184NY0140018
MVP Form ID (Off Exchange)	NY-HMO-DB-001-N (2014)	NY-HMO-DS-001-N (2014)	NY-HMOH-DB-003-N (2014)	NY-HMOH-DS-003-N (2014)	NY-HMOH-DG-002-N (2014)	NY-POS-DP-001-S (2014)
Final Index PMPM claim rate	\$323.96	\$323.96	\$323.96	\$323.96	\$323.96	\$323.96
Average Experience Period AV Pricing Value	0.808	0.808	0.808	0.808	0.808	0.808
Average Experience Period Induced Demand Factor	1.094	1.094	1.094	1.094	1.094	1.094
Average Experience Period Total AV Pricing Value	0.884	0.884	0.884	0.884	0.884	0.884
Plan Level Adjustments						
Pricing actuarial value (without induced demand factor)	0.591	0.696	0.568	0.723	0.781	0.926
Pricing actuarial value (only the induced demand factor)	1.000	1.030	1.000	1.030	1.080	1.150
Impact of provider network characteristics (non Standard Individual Only)	0.969	0.969	0.969	0.969	0.969	1.000
Impact of delivery system characteristics	1.000	1.000	1.000	1.000	1.000	1.000
Impact of utilization management practices	1.000	1.000	1.000	1.000	1.000	1.000
Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000
Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000
Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.170
Other (non standard Gym benefit above the standard Gym benefit)	\$0.24	\$0.24	\$0.24	\$0.24	\$0.24	\$0.00
Final Plan Specific Net Index PMPM claim rate (before non claim expense loads)	\$210.11	\$254.81	\$201.94	\$264.68	\$299.76	\$456.59
Non Claim Expenses for Taxes/Administration/Risk Charge						
Federal Taxes PMPM*	\$5.50	\$5.50	\$5.50	\$5.50	\$5.50	\$5.50
Federal Taxes (Premium Based)	2.0%	\$5.17	\$6.24	\$4.97	\$6.48	\$7.32
State Premium Taxes (Premium Based)	0.0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
State 332 Assessment Taxes (Premium Based)	0.7%	\$1.81	\$2.18	\$1.74	\$2.27	\$2.56
General Plan Administration(Premium Based)	9.7%	\$25.06	\$30.26	\$24.11	\$31.41	\$35.48
Administration Expense due to Quality Improvement (Premium Based)	0.8%	\$2.07	\$2.50	\$1.99	\$2.59	\$2.93
Broker Expense (Premium Based)	1.2%	\$3.10	\$3.74	\$2.98	\$3.89	\$4.39
Bad Debt Expense	0.15%	\$0.39	\$0.47	\$0.37	\$0.49	\$0.55
Profit/Contribution to surplus margins (Premium Based)	2.0%	\$5.17	\$6.24	\$4.97	\$6.48	\$7.32
Final Plan Specific Gross Index PMPM claim rate	\$258.37	\$311.93	\$248.58	\$323.77	\$365.80	\$553.73
Expected Earned Gross PMPM Premium net bad debt expense	\$257.98	\$311.46	\$248.21	\$323.28	\$365.26	\$552.90
NYS Target Loss Ratio	81.4%	81.8%	81.4%	81.9%	82.1%	82.6%
Federal Target Loss Ratio	86.4%	86.5%	86.4%	86.5%	86.5%	86.6%

Appendix H : Numerical Example Illustrating Methodology Used to Compute Standardized Premiums

Standardized Premium Example Calculation

Coplan	Rate Region	Renewal Month	Renewal Year	Pre-Renewal Members	Pre-Renewal Prem	Pre-Renewal Quarter	Post-Renewal Members	Post-Renewal Prem	Post-Renewal Quarter	Standard Premium
E050S	R	7	2010	2,996	\$714,964.22	3Q2009	1,335	\$306,011.64	3Q2010	\$1,995,332.13
E050S	R	7	2011	1024	\$330,713.17	3Q2010	146	\$50,387.64	3Q2011	\$574,757.52
E050S	R	7	2012	180	\$64,716.84	3Q2011	108	\$53,351.87	3Q2012	\$141,896.99

Coplan E050S Historical Rate Change w/ 4Q 2013 Aggregate Change

Quarterly Change	Quarterly Increase	Contract	Aggregate Change
2Q 09 / 1Q 09	1.020	1Q2009	2.288
3Q 09 / 2Q 09	1.053	2Q2009	2.243
4Q 09 / 3Q 09	1.020	3Q2009	2.131
1Q 10 / 4Q 09	1.285	4Q2009	2.089
2Q 10 / 1Q 10	1.022	1Q2010	1.625
3Q 10 / 2Q 10	1.030	2Q2010	1.589
4Q 10 / 3Q 10	1.023	3Q2010	1.542
1Q 11 / 4Q 10	1.124	4Q2010	1.508
2Q 11 / 1Q 11	1.023	1Q2011	1.342
3Q 11 / 2Q 11	1.022	2Q2011	1.312
4Q 11 / 3Q 11	1.023	3Q2011	1.284
1Q 12 / 4Q 11	1.089	4Q2011	1.255
2Q 12 / 1Q 12	1.023	1Q2012	1.153
3Q 12 / 2Q 12	1.022	2Q2012	1.127
4Q 12 / 3Q 12	1.031	3Q2012	1.103
1Q 13 / 4Q 12	1.000	4Q2012	1.069
2Q 13 / 1Q 13	1.023	1Q2013	1.069
3Q 13 / 2Q 13	1.023	2Q2013	1.046
4Q 13 / 3Q 13	1.022	3Q2013	1.022

Explanation of Methodology

Standard Premium for Period Year 2010 $(714,962.22 * 2.131) + (306,011.54 * 1.542)$
Standard Premium for Period Year 2011 $(330,713.17 * 1.542) + (50,387.64 * 1.284)$
Standard Premium for Period Year 2012 $(64,716.84 * 1.284) + (53,351.87 * 1.103)$

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

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: IND

- 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. In Column 4, market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY SG). Use the drop down list to enter the market segment.
- C. 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-ON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans and 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 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/Y)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholder s affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change	10. [Blank]	14.1 Beginning Date of the experience period (MM/DD/Y Y)	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 of 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 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) (\$)		
ECOC 2008	Preferred EPO	MVP Preferred EPO, TriVantage EPO, Bridgewell	Small Group HIC	01/01/14	SG	EPO	Yes	Open	1,220	8,345	XX	10/01/11	09/30/12	207,550	\$85,477,712	\$104,209,779	\$76,772,248	\$70,105,426	\$0	(\$36,058)	\$15,042,891	XX	
PCOC 2008	Preferred PPO	MVP Preferred PPO	Small Group HIC	01/01/14	SG	PPO	Yes	Open	211	1,667	XX	10/01/11	09/30/12	27,185	\$13,552,512	\$16,316,051	\$13,558,757	\$13,170,524	\$0	(\$6,774)	\$2,507,308	XX	
42-CERT-HDHP-EPO (6/05)	Preferred High Deductible EPO	MVP Preferred High Deductible EPO, LocalNet Capital District	Small Group HIC	01/01/14	SG	Consumer Health Plans	Yes	Open	1,890	20,590	XX	10/01/11	09/30/12	353,522	\$100,138,616	\$127,432,453	\$102,964,272	\$102,309,671	\$0	(\$52,622)	\$22,675,669	XX	
42-CERT-HDHP-PPO (6/05)	Preferred High Deductible PPO	MVP Preferred High Deductible PPO	Small Group HIC	01/01/14	SG	Consumer Health Plans	Yes	Open	171	1,492	XX	10/01/11	09/30/12	20,100	\$6,458,418	\$8,133,026	\$7,172,034	\$7,491,951	\$0	(\$3,853)	\$1,341,501	XX	
42-CERT-EPO (5/02)	EPO	EPO	Small Group HIC	01/01/14	SG	EPO	Yes	Closed	0	0	XX	10/01/11	09/30/12	0	\$0	\$0	\$9,110	\$0	\$0	(\$0)	\$0	XX	
42-CERT-PPO (3/01)	PPO	PPO	Small Group HIC	01/01/14	SG	PPO	Yes	Closed	0	0	XX	10/01/11	09/30/12	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	XX
ECOC 2008	Preferred EPO	MVP Preferred EPO, TriVantage EPO, Bridgewell	Small Group HIC	01/01/14	SP	EPO	Yes	Open	763	1,216	XX	10/01/11	09/30/12	25,834	\$12,293,123	\$14,781,696	\$14,080,148	\$13,306,555	\$0	(\$6,844)	\$1,963,265	XX	
PCOC 2008	Preferred PPO	MVP Preferred PPO	Small Group HIC	01/01/14	SP	PPO	Yes	Open	340	628	XX	10/01/11	09/30/12	8,733	\$5,216,564	\$6,331,370	\$6,628,627	\$6,219,935	\$0	(\$3,199)	\$859,516	XX	
42-CERT-HDHP-EPO (6/05)	Preferred High Deductible EPO	MVP Preferred High Deductible EPO, LocalNet Capital District	Small Group HIC	01/01/14	SP	Consumer Health Plans	Yes	Open	550	925	XX	10/01/11	09/30/12	15,269	\$4,904,957	\$5,930,490	\$4,107,963	\$4,119,282	\$0	(\$2,119)	\$1,018,992	XX	
42-CERT-HDHP-PPO (6/05)	Preferred High Deductible PPO	MVP Preferred High Deductible PPO	Small Group HIC	01/01/14	SP	Consumer Health Plans	Yes	Open	1	4	XX	10/01/11	09/30/12	180	\$44,452	\$50,797	\$4,473	\$4,830	\$0	(\$2)	\$11,099	XX	
		Small Group HIC Subtotal		01/01/14					5,146	34,867	XX	10/01/11	09/30/12	658,373	\$228,086,354	\$283,185,660	\$225,297,632	\$216,728,174	\$0	(\$111,473)	\$45,420,240	XX	
44-CERT-HMO (7/05)	HMO	HMO	SG HMO	01/01/14	SG	HMO	Yes	Open	913	3,542	XX	10/01/11	09/30/12	51,923	\$23,611,207	\$27,786,434	\$23,002,646	\$19,935,941	\$0	\$953,846	\$3,310,777	XX	
44-CERT-HMO (7/05)	HMO	HMO	SG HMO	01/01/14	SP	HMO	Yes	Open	0	0	XX	10/01/11	09/30/12	0	\$0	\$0	\$83,736	\$0	\$0	\$0	\$0	XX	
		SG HMO Subtotal		01/01/14					913	3,542	XX	10/01/11	09/30/12	51,923	\$23,611,207	\$27,786,434	\$23,086,382	\$19,935,941	\$0	\$953,846	\$3,310,777	XX	
HNY-GR-CNTR9/2000	HNY w Rx, HNY without Rx, HD HNY w Rx, HD HNY without Rx	Healthy NY with Rx, Healthy NY without Rx, High Deductible Healthy NY with Rx, High Deductible Healthy NY without Rx	HNY	01/01/14	SG	HMO	Yes	Open	1,286	5,237	XX	10/01/11	09/30/12	69,745	\$19,931,462	\$23,773,223	\$22,272,382	\$20,146,934	\$3,349,513	\$0	\$4,101,479	XX	
HNY-GR-CNTR9/2000	HNY w Rx, HNY without Rx, HD HNY w Rx, HD HNY without Rx	Healthy NY with Rx, Healthy NY without Rx, High Deductible Healthy NY with Rx, High Deductible Healthy NY without Rx	HNY	01/01/14	SP	HMO	Yes	Open	1,711	2,725	XX	10/01/11	09/30/12	30,991	\$8,335,915	\$9,974,236	\$9,945,706	\$11,102,833	\$1,845,893	\$0	\$1,815,502	XX	
HNY-I-SUB-CTR9/2000	HNY w Rx, HNY without Rx, HD HNY w Rx, HD HNY without Rx	Healthy NY with Rx, Healthy NY without Rx, High Deductible Healthy NY with Rx, High Deductible Healthy NY without Rx	HNY	01/01/14	HNY-IND	HMO	Yes	Open	2,468	3,248	XX	10/01/11	09/30/12	41,412	\$11,510,258	\$13,788,953	\$15,709,020	\$16,234,604	\$3,759,382	\$0	\$1,710,317	XX	
		HNY Subtotal		01/01/14					5,465	11,210	XX	10/01/11	09/30/12	142,148	\$39,777,635	\$47,536,412	\$47,927,108	\$47,484,370	\$8,954,787	\$0	\$7,627,298	XX	
OPEN2 (6/16/99)	Standard Individual Direct Pay	CompCare	CC	01/01/14	IND	HMO	No	Open	215	238	XX	10/01/11	09/30/12	2,828	\$3,102,337	\$3,372,887	\$4,774,236	\$4,252,775	\$226,204	(\$683,317)	\$430,358	XX	

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

Data Item for Spec			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) (\$)		
ECOC 2008	Preferred EPO	MVP Preferred EPO, TriVantage EPO, Bridgewell	10/01/10	09/30/11	367,456	\$132,037,029	\$186,401,722	\$122,484,319	\$116,737,762	\$0	(\$13,980)	\$24,841,862	XX	10/01/09	09/30/10	640,620	\$198,668,874	\$370,376,035	\$180,496,378	\$185,728,134	\$0	\$2,463,083	\$33,450,555	XX
PCOC 2008	Preferred PPO	MVP Preferred PPO	10/01/10	09/30/11	35,236	\$16,182,712	\$21,852,609	\$17,456,219	\$14,933,635	\$0	(\$1,788)	\$3,006,764	XX	10/01/09	09/30/10	49,629	\$19,531,762	\$34,449,265	\$20,665,935	\$21,596,677	\$0	\$286,410	\$3,235,111	XX
42-CERT-HDHP-EPO (6/05)	Preferred High Deductible EPO	MVP Preferred High Deductible EPO, LocalNet Capital District	10/01/10	09/30/11	386,060	\$96,403,483	\$142,701,271	\$79,713,470	\$90,922,199	\$0	(\$10,889)	\$23,003,555	XX	10/01/09	09/30/10	160,448	\$34,604,440	\$65,381,065	\$22,310,771	\$28,255,206	\$0	\$374,714	\$7,741,433	XX
42-CERT-HDHP-PPO (6/05)	Preferred High Deductible PPO	MVP Preferred High Deductible PPO	10/01/10	09/30/11	17,659	\$4,913,221	\$7,010,661	\$5,185,221	\$5,817,336	\$0	(\$697)	\$1,095,145	XX	10/01/09	09/30/10	7,664	\$1,812,633	\$3,102,204	\$922,835	\$1,229,479	\$0	\$16,305	\$383,154	XX
42-CERT-EPO (5/02)	EPO	EPO	10/01/10	09/30/11	280	\$148,070	\$194,381	\$546,369	\$459,602	\$0	(\$55)	\$22,058	XX	10/01/09	09/30/10	1,730	\$724,418	\$1,115,538	\$1,122,454	\$965,060	\$0	\$12,798	\$103,277	XX
42-CERT-PPO (3/01)	PPO	PPO	10/01/10	09/30/11	3	\$2,862	\$3,320	\$11,513	\$10,594	\$0	(\$1)	\$359	XX	10/01/09	09/30/10	110	\$69,865	\$112,954	\$61,625	\$59,032	\$0	\$783	\$8,954	XX
ECOC 2008	Preferred EPO	MVP Preferred EPO, TriVantage EPO, Bridgewell	10/01/10	09/30/11	37,499	\$16,091,411	\$22,203,165	\$16,345,628	\$15,960,933	\$0	(\$1,911)	\$2,707,643	XX	10/01/09	09/30/10	44,329	\$16,860,325	\$33,017,326	\$15,905,208	\$17,606,878	\$0	\$233,498	\$2,529,099	XX
PCOC 2008	Preferred PPO	MVP Preferred PPO	10/01/10	09/30/11	10,400	\$5,627,708	\$7,812,290	\$6,058,699	\$6,150,627	\$0	(\$737)	\$946,591	XX	10/01/09	09/30/10	10,477	\$4,768,035	\$8,923,479	\$5,733,740	\$5,578,239	\$0	\$73,977	\$726,221	XX
42-CERT-HDHP-EPO (6/05)	Preferred High Deductible EPO	MVP Preferred High Deductible EPO, LocalNet Capital District	10/01/10	09/30/11	12,202	\$3,495,314	\$4,831,808	\$2,004,643	\$2,475,609	\$0	(\$296)	\$765,279	XX	10/01/09	09/30/10	4,726	\$1,153,268	\$2,266,004	\$471,145	\$776,030	\$0	\$10,292	\$239,245	XX
42-CERT-HDHP-PPO (6/05)	Preferred High Deductible PPO	MVP Preferred High Deductible PPO	10/01/10	09/30/11	174	\$44,298	\$69,566	\$11,140	\$3,800	\$0	(\$0)	\$10,440	XX	10/01/09	09/30/10	470	\$120,553	\$203,836	\$106,971	\$102,528	\$0	\$1,360	\$24,284	XX
		Small Group HIC Subtotal	10/01/10	09/30/11	866,969	\$274,946,109	\$393,080,793	\$249,817,221	\$253,472,098	\$0	(\$30,355)	\$56,399,696	XX	10/01/09	09/30/10	920,203	\$278,314,174	\$518,947,706	\$247,797,061	\$261,897,263	\$0	\$3,473,220	\$48,441,334	XX
44-CERT-HMO (7/05)	HMO	HMO	10/01/10	09/30/11	109,412	\$44,763,803	\$59,267,592	\$41,492,599	\$38,635,105	\$0	\$1,194,824	\$6,423,029	XX	10/01/09	09/30/10	200,853	\$74,867,243	\$114,420,508	\$71,325,370	\$67,080,934	\$0	\$716,426	\$10,763,045	XX
44-CERT-HMO (7/05)	HMO	HMO	10/01/10	09/30/11	1,066	\$513,765	\$721,834	\$1,218,567	\$870,684	\$0	\$26,927	\$64,860	XX	10/01/09	09/30/10	5,074	\$2,352,728	\$3,692,951	\$3,666,062	\$2,992,018	\$0	\$31,955	\$283,626	XX
		SG HMO Subtotal	10/01/10	09/30/11	110,478	\$45,277,568	\$59,989,425	\$42,711,166	\$39,505,789	\$0	\$1,221,751	\$6,487,889	XX	10/01/09	09/30/10	205,927	\$77,219,972	\$118,113,460	\$74,991,432	\$70,072,952	\$0	\$748,381	\$11,046,672	XX
HNY-GR-CNTR9/2000	HNY w Rx, HNY without Rx, HD HNY w Rx, HD HNY without Rx	Healthy NY with Rx, Healthy NY without Rx, High Deductible Healthy NY with Rx, High Deductible Healthy NY without Rx	10/01/10	09/30/11	70,028	\$18,463,293	\$24,385,573	\$18,671,567	\$18,949,481	\$1,145,414	\$0	\$4,142,698	XX	10/01/09	09/30/10	69,544	\$16,541,267	\$24,999,614	\$14,798,476	\$13,181,069	\$4,780,280	\$0	\$2,998,423	XX
HNY-GR-CNTR9/2000	HNY w Rx, HNY without Rx, HD HNY w Rx, HD HNY without Rx	Healthy NY with Rx, Healthy NY without Rx, High Deductible Healthy NY with Rx, High Deductible Healthy NY without Rx	10/01/10	09/30/11	28,825	\$7,281,590	\$9,780,958	\$10,281,273	\$9,852,332	\$595,531	\$0	\$1,701,601	XX	10/01/09	09/30/10	25,617	\$6,168,223	\$9,335,495	\$2,188,950	\$4,494,699	\$1,630,059	\$0	\$1,105,271	XX
HNY-I-SUB-CNTR9/2000	HNY w Rx, HNY without Rx, HD HNY w Rx, HD HNY without Rx	Healthy NY with Rx, Healthy NY without Rx, High Deductible Healthy NY with Rx, High Deductible Healthy NY without Rx	10/01/10	09/30/11	46,607	\$12,111,250	\$16,027,656	\$17,381,213	\$17,992,091	\$1,259,743	\$0	\$1,271,767	XX	10/01/09	09/30/10	39,939	\$9,750,279	\$13,965,614	\$6,749,249	\$9,368,462	\$4,840,015	\$0	\$1,661,155	XX
		HNY Subtotal	10/01/10	09/30/11	145,460	\$37,856,133	\$50,194,187	\$46,334,053	\$46,793,904	\$3,000,688	\$0	\$7,116,066	XX	10/01/09	09/30/10	135,100	\$32,459,769	\$48,300,722	\$23,736,674	\$27,044,230	\$11,250,354	\$0	\$5,764,849	XX
OPEN2 (6/16/99)	Standard Individual Direct Pay	CompCare	10/01/10	09/30/11	2,554	\$2,756,639	\$3,061,191	\$3,607,670	\$4,074,977	\$75,401	(\$972,388)	\$217,855	XX	10/01/09	09/30/10	2,250	\$2,450,339	\$2,785,505	\$2,540,935	\$2,688,590	\$257,804	(\$344,345)	\$86,664	XX

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

<u>Line #</u>	<u>General</u>				
1	Product*	Exchange Standard Individual	Exchange Standard Individual	Exchange Standard Individual	Exchange Standard Individual
2	Product ID*	56184NY014	56184NY014	56184NY014	56184NY014
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold	Platinum
4	AV Metal Value (HHS Calculator)*	0.620	0.707	0.790	0.881
5	AV Pricing Value (total, risk pool experience based)*	0.570	0.724	0.834	0.926
6	Plan Type*	HMO	HMO	HMO	HMO
7	Plan Name*	Standard Bronze	Standard Silver	Standard Gold	Standard Platinum
8	Plan ID*	56184NY0140010	56184NY0140012	56184NY0140014	56184NY0140016
9	Exchange Plan?*	Yes	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	55,240,814
10B	Member-Months for Latest Experience Period	125,247
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	441.05
11	Average Pricing Actuarial Value reflected in experience period	0.918
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	480.47

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

Line #

General

**Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate**

13	Impact of adjusting experience period data to EHB benefit level	1.000
14	Market wide adjustment for changes in provider network **	1.000
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Impact on risk pool of changes in expected covered membership risk characteristics **	1.000
18	Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]	1.000
19	Adjustment for changes in distribution of risk pool membership by rating regions ** by the standard rating regions	1.000
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	1.000
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.000
24	Other 1 (specify)	1.000
25	Other 2 (specify)	1.000
26	Other 3 (specify)	1.000
27	Impact of Market Wide Adjustments (product L13 through L26)	1.000

** Not Included in Claim Trend Adjustment

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

Line #

General

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	
29	Pricing actuarial value (only the induced demand factor) #	
30	Impact of provider network characteristics ##	
31	Impact of delivery system characteristics ##	
32	Impact of utilization management practices ##	
33	Benefits in additional to EHB (greater than 1.00)	
34	Administrative costs (excluding Exchange user fees and profits)	
35	Profit/Contribution to surplus margins	
36	Impact of eligibility categories (catastrophic plans only)	
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	
39	Other 1 (specify)	
40	Other 2 (specify)	
41	Impact of Plan Level Adjustments (product L28 through L40)	0.000

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

Beyond what is reflected in Market Wide adjustments

42	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)	
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Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>				
1	Product*	Exchange Non-Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual
2	Product ID*	56184NY015	56184NY015	56184NY015	56184NY015
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold	Bronze
4	AV Metal Value (HHS Calculator)*	0.617	0.683	0.782	0.609
5	AV Pricing Value (total, risk pool experience based)*	0.597	0.719	0.822	0.591
6	Plan Type*	HMO	HMO	HMO	HMO
7	Plan Name*	Non-Standard Bronze 2	Non-Standard Silver 2	Non-Standard Gold 1	Non-Standard Bronze 1
8	Plan ID*	56184NY0150008	56184NY0150009	56184NY0150010	56184NY0150012
9	Exchange Plan?*	Yes	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period
10B	Member-Months for Latest Experience Period
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)
11	Average Pricing Actuarial Value reflected in experience period
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)

Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

Line #

General

Plan Level Adjustments

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

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)
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Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>				
1	Product*	Exchange Non-Standard Individual	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual
2	Product ID*	56184NY015	56184NY020	56184NY020	56184NY020
3	Metal Level (or catastrophic)*	Silver	Bronze	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.692	0.587	0.680	0.782
5	AV Pricing Value (total, risk pool experience based)*	0.696	0.568	0.723	0.781
6	Plan Type*	HMO	HDHP HMO	HDHP HMO	HDHP HMO
7	Plan Name*	Non-Standard Silver 1	Non-Standard Bronze 3 HDHP	Non-Standard Silver 3	Non-Standard Gold 2
8	Plan ID*	56184NY0150013	56184NY0200004	56184NY0200005	56184NY0200006
9	Exchange Plan?*	Yes	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period
10B	Member-Months for Latest Experience Period
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)
11	Average Pricing Actuarial Value reflected in experience period
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)

Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

Line #

General

Plan Level Adjustments

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

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)
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Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>	
1	Product*	Exchange Standard Individual
2	Product ID*	56184NY014
3	Metal Level (or catastrophic)*	Platinum
4	AV Metal Value (HHS Calculator)*	0.881
5	AV Pricing Value (total, risk pool experience based)*	0.926
6	Plan Type*	POS
7	Plan Name*	Compcare POS replacement
8	Plan ID*	56184NY0140018
9	Exchange Plan?*	No

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period
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)

Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

Line # **General**
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 (specify)
25	Other 2 (specify)
26	Other 3 (specify)
27	Impact of Market Wide Adjustments (product L13 through L26)

** Not Included in Claim Trend Adjustment

Exhibit 8 - Index Rate/Plan Design Level Adjustment Works

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

Line #

General

Plan Level Adjustments

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

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)
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Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Standard Individual	Exchange Standard Individual	Exchange Standard Individual
2	Product ID*	56184NY014	56184NY014	56184NY014
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.707	0.790
5	AV Pricing Value (total, risk pool experience based)*	0.570	0.724	0.834
6	Plan Type*	HMO	HMO	HMO
7	Plan Name*	Standard Bronze	Standard Silver	Standard Gold
8	Plan ID*	56184NY0140010	56184NY0140012	56184NY0140014
9	Exchange Plan?*	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	233,160,447		
10B	Member-Months for Latest Experience Period	730,025		
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	319.39		
11	Average Pricing Actuarial Value reflected in experience period	0.884		
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	361.30	361.30	361.30

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

<u>Line #</u>	<u>General</u>			
1		Product*	Exchange Standard Individual	Exchange Standard Individual
2		Product ID*	56184NY014	56184NY014

**Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate**

13	Impact of adjusting experience period data to EHB benefit level	1.020
14	Market wide adjustment for changes in provider network **	0.983
15	Market wide adjustment for fee schedule changes **	0.962
16	Market wide adjustment for utilization management changes **	0.995
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]	1.151
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)	0.884
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.900
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)	1.153
24	Other 1 (specify)	1.000
25	Other 2 (specify)	1.000

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Standard Individual	Exchange Standard Individual	Exchange Standard Individual
2	Product ID*	56184NY014	56184NY014	56184NY014
26	Other 3 (specify)	1.000		
27	Impact of Market Wide Adjustments (product L13 through L26)	1.014	1.014	1.014

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.570	0.724	0.834
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.030	1.080
30	Impact of provider network characteristics ##	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.205	1.198	1.194
35	Profit/Contribution to surplus margins	1.020	1.020	1.020
36	Impact of eligibility categories (catastrophic plans only)	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

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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

<u>Line #</u>	<u>General</u>			
1		Product*	Exchange Standard Individual	Exchange Standard Individual
2		Product ID*	56184NY014	56184NY014
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY		1.000	1.000
41	Other (non standard Gym benefit above the standard Gym benefit)		1.000	1.000
42	Impact of Plan Level Adjustments (product L28 through L41)		0.701	0.912

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

43	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L42)	256.90	334.07	402.14
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Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

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<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual
2	Product ID*	56184NY014	56184NY015	56184NY015
3	Metal Level (or catastrophic)*	Platinum	Bronze	Silver
4	AV Metal Value (HHS Calculator)*	0.881	0.617	0.683
5	AV Pricing Value (total, risk pool experience based)*	0.926	0.597	0.719
6	Plan Type*	HMO	HMO	HMO
7	Plan Name*	Standard Platinum	Non-Standard Bronze 2	Non-Standard Silver 2
8	Plan ID*	56184NY0140016	56184NY0150008	56184NY0150009
9	Exchange Plan?*	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period			
10B	Member-Months for Latest Experience Period			
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)			
11	Average Pricing Actuarial Value reflected in experience period			
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	361.30	361.30	361.30

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: Individual

je)

Line #	General			
1		Product*	Exchange Standard Individual	Exchange Non-Standard Individual
2		Product ID*	56184NY014	56184NY015

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 (specify)
25	Other 2 (specify)

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

je)

<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual
2	Product ID*	56184NY014	56184NY015	56184NY015
26	Other 3 (specify)			
27	Impact of Market Wide Adjustments (product L13 through L26)	1.014	1.014	1.014

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.926	0.597	0.719
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.000	1.030
30	Impact of provider network characteristics ##	1.000	0.969	0.969
31	Impact of delivery system characteristics ##	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.191	1.205	1.199
35	Profit/Contribution to surplus margins	1.020	1.020	1.020
36	Impact of eligibility categories (catastrophic plans only)	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

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: Individual

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<u>Line #</u>	<u>General</u>			
1		Product*	Exchange Standard Individual	Exchange Non-Standard Individual
2		Product ID*	56184NY014	56184NY015
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY		1.000	1.000
41	Other (non standard Gym benefit above the standard Gym benefit)		1.000	1.001
42	Impact of Plan Level Adjustments (product L28 through L41)		1.294	0.712

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

43	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L42)	474.24	260.92	322.01
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Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Non-Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual
2	Product ID*	56184NY015	56184NY015	56184NY015
3	Metal Level (or catastrophic)*	Gold	Bronze	Silver
4	AV Metal Value (HHS Calculator)*	0.782	0.609	0.692
5	AV Pricing Value (total, risk pool experience based)*	0.822	0.591	0.696
6	Plan Type*	HMO	HMO	HMO
7	Plan Name*	Non-Standard Gold 1	Non-Standard Bronze 1	Non-Standard Silver 1
8	Plan ID*	56184NY0150010	56184NY0150012	56184NY0150013
9	Exchange Plan?*	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period			
10B	Member-Months for Latest Experience Period			
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)			
11	Average Pricing Actuarial Value reflected in experience period			
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	361.30	361.30	361.30

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: Individual

Line #	General	Exchange Non-Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual
1	Product*			
2	Product ID*	56184NY015	56184NY015	56184NY015

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 (specify)
25	Other 2 (specify)

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Non-Standard Individual	Exchange Non-Standard Individual	Exchange Non-Standard Individual
2	Product ID*	56184NY015	56184NY015	56184NY015
26	Other 3 (specify)			
27	Impact of Market Wide Adjustments (product L13 through L26)	1.014	1.014	1.014

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.822	0.591	0.696
29	Pricing actuarial value (only the induced demand factor) #	1.080	1.000	1.030
30	Impact of provider network characteristics ##	0.969	0.969	0.969
31	Impact of delivery system characteristics ##	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.195	1.205	1.200
35	Profit/Contribution to surplus margins	1.020	1.020	1.020
36	Impact of eligibility categories (catastrophic plans only)	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

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>			
1		Product*	Exchange Non-Standard Individual	Exchange Non-Standard Individual
2		Product ID*	56184NY015	56184NY015
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY		1.000	1.000
41	Other (non standard Gym benefit above the standard Gym benefit)		1.001	1.001
42	Impact of Plan Level Adjustments (product L28 through L41)		1.050	0.705

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

43	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L42)	384.65	258.37	311.93
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Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>			
1	Product*	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual
2	Product ID*	56184NY020	56184NY020	56184NY020
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.587	0.680	0.782
5	AV Pricing Value (total, risk pool experience based)*	0.568	0.723	0.781
6	Plan Type*	HDHP HMO	HDHP HMO	HDHP HMO
7	Plan Name*	Non-Standard Bronze 3 HDHP	Non-Standard Silver 3	Non-Standard Gold 2
8	Plan ID*	56184NY0200004	56184NY0200005	56184NY0200006
9	Exchange Plan?*	Yes	Yes	Yes

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period			
10B	Member-Months for Latest Experience Period			
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)			
11	Average Pricing Actuarial Value reflected in experience period			
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	361.30	361.30	361.30

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>			
1		Product*	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual
2		Product ID*	56184NY020	56184NY020

**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 (specify)
25	Other 2 (specify)

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual
1	Product*			
2	Product ID*	56184NY020	56184NY020	56184NY020
26	Other 3 (specify)			
27	Impact of Market Wide Adjustments (product L13 through L26)	1.014	1.014	1.014

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.568	0.723	0.781
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.030	1.080
30	Impact of provider network characteristics ##	0.969	0.969	0.969
31	Impact of delivery system characteristics ##	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.206	1.199	1.196
35	Profit/Contribution to surplus margins	1.020	1.020	1.020
36	Impact of eligibility categories (catastrophic plans only)	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

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: Individual

<u>Line #</u>	<u>General</u>	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual	Exchange Non-Standard HD Individual
1	Product*			
2	Product ID*	56184NY020	56184NY020	56184NY020
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000
41	Other (non standard Gym benefit above the standard Gym benefit)	1.001	1.001	1.001
42	Impact of Plan Level Adjustments (product L28 through L41)	0.678	0.883	0.998

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

43	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L42)	248.58	323.77	365.80
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Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>	
1	Product*	Exchange Standard Individual
2	Product ID*	56184NY014
3	Metal Level (or catastrophic)*	Platinum
4	AV Metal Value (HHS Calculator)*	0.881
5	AV Pricing Value (total, risk pool experience based)*	0.926
6	Plan Type*	POS
7	Plan Name*	Compcare POS replacement
8	Plan ID*	56184NY0140018
9	Exchange Plan?*	No

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

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	
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)	361.30

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: Individual

Line #	General	
1	Product*	Exchange Standard Individual
2	Product ID*	56184NY014

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 (specify)
25	Other 2 (specify)

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>	
1	Product*	Exchange Standard Individual
2	Product ID*	56184NY014
26	Other 3 (specify)	
27	Impact of Market Wide Adjustments (product L13 through L26)	1.014

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.926
29	Pricing actuarial value (only the induced demand factor) #	1.150
30	Impact of provider network characteristics ##	1.000
31	Impact of delivery system characteristics ##	1.000
32	Impact of utilization management practices ##	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.189
35	Profit/Contribution to surplus margins	1.020
36	Impact of eligibility categories (catastrophic plans only)	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.170

Exhibit 8 "small group version" - Index Rate/Plan Design Level Adjustme

Company Name: MVP Health Plan, Inc.
NAIC Code: 95521
SERFF Number: MVPH-129027223
Market Segment: Individual

<u>Line #</u>	<u>General</u>	
1	Product*	Exchange Standard Individual
2	Product ID*	56184NY014
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000
41	Other (non standard Gym benefit above the standard Gym benefit)	1.000
42	Impact of Plan Level Adjustments (product L28 through L41)	1.511

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

43	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L42)	553.73
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EXHIBIT 9: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT FILING

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

Company Name: MVP Health Plan, Inc.
 NAIC Code: 95521
 SERFF Number: MVPH-129027223
 Market Segment: IND

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	
Bronze	Off Exchange	Standard Bronze	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	4.14%	9.70%	16.54%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.54%	1.80
Silver	Off Exchange	Standard Silver	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.65%	9.70%	16.05%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.05%	2.34
Gold	Off Exchange	Standard Gold	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.37%	9.70%	15.77%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.77%	2.81
Platinum	Off Exchange	Standard Platinum	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.16%	9.70%	15.56%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.56%	3.32
Bronze	Off Exchange	Non-Standard Bronze 2	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	4.11%	9.70%	16.51%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.51%	1.83
Silver	Off Exchange	Non-Standard Silver 2	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.71%	9.70%	16.11%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.11%	2.25
Gold	Off Exchange	Non-Standard Gold 1	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.43%	9.70%	15.83%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.83%	2.69
Bronze	Off Exchange	Non-Standard Bronze 1	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	4.13%	9.70%	16.53%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.53%	1.81
Silver	Off Exchange	Non-Standard Silver 1	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.76%	9.70%	16.16%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.16%	2.18
Bronze	Off Exchange	Non-Standard Bronze 3	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	4.21%	9.70%	16.61%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.61%	1.74
Silver	Off Exchange	Non-Standard Silver 3	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.70%	9.70%	16.10%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.10%	2.27
Gold	Off Exchange	Non-Standard Gold 2	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	3.50%	9.70%	15.90%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.90%	2.56
Platinum	Off Exchange	CompCare POS replacement	01/01/14	12/31/14	6.53%	0.70%	0.80%	1.20%	0.00%	2.99%	9.70%	15.39%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.39%	3.88

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Bronze	Off Exchange	Standard Bronze	2.06	3.08	0.00	10.64	24.92	42.49	5.14	0.00	0.00	0.00	47.63
Silver	Off Exchange	Standard Silver	2.67	4.01	0.00	12.18	32.40	53.61	6.68	0.00	0.00	0.00	60.29
Gold	Off Exchange	Standard Gold	3.22	4.83	0.00	13.54	39.01	63.41	8.04	0.00	0.00	0.00	71.45
Platinum	Off Exchange	Standard Platinum	3.79	5.69	0.00	14.98	46.00	73.79	9.48	0.00	0.00	0.00	83.27
Bronze	Off Exchange	Non-Standard Bronze 2	2.09	3.13	0.00	10.72	25.31	43.07	5.22	0.00	0.00	0.00	48.29
Silver	Off Exchange	Non-Standard Silver 2	2.58	3.86	0.00	11.94	31.24	51.87	6.44	0.00	0.00	0.00	58.31
Gold	Off Exchange	Non-Standard Gold 1	3.08	4.62	0.00	13.19	37.31	60.89	7.69	0.00	0.00	0.00	68.58
Bronze	Off Exchange	Non-Standard Bronze 1	2.07	3.10	0.00	10.67	25.06	42.70	5.17	0.00	0.00	0.00	47.87
Silver	Off Exchange	Non-Standard Silver 1	2.50	3.74	0.00	11.74	30.26	50.42	6.24	0.00	0.00	0.00	56.66
Bronze	Off Exchange	Non-Standard Bronze 3	1.99	2.98	0.00	10.47	24.11	41.30	4.97	0.00	0.00	0.00	46.27
Silver	Off Exchange	Non-Standard Silver 3	2.59	3.89	0.00	11.98	31.41	52.12	6.48	0.00	0.00	0.00	58.60
Gold	Off Exchange	Non-Standard Gold 2	2.93	4.39	0.00	12.82	35.48	58.18	7.32	0.00	0.00	0.00	65.49
Platinum	Off Exchange	CompCare POS replacement	4.43	6.64	0.00	16.57	53.71	85.24	11.07	0.00	0.00	0.00	96.31

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	MVP Health Plan, Inc. <small>Company submitting the rate adjustment request</small>	HMO - 44 <small>Company Type</small>	Not-for-Profit <small>Org. Type</small>	95221 <small>Company NAIC Code</small>
	625 State Street, Schenectady, NY 12305 <small>Company mailing address</small>			
B. Contact Person:	[REDACTED] <small>Rate filing contact person name, title</small>	[REDACTED] <small>Contact phone number</small>	[REDACTED] <small>Contact Email address</small>	
C. Actuarial Contact (If different from above):	[REDACTED] <small>Actuary name, title</small>	[REDACTED] <small>Actuary phone number</small>	[REDACTED] <small>Actuary Email address</small>	
D. New Rate Information (See Note #1):	1/1/14 - 12/31/14 <small>New rate applicability period</small>		1/1/2014 <small>New rate effective date</small>	MVPH-129027223 <small>SERFF Tracking Number</small>
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	Individual and Sole Proprietors			
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).				
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?				
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).				
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?				
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.				

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.



Actuarial Memorandum
MVP Health Plan, Inc.
2014 New York Individual OFF Exchange Rate Filing
(With Appendices B-H)

Scope and Purpose

This memorandum details the methods and assumptions underlying the proposed 2014 premium rates for the Individual Market outside the Exchange. These products will be issued by MVP Health Plan, Inc., a subsidiary of MVP Health Care, Inc. All of the products and premium rates proposed comply with the requirements of the Federal ACA. These are all new products and therefore are being filed as normal pre approval filings subject to Section 4308(b) of the New York Insurance law.

The Individual Market premium rates are effective between 1/1/2014 and 12/31/2014. Rates and benefits will be reset on 1/1/15.

The product portfolio and proposed premium rates included herein are the same as those offered on the Individual Exchange with the following exceptions:

1. The Non Standard Platinum 1 and Non Standard Platinum 2 plans offered on the Exchange will not be available off exchange and therefore are not included in this rate filing.
2. The Catastrophic Plan and all of the Silver Plan and American Indian/Native American subsidy plan variations are not included. These are only available on Exchange per Federal ACA Regulation.
3. One additional plan, the CompCare POS Replacement Plan, is new and offered only OFF exchange, per New York State requirements.

Market/Benefits

A summary description of benefit plans and riders being offered is included in the Rate Manual. All Essential Health Benefits (EHB) are covered. For the Non Standard Plan offerings two actuarial equivalent EHB substitutions were made, one for the Standard Gym reimbursement benefit and the other for the PT/OT/ST benefit. MVP contracted Milliman, Inc. to determine the actuarial equivalence of the benefit substitutions. The supporting memorandum is included as Appendix B. There are no additional benefits included in these proposed plans in excess of the EHB.

The Pediatric Dental EHB is being satisfied by a partnership with Delta Dental. MVP has signed a letter of intent to partner with Delta Dental to satisfy the EHB requirement relating to Pediatric Dental. The dental benefits and premium rates are not included in this rate filing. These benefits will be issued by Delta dental. The benefits and premium rates for these benefits will be the same benefits and rates Delta dental will offer for direct sale members. Members will be informed at the time of sale of this partnership. Members are not required to purchase Delta dental through MVP. The letter of intent is included in the supporting documentation included with the SERFF submission.

Experience Period Claims

MVP Health Plan, Inc. and MVP Health Insurance Company's existing small employer group market historical claim data was the starting basis of the premium rate development as directed by DFS. MVP Health Plan data comprised the commercial employer group market as well as the Healthy New York employer group market. All Sole Proprietor data was removed and excluded from this experience basis. Per New York State requirements, these covered members will be required to purchase in the Individual Market upon renewal in 2014. All grandfathered and non grandfathered membership was included. There were no products excluded. No adjustments were made to the experience period claims for the impact of Regulation 146 or for Stop Loss reimbursement pools.

MVP combined the experience of these two companies to form a more credible experience base. The claim data is assumed to be fully credible. The experience period for the historical claims is incurred dates of service beginning 10/1/11 through 9/30/12, paid through 3/31/13. The experience period data complies with the single risk pool requirement of the Federal ACA.

An allowance for incurred but not reported (IBNR) paid claims was added to the experience period claims. The IBNR factors were supplied directly from MVP's reserving actuary. MVP uses a combination PMPM and completion factor method to develop IBNR estimates. New York specific data for the experience period was used to develop the factors and they are consistent with the IBNR factors used in MVP's monthly financial statements.

The experience period claim data includes claims from our fee for service claim warehouse along with additional medical expenses like capitations and other non fee for service medical expenses like medical home, physician incentive payments, wellness incentives, New York State HCRA and Covered lives assessments and net reinsurance expenses.

The experience period claims were reconciled with the IBNR lag triangles to ensure accuracy.

Appendix F illustrates the development of the "Index" PMPM claim rate starting with the experience period claim data shown separately for the MVP Health Plan, Inc. and MVP Health Insurance Company small group membership so to illustrate the market wide adjustments made to each pool prior to combining for the single risk pool Index Rate.

Market Wide Adjustments to Experience Period Claims

Several adjustments to the experience period claim data were necessary to adjust for the benefit changes included in the EHB Benchmark plan for New York State as well as for current benefit mandates not yet reflected in the experience period. Most of the adjustments were made prior to trend. Some were made on the basis of the 2014 projection period as these adjustments were provided by Milliman, Inc. on a 2014 cost basis. The adjustments are explained below.

Benefit costs removed from Experience Period Claims

The following benefits were covered in one or more of the products included in the experience period risk pool either as a standard covered benefit or as an optional rider: pediatric dental, vision exams and hardware, acupuncture and wellness rewards. All expenses associated with these benefits were removed from the experience period data.

Benefit costs added to Experience Period Claims

The following benefits were not standard covered benefits in one or more of the products included in the experience period risk pool but are New York State EHB benchmark requirements: Mental Health and Substance Abuse, Chiropractic care and full Pharmacy coverage. Estimated expenses associated with these benefits were added to the experience period data.

In addition to new benefit cost adjustments, the cost sharing associated with preventative services covered under the Grandfathered Healthy New York products were added to the experience period as well as the cost sharing associated

with the Federal mandate to cover contraceptive drugs in full under the woman's preventative mandate. The costs associated with this mandate are not yet reflected in the experience period.

The net impact of the claim cost adjustments to the experience period claim costs are illustrated on Lines 4 and 5 in Appendix F.

Market Wide Projection Period Adjustments to Experience Period Claims

New Benefits

Several other new covered benefits need to be accounted for as adjustments to the Index PMPM claim rate. They are as follows: Skilled Nursing Facility, Pediatric Vision, Disposable Medical Supplies, Hearing Aids, Wigs and the benchmark Gym membership benefit. The SNF benefit cost adjustment was only needed for the portion of the experience period associated with Healthy New York membership. The rest of the adjustments were added based on all of the membership. The cost estimates for these additional benefits were provided by Milliman, Inc. on a 2014 cost basis and therefore no additional trend was added.

Trend Factors

Trend factors were applied to the adjusted experience period incurred claims to project costs to the 2014 rating period. Annual unit cost and utilization trends were estimated for medical and pharmacy claim expenses for 2013 and 2014. The total projection period was 27 months from the midpoint of the experience period to the midpoint of the rating period (4/1/12 to 7/1/14).

For medical expenses, unit cost trends reflect known and anticipated changes to contracted provider reimbursement rates. The unit cost trend factors vary by region but have been weighted together based on the experience period membership mix across MVP's service area. Utilization trend did not vary by region and reflects modest expected increase in utilization. Recent trend studies have illustrated little to no utilization trend and therefore an uptick is expected in the underwriting cycle.

For Pharmacy expenses, the assumed unit cost and utilization trend factors used in the projection reflect trend factors provided by MVP's Pharmacy vendor, Express Scripts. Projected increases in MVP's non fee for service medical expenses (i.e. Capitations, HCRA charges, Medical home, etc.) reflect the anticipated increases for each of these items separately. Total trend rates were adjusted for leveraging impact that fixed member copay and deductible amounts have on the actual increase passed on to MVP as claim liability.

The total combined trend projection factor used to project the experience period claims to the rating period was 15.3% or 6.53% annualized. This is illustrated in Line 6 of Appendix F.

The average annual unit cost trend was 3.9% for the fee for service medical claims and 2.1% for pharmacy claims. The average annual utilization trend was 1.9% for fee for service medical and 1.9% for pharmacy. The combined unit cost and utilization increases represents the expected increase in the Allowed claim cost but not the final trend realized by the Health Insurer due to the impact that fixed deductibles and copayments have on the Health Plan's liability. Therefore, an additional trend factor is applied to reflect the impact of cost share leveraging on realized trends. The average annual leverage factor added was 0.70% for the medical claims and 0.67% for the pharmacy claims.

These factors were computed by trending the allowed claims from the experience period by the total trend, the copay cost sharing by only the utilization trends and the deductible cost sharing by the utilization trend and only a portion of the unit cost trend to reflect that some members have not yet met their deductible. The net paid claim trend is then computed by subtracting the projected cost sharing amounts from the projected allowed amounts. The excess trend above the allowed trend is the leveraging component of trend.

Network Changes

MVP Health Insurance Company small employer group data, which is part of the single risk pool experience base used as the basis for this rate setting, reflects a national network product portfolio. MVP partners with CIGNA to offer this

national network on this product portfolio. The products rated in this filing are HMO products with a network limited to MVP Health Plan Inc.'s service area. A 2% reduction to the MVP Health Insurance Company small employer group data was applied to reflect the anticipated cost of this national network on the experience claim base. This factor was derived based on an analysis of claims covered by CIGNA providers outside of MVP's service area compared to claims covered by MVP providers. The analysis was done on a regional basis taking into consideration case mix intensity of services and aggregated across all the regions. The 2% reduction is reflected on line 9 of Appendix F.

Fee Schedule Changes

MVP's network management staff contracted with the hospitals and physicians in MVP's network for lower reimbursement rates for the Individual Market relative to the existing commercial contracts wherever they were able to. Some parts of our service area were agreeable to this while others were not. Collectively across the entire service area, the individual reimbursement rates are expected to be 3.7% less than the current commercial group rates. This savings is reflected in line 10 of Appendix F.

Utilization Management Changes

Using contracted vendor software, MVP identified specific inefficient providers in our current commercial network. The providers were identified as having practice patterns of care that exceeded the mean efficiency of their peers. These providers were not re-contracted with for the Individual Market. A 0.46% reduction to the combined small group experience period data was applied to reflect the anticipated cost savings associated with removing these providers from the Individual Market network. This savings is reflected in line 11 of Appendix F.

Ratio of Individual Risk Pool to Small Group Risk Pool Adjustment

This adjustment is intended to reflect the expected relative morbidity difference in the 2014 rating period between the Individual Market and the Small Employer Group Market. The 1.151 factor illustrated on line 13 of Appendix F comes directly from the Deloitte published paper titled Impact of the Affordable Care Act on the New York Small Group and Non-Group Markets. The factor adjustment is calculated using the Adjusted Baseline relative morbidity factors from Table 2B: Morbidity as a factor of Average Monthly Small Group Health Insurance. The factor adjustment equals Post ACA (2014) Non Group factor = 1.119 divided by Post ACA (2014) Small Group factor = 0.972.

Federal Risk Adjustment

The basis for this experience period adjustment was the DFS commissioned Transfer Payment Risk Simulation project conducted by Deloitte using membership and claim detail from all of the current health insurers operating in the small group market in New York. The simulation was done by licensed legal entity by market (group vs. individual) to simulate the actual HHS risk adjustment that will take place for the first time in the spring of 2015. MVP used only the simulation results for small group markets to correspond to the experience period data being used to rate both the small group and individual market products in 2014. The actual PMPM transfer amounts for MVP's two legal entities were the starting point for the adjustment and are shown on line 16 of Appendix F. Two adjustments were made to these PMPM results prior to applying as an adjustment to the Index rate.

First the PMPM amounts were adjusted to reflect the projected changes in the underlying experience period data between the experience period and the projection period due to the collective impact of medical inflation, network changes, fee schedule changes and utilization management changes.

This adjusted PMPM amount was then reduced by 25% to account for the likelihood for the margin of error in the simulation results. MVP felt the simulation was reasonable in its methods and assumptions and therefore should be directionally reliable. However, there were many areas where less than perfect data was relied upon in the calculations. An example of this is the calculated actuarial values for the in-force benefit plans which are relied upon in the risk transfer formula. The final Federal Calculator was not available for this simulation and therefore a draft version was relied upon. Calculated AV's between the old and new calculator are significantly different in some cases. In addition to the draft use of the AV calculator, Deloitte and DFS were forced to rely on the integrity of all of the data submissions without any measurable audit capabilities.

MVP did not feel it would be actuarially justified to rely upon the full amount of the projected payment given the nature of the simulation exercise.

The final adjustment to the Index rate to account for the expected payment from the Federal Risk Adjustment program is reflected in line 19 of Appendix F.

Federal Transitional Reinsurance Program Recovery

The basis for this experience period adjustment was the DFS commissioned Transfer Payment Risk Simulation project which included in it expected reinsurance amounts for MVP's small group experience block. MVP used only the simulation reinsurance results for small group markets to correspond to the experience period data being used to rate both the small group and individual market products in 2014. The actual PMPM reinsurance recovery amounts for MVP's two legal entities for the 6% annual trend rate scenario were used which is close to the 6.5% average annual trend assumed in MVP's projection. The PMPM amounts were averaged together based on experience period member months to arrive the assumed reinsurance recovery adjustment to the Individual Market Index rate and is reflected on line 20 of Appendix F.

Exchange User Fees

No adjustment was applied per DFS instructions.

Impact of anticipated changes in membership distribution by standard rating regions

No adjustment was made for anticipated membership changes.

Actuarial Values

The AV Metal Level for each plan was determined using the Federal prescribed Actuarial Value Calculator. Benefit Plans with copay cost sharing for Outpatient Facility and Outpatient Surgery services were valued consistently with the methodology employed by DFS for the Standard plans. The coinsurance equivalents for MVP's Non Standard plans for copays other than \$100 were linearly interpolated from the coinsurance equivalents of the \$100 copay plans. For the MVP non Standard Bronze plans, MVP relied on Milliman, Inc. to compute a similar \$100 copay coinsurance equivalent. No adjustments were made to the calculator results.

The AV Pricing Value for each plan was determined using MVP's in house benefit pricing tools. The pricing tools value the expected net paid claim cost associated with unique benefit plan designs from a starting single risk pool allowed amount. The AV is the ratio of the expected paid to allowed amount for each plan design. MVP did not reflect any induced demand in the projection of the net paid amounts for each unique benefit plan. The induced demand factors used to develop the Final AV Pricing Values are equal to those included in the HHS Notice of Benefits and Payment Parameters for 2014 (Platinum = 1.15, Gold = 1.08, Silver = 1.03, Bronze = 1.0).

The AV Metal Level and the AV Pricing Value were determined for all of the inforce benefit plans reflected in the experience period data. Using the AV Metal level values and the prescribed mapping by DFS, MVP mapped all of the inforce membership by Metal level and then computed the weighted average Induced Demand factor using the factors prescribed in Notice of Benefits and Payment Parameters for 2014 and the member months by plan as weights. The computed average induced demand factor for the experience period inforce block is 1.094. The weighted average AV Pricing Value for the experience period inforce block was also computed using the member months as weights. The computed average AV Pricing Value was 0.808.

The following table reflects the distribution of membership by AV Metal Level for the experience period inforce block of business:

EP Membership by Metal Level - Fed AVC AV (Final)	Total Small Group	Induced Demand Factor
Platinum	36%	1.150

Gold	44%	1.080
Silver	18%	1.030
Bronze	2%	1.000
Total	100%	1.094

The product of the average Induced Demand factor and the average AV Pricing value equals the Total AV Pricing Value reflected in the Index PMPM claim rate and used as the basis for the Plan level adjustments and resulting premium rates.

No adjustments were made to the calculated AV from the HHS Calculator for the Inforce block of business. Given the large range for mapping the plans to metal levels it was determined to be immaterial to the final distribution of plans by metal level.

Appendix E1 and E2 include the AVC screenshots for all of the Plans included in this rate filing.

Plan Level Adjustments / Plan Specific Net and Gross Index PMPM rates

The Final Index PMPM rate from Appendix F is the starting basis for the development of the Plan Specific Final Net and Gross Index PMPM rates calculated in Appendix G. The Plan Specific Index PMPM rate for each plan is computed as follows:

- Final Index PMPM rate / (Avg Inforce Pricing AV x Avg Inforce Induced Demand Factor)
- Multiplied by
- The plan specific AV Pricing Value x Metal Level Induced Demand Factor)
- Multiplied by
- The product of all of the plan specific adjustment factors
- Plus
- The plan specific PMPM adjustments

These collective adjustments arrive at the Final Plan Specific Net Index PMPM claim rate before non claim expense loads get added to the rate.

Next the Final Plan Specific Gross Index PMPM rate for each plan is derived based on adding the plan level adjustments for PMPM expense loads and percent of premium expense loads to the Plan Specific Net Index PMPM claim rate for each plan.

Each plan level adjustment is explained below:

Claim expense plan level adjustments

Impact of provider network characteristics

The provider network associated with the Non Standard plans is a reduced network relative to the provider network associated with the Standard Plans. The Hospitals and Physicians removed from the Standard network reflect some of the higher cost providers in MVP's Standard Network and as a result this plan specific adjustment applies to all of the Non Standard plans only. The specific adjustment factor equal to 0.969 reflects the anticipated savings associated with this smaller provider network.

Impact of delivery system characteristics

No plan specific adjustments were made.

Impact of utilization management practices

No plan specific adjustments were made.

Benefits in addition to EHB (greater than 1.00)

No plan specific adjustments were made. There are no benefits added in addition to the EHBs.

Impact of eligibility categories (catastrophic plans only)

There is no catastrophic plan off exchange.

Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)

As required by New York State, a single POS plan offering is available exclusively for MVP's current CompCare members enrolled in the CompCare POS product. This plan is identical to the Standard Platinum Plan but with an out of network benefit included. The out of network benefit is equal to the current CompCare out of network benefit. The plan level adjustment factor equal to 1.17 accounts for this out of network benefit. This adjustment factor is based on the out of network loads included in MVP's current small group PPO portfolio and is slightly lower than the current out of network load included in MVP's POS CompCare product. This plan will sunset if no eligible individuals buy it.

Other (non standard Gym benefit above the standard Gym benefit)

The Gym benefit included in the Standard Plans was part of the EHB Benchmark plan for New York. The cost associated with this benefit is included in the Final Index PMPM claim rate developed in Appendix F so there is no plan level adjustment needed for the Standard Plans. For the Non Standard plans MVP contracted Milliman, Inc. to determine the dollar amount of an actuarially equivalent EHB substitution for this Gym benefit reflecting MVP's desired Wellness Reward benefit. The actuarially equivalent benefit is a \$100 per contract reimbursement allowance for subscribers based on a choice of three wellness activities: gym membership, youth sports/fitness or healthy weight support. The actuarial certification is included as Appendix B to this Memorandum. MVP's actual Wellness Reward benefit included in the Non Standard Plans is for a reimbursement amount equal to \$125 per contract. The additional cost associated with the extra \$25 dollars above the actuarially equivalent benefit is added as a plan level adjustment to the Non Standard Plans.

Non Claim Expense plan level adjustments

Non claim expenses include both percent of premium loads and PMPM loads. The loads do not vary by plan. Each Standard and Non Standard plan is being loaded with the same PMPM and Percent of Premium loads. The loads are outlined below.

Federal Taxes PMPM based

A total of \$5.50 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis and includes the following 3 taxes: \$5.25 reinsurance contribution rate, \$0.08 HHS risk adjustment user fee and \$0.17 Patient Centered Outcome Research Fee.

Federal Taxes Premium based

This is referred to as the ACA Insurer Tax and will be assessed as a premium based tax applicable to all health insurance carriers. The fee collected by HHS will vary each year beginning with \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017 and \$14.3 billion in 2018. Estimates provided to MVP by Optum Insight estimate the fee to be approximately 2% of premium in 2014 and rising in later years.

State Taxes Premium based – Premium Tax

MVP Health Plan, Inc. is a tax exempt company and therefore exempt from State Premium Taxes.

State Taxes Premium based – 332 Assessment

New York State funds its insurance department budget with an industry assessment attributable to premium market share. The 332 assessment reflected in MVP Health Plan's 2012 Statutory filings is 0.7% of assessable premium. This amount was added as a plan level adjustment.

In last year's prior approval rate applications it was assumed, in error, that this expense was covered in the general administrative load and as a result was in effect not built into the premium rates since the administrative load was needed to fund just the administrative expenses. The Standard Exhibit 2 from 2013 prior approval rate filings identified the 332 Assessment load as 0.9%. This was based on the 2011 assessment as a percent of premium.

General Administrative Expense Load (including QI)

The total administrative expense load included as a plan level adjustment is equal to 10.5% of premium. This reflects a higher expected administrative expense burden for the Individual market compared to the group market. This is consistent with the administrative load included in the 2013 Healthy New York prior approval rate application (assuming the load for the 332 assessment was 0%). The 2013 prior approval administrative load for the Individual Direct Pay product was 4.5% but on a premium base that was about 3 times higher than the 2014 rates.

Included in this load is 0.8% allocated to Quality Improvement/Cost Containment Programs based on the 2012 Statutory SHCE filing for the Individual lines of business.

MVP is currently working towards improving administrative efficiencies to reduce its operating expenses to align with pricing loads and assuming membership growth in 2014. The following table summarizes the administrative expenses for small group and individual lines of business from the 2012 Statutory SHCE's.

Administrative Cost Summary from SHCE's for 2012 Statutory Filings

MVP Health Insurance Company								
SHCE NY only:	Premium	SHCE QI expenses	SHCE Broker Fees	SHCE All Other Admin Expenses	SHCE QI expenses	SHCE Broker Fees	All other Admin / Premium	Total Admin
Comprehensive Individual								
Comprehensive Small Group	213,205,297	2,450,445	9,044,376	19,979,322	1.1%	4.2%	9.4%	14.8%

MVP Health Plan								
SHCE NY only:	Premium	SHCE QI expenses	SHCE Broker Fees	SHCE All Other Admin Expenses	SHCE QI expenses	SHCE Broker Fees	All other Admin/Premium	Total Admin
Comprehensive Individual	14,904,312	117,109	165,317	1,716,588	0.8%	1.1%	11.5%	13.4%
Comprehensive Small Group	49,712,310	621,360	835,913	7,100,102	1.2%	1.7%	14.3%	17.2%

Combined								
SHCE NY only:	Premium	SHCE QI expenses	SHCE Broker Fees	SHCE All Other Admin Expenses	SHCE QI expenses	SHCE Broker Fees	All other Admin/Premium	Total Admin
Comprehensive Individual	14,904,312	117,109	165,317	1,716,588	0.8%	1.1%	11.5%	13.4%
Comprehensive Small Group	262,917,607	3,071,805	9,880,289	27,079,424	1.2%	3.8%	10.3%	15.2%
Total Individual/Small Group	277,821,919	3,188,914	10,045,605	28,796,012	1.1%	3.6%	10.4%	15.1%

Broker Expense

MVP's broker distribution channel has a strong presence in today's small group and sole proprietor market. In 2012 83% of MVP Health Insurance Company's small group and sole proprietor premium revenue was commissioned and 61% of MVP Health Plan, Inc.'s small group and sole proprietor premium revenue was commissioned for a total average small group broker penetration rate equal to 81% of premiums.

For the Individual Market, the 2014 Broker commission rate will be 3% of premiums. Because sole proprietors and some individual Healthy New York members are accustomed to relying on broker services we expect brokers to have a presence in the Individual Market sales as well. How much is yet to be determined however and many of the new entrants may rely solely on the Exchange funded Navigators. As a result, MVP is assuming a lower Broker penetration rate (40%) in the Individual Market and therefore the plan level adjustment for the broker expense is 1.2%.

Profit/Risk Charge

A 2% profit/risk charge is added to premium rates as an expected contribution to reserves or protection against adverse experience relative to pricing assumptions. Surplus for MVP Health Plan, Inc. was 17.6% of premium for the year ending December 31, 2012. We have assumed a 2% profit margin which translates to a targeted 11.4% return on surplus. We believe this to be in line with the industry.

Bad Debt Expense

A plan level adjustment equal to 0.15% of premium was added to account for non payment of premium risk. This is in line with the actual cost of bad debt for MVP's current book of business.

Per Contract Premium Rates

The Plan Specific Gross PMPM Index Claim Rates computed in the Appendix G are converted to per contract premium rates in the Rate Manual using the computed single conversion factor and the prescribed standard load ratios.

The Rate Manual includes the Base Rate for each plan as well as the regional rate for each plan along with the rates for the mandatory make available riders.

The single conversion factor (SCF) was calculated using subscriber and member exposure months by contract type from the experience period used to develop the Index rate. The SCF = weighted average contract size/ weighted average load ratio. The table below illustrates the data used to compute the SCF.

In the Individual Market, Child Only policies are required to be offered at 41.2% of the single rate. As a result, it is likely that Single Parent contracts with only one child will purchase separate policies, and pay the single and child only rate vs. paying for the Parent +1 contract type which would be more expensive. The same result is likely for 2 parent families with only one child. MVP accounted for this in the calculation of the SCF.

Contract Type	Actual Contract Mix	Average Contract Size	Weighted Contract Size	Desired Load Factors	Weighted Loading Factors
4T-Single	56.7%	1.000	0.567	1.000	0.567
4T-Double	13.8%	2.000	0.276	2.000	0.276
4T-Parent (1 Child)	2.4%	2.000	0.048	1.412	0.034
4T-Parent (2+ Children)	1.8%	3.336	0.060	1.700	0.031
4T-Family (1 Children)	7.3%	3.000	0.219	2.412	0.176
4T-Family (2+ Children)	18.1%	4.521	0.818	2.850	0.516
Total	100%		1.988		1.600

Single Conversion Factor (SCF)	1.243
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Mandatory Make Available Riders

Dependent Thru Age 29 Add on Rider

This is an optional add on rider for the Standard Plans only. For the Non Standard Plans, coverage to age 29 is included in the base.

The premium rate for the rider is a 1% load to each contract rate. The factor load was derived based on the current riders on file for this benefit for MVP's inforce business which charge a 1% load to the Family Contracts only.

Beginning in 2014, standard contract load ratios apply. However for this benefit add on, no single and double contract holders will choose the Standard Plans that include the dependent thru age 29 benefit. Therefore, it is still appropriate to charge the current 1% load and apply it to all contract tier types.

As claim experience for these dependents to age 29 emerges under these products the cost associated with this expanded coverage will be removed from the single risk pool index rate through a market wide adjustment and added back through as a plan level adjustment for the Non standard plans so not to include these costs in the Standard Plans without the rider.

Pediatric Dental Add on Rider

This is an optional rider available for all Standard and Non Standard Plans. MVP contracted Milliman, Inc. to derive the cost associated with this benefit. The cost was developed on a PMPM basis by Metal level by Standard and Non Standard dental benefit. The Net PMPM rider costs are outlined in the Appendix D attached. The per contract rider rates were derived by loading the same percent of premium retention loads included in the base rate development and the same single conversion factors and load ratios.

Standardized Rating Regions and Area Factors

MVP has established area factors for the 7 rate regions in which we are licensed to service plus an area factor for region 8 Long Island. The Region 8 Long Island area factor is included, along with filed premium rates for Region 8 for the sole use by Associations acting as brokers for their members. MVP is not licensed to sell directly to individuals and sole proprietors in Region 8.

The area factors were derived based an analysis of the relative cost differences of providing care across our service due to varying provider reimbursement rates and practice patterns. Cost differences were evaluated separately for Facility costs and Physician costs in each of the regions and then blended together to derive the total relative cost differences. Book of business claim weightings for Facility spend, Physician spend, Pharmacy Spend and other non fee for service expense were used to generate the total relative spend for each region. Pharmacy spend and non fee for service medical spend was assumed to not vary by rating region.

The area factors were derived without regard to differences in health status, age, sex, occupation among enrollees in each rating region and are in compliance with HHS regulations on rate review. The area factors established for the Individual Market premium rates for 2014 are as follows:

Rating Region Premium Factors	2014 MVP Area Rating Factors - Individual
1 Albany	0.902
2 Buffalo	0.801
3 Mid-Hudson	1.105
4 NYC	1.436
5 Rochester	0.792
6 Syracuse	1.031
7 Utica/Watertown	0.875
8 Long Island	1.293

Loss Ratios

The target pricing loss ratios included in these proposed premium rates comply with Federal and State requirements. The projected Traditional MLR and Federal MLR for each plan rider combination are illustrated at the bottom of Appendix G. The expected book of business average loss ratios are illustrated in the shaded column of Appendix G.

These were computed using the premium rate developed assuming the market wide final index PMPM rate used to derive all of the plan specific premiums.

Required Standard Exhibit 7

Exhibit 7 includes historical paid claims, incurred claims, earned premiums and standardized premiums for the prior 3 12 month experience periods. MVP Health Plan, Inc. as well as MVP Health Insurance Company's pre ACA individual and employer group policy forms are listed here. For the small employer group policy forms the data was shown separately for sole proprietor versus non sole proprietor per DFS request. Incurred and Paid claims reported in this exhibit were extracted from MVP's claim warehouse. Earned premium data was extracted from MVP's premium warehouse. Incurred claims for the most recent experience period included claim run out through 3/31/13. Claim run out for the prior 2 experience periods was through 12/31/12.

Standardized Premiums were developed for each reported earned premium in Exhibit 7. The Standardized Premiums were computed using a database of membership and earned premium data for every benefit plan in force in each of the 3 historical periods. The data was grouped by benefit plan, renewal month and rate region in order to apply the appropriate standardized premium adjustment factors to the earned premium. The premium data was split between pre renewal months and post renewal months. Standardized premium factors by benefit plan by rate region were calculated for every possible cumulative projection period and applied to the earned premium detail. For example, for the data included in the 2nd prior experience period, some of the earned premium reflected 4Q 2008 rate levels (ie. the pre renewal premium for the November and December 2009 renewal months). These premiums were multiplied by a standardized premium adjustment factor that reflected the product of all of the quarterly rate increases starting with 1Q09/4Q08 through the 4Q13/3Q13. The earned and computed standardized premiums were rolled up to the policy form level for reporting in Exhibit 7. A numerical example is included as Appendix H.

Reliance

I relied upon the Actuarial Certifications from ██████████ of Milliman, Inc. for the EHB substitutions included in the Non Standard Plan offerings as well as the benefit pricing for the new benefit expansions included in the EHB benchmark plan for New York.

Actuarial Certification

I, ██████████ am a Member of the American Academy of Actuaries. The projected Index Rate used in the development of these proposed premium rates is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)) and developed in compliance with the applicable Actuarial Standards of Practice. I have examined the assumptions and methods used in determining MVP's requested rates. Based on my review and examination, it is my opinion that the proposed premium rates are reasonable in relation to the benefits provided and that they are neither excessive, inadequate, nor unfairly discriminatory. They are developed using only the permitted rating classifications. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The Standard AV Calculator was used to determine the Metal AV Value to be shown in Worksheet 2 of the Part I Unified Rate Review template for all the plans.

I certify that I am knowledgeable as to the New York state rating laws and regulations that apply to this filing and that, to the best of my knowledge and belief, this filing is in compliance with such laws and regulations and provides all required benefits. I am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the PPACA and the HCERA of 2010.

I certify that each rate filing has been prepared in accordance with the following Actuarial Standards of Practice; ASOP #5, ASOP#8, ASOP #12, ASOP #23, ASOP # 25, ASOP#26,and ASOP#41.

, FSA, MAAA Date 5/15/2 013
MVP Health Care, Inc.

**Accident and Health Insurance Initial Premium Rates
Compliance Certification**

I, Mark A Fish, a duly authorized officer of MVP Health Plan, Inc., do hereby certify that I am knowledgeable as to the laws, regulations and circular letters applicable to the type of insurance coverage and premium rates submitted, and that such rates, actuarial memorandum, supporting rate materials and rate manual pages are in compliance with the applicable laws, regulations and circular letters to the best of my knowledge and belief. I further hereby certify that the information relating to rates set forth in the Accident and Health Insurance Standard Transmittal Form as submitted with, and made part of this filing, is true to the best of my knowledge and belief. I understand that the Insurance Department will rely on this certification, and should it be determined that this certification is materially false or incorrect, appropriate corrective and disciplinary action, as authorized by law, will be taken by the Insurance Department against the company and the officer completing this certification.

[Redacted Signature]

Signature of Authorized Officer

5/13/2013

Date

[Redacted Name]

Print Name of Authorized Officer

625 State Street

Address of Insurer, Article 43
Corporation or HMO

Executive Vice President & CFO

Title

Schenectady, New York 12305

City, State, Zip Code

[Redacted Telephone Number]

Direct Telephone Number

[Redacted E-Mail Address]

E-Mail Address

[Redacted Fax Number]

Fax Number

Clear Form