Filing at a Glance

Company:	North Shore LIJ Insurance Company
Product Name:	NSLIJ Group Off Exchange Filing
State:	New York
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.003G Small Group Only - Other
Filing Type:	Off Exchange NG Forms & Rates
Date Submitted:	05/15/2013
SERFF Tr Num:	HNMN-129025419
SERFF Status:	Pending State Action
State Tr Num:	2013050120
State Status:	
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *North Shore LIJ Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NSLIJ Group Off Exchange Filing*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Non Employer Group
Filing Status Changed: 05/20/2013
State Status Changed:
Created By: [redacted]
Corresponding Filing Tracking Number:

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

Deemer Date:
Submitted By: [redacted]

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
This filing contains small group products intended for sale "off-exchange".

Company and Contact

Filing Contact Information

[redacted]

Filing Company Information

(This filing was made by a third party - hinmanstraubpc)

[redacted]

CoCode: 0
Group Code:
Group Name:
FEIN Number: 46-2270382

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: *New York* **Filing Company:** *North Shore LIJ Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NSLIJ Group Off Exchange Filing*
Project Name/Number: */*

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

State: *New York* **Filing Company:** *North Shore LIJ Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NSLIJ Group Off Exchange Filing*
Project Name/Number: */*

Rate Information

Rate data applies to filing.

Filing Method: Prior Review
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 05/11/2013
Filing Method of Last Filing: New Company New Product No Prior Filing Submitted

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):
North Shore LIJ Insurance Company	New Product	%	%				%	%

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

Rate Review Detail

COMPANY:

Company Name: North Shore LIJ Insurance Company
HHS Issuer Id: 82483
Product Names: North Shore LIJ Small Group Off-Exchange Products
Trend Factors:

FORMS:

New Policy Forms: NSLIJGNS, NSLIJNSA, NSLIJNSB, NSLIJNSC, NSLIJGO, NSLIJR29, NSLIJRDP, NSLIJRFP, NSLIJB, NSLIJG, NSLIJP, NSLIJS100-150, NSLIJS150-200, NSLIJS200-250, NSLIJS
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 12
Benefit Change:
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

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

REQUESTED RATE:

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

State: *New York* **Filing Company:** *North Shore LIJ Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *NSLIJ Group Off Exchange Filing*
Project Name/Number: */*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Actuarial Memorandum		New		NSLIJIC Off-Exchange 2014 Act Memo 20130513.pdf,

Milliman

North Shore-LIJ Insurance Company

Small Group Off-Exchange Plans

2014 Premium Rates

Prepared for:
North Shore-LIJ Insurance Company, Inc.

Prepared by:

[redacted]

Milliman, Inc., New York

[redacted]

milliman.com

May 13, 2013

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ATTACHMENTS

Attachment A	Proposed rates for North Shore-LIJ Insurance Company's small group plans
Attachment B	Printouts of AV Calculator calculation pages
Attachment C	Description of quality improvement/cost containment programs

GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

Company legal name: North Shore-LIJ Insurance Company, Inc.

State: New York

HIOS Issuer ID: 82483

Market: Small Group

Effective Date: Quarterly rates effective January 1, 2014; April 1, 2014; July 1, 2014; October 1, 2014

COMPANY CONTACT INFORMATION

Primary Contact Name: [redacted]

Primary Contact Telephone Number: [redacted]

Primary Contact E-mail Address: [redacted]

PURPOSE

The purpose of this actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part 1 Unified Rate Review Template and New York State Department of Financial Services' Exhibit 8 "Index Rate/Plan Design Adjustment Worksheet", which supports compliance with the market rating rules and reasonableness of applicable rate increases.

ACTUARIAL QUALIFICATIONS

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

PROPOSED RATE INCREASE(S)

The proposed rates for North Shore-LIJ Insurance Company, Inc.'s (NS-LIJ's) small group plans to be offered off-Exchange in New York State are presented in Attachment A. NS-LIJ will be offering one gold, one silver, and one bronze plan.

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

- Underlying Claims Experience: As NS-LIJ does not have any historical experience on which to base its premium rating, we used Milliman's 2012 Health Cost Guidelines (HCGs) to develop a set of manual rates. The manual rate development is described in detail in this actuarial memorandum.

- Morbidity: The manual rates were adjusted to reflect the population NS-LIJ expects to enroll in 2014.
- Trend: We made no explicit utilization adjustment from the 2012 HCGs. Unit costs are reflective of anticipated 2014 contracted rates.
- Risk Adjustment: We adjusted the projected claims to reflect payments to or from the small group risk adjustment pool as a result of the ACA risk adjustment effective in 2014.
- Benefit Adjustment: The projected claims were adjusted to reflect the benefits that will be offered for each of the off-Exchange products.
- The resulting incurred claim estimate was converted to premium rates using a loss ratio of 85% plus additional taxes and fees.
- The premium rates also reflect the following taxes and fees for 2014:
    - Contributions to the Federal Transitional Reinsurance Program - $5.25 PMPM
    - Patient Centered Outcomes Research Fee - $2.00 PMPY
    - Risk adjustment user fee - $0.96 PMPY
    - Health Insurance Tax (HIT) – 0% of premium
    - Exchange User Fee – 0% of premium for 2014
    - New York State Premium Tax – 1.3% of premium for 2014

The rate development is based on generally accepted actuarial rating principals for rating small group blocks of business.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. NS-LIJ is a newly licensed insurer in New York State, therefore the premium rates presented are 100% manually rated.

BENEFIT CATEGORIES

The benefit categories are based on the algorithm used by Milliman's HCGs. The HCGs are the underlying claim dates we used to develop the manual rates for NS-LIJ. The HCG grouper uses a combination of Diagnosis Based Groups (DRGs), Current Procedural Terminology Codes – Fourth Edition (CPT-4 codes), Healthcare Common Procedural Coding System codes (HCPC), and revenue codes to allocate detailed claims into roughly 60 benefit categories. Service classification may also be dependent on criteria such as site of service, physician specialty and procedure code modifier (e.g., anesthesia modifier). The HCG grouper is updated annually to incorporate any new codes so the classification methodology remains current.

The detailed benefit categories are then collapsed into the five categories required by Worksheet 1, Section I of the Part 1 Unified Rate Review Template.

PROJECTION FACTORS

Not applicable. NS-LIJ is a newly licensed insurer in New York State. We made no adjustments to the experience period claims as the rates are 100% manually rated.

CREDIBILITY MANUAL RATE DEVELOPMENT

As NS-LIJ is a newly licensed health insurer in New York we developed a set of manual rates for NS-LIJ's off-Exchange plans.

Source and Appropriateness of Experience Data Used: We used Milliman's 2012 HCGs, adjusted for Long Island, as the basis for NS-LIJ's manual rate development. 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 Guidelines are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the Guidelines have been updated and expanded annually since that time. The Guidelines 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.

The HCGs consider utilization and average charge levels for roughly 60 benefit categories. These models make provision, by type of service category, for benefit characteristics such as copays, deductibles, coinsurance, and out-of-pocket maximums.

Adjustments Made to the Data: The HCGs represent claim levels for typical large group plans. Prior to the implementation of ACA, the expected utilization differential between a typical large group and small group claim levels could be as high as 15%. The expectation post-2014, after implementation of all the ACA provisions, is that small group utilization levels will resemble large group experience. While we believe this may be true eventually we do not think that this change will be fully realized in 2014. Therefore, in creating NS-LIJ's small group rates we assume that small group claim levels would be 5% higher than the HCG estimated large group levels for Long Island. We believe this 5% differential reflects the expected movement of small group utilization towards large group levels but recognizes that it may take a couple of years to reach that level.

The average cost per unit for each benefit category reflects NS-LIJ's expected cost per unit based on its 2014 provider contracts. Similarly, the prescription drug costs reflect NS-LIJ's agreement with its pharmacy benefit manager (PBM).

The resulting net claims costs for each plan reflect differences due to cost sharing and the impact of induced demand. We applied induced demand at a global level using the HHS induced demand factors presented in the *HHS Notice of Benefit and Payment Parameters for 2014* as shown in the table below:

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

We used the same induced demand adjustment for each plan within each metal level tier after re-normalizing for the effective tier in the underlying HCG data which is a platinum plan.

Conversion Factor: A conversion factor is required to convert the premium from a PMPM basis to a single premium basis. NS-LIJ's conversion factor is 1.288. We developed this factor using Milliman's HCGs, assuming standard demographics and an average family size of 1.71.

Standard Rating Regions: NS-LIJ is filing rates for both Long Island Area (Region 8) and New York City Area (Region 4). We assume no differences in cost between these two regions. As a result, the filed rates for each region do not differ.

Inclusion of Capitation Payments: The following services will be paid on a capitated basis and were added to our HCG net claims cost estimates, by metal level tier, as indicated in NS-LIJ's agreements with its vendors.

- Pediatric dental
- Pediatric vision

CREDIBILITY OF EXPERIENCE

Not applicable. As NS-LIJ will be a new health insurer in 2014 it has no claims experience on which to base its premium rating. Therefore, NS-LIJ's premium rates are 100% manually rated.

PAID TO ALLOWED RATIO

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

Using the approach described above in the Credibility Manual Rate Development section, we calculated expected net claims costs PMPM for each plan. We then took a weighted average across the entire pool using projected member months by plan as the

weighting to estimate the *Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM*. We then divided this by the *Projected Allowed Experience Claims PMPM* to develop the *Paid to Allowed Average Factor in the Projection Period*.

RISK ADJUSTMENT AND REINSURANCE

PROJECTED RISK ADJUSTMENT PMPM

NS-LIJ is a new health insurer for 2014. The premium rates are based on Milliman's HCGs adjusted for Long Island. As the purpose of risk adjustment is to bring all carriers to the same level, we priced the premium rate based on the expected claim levels of all carriers, i.e., an expected risk adjustment factor of 1.00. Therefore, we did not make any specific adjustment to reflect payments into, or from, the small group risk pool.

NON-BENEFIT EXPENSES AND PROFIT & RISK

ADMINISTRATIVE EXPENSE LOAD

The proposed rates reflect an 85% loss ratio, i.e. a 15% load for administration and profit. NS-LIJ estimated administrative expenses in the first year will be much higher than 15% due to the lack of economies of scale. NS-LIJ estimates first year administrative expenses of:

- $160,000 in salaries
- $12,000 in fixed expenses
- $23.37 PMPM for third party administrative services and claims processing
- $2.92 PMPM in general agent commissions
- 3.0% of premium in broker commissions
- $24.17 PMPM in other variable expenses, including finance, auditing and actuarial support, rent, insurance, legal, and telephone fees.

Salaries and fixed expenses were allocated to the small group products using projected 2014 membership.

PROFIT (CONTRIBUTION TO SURPLUS) & RISK MARGIN

The proposed rates do not reflect an allowance for profit margin. NS-LIJ anticipates making a loss in the first year.

TAXES AND FEES

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

Contributions to the Federal Transitional Reinsurance Program	$5.25 PMPM
Patient Centered Outcomes Research Fee	$2.00 PMPY
Risk Adjustment User Fee	$0.96 PMPY

Health Insurance Provider Fee	0.0%*
New York State Exchange User Fee	0.0%*
New York State Premium Tax	1.3%*

* Percent of premium

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

QUARTERLY TREND

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

2014 QUATERLY TREND RATES	2nd Qtr.	3rd Qtr.	4th Qtr.
Claim Trend	1.50%	1.50%	1.50%
Exchange User Fee*	0.88%	.87%	.86%
Quarterly Premium Trend	2.38%	2.37%	2.36%

*Percent of premium

Estimated 2015 trend is 6% and is based on most recent employer surveys of anticipated trends in the market.

Estimated 2015 Exchange User Fees is 3.5% of premium. We prorate this percentage for each quarter depending on how many months fall in 2015.

PROJECTED LOSS RATIO

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

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

2014 TARGET PRICING LOSS RATIOS	
1st Quarter	85%
2nd Quarter	85%
3rd Quarter	85%
4th Quarter	85%

One minus the target loss ratio reflects the percent administrative load.

INDEX RATE

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

As NS-LIJ will be a new health insurer in 2014 it has no claims experience, therefore it does not have an experience period index rate.

The projection period index rate is the projected allowed claims PMPM for the EHB, as shown in Section III of Worksheet 1 of the URRT. The index rate was calculated by taking a weighted average of the EHB claims for each of the small group plans that NS-LIJ intends to offer for sale off-Exchange. The plan index rates were weighted based on projected member months by plan.

For NS-LIJ total allowed claims equal the index rate for the projection period because NS-LIJ does not offer any benefits beyond EHB off-Exchange.

AV METAL VALUES

The AV Metal Values included in Worksheet 2 of the Part 1 Unified Rate Review Template were based on the Federal AV Calculator.

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

AV PRICING VALUES

The URRT requires the calculation of an AV Pricing Value for each plan based on a comparison to a fixed reference plan. For NS-LIJ the fixed reference plan is the gold plan for ages to 26.

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

MEMBERSHIP PROJECTIONS

The membership projections were developed by NS-LIJ. NS-LIJ used several avenues to gather intelligence to develop the membership projections:

- Urban Institute data to rationalize the market and how it will transition over the next three years
- Global demographic data to size the market in the NS-LIJ catchment area
- Feedback from brokers and general agents currently working in the area to rationalize the opportunity based on target position in the market
- Results of focus groups to understand and rationalize NS-LIJ's position in the market and the opportunity based on the market segments
- Analysis of the existing market to identify areas of opportunity
- Expected impact of the Affordable Care Act and State Reforms

TERMINATED PRODUCTS

Not applicable.

WARNING ALERTS

Not applicable.

DATA RELIANCE AND CAVEATS

In developing the premium rates presented in this actuarial memorandum, I relied upon data prepared by Patrick Tong, Assistant VP or Managed Care Analytics of NS-LIJ. I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate.

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

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

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

ACTUARIAL CERTIFICATION

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

I certify that to the best of my knowledge:

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

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

Signed: [redacted]

Title: [redacted]

Date: [redacted]

Attachment A

North Shore-LIJ
Off-Exchange Small Group Premium Rates Effective January 1, 2014

Product Description	Product ID	Total Medical Base Premium PMPM	Premium Per Contract: Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)
Non Standard Copay Plan A (Gold) - Dependent Age 26						
Domestic Partner & Family Planning	82483NY062	$509.09	$655.74	$1,311.48	$1,114.75	$1,868.85
Domestic Partner & No Family Planning	82483NY068	$506.50	$652.40	$1,304.80	$1,109.08	$1,859.34
No Domestic Partner & Family Planning	82483NY064	$509.09	$655.74	$1,311.48	$1,114.75	$1,868.85
No Domestic Partner & No Family Planning	82483NY066	$506.50	$652.40	$1,304.80	$1,109.08	$1,859.34
Non Standard Copay Plan A (Gold) - Dependent Age 29						
Domestic Partner & Family Planning	82483NY063	$512.75	$660.45	$1,320.90	$1,122.77	$1,882.28
Domestic Partner & No Family Planning	82483NY069	$510.14	$657.09	$1,314.18	$1,117.05	$1,872.71
No Domestic Partner & Family Planning	82483NY065	$512.75	$660.45	$1,320.90	$1,122.77	$1,882.28
No Domestic Partner & No Family Planning	82483NY067	$510.14	$657.09	$1,314.18	$1,117.05	$1,872.71
Non Standard Cost Share Plan B (Silver) - Dependent Age 26						
Domestic Partner & Family Planning	82483NY070	$437.06	$562.96	$1,125.92	$957.03	$1,604.44
Domestic Partner & No Family Planning	82483NY076	$434.84	$560.10	$1,120.20	$952.17	$1,596.29
No Domestic Partner & Family Planning	82483NY072	$437.06	$562.96	$1,125.92	$957.03	$1,604.44
No Domestic Partner & No Family Planning	82483NY074	$434.84	$560.10	$1,120.20	$952.17	$1,596.29
Non Standard Cost Share Plan B (Silver) - Dependent Age 29						
Domestic Partner & Family Planning	82483NY071	$440.19	$567.00	$1,134.00	$963.90	$1,615.95
Domestic Partner & No Family Planning	82483NY077	$437.96	$564.12	$1,128.24	$959.00	$1,607.74
No Domestic Partner & Family Planning	82483NY073	$440.19	$567.00	$1,134.00	$963.90	$1,615.95
No Domestic Partner & No Family Planning	82483NY075	$437.96	$564.12	$1,128.24	$959.00	$1,607.74
Non Standard HSA Plan C (Bronze) - Dependent Age 26						
Domestic Partner & Family Planning	82483NY078	$369.90	$476.45	$952.90	$809.97	$1,357.89
Domestic Partner & No Family Planning	82483NY084	$368.02	$474.04	$948.08	$805.86	$1,351.01
No Domestic Partner & Family Planning	82483NY080	$369.90	$476.45	$952.90	$809.97	$1,357.89
No Domestic Partner & No Family Planning	82483NY082	$368.02	$474.04	$948.08	$805.86	$1,351.01
Non Standard HSA Plan C (Bronze) - Dependent Age 29						
Domestic Partner & Family Planning	82483NY079	$372.54	$479.86	$959.72	$815.77	$1,367.61
Domestic Partner & No Family Planning	82483NY085	$370.66	$477.43	$954.86	$811.63	$1,360.68
No Domestic Partner & Family Planning	82483NY081	$372.54	$479.86	$959.72	$815.77	$1,367.61
No Domestic Partner & No Family Planning	82483NY083	$370.66	$477.43	$954.86	$811.63	$1,360.68

Note: All products include dental

Attachment B

User Inputs for Plan Parameters

Non Standard Copay Plan A

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,500.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$350.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☑	50%		☐	☐		
Skilled Nursing Facility	☑	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	88%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☐	☐		
Preferred Brand Drugs	☑	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Non Standard Cost Share Plan B

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$6,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$350.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☐	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☐	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☐	☑	50%		☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☐	☐		
Preferred Brand Drugs	☑	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.7%
Metal Tier:	Silver

User Inputs for Plan Parameters

Non Standard HSA Plan C

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,330.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☐	☐		
Preferred Brand Drugs	☑	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

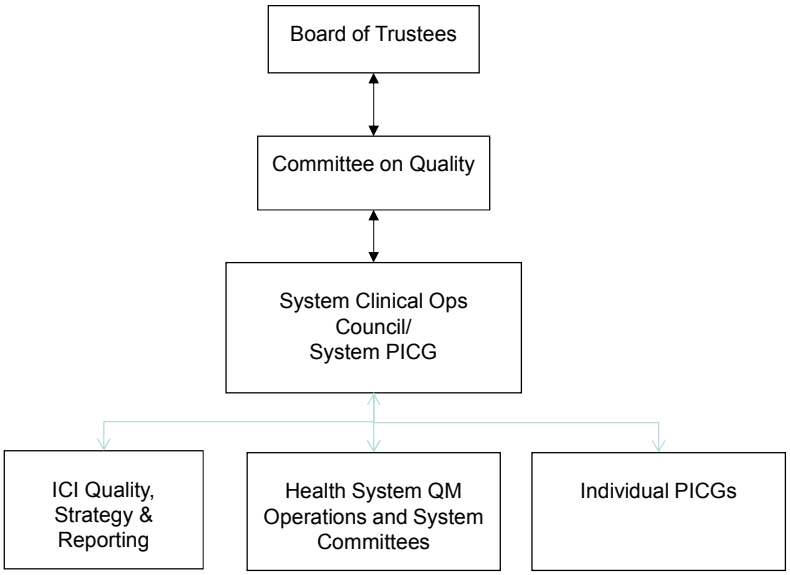
Attachment C

Quality Improvement Strategy

As a wholly owned subsidiary of NSLIJ, the ICI is part of a national health care leader committed to excellence, compassion and improving the health of the communities it serves. ICI benefits by being able to focus quality improvement activities at the point of care and in collaboration with the providers of the NSLIJ Health System and the broader community. ICI also benefits from the long-term focus and investment that the health system has, through the years, placed on delivery and measurement of high quality, high value health care services.

Per NSLIJ Health System's corporate by-laws, one of the roles of governance is to maintain oversight of performance improvement and patient safety activities and to ensure that a uniform standard of high quality care is delivered throughout the entire NSLIJ system. This is coordinated through an established governance structure which ultimately reports to the system's Board of Trustees. The structure has been established for monitoring, evaluating and improving the quality of care through organizational performance improvement programs covering both inpatient and ambulatory care and ensures alignment between quality improvement activities of ICI and that of the boarder health system. The figure below depicts the NSLIJ structure for ensuring high quality care across the health system.

Quality Oversight and Communication Structure



At the heart of the structure is the Committee on Quality (COQ). The COQ serves as a formal means of liaison and policy development among the Board of Trustees, senior medical leadership, the System Performance Improvement Coordinating Group (PICG) and Chief Quality Officer and VP for the Institute

for Clinical Excellence and Quality.[1] The COQ sets priorities for quality and safety activities and the evaluation measures used to assess care processes and outcomes across NSLIJ – including ICI – and is informed of the care delivered in each entity within the ICI provider network.

The System Clinical Operations Council/System PICG prioritizes and sets the standards for quality and performance improvement initiatives; assigns responsibility for enacting all performance improvement recommendations; monitors results and oversees the approval of administrative policies and procedures.

Individual PICGs chaired by a physician are responsible for directing, coordinating and overseeing performance improvement and patient safety activities appropriate to their scope of care and for communicating information to their entity clinical leadership, the System PICG/System Clinical Operations and the COQ.

Quality Improvement Strategy

ICI, in coordination with the NSLIJ COQ, the System Clinical Operations Council and PICG teams, is committed to meeting the quality requirements set forth in section 1311(g) of the ACA and by the New York Health Benefit Exchange. Below we describe our approach to:

- Improving Health Outcomes
- Preventing Hospital Re-Admissions
- Improving Patient Safety
- Implementing Wellness and Health Promotion Activities
- Reducing Health and Health Care Disparities
- Expanding Access to Mental Health Services

The quality and patient safety strategy is reviewed and updated annually with progress reported to the designated office of the New York State Department of Health, as required.

Improving Health Outcomes

Improving health outcomes for ICI members is a critical component of the quality strategy. Moving the dial on improving health outcomes requires investment in measuring and capturing clinical care data so that providers have the tools they need to manage patients.

The NSLIJ network contracted by ICI utilizes both inpatient and ambulatory electronic health record systems. Built into the inpatient system are numerous quality and safety tools, such as heparin dosing calculators and improved medication reconciliation tools, renal dose adjustment prompts, and provider handoffs. On the ambulatory side, there are several system features and reports to assist providers in

[1] The Institute provides the framework for each entity's quality improvement activities, including development of the corporate-wide performance and quality improvement plan and ensuring alignment based on national and state quality agendas. Additionally, the Institute maintains comprehensive occurrence and tracking systems, and collaborates across departments and organizations to ensure quality and safety goals are being achieved.

tracking the status of appropriate screening or diagnostic tests and/or referrals, as well as identifying high-risk members and tracking members not meeting treatment goals. Thus, the ability to electronically capture data can be used to support quality reporting, effective case/disease/medication management and care coordination which improves outcomes. In the area of medication management, NSLIJ's EHR supports the review and monitoring of critical medication management processes, including ordering and transcribing, preparing and dispensing. Each NSLIJ physician and contracted provider is required to develop and evaluate safe medication management practices for preventing and responding to adverse medication events and medication errors, and identifying and managing high risk and high alert medications.

NSLIJ EHRs are also being used to support a perinatal continuum of care effort in the coming year. Custom templates are being built into the office EHRs so that more than 160 discrete data elements will automatically flow from the physician office record and into the Labor and Delivery units of hospitals. This ensures a complete record is available to hospital staff at the time a pregnant mother presents for delivery and aides in improving birth outcomes.

Another important benefit of electronic clinical record keeping is the availability of patient data to allow monitoring of clinical and quality parameters across large populations. ICI will participate in NSLIJ's effort to manage outcomes across different disease areas. One example is the Diabetes Mellitus Registry. This registry includes not only dashboard views of diabetes-related quality metrics across the entire population of diabetics in the hospital system, but also patient-level details which will allow case managers to target health plan members for follow up and interventions, as needed, with the overall goal of improving outcomes for individuals with diabetes.

Quality reporting is managed through the Office of Integrated Data Analytics (OIDA), which is responsible for the integration of data resources and coordination of data analytics across the ICI/NSLIJ network. Working in conjunction with other departments, OIDA identifies opportunities to improve quality and services and develops tools, scorecards, dashboards and other concurrent and retrospective clinical support tools that enables NSLIJ health system and the ICI to measurable improve health outcomes.

Medication Management Activities Performed by PBM

In addition to the medication management practices adopted by the health system, the ICI is contracting with a vendor- CVS Caremark- that will also provide medication management activities. CVS Caremark designed its clinical strategy to fulfill two main objectives: Helping clients manage bad trend and promote good trend. CVS accomplishes this through a variety of unique drug utilization review strategies and their award-winning Pharmacy Advisor® approach. The CVS Caremark concurrent, retrospective and prospective drug utilization review programs are described below.

CONCURRENT DRUG UTILZATION REVIEW (DUR) PROGRAMS

Managing Bad Trend

The CVS Caremark Concurrent (POS) DUR program is an automatic, system-driven drug utilization review program performed for all clients on all prescriptions, at both mail and retail. No extra charge is made for this standard service.

Our concurrent DUR program is implemented through our single-platform information systems, which power CVS Caremark's online national retail pharmacy network, our National Network of point-of-sale pharmacies as well as our mail service pharmacy facilities. The system can perform up to 500 edits on every prescription to ensure that prescriptions meet administrative, plan-design, and member safety criteria.

Enhanced Concurrent DUR is available through the CVS Caremark Mail Service pharmacies as part of our Drug Savings Review solution. This concurrent DUR has features that extend beyond the standard safety edits to provide additional clinician review and interventions designed to reduce drug spend and improve appropriateness of overall pharmaceutical care.

Promoting Good Trend

Pharmacy Advisor Counseling: This approach leverages our vertically-integrated model, enabling pharmacists to intervene on members with chronic conditions in the most personalized manner, at CVS retail pharmacy. For the first time in the industry, pharmacists – on a broad scale – have access to critical patient information at the point of care, giving them the opportunity to pinpoint and discuss a member's specific health care scenario. The program also includes inbound call access to pharmacists for personalized consultation as well as an optional outbound phone call component.

RETROSPECTIVE DUR PROGRAMS

Managing Bad Trend

The CVS Caremark Safety and Monitoring Solution evaluates pharmacy claims for patterns of potential overuse or misuse. On a quarterly basis, CVS Caremark clinical pharmacists evaluate controlled-substance and other select drug claims (along with supporting medical data, if available) to identify potential medication abuse and fraudulent claims for appropriate intervention. This program uses utilization-based clinical rules designed specifically to identify cases of potentially excessive or abusive use. There is also a monthly review of claims for the most egregious cases of overutilization/high cost, in addition to the standard quarterly review. Monthly reviews give us the opportunity to spot egregious claims much sooner, and intervene for better outcomes for both members and clients.

The CVS Caremark Enhanced Safety and Monitoring Solution provides additional investigation and intervention when patterns of potential drug overuse or misuse are identified. In addition to the Core Safety and Monitoring Solution, the enhanced solution provides expanded written communications, coordination with pharmacy audit activities, prescriber toolkits, peer prescriber consultations with independent physician experts, and medication therapy counseling for select members.

The Retrospective Safety Review solution acts as a safety net for serious drug interactions. This solution reviews both mail and retail prescriptions within 72 hours after the claim adjudicates for potential safety issues not addressed at point-of- dispensing, and messages the prescriber with an actionable member-specific communication identifying the clinical issue and suggestions for improving medication therapy. This early retrospective intervention may allow for a change in the prescription before the member picks up the original prescription, resulting in increased member safety, less member disruption, and earlier savings capture for Oscar.

Promoting Good Trend

Closing gaps in medication therapy: We can provide a powerful "early-warning system" for your members' medical care and identifies high-risk members before they may experience significant medical events. Drug profiles are assessed daily, within 72 hours after claims adjudication, by a clinical pharmacist for any potential issues or complications associated with the disease or therapy. Identified issues are communicated to the prescriber along with suggested solutions to the issues.

PROSPECTIVE DUR PROGRAMS

Managing Bad Trend

The CVS Caremark prospective DUR programs include Prior Authorization, Step Therapy, and Quantity Limits.

CVS Caremark's Prior Authorization program offers several benefits, including:

- Promotes appropriate prescribing of drugs by ensuring adherence to approved treatment protocols
- Decreases expenses by shifting utilization to less expensive, clinically appropriate drugs
- Promotes member safety.

Our Step Therapy program ensures that members utilize the most therapeutically appropriate and cost-effective drugs first. Step therapy protocols optimize appropriate drug therapy while controlling costs by defining how and when a particular drug or drug class should be used, based on a member's drug history. Post-step prior authorization is also available to allow coverage for clinically appropriate situations that do not meet the initial step therapy protocol.

Quantity Limits are available as an alternative or a supplement to our Prior Authorization program. Clients that wish to maintain control over drugs with the potential for abuse, misuse, or safety concerns – without eliminating coverage – can do so by means of the Quantity Limits program.

Point of Service (POS) Safety Review is our baseline safety solution. Whether a prescription is presented through our mail service pharmacies or our retail

network, CVS Caremark systems automatically evaluate the prescription in the context of the member's complete drug history. When appropriate, real-time alerts are issued to the dispensing pharmacist regarding potential issues.

All prescriptions are first checked for member eligibility and plan design features. They are then compared against previous histories of prescriptions filled by the same pharmacy, by other participating retail network pharmacies, by the mail service pharmacies, and submitted paper claims. All drug conflicts are detected online when the prescription is entered into the computer system. If a conflict is identified, the pharmacist reviews the member's history and may contact the prescriber to make any adjustments prior to filling the prescription. Our program enables the pharmacist to override an edit when they have reviewed the data with the member or prescriber and have determined that the prescription is safe to dispense.

CVS Caremark's concurrent DUR program includes key edits such as drug-drug interactions, drug-allergy interactions, drug-age alerts, and therapeutic duplication. These automated claims messages are sent to mail and retail pharmacies in real-time, allowing for pharmacists to contact the prescriber and make adjustments before the prescription is dispensed.

Patient Centered Medical Homes

In outpatient primary care sites, a significant quality-related focus of ICI's contracted NSLIJ network in the coming year is achieving NCQA accreditation and recognition of ambulatory sites as Patient Centered Medical Homes (PCMHs). The use of a PCMH model will help improve health outcomes, particularly for members with chronic diseases which can be best served through improved management and coordination.

Preventing Hospital Re-admissions

Preventing re-admissions is a strategic priority for both NSLIJ and ICI. To achieve this goal, ICI and NSLIJ are focused on two areas: preventing re-hospitalizations and managing advanced illnesses.

NSLIJ has partnered with The Joint Commission Center for Transforming Healthcare (JCCTH)[2], Partnership for Patients[3] and AAMC & UHC Best Practices for Better Care[4] in the effort to reduce re-hospitalizations. Each of these initiatives provides tools and training for managing hospitals discharges, particularly around complex conditions such as heart failure, and ensuring that the member receives coordinated, appropriate and consistent follow up care to lower the readmission risk. A component of this care includes ensuring that patients and family receive education and training on post-discharge protocols and the resources available to them after hospitalization.

For managing advanced illness, NSLIJ has partnered with the IHI Strategic Partnership[5]. NSLIJ also utilizes the Advanced Illness Coordinating Committee (AICC), whose aim is to improve the care of patients with serious illness by aligning treatments with patient preferences. The goals are to ensure that patient preferences are known, documented and followed to decrease hospital admissions and readmissions and increase hospice average length of stay, reduce non-emergent ER visits by delivering care at home to patients with advance and terminal illness and reduce overall suffering.

[2] http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=5
[3] http://partnershipforpatients.cms.gov/
[4] https://www.aamc.org/initiatives/bestpractices/
[5] http://www.ihi.org/offerings/CustomExpertise/Pages/StrategicPartnership.aspx

Improving Patient Safety

NSLIJ and ICI utilize a Model for Improvement that provides a framework for developing, testing and implementing changes that lead to improvement to design patient safety programs. The model can be applied to improving processes, products and services in healthcare organizations and is based on Plan, Do, Study Act (PDSA) model popularized by Dr W. Edwards Deming, considered by many to be the father of modern quality control.

Under the Model for Improvement, knowledge is built by an iterative process of developing a theory, making predictions based on the theory, testing the predictions with data, improving the theory based on the results and making new predictions based on the revised theory. Tests of change are designed to answer questions that come from a combination of theory about the subject matter and conclusions from analysis of data from past studies. Each PDSA cycle is designed to answer specific questions related to the Patient Safety team's aim. Using PDSA cycles, staff measure key organizational functions across a variety of settings: inpatient, critical care, emergency care, ambulatory, home care, hospice, behavioral health, rehabilitation, and long term care.

The focus of the NSLIJ Performance Improvement/Patient Safety Program that ICI will leverage is to outline quality management methods for assessing the way care is delivered; prioritizing areas for improvement; improving processes based on the uniform collection of statistical data; evaluating and reevaluating processes of care; and communicating the results throughout the NSLIJ system.

Specific strategies to improve patient outcomes include:

- Conducting annual Culture of Safety surveys and developing action plans based on results
- Patient Safety Rounds in all NSLIJ entities to demonstrate leadership's commitment to working with staff to improve patient safety
- Sharing and benchmarking across institutions and entities for best practices, quality outcomes, indicators, occurrences, and lessons learned
- Improving safety through proactive risk assessments and standardized root cause analyses
- Implementing national patient safety initiatives
- Encouraging patient and family participation in care
- Developing and implementing system-wide initiatives
- Educating staff on safety topics and resolving safety issues raised by staff
- Partnering with external organizations
- Strategic partnerships (such as the ones previously mentioned with industry groups and collaborations)

Specific patient safety priorities across the ICI and health system in the current year are:

- Sepsis
- Heart Failure
- Advance Illness
- Infection Prevention

- Perinatal Safety

Each initiative, co-chaired by physician and/or nursing leadership, comprises an interdisciplinary team of clinical experts encouraged to study and adopt evidence-based clinical practices and measurement systems. Executive summary reports shall be provided to senior leadership at both the system and the hospital PICGs regarding the progress of each initiative toward achieving goals, implementing plans, barrier to success and measures of patient safety and performance.

In addition to the priorities and processes mentioned in this section, both ICI and the NSLIJ network will rely heavily on EHRs to ensure clinical and evidence-based protocols are adhered to and to monitor and measure clinical performance. The section entitled *"Health Outcomes"* addresses the role that technology plays in these areas.

Implementing Wellness and Health Promotion Activities

Knowledge related to one's health status can be critical to health promotion and wellness programs. Wellness has many different meanings but can simply be viewed as optimizing one's health status regardless of whether they have no health issues or if they have multiple chronic conditions. Avenues for information dissemination include seminars, such as "lunch and learn" meetings, health fairs, web-based articles, webinars and interactive quizzes on topics of wellness. Communication is a cornerstone to any successful wellness and health promotion activity.

Current wellness and health promotion activities done by the HSI center around four main areas: physical health, nutrition, stress management, and exercise. Incorporation of all of these elements into a wellness program for ICI will be critical to the success of the ICI.[6] Currently, HSI employees are encouraged to participate in these efforts, and can be rewarded for participation through wellness pledges that can offset employee contributions for health insurance coverage. In 2012 employees were given wellness credits for being tobacco free, participating in biometric screening and completing a health risk assessment, identifying a personal care physician and receiving an influenza vaccination.

In 2011 North Shore LIJ began a comprehensive wellness program that encompassed these four critical areas. All employees are encouraged to complete a health risk assessment, biometric screening, including height, weight, screening for cholesterol, diabetes risk and hypertension began, to inform individuals of their health status Having an initial biometric screening test is critical to establish a baseline health status for individuals, so that they can measure their progress towards improving their overall health. Cancer screening is available for all employees and these programs are highlighted during cancer awareness months for all employees.

Tobacco control programs are an important element in health promotion. At North Shore LIJ, our campuses have been tobacco free since 2010, including all vendors. We have worked with our Center

[6] The ICI understands that current federal regulations guide wellness program implementation in the small group market. The ICI will work in conjunction with the HSI to appropriately implement wellness efforts in accordance with federal and state regulations, including limiting the permissible reward for achieving a particular health outcome to 30% of the cost of health coverage.

for Tobacco Control to ensure that all employees have access to tobacco cessation programs, and that all costs related to smoking cessation are covered without any out-of-pocket expenses.

Fitness programs, such as walking programs, facilitated through walking trails, both indoors and outdoors, when feasible, encourage activity at the workplace. Walking challenges can increase employee engagement while promoting physical activity. For example, in 2012, a walking challenge, "The Walk to Paris", was held at North Shore LIJ, and over one-third of all employees participated in the twelve week program. There are subsidies for fitness centers at discounted monthly rates for employees. Fitness classes, such as zumba, yoga and Tai Chi are offered at many facilities.

Stress reduction programs, such as mindful meditation and seminars on how to better deal with family stresses, financial stresses and day-to-day challenges. Employee Assistance Programs to allow employees to have a confidential resource during times of need are critical to workplace health promotion and wellness.

Nutritional information, from basic labeling of vending machines, to providing healthier food alternatives and recipes, is an important component. Healthy food guidelines, that can be implemented in a workplace or used for individuals are an essential component of health promotion and wellness. This includes guidelines for food served in the cafeterias, and for meetings held within our health care system. Weight control programs, such as Weight Watchers at work, have been available for employees in the Health System, enabling employees to participate in a convenient manner. In 2012, we added an additional, online weight control program, BMIQ, to enable those employees who wished to participate in a program away from the workplace.

Reducing Health and Health Care Disparities

As surrounding communities become more diverse, the NSLIJ Health System recognized the need to cultivate diversity and has identified Diversity, Inclusion and Health Literacy (DIHL) as core characteristics and key components in the promotion of quality patient care. In July 2010, NSLIJ Health System and the Hofstra NSLIJ School of Medicine merged its existing diversity and health literacy initiatives, and established the Office of Diversity, Inclusion and Health Literacy (ODIHL). It was created to drive the health system's mission to provide excellent patient care, and foster an environment that supports principles of equity, diversity, inclusion and effective communication. ICI works in conjunction with the ODHIL and supports these principles for health plan members.

The ODIHL has the mission of establishing programs and policies intended to promote diversity, inclusion and health literacy as an integral part of the delivery of culturally competent, safe, quality patient-centered care. ODIHL works to build a community of excellence where the affirmation of differences is clearly seen in the composition of Health System and ICI leadership, faculty, staff and students, and reinforced through its policies, practices and organizational structure. ODIHL aims to be recognized by employees, patients, members, communities served and peer institutions as a leading model in DIHL while advancing cultural and linguistic competence and promoting effective communication to enhance patient outcomes and eliminate health disparities.

The ODIHL focuses efforts on increasing cultural and health literacy awareness in the workforce and has established various inter-disciplinary system-wide intramural educational initiatives that have helped to

transform the NSLIJ Health System climate and promote the delivery of excellent, safe, patient-centered care. For example, one effort has been to provide online education modules, including ones dealing with cultural competency and health literacy. There is also a link to an online resource called Culture Vision, which addresses various aspects of 47 different cultures that clinicians can reference at the point of care. These efforts have been cross-cutting in both discipline and mode of delivery through the development of inter-professional orientations and in-print, on-line and in-class educational opportunities. As ICI members visit NSLIJ Health, they will benefit from the effort and focus that ODIHL has placed on cultural and health literacy awareness.

ODIHL also oversees the Language Access Services program across the Health System which ensures meaningful access to health care services for patients and/or ICI members who are limited-English speaking, deaf or hearing impaired, or disabled. Language and Communication Access initiatives have included: an annual needs assessment, identifying limited English speaking populations comprising more than 1% of the total hospital service area population; standardization of vital documents; and enhancements to concurrent documentation and reporting of limited English proficient persons. Site specific educational opportunities have been provided to staff regarding the populations they serve as well as a variety of resources for continued learning.

Expanding Access to Mental Health Services

The NSLIH Health System is currently working on many initiatives which will be coordinated in conjunction with ICI programs and members. For quick returns in both patient care and in savings, NSLIJ is focused on expediting the use of Telepsychiatry in the Emergency Rooms, along with the connections being developed in the Ambulatory Network of Care. The objectives of this initiative are to: Divert Inpatient Admissions to lower levels of care; Reduce ALOS; and Reduce Readmissions.

Longer term, NSLIJ believes that the integration of behavioral health into primary care, especially pediatrics is critical. This requires developing the processes to identify behavioral health issues by incorporating Evidence Based screens in well care visits and the facilitation of referrals for care; which can be achieved through different models, all of which require an established ambulatory network.

Several specific initiatives currently underway to integrate behavioral and physical health are:

- Utilization of practice-specific screening protocols such as the PHQ9 and various SBIRT tools, with the goal of getting physicians to begin screening using an evidence-based tool and protocol.
- Development of relationships, training, and support for primary care office staff so that screening and other integration efforts are supported and part of the workflow.Providing PCPs with options for integrating a behavioral health specialist into their primary care setting, such as co-location. Communicating on a regular basis, whether by formal or impromptu meeting, shared EMR, telephone contact, secure e-mail, or faxed reports.
- Utilization of telepsychiatry to “meet” with patients as an option for consultation to the PCP.
- Providing a solid knowledge base of community resources to allow physician practices to implement a patient-centered care approach.

There are also other initiatives currently underway to further improve access to behavioral health services, including:

- Implementation of telepsych consultative services at various system EDs, strengthening and facilitating access to care for patients who present across the geographic reach of the health system.
- Linkage with the LIJMC OB GYN department and ZHH's Perinatal Psych program, identifying new or expectant mothers with mood disorders that may otherwise not seek treatment.
- Telepsych services offered to home bound expectant mothers in the perinatal program.
- Partnerships with local schools / colleges to appropriately identify students in crisis, link with appropriate resources, and facilitate inpatient admissions.
- Direct contracts and linkages with school districts to integrate behavioral health services when service needs exceed what the school can provide.
- Ambulatory partnerships with community based organizations to facilitate ED discharge linkages and strengthen inpatient psych discharge plans.

ICI Compliance with Exchange Quality Requirements

In addition to developing and maintaining and quality strategy, ICI will adhere to Exchange requirements for Qualified Health Plans (QHPs), including:

- Quality Assurance Reporting Requirements
- Consumer Assessment of Health Care Providers and Systems (CAHPS)
- Quality Improvement Initiatives
- Accreditation

These areas are addressed below.

Quality Assurance Reporting Requirements

ICI will follow New York State's Quality Assurance Reporting Requirements (QARR). ICI is incorporated into the robust quality improvement infrastructure of NSLIJ and will leverage the quality improvement efforts and high quality, high value nature of the NSLIJ network with which ICI contracts. ICI and NSLIJ leadership and staff fully understand that QARR reporting requires the organization to have HEDIS Volume 2 measure sets, programming for requirement measures, an NCQA audit conducted by a licensed audit organization of QARR data prior to submission and a certified CAHPS vendor to administer CAHPS. ICI will put in motion a plan to meet these requirements for submission of all items by June 2015 for calendar year experience in 2014.

Consumer Assessment of Health Care Providers and Systems (CAHPS)

ICI will contract with a certified CAHPS vendor to administer the CAHPS 5.0H survey to measure patient satisfaction. ICI understands that QHPs may be required to add New York State-specific questions to the tool to aid the state in learning about the newly insured's experience and/or to provide additional demographic or clinical detail. ICI will ensure compliance with Exchange timelines, which requires that survey be scheduled on or around fall of 2014.

Quality Improvement Initiatives

ICI understands that New York State will require Exchange participants to have the infrastructure in place (or the ability to contract) which allows ICI to implement its quality strategy and related improvement activities, as well as participate in a variety of state-sponsored quality improvement work. As previously discussed, ICI's quality strategy will be incorporated into the quality infrastructure of the NSLIJ system. As such, ICI anticipates performing most, if not all quality improvement activities, including participation in state-sponsored quality initiatives.

ICI further understands that performance that falls outside normal ranges for quality and satisfaction performance will require a barrier analysis and an improvement plan, to be developed and operationalized once approved by the designated New York State Department of Health office.

Accreditation

The ICI will seek accreditation for its plans in accordance with the New York State's timeline for accreditation.

Data Management Systems

ICI will contract with HF Administrative Services, Inc. (HFAS) to access a variety of software systems necessary to support ICI operations. The major systems that will be available to ICI are the same systems currently utilized by HFAS to support multiple established insurance operations, namely:

- DST Health Solutions PowerMHS – A fully integrated system for health plan administration and claims processing, PowerMHS processes and stores all claims and encounters.
- McKesson Comprehensive Care Management System (CCMS) – This flexible and scalable commercial care management software will support the care management and quality assurance programs. InterQual (IQ) Coordinated Care Content is embedded in CCMS and supports complex care planning and co-morbidity needs in a streamlined environment. This content allows support for members with complex needs with blended assessments and an integrated care plan.

All HFAS systems are HIPAA and ACA compliant for both electronic and paper records.

In addition, the data management systems of the NSLIJ network with which ICI is contracting have been nationally recognized[7] and will be integral to providing safe and efficient care for ICI members; implementing advanced quality programs for ICI; and collecting data required for ICI analysis and reporting.

[7] Health Care's 100 Most Wired Survey Award, Hospitals and Health Networks Magazine, July 2012 and "Michael Dowling Named CEO Information Technology Award Winner", Modern Healthcare magazine, June 23, 2011

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	
Attachment(s):	ah_sg_OffExch_2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	NSLIJ Flesch Score Cert.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	NSLIJIC Off-Exchange 2014 Act Memo 20130513.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	NSLIJ AV Calculations Small Group.pdf
Item Status:	
Status Date:	

Review Standards for

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

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

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

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

REVIEW REQUIREMENT	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
GENERAL REQUIREMENTS FOR ALL FILINGS	*Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions*	*Note: This checklist is intended to provide guidance in the preparation of policy or contract forms for submission and is not intended as a substitute for statute or regulation.*	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement		This submission contains a complete policy or contract form. Yes ☒ No ☐ If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☒ No ☐	Page 86

		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	Not applicable
Flesch Score	§3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	See attached
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF Filing Description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. §52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policyor contract form, the letter must identify the form number and	See attached

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

		approval by the Department. §52.32(a)(3) • That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(4) *Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the group requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.*	
Statement of ERISA rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes ☐ No ☒	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.	Not applicable
APPLICATION FORMS Model Application Used? Yes ☐ No ☐	Model Language		Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3221(q)(1) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy or contract to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy or contract void. An agreement that acceptance of any policy or contract issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
Verification of Compliance with Pediatric Essential Dental Health Benefit.	45 CFR § 156.150	In order to verify whether an individual has obtained stand-alone dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange, insurers should use the following language on their application/enrollment form:	

		A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	Page 1
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Not required
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	A table of contents is required.	Pages 2-3
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*For a complete listing of the definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§3221(k)(14) §4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Page 5
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	Page 10
Designation of Primary Care	§3217-e	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract	Not applicable

Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	Not applicable
Preauthorization			
Preauthorization Requirements Model Language Used? Yes ☒ No ☐	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or $500.00, whichever is less, is permissible.	Page 10
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	Page 11
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	Pages 11-12
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the	Page 13

		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☒	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	Not applicable
Standing Referrals Model Language Used? Yes ☐ No ☒	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	Not applicable
Specialty Care Center Model Language Used? Yes ☐ No ☒	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	Not applicable
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	Page 13
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the	Pages 13-14

		non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	Page 15
Reimbursement of Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	Not required by model language
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes ☒ No ☐	§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	Pages 1, 10
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language		Form/Page/Para Reference
Spouse	§4235(f)(1)(A) §4305(c)(1) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the group, this policy or contract form must provide coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex partners legally performed in this state and in other jurisdictions.	Page 17
Dependents	§4235(f)(1)(A)(i) §4305(c)(1) §3221(a)(7) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until age 26. *Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	Page 17

Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	If dependent coverage is selected by the group, this policy or contract must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in 4235(f).	Rider
Unmarried Students on Medical Leave of Absence	§3237 §4306-a 42 USC §300gg-7	If this policy or contract form provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	Page 17
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4305(c)(1) Model Language	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	Page 17
Newborn Infants	§4235(f)(2) §4305(c)(1) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.*	Page 17
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3) §4305(c)(1)	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage	Page 17

		on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4235(f)(1)(A) §4305(c)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	Rider
New Family Members Model Language Used? Yes ☒ No ☐	45 C.F.R. § 155.420 Model Language	The policy or contract form describes the requirements to add new family members to the policy or contract.	Page 17
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	Not applicable
Enrollment Periods	http://government.westlaw.com/linkedslice/default.asp?SP=nycrr-100011NYCRR52.70(e)(3) 45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	Pages 18-19
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS		**Except where noted below, the following benefits must be included in the policy or contract forms.** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including higher visit	Form/Page/Para Reference

		limitations; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review. The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	Pages 20-22
Federal Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	Pages 20-22
Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§3 221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	Page 21
Mammography Screening	§ 3221(l)(11) § 4303(p)	This policy or contract form includes the following coverage for mammography screening for occult breast cancer:	Page 21

Model Language Used? Yes ☒ No ☐	42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	• Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 21-22
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	Page 22
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and	Page 22

		• An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§ 3221(l)(15) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	Pages 23-24
Emergency Services Model Language Used? Yes ☒ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage	Pages 25-27

	(2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	Page 27
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	45 CFR § 156.100	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT	Page 28

Model Language Used? Yes ☒ No ☐	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 28
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 28
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 28
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3221(k)(11) §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	Page 28
Dialysis Coverage	§3221(k)(16) §4303(gg)	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis	Pages 28-29

Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 29
Benefit explanation:			

Home Health Services Model Language Used? Yes ☐ No ☒	§3221(k)(1) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	Page 29
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit and may provide coverage that is more favorable.*	Page 29
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§3221(k)(6) 4303(s) 11 NYCRR 52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs;	Pages 29-30

		cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 30
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 30
Office Visits Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 31
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 31
Preadmission Testing Model Language Used? Yes ☒ No ☐	§3221(k)(2) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 31
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has	Pages 31-32

Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.		undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.*	
Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§3221(k)(9) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	Page 32
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§3221(k)(3) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 32
Mandatory Second Surgical Opinion	§3221(k)(3) 4303(b)	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).	Page 32

Model Language Used? Yes ☒ No ☐	Circular Letter No. 29 (1979) Model Language	Such coverage may not be subject to deductibles, copayments and/or coinsurance.	
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 32
Surgical Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.6 Model Language	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 32-33
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 33
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3221(k)(8) §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	Page 33
Post Mastectomy Reconstruction	§3221(k)(10) §4303(x) Women's Health and	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a	Page 33

Model Language Used? Yes ☒ No ☐	Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	
Transplants Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 33-34
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy or contract provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.	Pages 35-37

		The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: Plans may apply either a medical or a prescription benefit depending upon whichever will provide a more generous benefit.* *Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," the policy or contract form may not limit coverage to care prescribed by a physician.*	Pages 37-38
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 38-39
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for plans but the limit may be removed or modified so that coverage is more favorable.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for	Page 39

		malfunctions. *{Drafting Note: The limit on hearing aids is required for plans but this limit may be removed or modified so that coverage is more favorable.}* Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3221(l)(10) §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.*	Page 39
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for plans, but the limit may be removed or modified so that coverage is more favorable.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 39-40

Hospital Services Model Language Used? Yes ☒ No ☐	11NYCRR52.5 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 41
Maternity Care Model Language Used? Yes ☒ No ☐	§3221(k)(5) 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3221(k)(1), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	Page 42

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Page 42
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: Plans must cover 60 days; however plans may exceed the required 60 day, and also may remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	Page 42
Benefit explanation:			
Skilled Nursing Facility Model Language Used? Yes ☒ No ☐	§3221(l)(2) §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: Plans must cover 200 days, but may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 42-43
End of Life Care Model Language Used?	§4805 PHL §4406-e 45 CFR § 156.100	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	Page 43

Yes ☒ No ☐	Model Language		
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§3221(l)(5) §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, small group health policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Page 44
Outpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	3221(l)(5) §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the*	Page 44

		treatment of mental health conditions and substance use disorder consistent with the federal law.	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(6) §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	Page 44
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(7) §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.	Pages 44-45

		Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	Pages 46-54
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited	Page 46

		diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	Pages 46-47
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	Page 48
Prohibition for Tier IV Drugs	§3221(a)(16) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	Not applicable
Eye Drops Model Language Used? Yes ☒ No ☐	§3221(k)(17) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	Page 47
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§3221(l)(12-a) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	Page 47
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes ☒ No ☐	§3221(l)(18) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	Page 49
Contraceptive Drugs and Devices Model Language Used?	§3221(l)(16) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. For groups that meet the definition of a religious employer in §§3221(l)(16)(A); 4303(cc)(1)(A), the subscriber will have the option to purchase the stand alone contraceptive coverage rider. Contraceptive coverage	Page 47

Yes ☒ No ☐		must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 §3239 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: Plans may offer more comprehensive coverage or may substitute this benefit.*	Page 55
Benefit explanation:			
Other Wellness Benefits	45 CFR § 156.100 §3239	Additional Wellness Benefits may be covered. All additional wellness benefits must comply with § 3239 of Insurance Law.	Not applicable
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care	45 CFR § 156.100	This policy or contract form provides coverage for pediatric vision care including: emergency,	Page 56

Model Language Used? Yes ☒ No ☐	Model Language	preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being provided by the insurer in this filing? Yes ☒ No ☐ If No, please provide information in the explanation box below as to how the insurer is meeting the requirement to offer the pediatric essential health benefit.	45 CFR § 156.100 45 CFR § 156.150 Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Insurers are required to offer the pediatric dental essential health benefit as either an embedded benefit (coverage provided by the insurer) or bundled benefit (coverage provided through an arrangement with another insurer).* *Embedded pediatric dental benefits must comply with all of the market reform and rating rules such guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums.* *If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:* *• The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the Exchange but offered outside the Exchange, including at the same premiums;* *• The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums;* *• The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost sharing and OOP maximums;* *• The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the Exchange but offered outside the Exchange.* *• The pediatric dental benefit meets the 70% or 85% actuarial value and $700 OOP maximum for one covered child (or $1,400 if more than one child in the family is covered);*	Pages 57-58

		• The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans; *• Insurers should specifically describe the legal and business arrangement between the medical issuer and the dental issuer when submitting the forms and rates to DFS, and each insurer must separately submit its own forms and rates for approval.* *If the insurer is reasonably assured that an individual has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange the insurer does not need to provide the dental benefit when coverage is issued. Insurers may include a question in their application/enrollment form in order to verify whether an insured has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange*	
Explanation:			
ADDITIONAL BENEFITS			
Family Vision Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	Not covered
Orthotics Model Language Used? Yes ☐ No ☒	45 CFR § 156.100 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	Not covered
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	http://public.leginfo.state ny.us/menugetf.cgi?COMMONQUERY=LAWS11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	Not applicable
Explanation:			

Acupuncture		This policy or contract form provides coverage for acupuncture.	
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(l)(2) § 4303(d)	This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	Pages 42-43
Licensed Clinical Social Worker	§ 3221(l)(4) § 4303(i)	If this policyor contract provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments by physicians, psychiatrists or psychologists, the policy or contract must make available and if requested by the policyholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	Page 44
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	Page 59
Convalescent and Custodial Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.	Page 59
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	Page 59
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	Page 59
Dental Services	11NYCRR52.16(c)(9	This policy or contract form excludes coverage for dental services except for: care or treatment due to	Page 59

Model Language Used? Yes ☒ No ☐	) Model Language	accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	Page 59
Felony Participation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	Pages 59-60
Foot Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	Page 60
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	Page 60
Medically Necessary Model Language Used? Yes ☒ No ☐	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent certified by the State.	Page 60
Medicare or Other Governmental Program Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	Page 60
Military Service Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	Page 60
No-Fault Automobile Insurance Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	Page 60

Services Separately Billed by Hospital Employees Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	Page 60
Services Provided by a Family Member Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	Page 60
Services With No Charge Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	Page 60
Services not Listed Model Language Used? Yes ☒ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy or contract form as being covered.	Page 60
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	Page 60
Workers' Compensation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	Page 61
War Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	Page 61
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim Model Language Used? Yes ☒ No ☐	§3221(a)(8) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	Page 62
Submission of Claim Model Language Used? Yes ☒ No ☐	§3221(a)(9) §4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	Page 62

GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(p) PHL § 4408-a 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any.	Pages 64-65
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	Pages 66-69
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	Pages 70-73

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

COORDINATION OF BENEFITS Model Language Used? Yes ☒ No ☐	11 NYCRR 52.23 Model Language	If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	Form/Page/Para Reference
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language	*The following are the only termination provisions permissible under the Insurance Law.*	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	Pages 77-78
Termination for Failure to Pay Premiums	§3221(p)(2)(A) §4305(j)(2)(A)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.	Pages 77-78
Termination for Fraud	§3221(p)(2)(B) §4305(j)(2)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	Pages 77-78
Termination for Failure to Comply With a Material Plan Provision	§3221(p)(2)(C) §4305(j)(2)(C)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to terminate coverage if the group has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	Pages 77-78
Discontinuation of a Class of Coverage	§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	Pages 77-78
Discontinuation of all Policies/Contracts in the Small Market	§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	Pages 77-78
Termination for Failure to Meet Requirements of Group	§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under §4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	Pages 77-78
Termination if there are No Longer Insureds in the Insurer's Service Area	§3221(p)(2)(F) §4305(j)(2)(F)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Pages 77-78
Termination for Spouses in cases of divorce		This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	Pages 77-78

Termination upon death of Subscriber		This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	Pages 77-78
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.	Pages 77-78
Rescission Model Language Used? Yes ☒ No ☐	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	Pages 77-78
Renewal	§3221(p) §3221(a)(5) 4305(j) 11 NYCRR 52.18(c)	This policy or contract provides that except as specified in §3221(p), or §4305(j) the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	Pages 77-78
Premiums	§3221(a)(4)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Pages 77-78
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☒ No ☐	11 NYCRR 52.18(b)(4); (5); and (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered persons' coverage terminates by reason of the termination of active employment, an extended benefit will be proved during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	Page 79
Continuation Coverage Model Language Used? Yes ☒ No ☐	§3221(e)(11) §3221(m) §4305(e) COBRA, Title X of Public Law 99-272 Model Language	This policy or contract form contains a provision regarding continuation coverage. §§3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage.	Page 80

		The continuation benefits terminate: • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	
Young Adult Option Model Language Used? Yes ☒ No ☐	§3221(r) §4305(l) Model Language	This policy or contract form provides notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy or contract, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r), and/or 4305(l). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy or contract. The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).	Rider
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	Pages 80-81
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language	If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	Pages 80-81

Model Language Used? Yes ☒ No ☐			
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☒ No ☐	§3221(e) §4303(d)	This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents. Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates. The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	Pages 83-84
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§3221(a)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	Page 86
Changes Model Language Used? Yes ☒ No ☐	§3221(a)(2) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	Page 85
Action in Law or Equity Model Language Used? Yes ☒ No ☐	§3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy or contract.	Page 89
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	Pages 88-89

	Model Language		
Unilateral Modification Model Language Used? Yes ☒ No ☐	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	Page 85
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	§3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	Page 89
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	Not applicable
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	Not applicable
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.	Not applicable
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☒ No ☐ If Out-of-Network coverage is offered please answer the following:	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not permit more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	Not applicable

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

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

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

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

North Shore-LIJ Insurance Company, Inc.

Flesch Score
44.6
44.0
43.9
44.1
39.3
35.7
48.8

[redacted]

[redacted]

Officer's Title

Date: April 24, 2013

4839-6577-7939, v. 1

Milliman

North Shore-LIJ Insurance Company

Small Group Off-Exchange Plans

2014 Premium Rates

Prepared for:
North Shore-LIJ Insurance Company, Inc.

Prepared by:

[redacted]

Milliman, Inc., New York

[redacted]

May 13, 2013

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ATTACHMENTS

Attachment A	Proposed rates for North Shore-LIJ Insurance Company's small group plans
Attachment B	Printouts of AV Calculator calculation pages
Attachment C	Description of quality improvement/cost containment programs

GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

Company legal name: North Shore-LIJ Insurance Company, Inc.

State: New York

HIOS Issuer ID: 82483

Market: Small Group

Effective Date: Quarterly rates effective January 1, 2014; April 1, 2014; July 1, 2014; October 1, 2014

COMPANY CONTACT INFORMATION

Primary Contact Name: [redacted]

Primary Contact Telephone Number: [redacted]

Primary Contact E-mail Address: [redacted]

PURPOSE

The purpose of this actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part 1 Unified Rate Review Template and New York State Department of Financial Services' Exhibit 8 "Index Rate/Plan Design Adjustment Worksheet", which supports compliance with the market rating rules and reasonableness of applicable rate increases.

ACTUARIAL QUALIFICATIONS

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

PROPOSED RATE INCREASE(S)

The proposed rates for North Shore-LIJ Insurance Company, Inc.'s (NS-LIJ's) small group plans to be offered off-Exchange in New York State are presented in Attachment A. NS-LIJ will be offering one gold, one silver, and one bronze plan.

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

- Underlying Claims Experience: As NS-LIJ does not have any historical experience on which to base its premium rating, we used Milliman's 2012 Health Cost Guidelines (HCGs) to develop a set of manual rates. The manual rate development is described in detail in this actuarial memorandum.

- Morbidity: The manual rates were adjusted to reflect the population NS-LIJ expects to enroll in 2014.
- Trend: We made no explicit utilization adjustment from the 2012 HCGs. Unit costs are reflective of anticipated 2014 contracted rates.
- Risk Adjustment: We adjusted the projected claims to reflect payments to or from the small group risk adjustment pool as a result of the ACA risk adjustment effective in 2014.
- Benefit Adjustment: The projected claims were adjusted to reflect the benefits that will be offered for each of the off-Exchange products.
- The resulting incurred claim estimate was converted to premium rates using a loss ratio of 85% plus additional taxes and fees.
- The premium rates also reflect the following taxes and fees for 2014:
    - Contributions to the Federal Transitional Reinsurance Program - $5.25 PMPM
    - Patient Centered Outcomes Research Fee - $2.00 PMPY
    - Risk adjustment user fee - $0.96 PMPY
    - Health Insurance Tax (HIT) – 0% of premium
    - Exchange User Fee – 0% of premium for 2014
    - New York State Premium Tax – 1.3% of premium for 2014

The rate development is based on generally accepted actuarial rating principals for rating small group blocks of business.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. NS-LIJ is a newly licensed insurer in New York State, therefore the premium rates presented are 100% manually rated.

BENEFIT CATEGORIES

The benefit categories are based on the algorithm used by Milliman's HCGs. The HCGs are the underlying claim dates we used to develop the manual rates for NS-LIJ. The HCG grouper uses a combination of Diagnosis Based Groups (DRGs), Current Procedural Terminology Codes – Fourth Edition (CPT-4 codes), Healthcare Common Procedural Coding System codes (HCPC), and revenue codes to allocate detailed claims into roughly 60 benefit categories. Service classification may also be dependent on criteria such as site of service, physician specialty and procedure code modifier (e.g., anesthesia modifier). The HCG grouper is updated annually to incorporate any new codes so the classification methodology remains current.

The detailed benefit categories are then collapsed into the five categories required by Worksheet 1, Section I of the Part 1 Unified Rate Review Template.

PROJECTION FACTORS

Not applicable. NS-LIJ is a newly licensed insurer in New York State. We made no adjustments to the experience period claims as the rates are 100% manually rated.

CREDIBILITY MANUAL RATE DEVELOPMENT

As NS-LIJ is a newly licensed health insurer in New York we developed a set of manual rates for NS-LIJ's off-Exchange plans.

Source and Appropriateness of Experience Data Used: We used Milliman's 2012 HCGs, adjusted for Long Island, as the basis for NS-LIJ's manual rate development. 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 Guidelines are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the Guidelines have been updated and expanded annually since that time. The Guidelines 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.

The HCGs consider utilization and average charge levels for roughly 60 benefit categories. These models make provision, by type of service category, for benefit characteristics such as copays, deductibles, coinsurance, and out-of-pocket maximums.

Adjustments Made to the Data: The HCGs represent claim levels for typical large group plans. Prior to the implementation of ACA, the expected utilization differential between a typical large group and small group claim levels could be as high as 15%. The expectation post-2014, after implementation of all the ACA provisions, is that small group utilization levels will resemble large group experience. While we believe this may be true eventually we do not think that this change will be fully realized in 2014. Therefore, in creating NS-LIJ's small group rates we assume that small group claim levels would be 5% higher than the HCG estimated large group levels for Long Island. We believe this 5% differential reflects the expected movement of small group utilization towards large group levels but recognizes that it may take a couple of years to reach that level.

The average cost per unit for each benefit category reflects NS-LIJ's expected cost per unit based on its 2014 provider contracts. Similarly, the prescription drug costs reflect NS-LIJ's agreement with its pharmacy benefit manager (PBM).

The resulting net claims costs for each plan reflect differences due to cost sharing and the impact of induced demand. We applied induced demand at a global level using the HHS induced demand factors presented in the *HHS Notice of Benefit and Payment Parameters for 2014* as shown in the table below:

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

We used the same induced demand adjustment for each plan within each metal level tier after re-normalizing for the effective tier in the underlying HCG data which is a platinum plan.

Conversion Factor: A conversion factor is required to convert the premium from a PMPM basis to a single premium basis. NS-LIJ's conversion factor is 1.288. We developed this factor using Milliman's HCGs, assuming standard demographics and an average family size of 1.71.

Standard Rating Regions: NS-LIJ is filing rates for both Long Island Area (Region 8) and New York City Area (Region 4). We assume no differences in cost between these two regions. As a result, the filed rates for each region do not differ.

Inclusion of Capitation Payments: The following services will be paid on a capitated basis and were added to our HCG net claims cost estimates, by metal level tier, as indicated in NS-LIJ's agreements with its vendors.

- Pediatric dental
- Pediatric vision

CREDIBILITY OF EXPERIENCE

Not applicable. As NS-LIJ will be a new health insurer in 2014 it has no claims experience on which to base its premium rating. Therefore, NS-LIJ's premium rates are 100% manually rated.

PAID TO ALLOWED RATIO

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

Using the approach described above in the Credibility Manual Rate Development section, we calculated expected net claims costs PMPM for each plan. We then took a weighted average across the entire pool using projected member months by plan as the

weighting to estimate the *Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM*. We then divided this by the *Projected Allowed Experience Claims PMPM* to develop the *Paid to Allowed Average Factor in the Projection Period*.

RISK ADJUSTMENT AND REINSURANCE

PROJECTED RISK ADJUSTMENT PMPM

NS-LIJ is a new health insurer for 2014. The premium rates are based on Milliman's HCGs adjusted for Long Island. As the purpose of risk adjustment is to bring all carriers to the same level, we priced the premium rate based on the expected claim levels of all carriers, i.e., an expected risk adjustment factor of 1.00. Therefore, we did not make any specific adjustment to reflect payments into, or from, the small group risk pool.

NON-BENEFIT EXPENSES AND PROFIT & RISK

ADMINISTRATIVE EXPENSE LOAD

The proposed rates reflect an 85% loss ratio, i.e. a 15% load for administration and profit. NS-LIJ estimated administrative expenses in the first year will be much higher than 15% due to the lack of economies of scale. NS-LIJ estimates first year administrative expenses of:

- $160,000 in salaries
- $12,000 in fixed expenses
- $23.37 PMPM for third party administrative services and claims processing
- $2.92 PMPM in general agent commissions
- 3.0% of premium in broker commissions
- $24.17 PMPM in other variable expenses, including finance, auditing and actuarial support, rent, insurance, legal, and telephone fees.

Salaries and fixed expenses were allocated to the small group products using projected 2014 membership.

PROFIT (CONTRIBUTION TO SURPLUS) & RISK MARGIN

The proposed rates do not reflect an allowance for profit margin. NS-LIJ anticipates making a loss in the first year.

TAXES AND FEES

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

Contributions to the Federal Transitional Reinsurance Program	$5.25 PMPM
Patient Centered Outcomes Research Fee	$2.00 PMPY
Risk Adjustment User Fee	$0.96 PMPY

Health Insurance Provider Fee	0.0%*
New York State Exchange User Fee	0.0%*
New York State Premium Tax	1.3%*

* Percent of premium

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

QUARTERLY TREND

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

2014 QUATERLY TREND RATES	2nd Qtr.	3rd Qtr.	4th Qtr.
Claim Trend	1.50%	1.50%	1.50%
Exchange User Fee*	0.88%	.87%	.86%
Quarterly Premium Trend	2.38%	2.37%	2.36%

*Percent of premium

Estimated 2015 trend is 6% and is based on most recent employer surveys of anticipated trends in the market.

Estimated 2015 Exchange User Fees is 3.5% of premium. We prorate this percentage for each quarter depending on how many months fall in 2015.

PROJECTED LOSS RATIO

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

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

2014 TARGET PRICING LOSS RATIOS	
1st Quarter	85%
2nd Quarter	85%
3rd Quarter	85%
4th Quarter	85%

One minus the target loss ratio reflects the percent administrative load.

INDEX RATE

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

As NS-LIJ will be a new health insurer in 2014 it has no claims experience, therefore it does not have an experience period index rate.

The projection period index rate is the projected allowed claims PMPM for the EHB, as shown in Section III of Worksheet 1 of the URRT. The index rate was calculated by taking a weighted average of the EHB claims for each of the small group plans that NS-LIJ intends to offer for sale off-Exchange. The plan index rates were weighted based on projected member months by plan.

For NS-LIJ total allowed claims equal the index rate for the projection period because NS-LIJ does not offer any benefits beyond EHB off-Exchange.

AV METAL VALUES

The AV Metal Values included in Worksheet 2 of the Part 1 Unified Rate Review Template were based on the Federal AV Calculator.

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

AV PRICING VALUES

The URRT requires the calculation of an AV Pricing Value for each plan based on a comparison to a fixed reference plan. For NS-LIJ the fixed reference plan is the gold plan for ages to 26.

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

MEMBERSHIP PROJECTIONS

The membership projections were developed by NS-LIJ. NS-LIJ used several avenues to gather intelligence to develop the membership projections:

- Urban Institute data to rationalize the market and how it will transition over the next three years
- Global demographic data to size the market in the NS-LIJ catchment area
- Feedback from brokers and general agents currently working in the area to rationalize the opportunity based on target position in the market
- Results of focus groups to understand and rationalize NS-LIJ's position in the market and the opportunity based on the market segments
- Analysis of the existing market to identify areas of opportunity
- Expected impact of the Affordable Care Act and State Reforms

TERMINATED PRODUCTS

Not applicable.

WARNING ALERTS

Not applicable.

DATA RELIANCE AND CAVEATS

In developing the premium rates presented in this actuarial memorandum, I relied upon data prepared by Patrick Tong, Assistant VP or Managed Care Analytics of NS-LIJ. I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate.

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

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

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

ACTUARIAL CERTIFICATION

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

I certify that to the best of my knowledge:

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

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

Signed: [redacted]

Title: [redacted]

Date: [redacted]

Attachment A

North Shore-LIJ
Off-Exchange Small Group Premium Rates Effective January 1, 2014

Product Description	Product ID	Total Medical Base Premium PMPM	Premium Per Contract: Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)
Non Standard Copay Plan A (Gold) - Dependent Age 26						
Domestic Partner & Family Planning	82483NY062	$509.09	$655.74	$1,311.48	$1,114.75	$1,868.85
Domestic Partner & No Family Planning	82483NY068	$506.50	$652.40	$1,304.80	$1,109.08	$1,859.34
No Domestic Partner & Family Planning	82483NY064	$509.09	$655.74	$1,311.48	$1,114.75	$1,868.85
No Domestic Partner & No Family Planning	82483NY066	$506.50	$652.40	$1,304.80	$1,109.08	$1,859.34
Non Standard Copay Plan A (Gold) - Dependent Age 29						
Domestic Partner & Family Planning	82483NY063	$512.75	$660.45	$1,320.90	$1,122.77	$1,882.28
Domestic Partner & No Family Planning	82483NY069	$510.14	$657.09	$1,314.18	$1,117.05	$1,872.71
No Domestic Partner & Family Planning	82483NY065	$512.75	$660.45	$1,320.90	$1,122.77	$1,882.28
No Domestic Partner & No Family Planning	82483NY067	$510.14	$657.09	$1,314.18	$1,117.05	$1,872.71
Non Standard Cost Share Plan B (Silver) - Dependent Age 26						
Domestic Partner & Family Planning	82483NY070	$437.06	$562.96	$1,125.92	$957.03	$1,604.44
Domestic Partner & No Family Planning	82483NY076	$434.84	$560.10	$1,120.20	$952.17	$1,596.29
No Domestic Partner & Family Planning	82483NY072	$437.06	$562.96	$1,125.92	$957.03	$1,604.44
No Domestic Partner & No Family Planning	82483NY074	$434.84	$560.10	$1,120.20	$952.17	$1,596.29
Non Standard Cost Share Plan B (Silver) - Dependent Age 29						
Domestic Partner & Family Planning	82483NY071	$440.19	$567.00	$1,134.00	$963.90	$1,615.95
Domestic Partner & No Family Planning	82483NY077	$437.96	$564.12	$1,128.24	$959.00	$1,607.74
No Domestic Partner & Family Planning	82483NY073	$440.19	$567.00	$1,134.00	$963.90	$1,615.95
No Domestic Partner & No Family Planning	82483NY075	$437.96	$564.12	$1,128.24	$959.00	$1,607.74
Non Standard HSA Plan C (Bronze) - Dependent Age 26						
Domestic Partner & Family Planning	82483NY078	$369.90	$476.45	$952.90	$809.97	$1,357.89
Domestic Partner & No Family Planning	82483NY084	$368.02	$474.04	$948.08	$805.86	$1,351.01
No Domestic Partner & Family Planning	82483NY080	$369.90	$476.45	$952.90	$809.97	$1,357.89
No Domestic Partner & No Family Planning	82483NY082	$368.02	$474.04	$948.08	$805.86	$1,351.01
Non Standard HSA Plan C (Bronze) - Dependent Age 29						
Domestic Partner & Family Planning	82483NY079	$372.54	$479.86	$959.72	$815.77	$1,367.61
Domestic Partner & No Family Planning	82483NY085	$370.66	$477.43	$954.86	$811.63	$1,360.68
No Domestic Partner & Family Planning	82483NY081	$372.54	$479.86	$959.72	$815.77	$1,367.61
No Domestic Partner & No Family Planning	82483NY083	$370.66	$477.43	$954.86	$811.63	$1,360.68

Note: All products include dental

Attachment B

User Inputs for Plan Parameters

Non Standard Copay Plan A

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,500.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$350.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☑	50%		☐	☐		
Skilled Nursing Facility	☑	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	88%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☐	☐		
Preferred Brand Drugs	☑	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Non Standard Cost Share Plan B

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)	$6,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$350.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☐	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☐	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☐	☑	50%		☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☐	☐		
Preferred Brand Drugs	☑	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.7%
Metal Tier:	Silver

User Inputs for Plan Parameters

Non Standard HSA Plan C

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,330.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☐	☐		
Preferred Brand Drugs	☑	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☐		$75.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

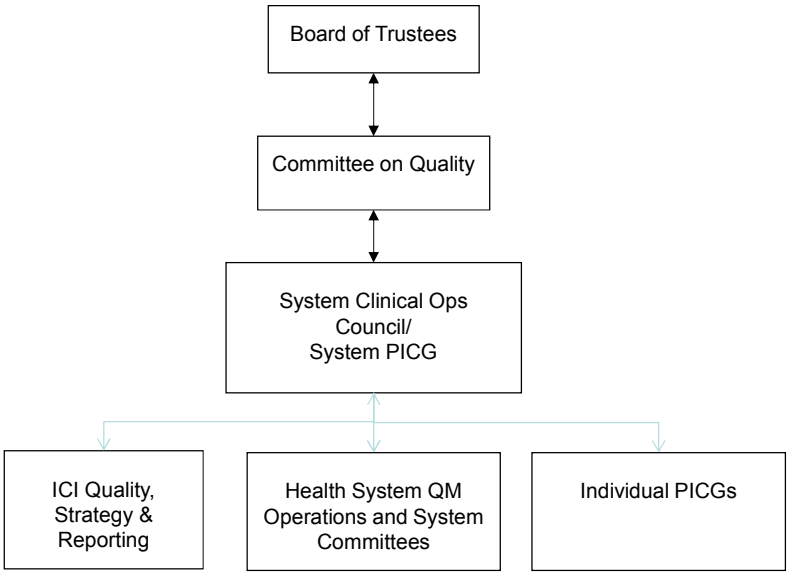
Attachment C

Quality Improvement Strategy

As a wholly owned subsidiary of NSLIJ, the ICI is part of a national health care leader committed to excellence, compassion and improving the health of the communities it serves. ICI benefits by being able to focus quality improvement activities at the point of care and in collaboration with the providers of the NSLIJ Health System and the broader community. ICI also benefits from the long-term focus and investment that the health system has, through the years, placed on delivery and measurement of high quality, high value health care services.

Per NSLIJ Health System's corporate by-laws, one of the roles of governance is to maintain oversight of performance improvement and patient safety activities and to ensure that a uniform standard of high quality care is delivered throughout the entire NSLIJ system. This is coordinated through an established governance structure which ultimately reports to the system's Board of Trustees. The structure has been established for monitoring, evaluating and improving the quality of care through organizational performance improvement programs covering both inpatient and ambulatory care and ensures alignment between quality improvement activities of ICI and that of the boarder health system. The figure below depicts the NSLIJ structure for ensuring high quality care across the health system.

Quality Oversight and Communication Structure



At the heart of the structure is the Committee on Quality (COQ). The COQ serves as a formal means of liaison and policy development among the Board of Trustees, senior medical leadership, the System Performance Improvement Coordinating Group (PICG) and Chief Quality Officer and VP for the Institute

for Clinical Excellence and Quality.[1] The COQ sets priorities for quality and safety activities and the evaluation measures used to assess care processes and outcomes across NSLIJ – including ICI – and is informed of the care delivered in each entity within the ICI provider network.

The System Clinical Operations Council/System PICG prioritizes and sets the standards for quality and performance improvement initiatives; assigns responsibility for enacting all performance improvement recommendations; monitors results and oversees the approval of administrative policies and procedures.

Individual PICGs chaired by a physician are responsible for directing, coordinating and overseeing performance improvement and patient safety activities appropriate to their scope of care and for communicating information to their entity clinical leadership, the System PICG/System Clinical Operations and the COQ.

Quality Improvement Strategy

ICI, in coordination with the NSLIJ COQ, the System Clinical Operations Council and PICG teams, is committed to meeting the quality requirements set forth in section 1311(g) of the ACA and by the New York Health Benefit Exchange. Below we describe our approach to:

- Improving Health Outcomes
- Preventing Hospital Re-Admissions
- Improving Patient Safety
- Implementing Wellness and Health Promotion Activities
- Reducing Health and Health Care Disparities
- Expanding Access to Mental Health Services

The quality and patient safety strategy is reviewed and updated annually with progress reported to the designated office of the New York State Department of Health, as required.

Improving Health Outcomes

Improving health outcomes for ICI members is a critical component of the quality strategy. Moving the dial on improving health outcomes requires investment in measuring and capturing clinical care data so that providers have the tools they need to manage patients.

The NSLIJ network contracted by ICI utilizes both inpatient and ambulatory electronic health record systems. Built into the inpatient system are numerous quality and safety tools, such as heparin dosing calculators and improved medication reconciliation tools, renal dose adjustment prompts, and provider handoffs. On the ambulatory side, there are several system features and reports to assist providers in

[1] The Institute provides the framework for each entity's quality improvement activities, including development of the corporate-wide performance and quality improvement plan and ensuring alignment based on national and state quality agendas. Additionally, the Institute maintains comprehensive occurrence and tracking systems, and collaborates across departments and organizations to ensure quality and safety goals are being achieved.

tracking the status of appropriate screening or diagnostic tests and/or referrals, as well as identifying high-risk members and tracking members not meeting treatment goals. Thus, the ability to electronically capture data can be used to support quality reporting, effective case/disease/medication management and care coordination which improves outcomes. In the area of medication management, NSLIJ's EHR supports the review and monitoring of critical medication management processes, including ordering and transcribing, preparing and dispensing. Each NSLIJ physician and contracted provider is required to develop and evaluate safe medication management practices for preventing and responding to adverse medication events and medication errors, and identifying and managing high risk and high alert medications.

NSLIJ EHRs are also being used to support a perinatal continuum of care effort in the coming year. Custom templates are being built into the office EHRs so that more than 160 discrete data elements will automatically flow from the physician office record and into the Labor and Delivery units of hospitals. This ensures a complete record is available to hospital staff at the time a pregnant mother presents for delivery and aides in improving birth outcomes.

Another important benefit of electronic clinical record keeping is the availability of patient data to allow monitoring of clinical and quality parameters across large populations. ICI will participate in NSLIJ's effort to manage outcomes across different disease areas. One example is the Diabetes Mellitus Registry. This registry includes not only dashboard views of diabetes-related quality metrics across the entire population of diabetics in the hospital system, but also patient-level details which will allow case managers to target health plan members for follow up and interventions, as needed, with the overall goal of improving outcomes for individuals with diabetes.

Quality reporting is managed through the Office of Integrated Data Analytics (OIDA), which is responsible for the integration of data resources and coordination of data analytics across the ICI/NSLIJ network. Working in conjunction with other departments, OIDA identifies opportunities to improve quality and services and develops tools, scorecards, dashboards and other concurrent and retrospective clinical support tools that enables NSLIJ health system and the ICI to measurable improve health outcomes.

Medication Management Activities Performed by PBM

In addition to the medication management practices adopted by the health system, the ICI is contracting with a vendor- CVS Caremark- that will also provide medication management activities. CVS Caremark designed its clinical strategy to fulfill two main objectives: Helping clients manage bad trend and promote good trend. CVS accomplishes this through a variety of unique drug utilization review strategies and their award-winning Pharmacy Advisor® approach. The CVS Caremark concurrent, retrospective and prospective drug utilization review programs are described below.

CONCURRENT DRUG UTILZATION REVIEW (DUR) PROGRAMS

Managing Bad Trend

The CVS Caremark Concurrent (POS) DUR program is an automatic, system-driven drug utilization review program performed for all clients on all prescriptions, at both mail and retail. No extra charge is made for this standard service.

Our concurrent DUR program is implemented through our single-platform information systems, which power CVS Caremark's online national retail pharmacy network, our National Network of point-of-sale pharmacies as well as our mail service pharmacy facilities. The system can perform up to 500 edits on every prescription to ensure that prescriptions meet administrative, plan-design, and member safety criteria.

Enhanced Concurrent DUR is available through the CVS Caremark Mail Service pharmacies as part of our Drug Savings Review solution. This concurrent DUR has features that extend beyond the standard safety edits to provide additional clinician review and interventions designed to reduce drug spend and improve appropriateness of overall pharmaceutical care.

Promoting Good Trend

Pharmacy Advisor Counseling: This approach leverages our vertically-integrated model, enabling pharmacists to intervene on members with chronic conditions in the most personalized manner, at CVS retail pharmacy. For the first time in the industry, pharmacists – on a broad scale – have access to critical patient information at the point of care, giving them the opportunity to pinpoint and discuss a member's specific health care scenario. The program also includes inbound call access to pharmacists for personalized consultation as well as an optional outbound phone call component.

RETROSPECTIVE DUR PROGRAMS

Managing Bad Trend

The CVS Caremark Safety and Monitoring Solution evaluates pharmacy claims for patterns of potential overuse or misuse. On a quarterly basis, CVS Caremark clinical pharmacists evaluate controlled-substance and other select drug claims (along with supporting medical data, if available) to identify potential medication abuse and fraudulent claims for appropriate intervention. This program uses utilization-based clinical rules designed specifically to identify cases of potentially excessive or abusive use. There is also a monthly review of claims for the most egregious cases of overutilization/high cost, in addition to the standard quarterly review. Monthly reviews give us the opportunity to spot egregious claims much sooner, and intervene for better outcomes for both members and clients.

The CVS Caremark Enhanced Safety and Monitoring Solution provides additional investigation and intervention when patterns of potential drug overuse or misuse are identified. In addition to the Core Safety and Monitoring Solution, the enhanced solution provides expanded written communications, coordination with pharmacy audit activities, prescriber toolkits, peer prescriber consultations with independent physician experts, and medication therapy counseling for select members.

The Retrospective Safety Review solution acts as a safety net for serious drug interactions. This solution reviews both mail and retail prescriptions within 72 hours after the claim adjudicates for potential safety issues not addressed at point-of- dispensing, and messages the prescriber with an actionable member-specific communication identifying the clinical issue and suggestions for improving medication therapy. This early retrospective intervention may allow for a change in the prescription before the member picks up the original prescription, resulting in increased member safety, less member disruption, and earlier savings capture for Oscar.

Promoting Good Trend

Closing gaps in medication therapy: We can provide a powerful "early-warning system" for your members' medical care and identifies high-risk members before they may experience significant medical events. Drug profiles are assessed daily, within 72 hours after claims adjudication, by a clinical pharmacist for any potential issues or complications associated with the disease or therapy. Identified issues are communicated to the prescriber along with suggested solutions to the issues.

PROSPECTIVE DUR PROGRAMS

Managing Bad Trend

The CVS Caremark prospective DUR programs include Prior Authorization, Step Therapy, and Quantity Limits.

CVS Caremark's Prior Authorization program offers several benefits, including:

- Promotes appropriate prescribing of drugs by ensuring adherence to approved treatment protocols
- Decreases expenses by shifting utilization to less expensive, clinically appropriate drugs
- Promotes member safety.

Our Step Therapy program ensures that members utilize the most therapeutically appropriate and cost-effective drugs first. Step therapy protocols optimize appropriate drug therapy while controlling costs by defining how and when a particular drug or drug class should be used, based on a member's drug history. Post-step prior authorization is also available to allow coverage for clinically appropriate situations that do not meet the initial step therapy protocol.

Quantity Limits are available as an alternative or a supplement to our Prior Authorization program. Clients that wish to maintain control over drugs with the potential for abuse, misuse, or safety concerns – without eliminating coverage – can do so by means of the Quantity Limits program.

Point of Service (POS) Safety Review is our baseline safety solution. Whether a prescription is presented through our mail service pharmacies or our retail

network, CVS Caremark systems automatically evaluate the prescription in the context of the member's complete drug history. When appropriate, real-time alerts are issued to the dispensing pharmacist regarding potential issues.

All prescriptions are first checked for member eligibility and plan design features. They are then compared against previous histories of prescriptions filled by the same pharmacy, by other participating retail network pharmacies, by the mail service pharmacies, and submitted paper claims. All drug conflicts are detected online when the prescription is entered into the computer system. If a conflict is identified, the pharmacist reviews the member's history and may contact the prescriber to make any adjustments prior to filling the prescription. Our program enables the pharmacist to override an edit when they have reviewed the data with the member or prescriber and have determined that the prescription is safe to dispense.

CVS Caremark's concurrent DUR program includes key edits such as drug-drug interactions, drug-allergy interactions, drug-age alerts, and therapeutic duplication. These automated claims messages are sent to mail and retail pharmacies in real-time, allowing for pharmacists to contact the prescriber and make adjustments before the prescription is dispensed.

Patient Centered Medical Homes

In outpatient primary care sites, a significant quality-related focus of ICI's contracted NSLIJ network in the coming year is achieving NCQA accreditation and recognition of ambulatory sites as Patient Centered Medical Homes (PCMHs). The use of a PCMH model will help improve health outcomes, particularly for members with chronic diseases which can be best served through improved management and coordination.

Preventing Hospital Re-admissions

Preventing re-admissions is a strategic priority for both NSLIJ and ICI. To achieve this goal, ICI and NSLIJ are focused on two areas: preventing re-hospitalizations and managing advanced illnesses.

NSLIJ has partnered with The Joint Commission Center for Transforming Healthcare (JCCTH)[2], Partnership for Patients[3] and AAMC & UHC Best Practices for Better Care[4] in the effort to reduce re-hospitalizations. Each of these initiatives provides tools and training for managing hospitals discharges, particularly around complex conditions such as heart failure, and ensuring that the member receives coordinated, appropriate and consistent follow up care to lower the readmission risk. A component of this care includes ensuring that patients and family receive education and training on post-discharge protocols and the resources available to them after hospitalization.

For managing advanced illness, NSLIJ has partnered with the IHI Strategic Partnership[5]. NSLIJ also utilizes the Advanced Illness Coordinating Committee (AICC), whose aim is to improve the care of patients with serious illness by aligning treatments with patient preferences. The goals are to ensure that patient preferences are known, documented and followed to decrease hospital admissions and readmissions and increase hospice average length of stay, reduce non-emergent ER visits by delivering care at home to patients with advance and terminal illness and reduce overall suffering.

[2] http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=5
[3] http://partnershipforpatients.cms.gov/
[4] https://www.aamc.org/initiatives/bestpractices/
[5] http://www.ihi.org/offerings/CustomExpertise/Pages/StrategicPartnership.aspx

Improving Patient Safety

NSLIJ and ICI utilize a Model for Improvement that provides a framework for developing, testing and implementing changes that lead to improvement to design patient safety programs. The model can be applied to improving processes, products and services in healthcare organizations and is based on Plan, Do, Study Act (PDSA) model popularized by Dr W. Edwards Deming, considered by many to be the father of modern quality control.

Under the Model for Improvement, knowledge is built by an iterative process of developing a theory, making predictions based on the theory, testing the predictions with data, improving the theory based on the results and making new predictions based on the revised theory. Tests of change are designed to answer questions that come from a combination of theory about the subject matter and conclusions from analysis of data from past studies. Each PDSA cycle is designed to answer specific questions related to the Patient Safety team's aim. Using PDSA cycles, staff measure key organizational functions across a variety of settings: inpatient, critical care, emergency care, ambulatory, home care, hospice, behavioral health, rehabilitation, and long term care.

The focus of the NSLIJ Performance Improvement/Patient Safety Program that ICI will leverage is to outline quality management methods for assessing the way care is delivered; prioritizing areas for improvement; improving processes based on the uniform collection of statistical data; evaluating and reevaluating processes of care; and communicating the results throughout the NSLIJ system.

Specific strategies to improve patient outcomes include:

- Conducting annual Culture of Safety surveys and developing action plans based on results
- Patient Safety Rounds in all NSLIJ entities to demonstrate leadership's commitment to working with staff to improve patient safety
- Sharing and benchmarking across institutions and entities for best practices, quality outcomes, indicators, occurrences, and lessons learned
- Improving safety through proactive risk assessments and standardized root cause analyses
- Implementing national patient safety initiatives
- Encouraging patient and family participation in care
- Developing and implementing system-wide initiatives
- Educating staff on safety topics and resolving safety issues raised by staff
- Partnering with external organizations
- Strategic partnerships (such as the ones previously mentioned with industry groups and collaborations)

Specific patient safety priorities across the ICI and health system in the current year are:

- Sepsis
- Heart Failure
- Advance Illness
- Infection Prevention

- Perinatal Safety

Each initiative, co-chaired by physician and/or nursing leadership, comprises an interdisciplinary team of clinical experts encouraged to study and adopt evidence-based clinical practices and measurement systems. Executive summary reports shall be provided to senior leadership at both the system and the hospital PICGs regarding the progress of each initiative toward achieving goals, implementing plans, barrier to success and measures of patient safety and performance.

In addition to the priorities and processes mentioned in this section, both ICI and the NSLIJ network will rely heavily on EHRs to ensure clinical and evidence-based protocols are adhered to and to monitor and measure clinical performance. The section entitled *"Health Outcomes"* addresses the role that technology plays in these areas.

Implementing Wellness and Health Promotion Activities

Knowledge related to one's health status can be critical to health promotion and wellness programs. Wellness has many different meanings but can simply be viewed as optimizing one's health status regardless of whether they have no health issues or if they have multiple chronic conditions. Avenues for information dissemination include seminars, such as "lunch and learn" meetings, health fairs, web-based articles, webinars and interactive quizzes on topics of wellness. Communication is a cornerstone to any successful wellness and health promotion activity.

Current wellness and health promotion activities done by the HSI center around four main areas: physical health, nutrition, stress management, and exercise. Incorporation of all of these elements into a wellness program for ICI will be critical to the success of the ICI.[6] Currently, HSI employees are encouraged to participate in these efforts, and can be rewarded for participation through wellness pledges that can offset employee contributions for health insurance coverage. In 2012 employees were given wellness credits for being tobacco free, participating in biometric screening and completing a health risk assessment, identifying a personal care physician and receiving an influenza vaccination.

In 2011 North Shore LIJ began a comprehensive wellness program that encompassed these four critical areas. All employees are encouraged to complete a health risk assessment, biometric screening, including height, weight, screening for cholesterol, diabetes risk and hypertension began, to inform individuals of their health status Having an initial biometric screening test is critical to establish a baseline health status for individuals, so that they can measure their progress towards improving their overall health. Cancer screening is available for all employees and these programs are highlighted during cancer awareness months for all employees.

Tobacco control programs are an important element in health promotion. At North Shore LIJ, our campuses have been tobacco free since 2010, including all vendors. We have worked with our Center

[6] The ICI understands that current federal regulations guide wellness program implementation in the small group market. The ICI will work in conjunction with the HSI to appropriately implement wellness efforts in accordance with federal and state regulations, including limiting the permissible reward for achieving a particular health outcome to 30% of the cost of health coverage.

for Tobacco Control to ensure that all employees have access to tobacco cessation programs, and that all costs related to smoking cessation are covered without any out-of-pocket expenses.

Fitness programs, such as walking programs, facilitated through walking trails, both indoors and outdoors, when feasible, encourage activity at the workplace. Walking challenges can increase employee engagement while promoting physical activity. For example, in 2012, a walking challenge, "The Walk to Paris", was held at North Shore LIJ, and over one-third of all employees participated in the twelve week program. There are subsidies for fitness centers at discounted monthly rates for employees. Fitness classes, such as zumba, yoga and Tai Chi are offered at many facilities.

Stress reduction programs, such as mindful meditation and seminars on how to better deal with family stresses, financial stresses and day-to-day challenges. Employee Assistance Programs to allow employees to have a confidential resource during times of need are critical to workplace health promotion and wellness.

Nutritional information, from basic labeling of vending machines, to providing healthier food alternatives and recipes, is an important component. Healthy food guidelines, that can be implemented in a workplace or used for individuals are an essential component of health promotion and wellness. This includes guidelines for food served in the cafeterias, and for meetings held within our health care system. Weight control programs, such as Weight Watchers at work, have been available for employees in the Health System, enabling employees to participate in a convenient manner. In 2012, we added an additional, online weight control program, BMIQ, to enable those employees who wished to participate in a program away from the workplace.

Reducing Health and Health Care Disparities

As surrounding communities become more diverse, the NSLIJ Health System recognized the need to cultivate diversity and has identified Diversity, Inclusion and Health Literacy (DIHL) as core characteristics and key components in the promotion of quality patient care. In July 2010, NSLIJ Health System and the Hofstra NSLIJ School of Medicine merged its existing diversity and health literacy initiatives, and established the Office of Diversity, Inclusion and Health Literacy (ODIHL). It was created to drive the health system's mission to provide excellent patient care, and foster an environment that supports principles of equity, diversity, inclusion and effective communication. ICI works in conjunction with the ODHIL and supports these principles for health plan members.

The ODIHL has the mission of establishing programs and policies intended to promote diversity, inclusion and health literacy as an integral part of the delivery of culturally competent, safe, quality patient-centered care. ODIHL works to build a community of excellence where the affirmation of differences is clearly seen in the composition of Health System and ICI leadership, faculty, staff and students, and reinforced through its policies, practices and organizational structure. ODIHL aims to be recognized by employees, patients, members, communities served and peer institutions as a leading model in DIHL while advancing cultural and linguistic competence and promoting effective communication to enhance patient outcomes and eliminate health disparities.

The ODIHL focuses efforts on increasing cultural and health literacy awareness in the workforce and has established various inter-disciplinary system-wide intramural educational initiatives that have helped to

transform the NSLIJ Health System climate and promote the delivery of excellent, safe, patient-centered care. For example, one effort has been to provide online education modules, including ones dealing with cultural competency and health literacy. There is also a link to an online resource called Culture Vision, which addresses various aspects of 47 different cultures that clinicians can reference at the point of care. These efforts have been cross-cutting in both discipline and mode of delivery through the development of inter-professional orientations and in-print, on-line and in-class educational opportunities. As ICI members visit NSLIJ Health, they will benefit from the effort and focus that ODIHL has placed on cultural and health literacy awareness.

ODIHL also oversees the Language Access Services program across the Health System which ensures meaningful access to health care services for patients and/or ICI members who are limited-English speaking, deaf or hearing impaired, or disabled. Language and Communication Access initiatives have included: an annual needs assessment, identifying limited English speaking populations comprising more than 1% of the total hospital service area population; standardization of vital documents; and enhancements to concurrent documentation and reporting of limited English proficient persons. Site specific educational opportunities have been provided to staff regarding the populations they serve as well as a variety of resources for continued learning.

Expanding Access to Mental Health Services

The NSLIH Health System is currently working on many initiatives which will be coordinated in conjunction with ICI programs and members. For quick returns in both patient care and in savings, NSLIJ is focused on expediting the use of Telepsychiatry in the Emergency Rooms, along with the connections being developed in the Ambulatory Network of Care. The objectives of this initiative are to: Divert Inpatient Admissions to lower levels of care; Reduce ALOS; and Reduce Readmissions.

Longer term, NSLIJ believes that the integration of behavioral health into primary care, especially pediatrics is critical. This requires developing the processes to identify behavioral health issues by incorporating Evidence Based screens in well care visits and the facilitation of referrals for care; which can be achieved through different models, all of which require an established ambulatory network.

Several specific initiatives currently underway to integrate behavioral and physical health are:

- Utilization of practice-specific screening protocols such as the PHQ9 and various SBIRT tools, with the goal of getting physicians to begin screening using an evidence-based tool and protocol.
- Development of relationships, training, and support for primary care office staff so that screening and other integration efforts are supported and part of the workflow.Providing PCPs with options for integrating a behavioral health specialist into their primary care setting, such as co-location. Communicating on a regular basis, whether by formal or impromptu meeting, shared EMR, telephone contact, secure e-mail, or faxed reports.
- Utilization of telepsychiatry to “meet” with patients as an option for consultation to the PCP.
- Providing a solid knowledge base of community resources to allow physician practices to implement a patient-centered care approach.

There are also other initiatives currently underway to further improve access to behavioral health services, including:

- Implementation of telepsych consultative services at various system EDs, strengthening and facilitating access to care for patients who present across the geographic reach of the health system.
- Linkage with the LIJMC OB GYN department and ZHH's Perinatal Psych program, identifying new or expectant mothers with mood disorders that may otherwise not seek treatment.
- Telepsych services offered to home bound expectant mothers in the perinatal program.
- Partnerships with local schools / colleges to appropriately identify students in crisis, link with appropriate resources, and facilitate inpatient admissions.
- Direct contracts and linkages with school districts to integrate behavioral health services when service needs exceed what the school can provide.
- Ambulatory partnerships with community based organizations to facilitate ED discharge linkages and strengthen inpatient psych discharge plans.

ICI Compliance with Exchange Quality Requirements

In addition to developing and maintaining and quality strategy, ICI will adhere to Exchange requirements for Qualified Health Plans (QHPs), including:

- Quality Assurance Reporting Requirements
- Consumer Assessment of Health Care Providers and Systems (CAHPS)
- Quality Improvement Initiatives
- Accreditation

These areas are addressed below.

Quality Assurance Reporting Requirements

ICI will follow New York State's Quality Assurance Reporting Requirements (QARR). ICI is incorporated into the robust quality improvement infrastructure of NSLIJ and will leverage the quality improvement efforts and high quality, high value nature of the NSLIJ network with which ICI contracts. ICI and NSLIJ leadership and staff fully understand that QARR reporting requires the organization to have HEDIS Volume 2 measure sets, programming for requirement measures, an NCQA audit conducted by a licensed audit organization of QARR data prior to submission and a certified CAHPS vendor to administer CAHPS. ICI will put in motion a plan to meet these requirements for submission of all items by June 2015 for calendar year experience in 2014.

Consumer Assessment of Health Care Providers and Systems (CAHPS)

ICI will contract with a certified CAHPS vendor to administer the CAHPS 5.0H survey to measure patient satisfaction. ICI understands that QHPs may be required to add New York State-specific questions to the tool to aid the state in learning about the newly insured's experience and/or to provide additional demographic or clinical detail. ICI will ensure compliance with Exchange timelines, which requires that survey be scheduled on or around fall of 2014.

Quality Improvement Initiatives

ICI understands that New York State will require Exchange participants to have the infrastructure in place (or the ability to contract) which allows ICI to implement its quality strategy and related improvement activities, as well as participate in a variety of state-sponsored quality improvement work. As previously discussed, ICI's quality strategy will be incorporated into the quality infrastructure of the NSLIJ system. As such, ICI anticipates performing most, if not all quality improvement activities, including participation in state-sponsored quality initiatives.

ICI further understands that performance that falls outside normal ranges for quality and satisfaction performance will require a barrier analysis and an improvement plan, to be developed and operationalized once approved by the designated New York State Department of Health office.

Accreditation

The ICI will seek accreditation for its plans in accordance with the New York State's timeline for accreditation.

Data Management Systems

ICI will contract with HF Administrative Services, Inc. (HFAS) to access a variety of software systems necessary to support ICI operations. The major systems that will be available to ICI are the same systems currently utilized by HFAS to support multiple established insurance operations, namely:

- DST Health Solutions PowerMHS – A fully integrated system for health plan administration and claims processing, PowerMHS processes and stores all claims and encounters.
- McKesson Comprehensive Care Management System (CCMS) – This flexible and scalable commercial care management software will support the care management and quality assurance programs. InterQual (IQ) Coordinated Care Content is embedded in CCMS and supports complex care planning and co-morbidity needs in a streamlined environment. This content allows support for members with complex needs with blended assessments and an integrated care plan.

All HFAS systems are HIPAA and ACA compliant for both electronic and paper records.

In addition, the data management systems of the NSLIJ network with which ICI is contracting have been nationally recognized[7] and will be integral to providing safe and efficient care for ICI members; implementing advanced quality programs for ICI; and collecting data required for ICI analysis and reporting.

[7] Health Care's 100 Most Wired Survey Award, Hospitals and Health Networks Magazine, July 2012 and "Michael Dowling Named CEO Information Technology Award Winner", Modern Healthcare magazine, June 23, 2011

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

User Inputs for Plan Parameters

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

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

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

Tier 1 Plan Benefit Design	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

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

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

Output

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

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

User Inputs for Plan Parameters

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

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

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

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

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

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

Output

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

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

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design		
	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

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

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

Output

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

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

User Inputs for Plan Parameters

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

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

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

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

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

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

Output

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

*****SILVER CSR 200-250% FPL PLAN (3-5-2013)*****

User Inputs for Plan Parameters

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

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

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$1,750.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$4,000.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

*****SILVER CSR 200-250% FPL PLAN (3-5-2013)*****
Per HHS Reg, AV for this plan must be at least 2 points higher than AV for corresponding regular silver plan

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.4%
Metal Tier:	Silver

User Inputs for Plan Parameters

*****SILVER CSR 150-200% FPL PLAN (3-5-2013)*****

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$250.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.830%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.600%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

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

*****SILVER CSR 150-200% FPL PLAN (3-5-2013)*****
The 150-200% FPL plan must use the GOLD tables,
any error message is to be ignored, per AV methodology reg.

Output

Status/Error Messages:	Calculation resolved without matching metal tiers.
Actuarial Value:	86.7%
Metal Tier:	Platinum

User Inputs for Plan Parameters ******SILVER CSR 100-150% FPL PLAN (3-5-2013)******

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.480%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.760%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

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

******SILVER CSR 100-150% FPL PLAN (3-5-2013)******

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: Small Group

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

Line #	General				
1	Product*	North Shore-LIJ Non Standard Copay Plan	North Shore-LIJ Non Standard Copay Plan A	North Shore-LIJ Non Standard Copay Plan A	North Shore-LIJ Non Standard Copay Plan A
2	Product ID*	82483NY062	82483NY063	82483NY064	82483NY065
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.79	0.79	0.79	0.79
5	AV Pricing Value (total, risk pool experience based)*	0.95	0.96	0.95	0.96
6	Plan Type*	EPO	EPO	EPO	EPO
7	Plan Name*	TBD	TBD	TBD	TBD
8	Plan ID*	82483NY0620001	82483NY0630001	82483NY0640001	82483NY0650001
9	Exchange Plan?*	No	No	No	No

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

	Experience Period Index Rate				
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	n/a			
10B	Member-Months for Latest Experience Period	n/a			
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	n/a			
11	Average Pricing Actuarial Value reflected in experience period	n/a			
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**506.28**	**506.28**	**506.28**	**506.28**

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 **	1.000			
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000			
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000			
22	Impact of adjustments due to experience period claim data not being sufficiently cred ble	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**	**1.000**	**1.000**	**1.000**

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.867	0.867	0.867	0.867
29	Pricing actuarial value (only the induced demand factor) #	0.939	0.939	0.939	0.939
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.007	1.000	1.007
34	Administrative costs (excluding Exchange user fees and profits)	1.205	1.205	1.205	1.205
35	Profit/Contribution to surplus margins	1.000	1.000	1.000	1.000
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000
39	Addition of capitation rates for pediatric dental and vision - differs by metallic tier (Other 1)	1.025	1.025	1.025	1.025
40	Adjustment for Removal of Family Planning and Contraceptives (Other 2)	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.006**	**1.013**	**1.006**	**1.013**

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

Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)**	**509.09**	**512.75**	**509.09**	**512.75**

North Shore-LIJ Non Standard Copay Plan A	North Shore-LIJ Non Standard Copay Plan A	North Shore-LIJ Non Standard Copay Plan A	North Shore-LIJ Non Standard Copay Plan A	North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard Cost Share
82483NY066	82483NY067	82483NY068	82483NY069	82483NY070	82483NY071	82483NY072	82483NY073
Gold	Gold	Gold	Gold	Silver	Silver	Silver	Silver
0.79	0.79	0.79	0.79	0.72	0.72	0.72	0.72
0.95	0.96	0.95	0.96	0.82	0.82	0.82	0.82
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
82483NY0660001	82483NY0670001	82483NY0680001	82483NY0690001	82483NY0700001	82483NY0710001	82483NY0720001	82483NY0730001
No	No	No	No	No	No	No	No

506.28	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**

0.867	0.867	0.867	0.867	0.781	0.781	0.781	0.781
0.939	0.939	0.939	0.939	0.896	0.896	0.896	0.896
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.007	1.000	1.007	1.000	1.007	1.000	1.007
1.205	1.205	1.205	1.205	1.207	1.207	1.207	1.207
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.025	1.025	1.025	1.025	1.022	1.022	1.022	1.022
0.995	0.995	0.995	0.995	1.000	1.000	1.000	1.000
1.000	**1.008**	**1.000**	**1.008**	**0.863**	**0.869**	**0.863**	**0.869**

506.50	**510.14**	**506.50**	**510.14**	**437.06**	**440.19**	**437.06**	**440.19**

North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard Cost Share	North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Non Standard HSA Plan C
82483NY074	82483NY075	82483NY076	82483NY077	82483NY078	82483NY079	82483NY080	82483NY081
Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze
0.72	0.72	0.72	0.72	0.62	0.62	0.62	0.62
0.81	0.82	0.81	0.82	0.69	0.70	0.69	0.70
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
82483NY0740001	82483NY0750001	82483NY0760001	82483NY0770001	82483NY0780001	82483NY0790001	82483NY0800001	82483NY0810001
No	No	No	No	No	No	No	No

506.28	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**

0.781	0.781	0.781	0.781	0.681	0.681	0.681	0.681
0.896	0.896	0.896	0.896	0.870	0.870	0.870	0.870
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.007	1.000	1.007	1.000	1.007	1.000	1.007
1.207	1.207	1.207	1.207	1.210	1.210	1.210	1.210
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.022	1.022	1.022	1.022	1.020	1.020	1.020	1.020
0.995	0.995	0.995	0.995	1.000	1.000	1.000	1.000
0.859	**0.865**	**0.859**	**0.865**	**0.731**	**0.736**	**0.731**	**0.736**

434.84	**437.96**	**434.84**	**437.96**	**369.90**	**372.54**	**369.90**	**372.54**

North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Non Standard HSA Plan C	North Shore-LIJ Platinum Off Exchange	North Shore-LIJ Platinum Off Exch	North Shore-LIJ Platinum Off Exch	North Shore-LIJ Platinum Off Exch
82483NY082	82483NY083	82483NY084	82483NY085	82483NY118	82483NY124	82483NY120	82483NY122
Bronze	Bronze	Bronze	Bronze	Platinum	Platinum	Platinum	Platinum
0.62	0.62	0.62	0.62	0.88	0.88	0.88	0.88
0.69	0.69	0.69	0.69	1.09	1.08	1.09	1.08
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
82483NY0820001	82483NY0830001	82483NY0840001	82483NY0850001	82483NY1180001	82483NY1240001	82483NY1200001	82483NY1220001
No	No	No	No	No	No	No	No

506.28	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**

0.681	0.681	0.681	0.681	0.924	0.924	0.924	0.924
0.870	0.870	0.870	0.870	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.007	1.000	1.007	1.000	1.000	1.000	1.000
1.210	1.210	1.210	1.210	1.203	1.203	1.203	1.203
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.020	1.020	1.020	1.020	1.029	1.029	1.029	1.029
0.995	0.995	0.995	0.995	1.000	0.995	1.000	0.995
0.727	**0.732**	**0.727**	**0.732**	**1.144**	**1.138**	**1.144**	**1.138**

368.02	**370.66**	**368.02**	**370.66**	**579.27**	**576.32**	**579.27**	**576.32**

North Shore-LIJ Platinum Off Exchange	North Shore-LIJ Platinum Off Exch	North Shore-LIJ Platinum Off Exch	North Shore-LIJ Platinum Off Exch	North Shore-LIJ Gold Off Exchange	North Shore-LIJ Gold Off Exchange	North Shore-LIJ Gold Off Exchange	North Shore-LIJ Gold Off Exchange
82483NY119	82483NY125	82483NY121	82483NY123	82483NY110	82483NY116	82483NY112	82483NY114
Platinum	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold
0.88	0.88	0.88	0.88	0.80	0.80	0.80	0.80
1.10	1.09	1.10	1.09	0.95	0.94	0.95	0.94
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
82483NY1190001	82483NY1250001	82483NY1210001	82483NY1230001	82483NY1100001	82483NY1160001	82483NY1120001	82483NY1140001
No	No	No	No	No	No	No	No

506.28	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**

0.924	0.924	0.924	0.924	0.861	0.861	0.861	0.861
1.000	1.000	1.000	1.000	0.939	0.939	0.939	0.939
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.007	1.007	1.007	1.007	1.000	1.000	1.000	1.000
1.203	1.203	1.203	1.203	1.205	1.205	1.205	1.205
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.029	1.029	1.029	1.029	1.025	1.025	1.025	1.025
1.000	0.995	1.000	0.995	1.000	0.995	1.000	0.995
1.152	**1.147**	**1.152**	**1.147**	**0.999**	**0.994**	**0.999**	**0.994**

583.44	**580.47**	**583.44**	**580.47**	**505.85**	**503.28**	**505.85**	**503.28**

North Shore-LIJ Gold Off Exchange	North Shore-LIJ Gold Off Exchange	North Shore-LIJ Gold Off Exchange	North Shore-LIJ Gold Off Exchange	North Shore-LIJ Silver Off Exchange	North Shore-LIJ Silver Off Exchange	North Shore-LIJ Silver Off Exchange	North Shore-LIJ Silver Off Exch Dependent
82483NY111	82483NY117	82483NY113	82483NY115	82483NY102	82483NY108	82483NY104	82483NY106
Gold	Gold	Gold	Gold	Silver	Silver	Silver	Silver
0.80	0.80	0.80	0.80	0.70	0.70	0.70	0.70
0.96	0.95	0.96	0.95	0.83	0.82	0.83	0.82
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
82483NY1110001	82483NY1170001	82483NY1130001	82483NY1150001	82483NY1020001	82483NY1080001	82483NY1040001	82483NY1060001
No	No	No	No	No	No	No	No

506.28	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**

0.861	0.861	0.861	0.861	0.788	0.788	0.788	0.788
0.939	0.939	0.939	0.939	0.896	0.896	0.896	0.896
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.007	1.007	1.007	1.007	1.000	1.000	1.000	1.000
1.205	1.205	1.205	1.205	1.207	1.207	1.207	1.207
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.025	1.025	1.025	1.025	1.022	1.022	1.022	1.022
1.000	0.995	1.000	0.995	1.000	0.995	1.000	0.995
1.006	**1.001**	**1.006**	**1.001**	**0.871**	**0.867**	**0.871**	**0.867**

509.49	**506.89**	**509.49**	**506.89**	**441.01**	**438.77**	**441.01**	**438.77**

North Shore-LIJ Silver Off Exchange	North Shore-LIJ Silver Off Exchange	North Shore-LIJ Silver Off Exchange	North Shore-LIJ Silver Off Exch Dependent	North Shore-LIJ Bronze Off Exchange	North Shore-LIJ Bronze Off Exch Dependent	North Shore-LIJ Bronze Off Exchange	North Shore-LIJ Bronze Off Exch Dependent
82483NY103	82483NY109	82483NY105	82483NY107	82483NY094	82483NY100	82483NY096	82483NY098
Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze
0.70	0.70	0.70	0.70	0.62	0.62	0.62	0.62
0.83	0.83	0.83	0.83	0.68	0.67	0.68	0.67
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
82483NY1030001	82483NY1090001	82483NY1050001	82483NY1070001	82483NY0940001	82483NY1000001	82483NY0960001	82483NY0980001
No	No	No	No	No	No	No	No

506.28	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**	**1.000**

0.788	0.788	0.788	0.788	0.667	0.667	0.667	0.667
0.896	0.896	0.896	0.896	0.870	0.870	0.870	0.870
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.007	1.007	1.007	1.007	1.000	1.000	1.000	1.000
1.207	1.207	1.207	1.207	1.210	1.210	1.210	1.210
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.022	1.022	1.022	1.022	1.020	1.020	1.020	1.020
1.000	0.995	1.000	0.995	1.000	0.995	1.000	0.995
0.877	**0.873**	**0.877**	**0.873**	**0.716**	**0.712**	**0.716**	**0.712**

444.17	**441.92**	**444.17**	**441.92**	**362.41**	**360.58**	**362.41**	**360.58**

North Shore-LIJ Bronze Off Exchange	North Shore-LIJ Bronze Off Exch Dependent	North Shore-LIJ Bronze Off Exch Dependent	North Shore-LIJ Bronze Off Exchange
82483NY095	82483NY101	82483NY099	82483NY097
Bronze	Bronze	Bronze	Bronze
0.62	0.62	0.62	0.62
0.68	0.68	0.68	0.68
EPO	EPO	EPO	EPO
TBD	TBD	TBD	TBD
82483NY0950001	82483NY1010001	82483NY0990001	82483NY0970001
No	No	No	No

506.28	**506.28**	**506.28**	**506.28**

1.000	**1.000**	**1.000**	**1.000**

0.667	0.667	0.667	0.667
0.870	0.870	0.870	0.870
1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000
1.007	1.007	1.007	1.007
1.210	1.210	1.210	1.210
1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000
1.020	1.020	1.020	1.020
1.000	0.995	0.995	1.000
0.721	**0.717**	**0.717**	**0.721**

365.01	**363.16**	**363.16**	**365.01**

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

North Shore-LIJ Insurance Company, Inc.	A&H - 42	For Profit	
Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code

145 Community Drive Great Neck, NY 11021

Company mailing address

B. Contact Person:

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

C. Actuarial Contact (If different from above):

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

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

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

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

F. Provide responses for the following questions:

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

Notes:

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

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

Use the following SERFF filing types for rate adjustment filings:

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

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

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administra ive expenses for activities that improve heal h 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
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, Domestic Partner & Family Planning	01/01/14	12/31/14		6.83%	1.49%	3.57%	1.30%	1.08%	40.08%	54 35%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, Domestic Partner & Family Planning	01/01/14	12/31/14		6.78%	1.48%	3.57%	1.30%	1.07%	39.79%	53 99%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, No Domestic Partner & Family Planning	01/01/14	12/31/14		6.83%	1.49%	3.57%	1.30%	1.08%	40.08%	54 35%	0.00%	0.00%

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1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	53.79%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	53.43%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	53.79%

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Heal h Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12 5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administra ive expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, Domestic Partner & Family Planning	34.75	7 57	18.19	6.62	5.50	204.04	276.67	0.00	0.00	0.00	-2.85	273.82
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, Domestic Partner & Family Planning	34.75	7 57	18.30	6.67	5.50	204.04	276.83	0.00	0.00	0.00	-2.85	273.97
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, No Domestic Partner & Family Planning	34.75	7 57	18.19	6.62	5.50	204.04	276.67	0.00	0.00	0.00	-2.85	273.82

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, No Domestic Partner & Family Planning	01/01/14	12/31/14		6.78%	1.48%	3.57%	1.30%	1.07%	39.79%	53 99%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, No Domestic Partner & No Family Planning	01/01/14	12/31/14		6.86%	1.49%	3.58%	1.30%	1.09%	40.28%	54.60%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, No Domestic Partner & No Family Planning	01/01/14	12/31/14		6.81%	1.48%	3.57%	1.30%	1.08%	40.00%	54 24%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, Domestic Partner & No Family Planning	01/01/14	12/31/14		6.86%	1.49%	3.58%	1.30%	1.09%	40.28%	54.60%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, Domestic Partner & No Family Planning	01/01/14	12/31/14		6.81%	1.48%	3.57%	1.30%	1.08%	40.00%	54 24%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, Domestic Partner & Family Planning	01/01/14	12/31/14		7.95%	1.73%	3.67%	1.30%	1.26%	46.68%	62 59%	0.00%	0.00%

Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	53.43%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.56%	54.04%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.56%	53.68%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.56%	54.04%
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.56%	53.68%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.65%	61.94%

Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, No Domestic Partner & Family Planning	34.75	7 57	18.30	6.67	5.50	204.04	276.83	0.00	0.00	0.00	-2.85	273.97
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, No Domestic Partner & No Family Planning	34.75	7 57	18.12	6.58	5.50	204.04	276.56	0.00	0.00	0.00	-2.85	273.71
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, No Domestic Partner & No Family Planning	34.75	7 57	18.22	6.63	5.50	204.04	276.71	0.00	0.00	0.00	-2.85	273.86
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 26, Domestic Partner & No Family Planning	34.75	7 57	18.12	6.58	5.50	204.04	276.56	0.00	0.00	0.00	-2.85	273.71
Gold	Off Exchange	North Shore-LIJ Non Standard Copay Plan A Dependent Age 29, Domestic Partner & No Family Planning	34.75	7 57	18.22	6.63	5.50	204.04	276.71	0.00	0.00	0.00	-2.85	273.86
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, Domestic Partner & Family Planning	34.75	7 57	16.03	5.68	5.50	204.04	273.57	0.00	0.00	0.00	-2.85	270.72

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, Domestic Partner & Family Planning	01/01/14	12/31/14		7.90%	1.72%	3.66%	1.30%	1.25%	46.35%	62.18%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, No Dom. Partner & Family Planning	01/01/14	12/31/14		7.95%	1.73%	3.67%	1.30%	1.26%	46.68%	62 59%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, No Dom. Partner & Family Planning	01/01/14	12/31/14		7.90%	1.72%	3.66%	1.30%	1.25%	46.35%	62.18%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, No Dom. Partner, No Family Planning	01/01/14	12/31/14		7.99%	1.74%	3.67%	1.30%	1.26%	46.92%	62 89%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, No Dom. Partner, No Family Planning	01/01/14	12/31/14		7.94%	1.73%	3.67%	1.30%	1.26%	46.59%	62.47%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, Dom. Partner & No Family Planning	01/01/14	12/31/14		7.99%	1.74%	3.67%	1.30%	1.26%	46.92%	62 89%	0.00%	0.00%

Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.65%	61.53%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, No Dom. Partner & Family Planning	7.10%	0.00%	39.60%	-0.65%	61.94%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, No Dom. Partner & Family Planning	7.10%	0.00%	39.60%	-0.65%	61.53%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, No Dom. Partner, No Family Planning	7.10%	0.00%	39.60%	-0.66%	62.24%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, No Dom. Partner, No Family Planning	7.10%	0.00%	39.60%	-0.65%	61.82%
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, Dom. Partner & No Family Planning	7.10%	0.00%	39.60%	-0.66%	62.24%

Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, Domestic Partner & Family Planning	34.75	7 57	16.13	5.72	5.50	204.04	273.71	0.00	0.00	0.00	-2.85	270.85
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, No Dom. Partner & Family Planning	34.75	7 57	16.03	5.68	5.50	204.04	273.57	0.00	0.00	0.00	-2.85	270.72
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, No Dom. Partner & Family Planning	34.75	7 57	16.13	5.72	5.50	204.04	273.71	0.00	0.00	0.00	-2.85	270.85
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, No Dom. Partner, No Family Planning	34.75	7 57	15.97	5.65	5.50	204.04	273.48	0.00	0.00	0.00	-2.85	270.62
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, No Dom. Partner, No Family Planning	34.75	7 57	16.06	5.69	5.50	204.04	273.61	0.00	0.00	0.00	-2.85	270.76
Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 26, Dom. Partner & No Family Planning	34.75	7 57	15.97	5.65	5.50	204.04	273.48	0.00	0.00	0.00	-2.85	270.62

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, Dom. Partner & No Family Planning	01/01/14	12/31/14		7.94%	1.73%	3.67%	1.30%	1.26%	46.59%	62.47%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, Domestic Partner & Family Planning	01/01/14	12/31/14		9.40%	2.05%	3.79%	1.30%	1.49%	55.16%	73.18%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, Domestic Partner & Family Planning	01/01/14	12/31/14		9.33%	2.03%	3.78%	1.30%	1.48%	54.77%	72.69%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, No Domestic Partner & Family Planning	01/01/14	12/31/14		9.40%	2.05%	3.79%	1.30%	1.49%	55.16%	73.18%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, No Domestic Partner & Family Planning	01/01/14	12/31/14		9.33%	2.03%	3.78%	1.30%	1.48%	54.77%	72.69%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, No Domestic Partner & No Family Planning	01/01/14	12/31/14		9.44%	2.06%	3.79%	1.30%	1.49%	55.44%	73 53%	0.00%	0.00%

Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, Dom. Partner & No Family Planning	7.10%	0.00%	39.60%	-0.65%	61.82%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.77%	72.41%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.77%	71.92%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.77%	72.41%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.77%	71.92%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.78%	72.75%

Silver	Off Exchange	North Shore-LIJ Non Standard Cost Share Plan B Dependent Age 29, Dom. Partner & No Family Planning	34.75	7 57	16.06	5.69	5.50	204.04	273.61	0.00	0.00	0.00	-2.85	270.76
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, Domestic Partner & Family Planning	34.75	7 57	14.02	4.81	5.50	204.04	270.68	0.00	0.00	0.00	-2.85	267.83
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, Domestic Partner & Family Planning	34.75	7 57	14.10	4.84	5.50	204.04	270.80	0.00	0.00	0.00	-2.85	267.95
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, No Domestic Partner & Family Planning	34.75	7 57	14.02	4.81	5.50	204.04	270.68	0.00	0.00	0.00	-2.85	267.83
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, No Domestic Partner & Family Planning	34.75	7 57	14.10	4.84	5.50	204.04	270.80	0.00	0.00	0.00	-2.85	267.95
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, No Domestic Partner & No Family Planning	34.75	7 57	13.96	4.78	5.50	204.04	270.60	0.00	0.00	0.00	-2.85	267.75

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, No Domestic Partner & No Family Planning	01/01/14	12/31/14		9.38%	2.04%	3.79%	1.30%	1.48%	55.05%	73 04%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, Domestic Partner & No Family Planning	01/01/14	12/31/14		9.44%	2.06%	3.79%	1.30%	1.49%	55.44%	73 53%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, Domestic Partner & No Family Planning	01/01/14	12/31/14		9.38%	2.04%	3.79%	1.30%	1.48%	55.05%	73 04%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		6.00%	1.31%	3.50%	1.30%	0.95%	35.22%	48 28%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		6.03%	1.31%	3.51%	1.30%	0.95%	35.40%	48 51%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		6.00%	1.31%	3.50%	1.30%	0.95%	35.22%	48 28%	0.00%	0.00%

Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.77%	72.27%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.78%	72.75%
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.77%	72.27%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exchange Dependent Age 26, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.49%	47.79%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.49%	48.01%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.49%	47.79%

Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, No Domestic Partner & No Family Planning	34.75	7 57	14.04	4.82	5.50	204.04	270.72	0.00	0.00	0.00	-2.85	267.86
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 26, Domestic Partner & No Family Planning	34.75	7 57	13.96	4.78	5.50	204.04	270.60	0.00	0.00	0.00	-2.85	267.75
Bronze	Off Exchange	North Shore-LIJ Non Standard HSA Plan C Dependent Age 29, Domestic Partner & No Family Planning	34.75	7 57	14.04	4.82	5.50	204.04	270.72	0.00	0.00	0.00	-2.85	267.86
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	34.75	7 57	20.30	7.53	5.50	204.04	279.69	0.00	0.00	0.00	-2.85	276.83
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, Domestic Partner & No Family Planning	34.75	7 57	20.21	7.49	5.50	204.04	279.56	0.00	0.00	0.00	-2.85	276.71
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, No Domestic Partner & Family Planning	34.75	7 57	20.30	7.53	5.50	204.04	279.69	0.00	0.00	0.00	-2.85	276.83

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).
C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.
D. This form must be submitted as an Excel file and as a PDF file.

Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		6.03%	1.31%	3.51%	1.30%	0.95%	35.40%	48 51%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		5.96%	1.30%	3.50%	1.30%	0.94%	34.97%	47 97%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		5.99%	1.30%	3.50%	1.30%	0.95%	35.15%	48.19%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		5.96%	1.30%	3.50%	1.30%	0.94%	34.97%	47 97%	0.00%	0.00%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		5.99%	1.30%	3.50%	1.30%	0.95%	35.15%	48.19%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		6.87%	1.50%	3.58%	1.30%	1.09%	40.34%	54.67%	0.00%	0.00%

Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.49%	48.01%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exchange Dependent Age 29, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.49%	47.48%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.49%	47.70%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.49%	47.48%
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.49%	47.70%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	54.10%

Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	34.75	7 57	20.21	7.49	5.50	204.04	279.56	0.00	0.00	0.00	-2.85	276.71
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	34.75	7 57	20.42	7.58	5.50	204.04	279.87	0.00	0.00	0.00	-2.85	277.01
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, Domestic Partner & No Family Planning	34.75	7 57	20.33	7.55	5.50	204.04	279.74	0.00	0.00	0.00	-2.85	276.89
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, No Domestic Partner & Family Planning	34.75	7 57	20.42	7.58	5.50	204.04	279.87	0.00	0.00	0.00	-2.85	277.01
Platinum	Off Exchange	North Shore-LIJ Platinum Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	34.75	7 57	20.33	7.55	5.50	204.04	279.74	0.00	0.00	0.00	-2.85	276.89
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	34.75	7 57	18.10	6.58	5.50	204.04	276.53	0.00	0.00	0.00	-2.85	273.68

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		6.91%	1.50%	3.58%	1.30%	1.09%	40.54%	54 92%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		6.87%	1.50%	3.58%	1.30%	1.09%	40.34%	54.67%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		6.91%	1.50%	3.58%	1.30%	1.09%	40.54%	54 92%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		6.82%	1.49%	3.57%	1.30%	1.08%	40.05%	54 31%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		6.86%	1.49%	3.58%	1.30%	1.09%	40.25%	54 56%	0.00%	0.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		6.82%	1.49%	3.57%	1.30%	1.08%	40.05%	54 31%	0.00%	0.00%

Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.57%	54.36%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	54.10%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.57%	54.36%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	53.75%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.56%	54.00%
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.56%	53.75%

Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, Domestic Partner & No Family Planning	34.75	7 57	18.02	6.54	5.50	204.04	276.42	0.00	0.00	0.00	-2.85	273.57
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	34.75	7 57	18.10	6.58	5.50	204.04	276.53	0.00	0.00	0.00	-2.85	273.68
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 26, Dental, No Domestic Partner & No Family Planning	34.75	7 57	18.02	6.54	5.50	204.04	276.42	0.00	0.00	0.00	-2.85	273.57
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	34.75	7 57	18.21	6.62	5.50	204.04	276.69	0.00	0.00	0.00	-2.85	273.83
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, Domestic Partner & No Family Planning	34.75	7 57	18.13	6.59	5.50	204.04	276.58	0.00	0.00	0.00	-2.85	273.72
Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	34.75	7 57	18.21	6.62	5.50	204.04	276.69	0.00	0.00	0.00	-2.85	273.83

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		6.86%	1.49%	3.58%	1.30%	1.09%	40.25%	54 56%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		7.88%	1.72%	3.66%	1.30%	1.25%	46.27%	62 07%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		7.92%	1.72%	3.67%	1.30%	1.25%	46.50%	62 37%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		7.88%	1.72%	3.66%	1.30%	1.25%	46.27%	62 07%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		7.92%	1.72%	3.67%	1.30%	1.25%	46.50%	62 37%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		7.82%	1.70%	3.66%	1.30%	1.24%	45.94%	61.66%	0.00%	0.00%

Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.56%	54.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.65%	61.43%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.65%	61.72%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.65%	61.43%
Silver	Off Exchange	North Shore-LIJ Silver Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.65%	61.72%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.64%	61.02%

Gold	Off Exchange	North Shore-LIJ Gold Off Exchange Dependent Age 29, Dental, No Domestic Partner & No Family Planning	34.75	7 57	18.13	6.59	5.50	204.04	276.58	0.00	0.00	0.00	-2.85	273.72
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	34.75	7 57	16.15	5.73	5.50	204.04	273.74	0.00	0.00	0.00	-2.85	270.89
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, Domestic Partner & No Family Planning	34.75	7 57	16.08	5.70	5.50	204.04	273.65	0.00	0.00	0.00	-2.85	270.79
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	34.75	7 57	16.15	5.73	5.50	204.04	273.74	0.00	0.00	0.00	-2.85	270.89
Silver	Off Exchange	North Shore-LIJ Silver Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	34.75	7 57	16.08	5.70	5.50	204.04	273.65	0.00	0.00	0.00	-2.85	270.79
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	34.75	7 57	16.25	5.77	5.50	204.04	273.88	0.00	0.00	0.00	-2.85	271.03

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

A. Complete a separate ROW for Metal Level/Exchange product in the current new On/Off Exchange product filing.
- Information should be for all the benefits included in that plan design (medical, drugs, etc).
- Enter the Metal Tier the On/Off Exchange product belongs to using the drop down menu, or enter a value.
- Enter the On/Off Designation using the drop down menu.
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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.

Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		7.86%	1.71%	3.66%	1.30%	1.24%	46.17%	61 95%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		7.82%	1.70%	3.66%	1.30%	1.24%	45.94%	61.66%	0.00%	0.00%
Silver	Off Exchange	North Shore-LIJ Silver Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		7.86%	1.71%	3.66%	1.30%	1.24%	46.17%	61 95%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		9.59%	2.09%	3.81%	1.30%	1.52%	56.30%	74.60%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 26, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		9.64%	2.10%	3.81%	1.30%	1.53%	56.59%	74 96%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		9.59%	2.09%	3.81%	1.30%	1.52%	56.30%	74.60%	0.00%	0.00%

Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.65%	61.31%
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.64%	61.02%
Silver	Off Exchange	North Shore-LIJ Silver Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.65%	61.31%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 26, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.79%	73.81%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 26, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.79%	74.17%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.79%	73.81%

Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, Domestic Partner & No Family Planning	34.75	7 57	16.18	5.74	5.50	204.04	273.78	0.00	0.00	0.00	-2.85	270.93
Silver	Off Exchange	North Shore-LIJ Silver Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	34.75	7 57	16.25	5.77	5.50	204.04	273.88	0.00	0.00	0.00	-2.85	271.03
Silver	Off Exchange	North Shore-LIJ Silver Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	34.75	7 57	16.18	5.74	5.50	204.04	273.78	0.00	0.00	0.00	-2.85	270.93
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 26, Dental, Domestic Partner & Family Planning	34.75	7 57	13.79	4.71	5.50	204.04	270.36	0.00	0.00	0.00	-2.85	267.51
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 26, Dental, Domestic Partner & No Family Planning	34.75	7 57	13.74	4.69	5.50	204.04	270.28	0.00	0.00	0.00	-2.85	267.43
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 26, Dental, No Domestic Partner & Family Planning	34.75	7 57	13.79	4.71	5.50	204.04	270.36	0.00	0.00	0.00	-2.85	267.51

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

Company Name: North Shore-LIJ Insurance Company, Inc.
NAIC Code:
SERFF Number:
Market Segment: SG

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

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

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

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

Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		9.64%	2.10%	3.81%	1.30%	1.53%	56.59%	74 96%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	01/01/14	12/31/14		9.52%	2.07%	3.80%	1.30%	1.51%	55.90%	74.10%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 29, Dental, Domestic Partner & No Family Planning	01/01/14	12/31/14		9.57%	2.08%	3.80%	1.30%	1.51%	56.18%	74.46%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	01/01/14	12/31/14		9.57%	2.08%	3.80%	1.30%	1.51%	56.18%	74.46%	0.00%	0.00%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	01/01/14	12/31/14		9.52%	2.07%	3.80%	1.30%	1.51%	55.90%	74.10%	0.00%	0.00%

Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.79%	74.17%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 29, Dental, Domes ic Partner & Family Planning	7.10%	0.00%	39.60%	-0.78%	73.32%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 29, Dental, Domes ic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.79%	73.67%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	7.10%	0.00%	39.60%	-0.79%	73.67%
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	7.10%	0.00%	39.60%	-0.78%	73.32%

Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 26, Dental, No Domestic Partner & No Family Planning	34.75	7 57	13.74	4.69	5.50	204.04	270.28	0.00	0.00	0.00	-2.85	267.43
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 29, Dental, Domestic Partner & Family Planning	34.75	7 57	13.87	4.75	5.50	204.04	270.47	0.00	0.00	0.00	-2.85	267.62
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 29, Dental, Domestic Partner & No Family Planning	34.75	7 57	13.82	4.72	5.50	204.04	270.39	0.00	0.00	0.00	-2.85	267.54
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exch Dependent Age 29, Dental, No Domestic Partner & No Family Planning	34.75	7 57	13.82	4.72	5.50	204.04	270.39	0.00	0.00	0.00	-2.85	267.54
Bronze	Off Exchange	North Shore-LIJ Bronze Off Exchange Dependent Age 29, Dental, No Domestic Partner & Family Planning	34.75	7 57	13.87	4.75	5.50	204.04	270.47	0.00	0.00	0.00	-2.85	267.62