

State: New York **Filing Company:** UnitedHealthcare Insurance Company of New York
TOI/Sub-TOI: H06 Health - Conversion/H06.000 Health - Conversion
Product Name: 2014 Conv UHIC Plans
Project Name/Number: 2014 Conv UHIC Plans/2014 Conv UHIC Plans

Filing at a Glance

Company: UnitedHealthcare Insurance Company of New York
Product Name: 2014 Conv UHIC Plans
State: New York
TOI: H06 Health - Conversion
Sub-TOI: H06.000 Health - Conversion
Filing Type: Off Exchange NG Forms & Rates
Date Submitted: 07/24/2013
SERFF Tr Num: XFRD-129122115
SERFF Status: Assigned
State Tr Num: 2013070115
State Status:
Co Tr Num: UHIC_CONV_COC_2014
Implementation: 01/01/2014
Date Requested:
Author(s): 
Reviewer(s): 
Disposition Date:
Disposition Status:
Implementation Date:
State Filing Description:

State: New York Filing Company: UnitedHealthcare Insurance Company of New York
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General Information

Project Name: 2014 Conv UHIC Plans Status of Filing in Domicile: Not Filed
Project Number: 2014 Conv UHIC Plans Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type: Individual
Overall Rate Impact: Filing Status Changed: 07/25/2013
State Status Changed:
Deemer Date: Created By:
Submitted By: Corresponding Filing Tracking Number:
PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null
Include Exchange Intentions: No

Filing Description:
2014 UHIC Conversion Plans

Company and Contact

Filing Contact Information

[Redacted contact information]

Filing Company Information

UnitedHealthcare Insurance CoCode: 60093 State of Domicile: New York
Company of New York Group Code: 707 Company Type:
2 Penn Plaza, Suite 700 Group Name: State ID Number: 60093
New York, NY 10121 FEIN Number: 11-3283886
(212) 216-6400 ext. [Phone]

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

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1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): 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.): Yes. All previously approved conversion forms will be replaced by this filing.
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

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Rate Information

Rate data applies to filing.

Filing Method:

Prior Approval

Rate Change Type:

%

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
UnitedHealthcare Insurance Company of New York	New Product	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Rate Review Detail

COMPANY:

Company Name: UnitedHealthcare Insurance Company of New York
 HHS Issuer Id: 54297
 Product Names: New Off exchange conversion plans
 Trend Factors:

FORMS:

New Policy Forms: UHIC_CONV_COC_2014
 Affected Forms:
 Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
 Member Months: 0
 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: 730.04 Max: 1,194.76 Avg: 1,009.16

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Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	
Attachment(s):	2014_UHIC_Conv_OffExch_SERFF_Checklist.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	NY Readability - UHIC - Conv.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Explanation of Variability
Bypass Reason:	The explanation of variability is contained within the text of the documents in endnotes.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	2014 UHIC Individual Actuarial Memorandum
Attachment(s):	2014 UHIC Conv Actuarial Memorandum.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	2014 UHIC URRT Part III 2014 UHIC URRT Part III - REDACTED
Attachment(s):	2014 UHIC IND Conversion URRT Part III.pdf 2014 UHIC IND Conversion URRT Part III_Redacted.pdf
Item Status:	

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Status Date:	
Satisfied - Item:	Exhibit 1-General Information
Comments:	UHIC Exhibit 1 - PDF & Excel versions UHIC Exhibit 1 - REDACTED
Attachment(s):	UHIC Ind Conversion Exhibit 1.pdf UHIC Ind Conversion Exhibit 1.xls UHIC Ind Conversion Exhibit 1_Redacted.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 7-Historical Data
Comments:	UHIC Exhibit 7 - PDF & Excel versions
Attachment(s):	UHIC Ind Conversion Exhibit 7.xls UHIC Ind Conversion Exhibit 7.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	UHIC Exhibit 8 - PDF & Excel versions
Attachment(s):	UHIC Indiv Conversion Ex 8.pdf UHIC Indiv Conversion Ex 8.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	UHIC Exhibit 9 - PDF & Excel versions
Attachment(s):	UHIC Ind Conversion Exhibit 9.xls UHIC Ind Conversion Exhibit 9.pdf
Item Status:	
Status Date:	

SERFF Tracking #:

XFRD-129122115

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2013070115

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UHIC_CONV_COC_2014

State:

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

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Satisfied - Item:	Unified Rate Review Template
Comments:	2014 UHIC Unified Rate Review Template - PDF & Excel versions
Attachment(s):	2014 UHIC Conversion Unified Rate Review Template OG.xlsm 2014 UHIC Conversion Unified Rate Review Template with Plans.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter
Comments:	NY UHIC Cover Letter NY UHIC Cover Letter - Redacted
Attachment(s):	2014 UHIC Cover letter.pdf 2014 UHIC Cover letter_REDACTED.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Manual
Comments:	2014 UHIC Conversion Rate Manual
Attachment(s):	UHIC Conversion Rate Manual 2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Certification
Comments:	NY UHIC Certification NY UHIC Certification - Redacted
Attachment(s):	2014 UHIC Indiv Certification.pdf 2014 UHIC Indiv Certification_REDACTED.pdf
Item Status:	
Status Date:	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Major Medical and Other Similar-Type Comprehensive Health Insurance Checklist for Individuals

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Major Medical and Other Similar-Type Comprehensive Health Insurance Checklist for Individuals

As of 5/3/13

Instructions for SERFF Checklist:

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Major Medical and Other Similar-Type Comprehensive Health Insurance Checklist for Individuals

LINE OF BUSINESS: **Individual Major Medical or Similar-Type Comprehensive Health Insurance**

	<u>TOI</u>	<u>LINE(S)</u>	<u>OF INSURANCE</u>	<u>Sub-TOI</u>
HOrg021		Individual Health	Health Organization Maintenance (HMO)	rg021.005B Individual POS rg021.005D Individual HMO
Individual Health		Major H16	Medical H16	1.005A Individual PPO 1.005C Individual Other
Individual Health			Hospital Surgical Medical Expense	H15I.001 Health
H06		Health	Conversion H06.0	00 Conversion

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

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	<i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions</i>	<i>Note: This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.</i>	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement	§4306(d) §4306(e) §3102(c)	This submission contains a complete policy or contract form. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No statement by the individual in his application for a contract or policy shall avoid the contract or be used in legal proceedings thereunder, unless such application or an exact copy thereof is included in or attached to such contract.	

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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		<p>control number assigned by the Department and the submission date. § 52.33(d)</p> <ul style="list-style-type: none"> • 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 other than a policy or contract form, the letter must identify the form number and 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) • <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.</i> 	
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	This standard has been met.
APPLICATION FORMS	Model Language		Form/Page/Para Reference
Model Application Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	This submission does not include an application
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	This submission does not include
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	<p>The application does NOT contain:</p> <p>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.</p> <p>A provision that changes the terms of the policy to which it is attached.</p> <p>A statement that the applicant has not withheld any information or concealed any facts.</p> <p>An agreement that an untrue or false answer material to the risk will render the policy void.</p> <p>An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).</p>	This submission does not include an application.

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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.	This submission does not include an application.
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	Cover page
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Cover page
Free Look	§4306 §3216(c)(10)	This contract or policy contains a “free look” provision that is for a period of not less than 10 days and not more than 20 days.	Cover page
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	Cover page
Table of Contents Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3102(c)(1)(G) Model Language	A table of contents is required.	pages 2-3
DEFINITIONS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 3217 Model Language	<i>For a complete listing of the definitions click on the adjacent Model Language link.</i>	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§4303(dd) §4328	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			Form/Page/Para

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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WORKS			Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	page 10 & 82
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child’s PCP if the provider is in-network and available to accept the child.	N/A
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual’s primary care practitioner in accordance with the insurer’s requirements; and • such qualified provider agrees to adhere to the insurer’s policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	N/A
Preauthorization			
Preauthorization Requirements Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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?	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	page 10-11

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Contact Information Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(16) §4324(a)(16) PHL §4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	page 11-12
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	page 13
Specialty Care Provider as PCP Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	N/A
Standing Referrals Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	N/A
Specialty Care Center Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	N/A
Transitional Care When A Provider Leaves the Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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	page 13

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		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.	
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured’s coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured’s coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer’s fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured’s care and to adhere to the insurer’s policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	page 13-14
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	page 15-16
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	page 15-16
ELIGIBILITY Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		Form/Page/Para Reference

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Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	
Spouse	§4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	page 17
Dependents	§4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	page 17
Unmarried Disabled Children	§4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. <i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i>	page 17
Newborn Infants	§4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 60 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. <i>Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 60 days of the day of birth to make coverage effective from the moment of birth.</i>	page 17 & 19
Adopted Children and Step-Children	11NYCRR52.17(a)(30) , (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child	page 17

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		during any waiting period prior to the finalization of the child’s adoption.	
Domestic Partners	§4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner’s bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other’s life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners’ financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	page 19-20
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	page 18-19
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	Except where noted below, the following benefits must be included in the policy or contract form. Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review. The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	Form/Page/Para Reference
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits.	

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		The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
<p>Primary and Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100</p>	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	page 22-25
<p>Federally Mandated Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	page 22
<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	page 23
<p>Mammography Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(11) §4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. A single, baseline mammogram for covered persons aged 35-39, inclusive. 	page 23

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	<p>HRSA Guidelines</p>	<ul style="list-style-type: none"> • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 23-24</p>
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance</p>	<p>page 24</p>
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. 	<p>page 24-25</p>

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		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(24) §4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting. 	page 25-26
<p>Emergency Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §4303(a)(2) §3216(i)(9) §3217-a(a)(8) §4900(c) §4303(a)(2) Circular Letter No.1</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; 	page 26-28

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	<p>(2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR § 147.138(b) 45 CFR § 156.100 Model Language</p>	<ul style="list-style-type: none"> the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. <p><i>Note the following definitions must be used:</i> <i>Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph “to stabilize” means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).</i></p>	
<p>Urgent Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l)</p>	<p>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.</p>	<p>page 28-29</p>
<p>OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES</p>			
<p>Advanced Imaging</p>	<p>45 CFR § 156.100 §4328</p>	<p>This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans.</p>	<p>page 29</p>

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) Model Language</p>	<p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l) Model Language</p>	<p>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.</p>	<p>page 29</p>
<p>Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l) Model Language</p>	<p>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.</p>	<p>page 29</p>
<p>Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l) Model Language</p>	<p>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.</p>	<p>page 29</p>
<p>Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(21) §4328 §4303(y) Model Language</p>	<p>This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such 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. <i>Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	<p>page 29</p>

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<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.</p>	<p>page 29-30</p>
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>	<p>§4328 §3216(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 30</p>
<p><u>Benefit explanation:</u> Limits for habilitative services will be as follows: 60 PT visits per year; 60 ST visits per year; 60 OT visits per year.</p>			

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<p>Home Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(6) §4303(a)(3) Model Language</p>	<p>This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p>	<p>page 30</p>
<p>Interruption of Pregnancy</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l) Model Language</p>	<p>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.</p> <p><i>Note: Plans must include the one procedure limit and may provide coverage that is more favorable.</i></p>	<p>page 30</p>
<p>Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(13) §4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language</p>	<p>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.</p> <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. 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: 	<p>page 30-31</p>

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		in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	
Infusion Therapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 31
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 31
Office Visits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for 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 32
Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 32
Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 32
Outpatient Rehabilitative Services	45 CFR § 156.100 §4328 §3216(l)	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.	page 32-33

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>	<p>Model Language</p>	<p><i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i></p> <p>Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury.</p> <p>Speech, physical and occupational therapy services must begin within six months of the later to occur:</p> <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. <p>In no event will the therapy continue beyond 365 days after such event.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>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.</i></p>	
<p><u>Benefit explanation:</u> Limits for habilitative services will be as follows: 60 PT visits per year; 60 ST visits per year; 60 OT visits per year.</p>			
<p>Second Medical Opinion for Cancer Diagnosis</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(19)(A)(i) §4303(w) Model Language</p>	<p>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.</p> <ul style="list-style-type: none"> • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>page 33</p>

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<p>Second Surgical Opinion</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(8) §4303(b) Circular Letter No. 29 (1979) Model Language</p>	<p>This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Mandatory Second Surgical Opinion</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4303(b) §4328 Circular Letter No. 29 (1979) Model Language</p>	<p>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).</p> <p>Such coverage may not be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Second Opinion in Other Cases</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Surgical Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l) 11 NYCRR § 52.6 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 34</p>
<p>Oral Surgery</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR§52.16(c)(9) §4328 §3216(l) Model Language</p>	<p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures:</p> <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 34</p>
<p>Mastectomy Care</p>	<p>§3216(l)</p>	<p>This policy or contract form includes coverage for a period of inpatient hospital care as is determined</p>	<p>page 34</p>

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(20) §4328 §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Post Mastectomy Reconstruction Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(20) §4328 §4303(x) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.</p>	<p>page 34</p>
<p>Transplants Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3215(l) §4328 Model Language</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 35</p>
<p>Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(25) Model Language 11 NYCRR 440</p>	<p>This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p>	<p>page 35-37</p>

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		<p>The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.</p> <p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language</p>	<p>This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits.</p> <p><i>Note: Plans may apply either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.</i></p> <p><i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i></p>	page 37-39
<p>Durable Medical Equipment and Braces</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form 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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	page 39
<p>Hearing Aids</p> <p>Model Language Used?</p>	<p>45 CFR § 156.100 §4328 §3216(l)</p>	<p>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</p>	page 40

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	<p>into the ear. A hearing aid consists of a microphone, amplifier and receiver.</p> <p>Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. <i>{Note: The three year limit on hearing aids is required for plans but the limit may be removed or modified so that coverage is more favorable.}</i></p> <p>Bone anchored hearing aids must be covered only if an insured has either of the following:</p> <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. <p>Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. <i>{Drafting Note: The limit on hearing aids is required for plans but this limit may be removed or modified so that coverage is more favorable.}</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
Hospice Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	<p>This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member’s immediate family cope with the emotional and social issues related to the Member’s death.</p> <p>Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.</i></p>	page 40
Prosthetics	45 CFR § 156.100 §3216(l)	<u>External Prosthetic Devices:</u> 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	page 40-41

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 Model Language</p>	<p>external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown.</p> <p><i>Note: The limit on prosthetic devices is required for plans, but the limit may be removed for modified so that coverage is more favorable.</i></p> <p>Internal Prosthetic Devices: This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR§52.5 45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 41-42</p>
<p>Maternity Care</p>	<p>§3216(i)(10) §4328</p>	<p>This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal</p>	<p>page 42</p>

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>4303(c) Model Language</p>	<p>complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951.</p> <p>Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Autologous Blood Banking Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form 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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 43</p>
<p>Inpatient Rehabilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition</p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>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.</p> <p><i>Note: Plans must cover 60 days; however plans may exceed the required 60 days, and also may remove the "per condition" and/or "per lifetime" limit.</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i></p>	<p>page 43</p>

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differs from the Model Language in the space provided.			
<u>Benefit explanation:</u> unlimited benefit			
Skilled Nursing Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(6) §4328 §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. <i>Note: Plans must cover 200 days, but may cover more than 200 days.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 43
End of Life Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	page 43-44
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	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. <i>Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i>	page 44
Outpatient Mental Health Care Services	§3216(i)(4) §4328	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	page 44

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p>to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>page 45</p>

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<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy 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.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	<p>page 45</p>
<p>PRESCRIPTION DRUGS</p>			

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<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §3216(l) §4328 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 45-55</p>
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 46</p>
<p>Off-Label Cancer Drug Usage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(12) §4328 §4303(q) Model Language</p>	<p>This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard’s Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.</p>	<p>page 46-47</p>
<p>Usual and Customary Cost of Prescribed Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language</p>	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	<p>page 47</p>
<p>Prohibition for Tier IV Drugs</p>	<p>§4328 §3216(l)</p>	<p>The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or</p>	<p>This contract does not contain</p>

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	§4303(gg) PHL §4406-c(7)	brand drugs if there is no non-preferred brand drug category).	
Eye Drops Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(12-a)(A) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	page 47 & 50-51
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	page 48
Contraceptive Drugs and Devices Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(l) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. Contraceptive coverage must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law....," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	page 47
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of \$200.00 for the subscriber and \$100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. <i>Note: Plans may offer more comprehensive coverage or may substitute this benefit.</i>	page 55

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<p><i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.</i></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Model Language in the space provided.</p>			
<u>Benefit explanation:</u>			
Other Wellness Benefits	45 CFR § 156.100 §3239 §4328 §3216(l)	Additional Wellness Benefits may be covered. All additional wellness benefits <u>must</u> comply with § 3239 of Insurance Law.	No other wellness benefits being added.
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 55-56
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is dental coverage being provided by this filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If No, please provide	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>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).</i>	page 56-58

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<p>information in the explanation box below as to how the insurer is meeting the requirement to offer the pediatric essential health benefit.</p>	<p><i>Embedded pediatric dental benefits must comply with all of the market reform and rating rules such as 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.</i></p> <p><i>If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:</i></p> <ul style="list-style-type: none"> <i>• 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;</i> <i>• 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;</i> <i>• 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;</i> <i>• 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.</i> <i>• 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);</i> <i>• The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans;</i> <i>• 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.</i> <p><i>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</i></p>	
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Explanation:

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ADDITIONAL BENEFITS			
Family Vision Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
<u>Explanation:</u>			
Acupuncture		This policy or contract form provides coverage for acupuncture.	
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3216(j) § 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.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used?	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

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Convalescent and Custodial Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	page 59
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	page 59
Dental Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	page 59
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	page 59
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	page 59
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(6) Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	page 60
Government Facility Model Language Used?	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

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Medically Necessary Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	page 60
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4) (i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	page 60
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	page 60
Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	page 60
Services Provided by a Family Member Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	page 60
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	page 60
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	page 60
Vision Services	11NYCRR52.16(c)(10)	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

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		
Workers' Compensation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	page 60
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	page 60
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E) 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 61
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	page 61
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 	page 63-64
Utilization Review Policies and Procedures	§3217-a(a)(3) §4324(a)(3) Article 49	This policy or contract form includes a description of the utilization review policies and procedures, including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; 	page 64-68

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language</p>	<ul style="list-style-type: none"> 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. 	
<p>External Appeal Procedures</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language</p>	<p>This policy or contract form includes a description of the external appeal procedures, including:</p> <ul style="list-style-type: none"> Instructions on how to request an external appeal; The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and The timeframe for submitting an external appeal. 	<p>page 68-71</p>
<p>COORDINATION OF BENEFITS</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.23 Model Language</p>	<p>If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.</p>	<p>Form/Page/Para Reference</p>
<p>TERMINATION OF COVERAGE</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language §4306(c) §4304(c)</p>	<p><i>The following are the only termination provisions permissible under the Insurance Law.</i></p>	<p>Form/Page/Para Reference</p>
<p>Notice of Termination</p>	<p>11 NYCRR 52.17</p>	<p>Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.</p>	<p>page 72</p>
<p>Termination for Failure to Pay Premiums</p>	<p>§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)</p>	<p>This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.</p>	<p>page 72</p>
<p>Reinstatement Following Default</p>	<p>§4306(g) §3216(d)(1)(D)</p>	<p>Contracts include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only</p>	<p>page 78</p>

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		to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	page 72
Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	page 72-73
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	page 73
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	page 73
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	page 72
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	page 72
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.	page 72
Rescission Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	page 72
Renewal	§3216(g) §4304(b)(2) 11 NYCRR	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber.	page 72

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	§2.17(a)(2)	The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the subscriber or such other person designated, by the due date, with a grace period as specified.	page 72
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11 NYCRR §2.17(a)(15) Model Language	If the covered persons' coverage terminates, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.	page 74
Suspension of Coverage Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension. 	N/A
Conversion - Right to a New Contract After Termination Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(i) §3216(c)(5)	This policy or contract form provides that (a) if an individual is no longer covered under a "family policy or contract" because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e. bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the "family policy or contract" or whose young adult coverage terminates. 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.	page 74-75
GENERAL PROVISIONS			Form/Page/Para

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			Reference
Incontestability Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306 §3216(d)(1)(B)(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 77
Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	page 76
Action in Law or Equity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	page 79
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	page 79
Unilateral Modification Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11 NYCRR52.17(a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	page 76
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	page 79
SCHEDULE OF BENEFITS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization <u>must</u> be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	There are no lifetime dollar limits included in this contract.
Limitations on Annual	§4328	The policy or contract form may not impose “restricted” annual dollar limits for essential health	

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Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	benefits.	There are no annual dollar limits included in this contract.
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.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input checked="" type="checkbox"/>	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	N/A
Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	page 17
PROVIDER NETWORKS			
Has network been submitted to and/or approved by the Department of Health or the Exchange? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, please indicate the name of the network, the	§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	This will be used with our Choice Network.

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<p>network ID number, and the dates that the network was submitted to and/or approved by the Department of Health or the Exchange.</p> <p>Network Name:</p> <p>Network ID #:</p> <p>Date Submitted:</p> <p>Date Approved:</p>		<p>by the Department of Health and/or the Exchange .</p> <p>In addition, the following items or information must be submitted as part of this filing:</p> <ul style="list-style-type: none"> • 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. <p><i>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.</i></p>	
<p>ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY</p>		<p>PLEASE NOTE: A new and detailed set of instructions “Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans” will be posted on the Department website and on SERFF.</p> <p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	
<p>ACTUARIAL MEMORANDUM</p>	<p>11NYCRR52.40(a)(1)</p>	<p>Actuarial qualifications:</p> <ol style="list-style-type: none"> 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. 	
<p>Justification of Rates</p>	<p>§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)</p>	<p>Individual:</p> <ol style="list-style-type: none"> a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 81.3 %. 	<p>Actuarial Memorandum</p>

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Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	Actuarial Memorandum
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	Actuarial Memorandum
Actuarial Certification	11NYCRR52.40(a)(1)	<ul style="list-style-type: none"> 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. 	Actuarial Certification
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: <input type="text" value="81.3"/> %.	Actuarial Memorandum
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	<ul style="list-style-type: none"> a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s). 	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		<i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products. (For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</i>	F
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: <ul style="list-style-type: none"> a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	
Justification of Rates	11NYCRR52.40(d)(2)	<ul style="list-style-type: none"> a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Description, in detail, of policy benefits. d. Provide complete annual and total New York and nationwide claims experience respectively, since inception, including: 	

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		<ul style="list-style-type: none"> (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. <ul style="list-style-type: none"> e. Derivation of the proposed rate revision in detail, including: <ul style="list-style-type: none"> (i) Demonstration that the expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosed loss ratio (ii) Actuarial justification of proposed rates revision (increase/decrease) f. Non-claim expense components as a percentage of gross premium. g. Impact on rates as a result of each of the changes with actuarial justification. h. Expected loss ratio(s) after the proposed changes. 	
Actuarial Certification	11NYCRR52.40(a)(1)	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: <input type="text"/> %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(c)(2)	<ul style="list-style-type: none"> a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s). 	

Name of Company: UnitedHealthcare Insurance Company of New York

This is to certify that the forms listed on the attached page(s) are in compliance with NY INS § 3102(c).

A. Option Selected

 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is .

X 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are:

UHIC_CONV_COC_2014	<u>45.1</u>
UHIC_CONV_SLVR_SBN_2014	<u>46.3</u>
UHIC_CONV_GOLD_SBN_2014	<u>46.3</u>
UHIC_CONV_PLTNM_SBN_2014	<u>46.3</u>
UHIC_CONV_BRNZ_SBN_2014	<u>46.3</u>

B. Test Option Selected

X 1. Test was applied to entire policy form(s).

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

C. Standards of Certification

A checked block indicates the standard has been achieved.

X 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

X 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)

X 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

X 4. The section titles are captioned in bold face or otherwise stand out, significantly from the text.

X 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

X 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

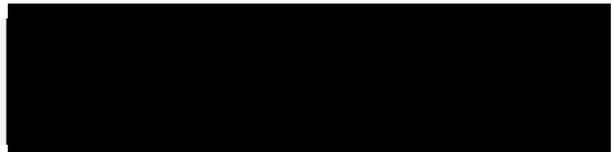
 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)



Officer's Name



Officer's Title



Officer's Signature

7/16/13

Date



UnitedHealthcare Insurance Company of New York, Inc.
New York Individual Conversion Plan Rates
HIOS ID: 54235
Effective January 2014 – December 2014

ACTUARIAL MEMORANDUM

I. Introduction

This rate filing addresses the rate development for the New York Individual Conversion plans written by UnitedHealthcare Insurance Company of New York, Inc. (“UHC”). We will offer the New York state-defined standard plan designs as Individual Conversion plans as required by New York. Rates are effective from January 1, 2014 through December 31, 2014. This rate filing is being submitted under Section 4308(b) of the New York State Insurance Law.

The rates for the Individual Exchange plans written by UnitedHealthcare of New York, Inc. (“UHC”) were filed with the New York State Department of Financial Services (“DFS”) on April 30, 2013. The rate level for the Conversion plans included in this filing is the same as the previously filed Exchange rate level except for adjustments to reflect network differences and the lack of Primary Care Provider gatekeeping.

II. Determination of the Index Rate

A. Experience Period Claims

Please refer to Exhibit 8 for the development of the index rate. Because the Individual product is new, we used Oxford Health Insurance, Inc. (“OHI”) small group claims data with additional adjustments as described in this Actuarial Memorandum to calculate the Individual Conversion rates. Specifically, we used OHI small group claims incurred between October 1, 2011 and September 30, 2012 paid through December 31, 2012 with an adjustment for claims incurred but not reported (“IBNR”). We excluded experience for sole proprietors and groups without pharmacy coverage consistent with the pricing/filing instructions issued by the DFS. The experience includes all other groups active in the period. Regulation 146 amendments were removed from the experience period claims. The resulting in-network only experience period claim PMPM excluding Regulation 146 is \$390.60.

B. Average AV Pricing Value

We used the UnitedHealthcare proprietary pricing model to determine the pricing actuarial values (“AVs”) for each of the in-force small group plans on the OHI license. We also assigned gatekeeper and network factors to each existing in-force plan using our latest estimated adjustments. The estimated gatekeeper adjustment is -4.0%, and the estimated Liberty network adjustment is -3.0% versus the Freedom network. Both of these

adjustments apply to medical in-network rates only. We then calculated the average pricing AVs, gatekeeper, and network factors based up on the membership distribution within the experience period for OHI. These are shown below.

In-Network Pricing Actuarial Value (AV) Excluding Gatekeeper & Network	0.821
Average Gatekeeper and Network Benefit Adjustment	0.993

C. Average Induced Demand Adjustment

We calculated the induced demand factors using the UnitedHealthcare proprietary pricing model. We calculated these by running the current and new portfolios through the pricing model with and without model utilization adjustments. The model adjustments are based strictly upon expected utilization differences due to cost sharing and do not reflect any differences due to health status. We then calculated the average utilization adjustments by metal level where the metal levels were determined by the HHS Actuarial Value calculator.

These resulting induced demand adjustments are shown below.

Bronze	0.7930
Silver	0.8018
Gold	0.8406
Platinum	0.8946

The resulting factors normalized to the bronze metal level are as follows and fall within the maximum values permitted by DFS.

Bronze	1.000
Silver	1.011
Gold	1.060
Platinum	1.128

We assigned the induced demand factors above to each in-force plan design based upon its HHS calculator metal level and calculated the average induced demand factor of 0.851 for the experience period.

D. Trend Assumptions

The OHI annual trend factor applied to adjust past claims to the rating period is 10.5%. This breaks down into the following components: 4.6% unit cost, 4.7% utilization, and 0.9% trend leveraging. Please note that this trend factor excludes any risk margin.

We have trended the small group experience period claim PMPM using the 10.5% OHI annual trend factor and the 28 months between the midpoint of the experience period (April 1, 2012) and the midpoint of the first quarter 2014 rating period (August 1, 2014). Please

note that the midpoint of the rating period assumes an average effective date of February 1, 2014 for groups new or renewing in the first quarter of 2014.

The small group trended incurred in-network claim PMPM of \$493.39 was calculated by multiplying the experience period incurred in-network claim PMPM of \$390.60 by the trend factor of 1.263.

E. Projected Average PMPM Claims

We have calculated the experience-period in-network index rate PMPM adjusted for AV, induced demand, and gating and network provisions of \$562.78. The small group trended AV-adjusted experience period in-network index rate PMPM is \$710.88.

F. Market-Wide Index Rate Adjustments

The development of the market wide adjustments is described below.

1. Federal Risk Adjustment: We have assumed a risk transfer factor of 1.000 for the Individual product since it will be new and, in the absence of any other information, we assume that the risk of the members we write will be at the statewide average.
2. Federal Transitional Reinsurance Program: We have estimated that we will receive 12.9% of claims through the reinsurance program. We developed this estimate by trending the member level claims for OHP and OHI small group, Healthy NY, and Individual to 2014 and then running the trended claims through the federal reinsurance formula.
3. Exchange User Fees: As instructed by DFS, we have not included an adjustment for exchange user fees in the 2014 premium rates. We understand this instruction is due to the assumption that the 2014 calendar year fees will be covered by federal funds.
4. Essential Health Benefits: The Essential Health Benefits (“EHB”) adjustments described in this section were applied in the OHI small group claim projection that is being used to calculate the Individual rates. While the Oxford EPO plan was chosen as the benchmark plan, there are some required modifications to comply with the EHB provision of PPACA. These changes and the estimated claim impacts are as follows.

Removal of \$1,500 DME Maximum	1.0%
Clinical Trials	0.03%
Habilitative Benefits	0.8%
Federal Mental Health Parity	1.3%
Total	3.2%

The claim cost estimates for DME, clinical trials, and habilitative benefits were developed using national UnitedHealthcare data and the proprietary UnitedHealthcare pricing model.

The estimate for federal mental health parity was developed based upon the previously filed and approved federal mental health parity rates. These were filed with DFS on September 9, 2010. The SERFF tracking numbers for these filings are UHLC-126809471 and UHLC-126809499. The approved rates from these filings included a selection load to account for the fact that the coverage was optional for groups defined as small under both the state and federal definitions. When we remove the selection load since the coverage is no longer optional, the average cost impact is 1.7% of medical premium. We calculated the final 1.3% estimate after making an adjustment to reflect that this impacts medical costs only and also to reflect that the impact will be less for those members who currently have the Timothy's Law buy-up rider or full federal mental health parity. The calculation is shown below.

Average Federal MH Parity *:	1.7%
Estimated Medical Claims %	80%
Overall Impact %	1.4%

Current Rider	Member %	% Claim Difference
No MH Rider	93.6%	1.4%
Timothy's Law Rider	4.4%	0.9%
Federal MH Parity	2.1%	0.0%
Total increase of claims		1.3%

* Medical only from filing excluding selection load

5. Provider Network & Fee Schedule Changes: The Individual Conversion product on the UHIC license will utilize the existing UHIC network.
6. Utilization Management Changes: This is not applicable since this is a new product.
7. Expected Covered Membership Risk: The development of the morbidity adjustment to apply to the 2014 OHI small group rates is described in the 2014 UHC Individual Exchange rate filing submitted on April 30, 2013. The population morbidity adjustment to apply to small group to convert to Individual (assuming 2014 penalties) is 40.5%. After applying the 12.9% projected reinsurance receivable, the 2014 Individual cost assumption is 22.3% higher than small group.
8. Distribution of Membership by Rating Region: This is not applicable since this is a new product.
9. Credibility Adjustment: We used the OHI small group business to price the Individual rates. We had an average of 350,548 members in OHI small group plans during the experience period. We consider this to be fully credible and therefore have made no adjustments.

10. Benefit Changes: The OHI small group claim projection includes a -0.1% adjustment to reflect the expected average decrease in benefits for the changes (Sweeps) to the OHI plans that were separately filed by OHI and approved by DFS effective January 1, 2011. In addition, the experience period used to develop rates does not include claims incurred for mandated autism services. Therefore, we have increased the projected claims by the 1.3% increase previously approved by the New York State Department of Financial Services (“DFS”) for mandated autism coverage. Finally, ten months of the experience period used to develop rates does not reflect 100% coverage of women’s preventive services. The increase previously approved by DFS was 0.32% for mandated 100% women’s preventive coverage. Therefore, we have increased the projected claims by 0.27% to account for the ten months in the experience period where the 100% coverage did not apply.

11. Migration Adjustment: The OHI small group claim projection includes a 0.6% adjustment to the experience period claims to account for the fact that migration between products increases expected claim costs by more than is considered by the trend projection factor. This development is consistent with approach that we have previously presented to DFS and included in prior rate filings. The 0.6% migration impact is less than we have projected in previous filings because we only expect the historically observed migration pattern to continue until December 31, 2013. While we believe there will be significant member movement in 2014, we have not included any adjustment in the claim projection. The 0.6% was calculated by assuming the claim cost relationships that we measured in the detailed member level migration analysis that we presented to DFS. We also assumed that the 2013 migration pattern would be consistent with the actual patterns we observed in 2012.

III. Determination of the Premium Rates

A. Plan Level Adjustments

1. Pricing Actuarial Values: Consistent with the calculation of the average pricing AV values for the experience period, we also used the UnitedHealthcare proprietary pricing model to determine the AVs for each of the new Individual Conversion plans on the OHP license.

2. Induced Demand Adjustments: The development of the induced demand factors is described in Section II(C). We used the same values to calculate the new plan rates as were used to calculate the average induced demand adjustment for the experience period. These values are as follows:

Bronze	0.7930
Silver	0.8018
Gold	0.8406
Platinum	0.8946

3. Provider Network Characteristics: We have increased the projected OHI claim PMPM by 3.8% to adjust from OHI to UHIC contracted rates.

4. Delivery System Characteristics: Consistent with the values used to calculate the average experience period gatekeeper value, we have assumed 1.0 for non-gatekeeper and 0.96 for gatekeeper. These factors apply to the in-network medical portion of the rates only. The Conversion plans are non-gated.
5. Utilization Management Practices: This is not applicable since this is a new product.
6. Benefits in Addition to EHB: We are not adding any benefits in addition to EHB that would require a rate adjustment.
7. Administrative Costs (Excluding Exchange User Fees and Profits): The projected 2014 expense percentage for UHIC Individual Conversion is 11.3% excluding exchange user fees and profits. This includes administration (4.7%), commissions (0.5%), state premium taxes (2.9%), the PPACA insurer fee (2.2%), and the PPACA reinsurance fee (1.0%). The 0.5% commission percentage reflects \$5 PEPM.
8. Profit: The requested rates reflect an 84.0% target BCR before the application of the PPACA fees and assessments and 81.3% after the application of the PPACA fees and assessments. This reflects projected profit of 7.4% for UHIC Individual Conversion based upon premium including the PPACA fees and assessments. The projected loss ratio using federally prescribed MLR methodology is 86.9%.

B. Census Factors

The requested premium rates reflect the state-mandated tier factors as shown in the table below. We calculated the PMPM-to-single conversion factor of 1.256 using the combined OHP and OHI distribution of small group members and subscribers for the experience period of October 1, 2011 through September 30, 2012 as shown in the table below. This is the same conversion factor as that used in our UHC Individual Exchange filing, which was approved by DFS.

Tier	Individual			Conversion Factor
	Members	Subs	Relativity	
Single	2,389,244	2,389,244	1.000	1.256
Parent/Child(ren)	529,695	152,836	1.700	
Couple	1,113,480	556,746	2.000	
Family	2,381,941	513,956	2.850	
Child Only Tier	309,510	309,510	0.412	

C. Area Factors

We have determined the proposed area factors based upon a unit cost analysis by region as defined by DFS. For each county, claims were re-priced at a national unit cost basis. Actual allowed amounts for each county were then compared to the re-priced dollars in order to derive area factors. The resulting proposed area factors are as follows. The rate

development as described above was for area 4, so other areas' rates are determined by the ratios of these area factors.

Region	Counties	Area Factor
1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	1.149
2	Niagara, Orleans, Erie, Genesee, Wyoming, Chautauqua, Cattaraugus, Allegany	0.942
3	Delaware	1.229
4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	1.188
5	Monroe, Wayne, Livingston, Ontario, Yates, Seneca	1.053
6	Broome, Onondaga, Tioga, Cortland, Cayuga, Tompkins, Schuyler, Chemung, Steuben	1.018
7	Jefferson, Oswego, Lewis, Madison, Oneida, Otsego, Chenango, Herkimer, Clinton, Essex, Franklin, Hamilton, St. Lawrence	0.975
8	Suffolk, Nassau	1.188

IV. Supporting Details

A. HHS Actuarial Value Calculator Adjustments

DFS determined the metal levels for the new state-mandated plans.

B. Trend

We develop forward-looking medical expense estimates based on a number of considerations. As a general matter, we review our own recent/emerging claims experience at the state level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Forward looking utilization levels are developed based on emerging state level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

The UHIC future projected annual trend factor is 12.1%. This breaks down into the following components: 5.7% unit cost, 4.9% utilization, and 1.1% trend leveraging. Please note that this trend factor excludes any risk margin.

C. Administrative Costs

The projected 2014 expense percentage for UHIC Individual Conversion is 11.3%

excluding exchange user fees and profits but including PPACA fees and assessments. This is a new product; therefore no historical comparison is possible.

D. Profit Assumptions

The requested rates reflect an 84% target loss ratio before PPACA fees and assessments which is in excess of the 82% minimum loss ratio allowed by New York state law. The resulting projected profit percentage is 7.4% relative to premium not including PPACA fees.

We have not included a projection of return on equity since this is a new product.

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For UnitedHealthcare Insurance Company of
New York, Inc.

State of New York Rate Review

General Information

Purpose: The purpose of this actuarial memorandum is to provide information relevant to the Part I Uniform Rate Review Template (URRT).

Company Identifying Information:

- **Company Legal Name:** UnitedHealthcare Insurance Company of New York, Inc.
- **State:** New York
- **HIOS Issuer ID:** 54235
- **Market:** Individual Conversion
- **Effective Date:** 1/1/2014 – 12/31/2014

Company Contact Information:

- **Primary Contact Name:** Brian Landrigan
- **Primary Contact Telephone Number:** 203-459-7785
- **Primary Contact Email Address:** brian_w_landrigan@uhc.com

Proposed Rate Increase

UnitedHealthcare Insurance Company of New York, Inc. ("UHIC") is filing rates for new Individual Conversion benefit plans written under new policy forms and new certificates of coverage that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). There is no rate increase to report since these are all new plan designs.

The rates for the Individual Exchange plans written by UnitedHealthcare of New York, Inc. ("UHC") were filed with the New York State Department of Financial Services ("DFS") on April 30, 2013. The rate level for the Conversion plans included in this filing is the same as the previously filed Exchange rate level except for an adjustment to reflect network differences and the lack of Primary Care Provider gatekeeping.

Reasons for Rate Increase

The products are new effective 1/1/2014 so there is no initial rate increase. The rates are effective for 2014.

Experience Period Premiums and Claims

- **Experience Period:** There is no experience period data to report because this is a new product.
- **Premiums (net of MLR Rebate) in Experience Period:** There is no experience period data to report because this is a new product.
- **Allowed and Incurred Claims Incurred During the Experience Period:** There is no experience period data to report because this is a new product.

Benefit Categories

There is no experience period data to report because this is a new product.

Projection Factors

Projection factors were not used since there are no experience period claims to project for this new product.

Credibility

Because the Individual Conversion product is new, we have no claims experience to project forward in the development of the rates. At the direction of the New York State Department of Financial Services ("DFS"), we adjusted the index rate for Oxford Health Insurance, Inc. ("OHI") small group by a morbidity adjustment to calculate the Individual rates. The development of the OHI small group index PMPM is described in the Part III Actuarial Memorandum for the OHI Small Group Filing (HIOS ID 85629). We calculated the morbidity adjustment factor of 1.405 relative to small group by building up the expected 2014 Individual cost and comparing to the projected small group cost. This calculation was based upon:

- (a) The 2014 subsidies that will be available to individuals based upon income level.
- (b) The assumed distribution of currently uninsured that are expected to purchase coverage in 2014 by income level.
- (c) The assumed distribution of the individuals expected to purchase coverage in 2014 by current source of coverage.
- (d) The expected cost for each of the aforementioned categories based upon the subsidy modeling and actual claim data for currently covered individuals with similar characteristics.

Paid to Allowed Ratio

We have developed the average paid to allowed factor for the projection period based upon an estimated distribution of Individual business in 2014 by metal level and the pricing actuarial values for those new plans.

Risk Adjustment and Reinsurance

- **Projected Risk Adjustments:** We have assumed a risk transfer factor of 1.000 for the Individual Conversion product since it will be new and, in the absence of any other information, we assume that the risk of the members we write will be at the statewide average.
- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** We have assumed a payment of \$5.25 PMPM for the reinsurance fee. We have estimated that we will receive 12.9% of claims through the reinsurance program. We developed this estimate by trending the member level claims for OHP and

OHI small group, Healthy NY, and Individual to 2014 and then running the trended claims through the federal reinsurance formula.

Non-Benefit Expenses and Risk Margin

The 5.2% administrative expense load includes general administration (4.7%) and broker commissions (0.5%). We have estimated the expenses included in the development of the proposed rates based upon financial projections.

Projected Profit & Risk Margin

The projected profit and risk margin is 7.4%.

Taxes and Fees

The 5.2% load for taxes and fees includes state premium tax (2.0%), New York Section 332 assessments (0.90%), and PPACA Insurer fees (2.2%). This excludes the \$5.25 PMPM reinsurance fee.

Projected Loss Ratio

The projected loss ratio using federally prescribed MLR methodology is 86.9%.

Index Rate

There is no index rate for the experience period because this is a new product. The projected index rate of \$908.33 was calculated by applying the Individual morbidity adjustment to the 1st quarter 2014 OHI index rate.

AV Metal Values

AV metal values were calculated by DFS.

AV Pricing Values

The NY Standard Platinum plan is the fixed reference plan. The AV pricing values in Worksheet 2 reflect the product of plan relativities from the proprietary UnitedHealthcare pricing model, utilization adjustments, gatekeeper adjustments, and network adjustments. The relativities from the UnitedHealthcare model reflect the cost sharing differences between plans and do not include any adjustments for health status or utilization. The utilization adjustments were also determined by the proprietary UnitedHealthcare pricing model and only reflect utilization differences due to the levels of cost sharing. These plans are not gated, so there are no gatekeeper adjustments. For the network differences, we have increased the projected OHI claim PMPM by 3.8% to adjust from OHI to UHIC contracted rates. The Conversion plans will be on the UHIC network. These adjustments do not reflect any differences in anticipated risk status.

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Membership Projections

We expect negligible membership on these plans, due to the availability of individual exchange plans.

Terminated Products

No Individual products currently exist on this license.

Plan Type

Not applicable.

Warning Alerts

Reliance

Not applicable.

Actuarial Certification

I, [REDACTED] am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

- a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- b. Developed in compliance with the applicable Actuarial Standards of Practice,
- c. Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- d. Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

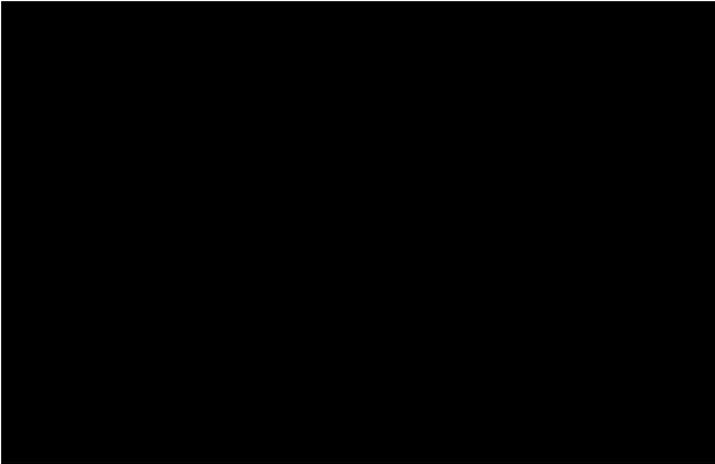
I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is

Proprietary & Confidential

described in detail in my state submitted actuarial memorandum. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,



Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For UnitedHealthcare Insurance Company of
New York, Inc.

State of New York Rate Review

General Information

Purpose: The purpose of this actuarial memorandum is to provide information relevant to the Part I Uniform Rate Review Template (URRT).

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- **Company Legal Name:** UnitedHealthcare Insurance Company of New York, Inc.
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- **Market:** Individual Conversion
- **Effective Date:** 1/1/2014 – 12/31/2014

Company Contact Information:

- **Primary Contact Name:** Brian Landrigan
- **Primary Contact Telephone Number:** 203-459-7785
- **Primary Contact Email Address:** brian_w_landrigan@uhc.com

Proposed Rate Increase

UnitedHealthcare Insurance Company of New York, Inc. ("UHIC") is filing rates for new Individual Conversion benefit plans written under new policy forms and new certificates of coverage that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). There is no rate increase to report since these are all new plan designs.

The rates for the Individual Exchange plans written by UnitedHealthcare of New York, Inc. ("UHC") were filed with the New York State Department of Financial Services ("DFS") on April 30, 2013. The rate level for the Conversion plans included in this filing is the same as the previously filed Exchange rate level except for an adjustment to reflect network differences and the lack of Primary Care Provider gatekeeping.

Reasons for Rate Increase

The products are new effective 1/1/2014 so there is no initial rate increase. The rates are effective for 2014.

Experience Period Premiums and Claims

- **Experience Period:** There is no experience period data to report because this is a new product.
- **Premiums (net of MLR Rebate) in Experience Period:** There is no experience period data to report because this is a new product.
- **Allowed and Incurred Claims Incurred During the Experience Period:** There is no experience period data to report because this is a new product.

Benefit Categories

There is no experience period data to report because this is a new product.

Projection Factors

Projection factors were not used since there are no experience period claims to project for this new product.

Credibility

Because the Individual Conversion product is new, we have no claims experience to project forward in the development of the rates. At the direction of the New York State Department of Financial Services ("DFS"), we adjusted the index rate for Oxford Health Insurance, Inc. ("OHI") small group by a morbidity adjustment to calculate the Individual rates. The development of the OHI small group index PMPM is described in the Part III Actuarial Memorandum for the OHI Small Group Filing (HIOS ID 85629). We calculated the morbidity adjustment factor of 1.405 relative to small group by building up the expected 2014 Individual cost and comparing to the projected small group cost. This calculation was based upon:

- (a) The 2014 subsidies that will be available to individuals based upon income level.
- (b) The assumed distribution of currently uninsured that are expected to purchase coverage in 2014 by income level.
- (c) The assumed distribution of the individuals expected to purchase coverage in 2014 by current source of coverage.
- (d) The expected cost for each of the aforementioned categories based upon the subsidy modeling and actual claim data for currently covered individuals with similar characteristics.

Paid to Allowed Ratio

We have developed the average paid to allowed factor for the projection period based upon an estimated distribution of Individual business in 2014 by metal level and the pricing actuarial values for those new plans.

Risk Adjustment and Reinsurance

- **Projected Risk Adjustments:** We have assumed a risk transfer factor of 1.000 for the Individual Conversion product since it will be new and, in the absence of any other information, we assume that the risk of the members we write will be at the statewide average.
- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** We have assumed a payment of \$5.25 PMPM for the reinsurance fee. We have estimated that we will receive 12.9% of claims through the reinsurance program. We developed this estimate by trending the member level claims for OHP and

OHI small group, Healthy NY, and Individual to 2014 and then running the trended claims through the federal reinsurance formula.

Non-Benefit Expenses and Risk Margin

The 5.2% administrative expense load includes general administration (4.7%) and broker commissions (0.5%). We have estimated the expenses included in the development of the proposed rates based upon financial projections.

Projected Profit & Risk Margin

The projected profit and risk margin is 7.4%.

Taxes and Fees

The 5.2% load for taxes and fees includes state premium tax (2.0%), New York Section 332 assessments (0.90%), and PPACA Insurer fees (2.2%). This excludes the \$5.25 PMPM reinsurance fee.

Projected Loss Ratio

The projected loss ratio using federally prescribed MLR methodology is 86.9%.

Index Rate

There is no index rate for the experience period because this is a new product. The projected index rate of \$908.33 was calculated by applying the Individual morbidity adjustment to the 1st quarter 2014 OHI index rate.

AV Metal Values

AV metal values were calculated by DFS.

AV Pricing Values

The NY Standard Platinum plan is the fixed reference plan. The AV pricing values in Worksheet 2 reflect the product of plan relativities from the proprietary UnitedHealthcare pricing model, utilization adjustments, gatekeeper adjustments, and network adjustments. The relativities from the UnitedHealthcare model reflect the cost sharing differences between plans and do not include any adjustments for health status or utilization. The utilization adjustments were also determined by the proprietary UnitedHealthcare pricing model and only reflect utilization differences due to the levels of cost sharing. These plans are not gated, so there are no gatekeeper adjustments. For the network differences, we have increased the projected OHI claim PMPM by 3.8% to adjust from OHI to UHIC contracted rates. The Conversion plans will be on the UHIC network. These adjustments do not reflect any differences in anticipated risk status.

Proprietary & Confidential

Membership Projections

We expect negligible membership on these plans, due to the availability of individual exchange plans.

Terminated Products

No Individual products currently exist on this license.

Plan Type

Not applicable.

Warning Alerts

Reliance

Not applicable.

Actuarial Certification

I, [REDACTED], am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

- a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- b. Developed in compliance with the applicable Actuarial Standards of Practice,
- c. Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- d. Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that 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.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is

Proprietary & Confidential

described in detail in my state submitted actuarial memorandum. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

[Redacted signature block]

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information:	<u>UnitedHealthcare Insurance Company of New York</u>	<u>A&H - 42</u>	<u>For Profit</u>	<u>60093</u>
		48 Monroe Turnpike, Trumbull, CT 06611	Company Type	Org. Type	Company NAIC Code
		Company mailing address			
B.	Contact Person:	<u>[REDACTED]</u>	<u>[REDACTED]</u>	<u>[REDACTED]</u>	
		Rate filing contact person name, title	Contact phone number	Contact Email address	
C.	Actuarial Contact (If different from above):	<u></u>	<u></u>	<u></u>	
		Actuary name, title	Actuary phone number	Actuary Email address	
D.	New Rate Information (See Note #1):	<u>February 15, 2014 through November 14, 2015</u>	<u>1/1/2014</u>	<u>XFRD-129122115</u>	
		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):	<u>Individual</u>			
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).	<u>Yes</u>			
	2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	<u>No</u>			
	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).	<u>NA</u>			
	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?	<u>Yes, all the required exhibits have been submitted with this rate application</u>			
	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 prefilling.	<u>NA</u>			

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 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: UnitedHealthcare Insurance Company of New York

NAIC Code: 60093

SERFF Number: XFRD-129122115

Market Segment: Individual Conversion

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

Line #	General				
1	Product*	EPO	EPO	EPO	EPO
2	Product ID*	54297NY003	54297NY003	54297NY003	54297NY003
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold	Platinum
4	AV Metal Value (HHS Calculator)*	62.0%	70.7%	79.0%	88.1%
5	AV Pricing Value (total, risk pool experience based)*	59.8%	69.4%	81.9%	100.0%
6	Plan Type*	EPO	EPO	EPO	EPO
7	Plan Name*	Indiv Conversion DFS Standard Bronze	Indiv Conversion DFS Standard Silver	Indiv Conversion DFS Standard Gold	Indiv Conversion DFS Standard Platinum
8	Plan ID*	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041
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	\$ 1,643,088,050			
10B	Member-Months for Latest Experience Period	4,206,574			
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	390.60			
11	Average Pricing Actuarial Value reflected in experience period	0.696			
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	561.08	561.08	561.08	561.08

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: XFRD-129122115
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Separate column for each plan design (on or off Exchange)

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1	Product*	EPO	EPO	EPO	EPO
2	Product ID*	54297NY003	54297NY003	54297NY003	54297NY003
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6	Plan Type*	EPO	EPO	EPO	EPO
7	Plan Name*	Indiv Conversion DFS Standard Bronze	Indiv Conversion DFS Standard Silver	Indiv Conversion DFS Standard Gold	Indiv Conversion DFS Standard Platinum
8	Plan ID*	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041

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

13	Impact of adjusting experience period data to EHB benefit level	1.032			
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]	1.405			
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)	0.871			
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000			
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.263			
24	2011 Sweeps Benefit Change	1.015			
25	2013 Migration Adjustment	1.006			
26	Other 3 (specify)	1.000			
27	Impact of Market Wide Adjustments (product L13 through L26)	1.627	1.627	1.627	1.627

** Not Included in Claim Trend Adjustment

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: UnitedHealthcare Insurance Company of New York

NAIC Code: 60093

SERFF Number: XFRD-129122115

Market Segment: Individual Conversion

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

Line #	General				
1	Product*	EPO	EPO	EPO	EPO
2	Product ID*	54297NY003	54297NY003	54297NY003	54297NY003
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold	Platinum
4	AV Metal Value (HHS Calculator)*	62.0%	70.7%	79.0%	88.1%
5	AV Pricing Value (total, risk pool experience based)*	59.8%	69.4%	81.9%	100.0%
6	Plan Type*	EPO	EPO	EPO	EPO
7	Plan Name*	Indiv Conversion DFS Standard Bronze	Indiv Conversion DFS Standard Silver	Indiv Conversion DFS Standard Gold	Indiv Conversion DFS Standard Platinum
8	Plan ID*	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.626	0.727	0.820	0.910
29	Pricing actuarial value (only the induced demand factor) #	0.793	0.802	0.841	0.895
30	Impact of provider network characteristics ##	1.050	1.050	1.050	1.050
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	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.100	1.100	1.100	1.100
35	Profit/Contribution to surplus margins	1.082	1.082	1.082	1.082
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	PPACA Fees	1.033	1.033	1.033	1.033
40	Other 2 (specify)	1.000	1.000	1.000	1.000
41	Impact of Plan Level Adjustments (product L28 through L40)	0.641	0.752	0.890	1.051

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

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: UnitedHealthcare Insurance Company of New York

NAIC Code: 60093

SERFF Number: XFRD-129122115

Market Segment: Individual Conversion

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

Line #	General				
1	Product*	EPO	EPO	EPO	EPO
2	Product ID*	54297NY003	54297NY003	54297NY003	54297NY003
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold	Platinum
4	AV Metal Value (HHS Calculator)*	62.0%	70.7%	79.0%	88.1%
5	AV Pricing Value (total, risk pool experience based)*	59.8%	69.4%	81.9%	100.0%
6	Plan Type*	EPO	EPO	EPO	EPO
7	Plan Name*	Indiv Conversion DFS Standard Bronze	Indiv Conversion DFS Standard Silver	Indiv Conversion DFS Standard Gold	Indiv Conversion DFS Standard Platinum
8	Plan ID*	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041
42	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)	585.07	686.59	812.58	959.48

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	X	Y						
1	Data Collection Template																													
2																														
3	Company Legal Name:		UnitedHealthcare Insurance Co												State:		NY													
4	HIOS Issuer ID:		54297												Market:		Individual													
5	Effective Date of Rate Change(s):		1/1/2014																											
6																														
7																														
8	Market Level Calculations (Same for all Plans)																													
9																														
10																														
11	Section I: Experience period data																													
12	Experience Period:		10/1/2011		to		9/30/2012																							
13			<u>Experience Period</u>																											
14			<u>Aggregate Amount</u>		<u>PMPM</u>		<u>% of Prem</u>																							
15	Premiums (net of MLR Rebate) in Experience Period:		\$1		\$1.00		100.00%																							
16	Incurred Claims in Experience Period		\$1		1.00		100.00%																							
17	Allowed Claims:		\$1		1.00		100.00%																							
18	Index Rate of Experience Period				\$0.00																									
19	Experience Period Member Months				1																									
20																														
21	Section II: Allowed Claims, PMPM basis																													
22			<u>Experience Period</u>				<u>Projection Period: 1/1/2014 to 12/31/2014</u>				<u>Mid-point to Mid-point, Experience to Projection: 27 months</u>																			
23			<u>on Actual Experience Allowed</u>				<u>Adj't. from Experience to Annualized Trend Projection Period Factors</u>				<u>Projections, before credibility Adjustment</u>				<u>Credibility Manual</u>															
24	Benefit Category		Utilization Description		Utilization per 1,000		Average Cost/Service		PMPM		Pop'l risk Morbidity		Other		Cost		Util		Utilization per 1,000		Average Cost/Service		PMPM							
25	Inpatient Hospital		Days		0.00		\$0.00		\$0.00		1.000		1.000		1.000		1.000		0.00		\$0.00		\$0.00		528.00		\$5,273.97		\$232.05	
26	Outpatient Hospital		Services		0.00		\$0.00		0.00		1.000		1.000		1.000		1.000		0.00		0.00		0.00		10601.97		\$196.00		173.16	
27	Professional		Services		0.00		\$0.00		0.00		1.000		1.000		1.000		1.000		0.00		0.00		0.00		34898.64		\$124.30		361.50	
28	Other Medical		Services		0.00		\$0.00		0.00		1.000		1.000		1.000		1.000		0.00		0.00		0.00		6460.18		\$231.56		124.66	
29	Capitation		Services		0.00		\$0.00		0.00		1.000		1.000		1.000		1.000		0.00		0.00		0.00		1203.86		\$283.92		28.48	
30	Prescription Drug		Prescriptions		0.00		\$0.00		0.00		1.000		1.000		1.000		1.000		0.00		0.00		0.00		18061.24		\$133.08		200.30	
31	Total								\$0.00										0.00		0.00		0.00						\$1,120.16	
32	Section III: Projected Experience:		Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)												0.00%		100.00%		\$1,120.16		\$1,120									
33			Paid to Allowed Average Factor in Projection Period																0.696											
34			Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM																\$779.97		\$780									
35			Projected Risk Adjustments PMPM																0.00		0									
36			Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM																\$779.97		\$780									
37			Projected ACA reinsurance recoveries, net of rein prem, PMPM																-85.31		(85)									
38			Projected Incurred Claims																\$865.28		\$865									
39			Administrative Expense Load																4.90%		51.34		51							
40			Profit & Risk Load																7.36%		77.15		77							
41			Taxes & Fees																5.16%		54.02		54							
42			Single Risk Pool Gross Premium Avg. Rate, PMPM																		\$1,047.78		\$1,048							
43			Index Rate for Projection Period																		\$1,009.16									
44			% increase over Experience Period																		104678.49%									
45			% Increase, annualized:																		2099.60%									
46			Projected Member Months																				1							
47																														
48																														
49	Information Not Releasable to the Public Unless Authorized by Law: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.																													
50																														

Product-Plan Data Collection

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

UnitedHealthcare Insurance Company of New York
 54297
 1/1/2014

State: NY
 Market: Individual

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product ID:	EPO 54297NY003				EPO 54297NY003
	Bronze	Silver	Gold	Platinum	Catastrophic
AV Metal Value	0.620	0.707	0.790	0.881	0.000
AV Pricing Value	0.598	0.694	0.819	1.000	0.000
Plan Type:	EPO	EPO	EPO	EPO	EPO
Plan Name	Indiv Conversion DFS Standard Bronze	Indiv Conversion DFS Standard Silver	Indiv Conversion DFS Standard Gold	Indiv Conversion DFS Standard Platinum	Terminated Products
Plan ID (Standard Component ID):	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041	54297NY0030000
Exchange Plan?	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2	0.00%				0.00%
Historical Rate Increase - Calendar Year - 1	0.00%				0.00%
Historical Rate Increase - Calendar Year 0	0.00%				0.00%
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%
Com'live Rate Change % (over 12 mos prior)	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Expt. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%				0.00%

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

Plan ID (Standard Component ID):	Total	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041	54297NY0030000
Inpatient	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Outpatient	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Professional	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Prescription Drug	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Copayment	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Administration	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Taxes & Fees	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Risk & Profit Charge	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total Rate Increase	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Member Cost Share Increase	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Average Current Rate PMPM	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Projected Member Months	0	0	0	0	0	0

Section III: Experience Period Information

Plan ID (Standard Component ID):	Total	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041	54297NY0030000
Average Rate PMPM	#DIV/0!					
Member Months	0					
Total Premium (TP)	\$0	\$0	\$0	\$0	\$0	\$0
EHB basis or full portion of TP, [see instructions]	#DIV/0!					
state mandated benefits portion of TP that are other than EHB	#DIV/0!					
Other benefits portion of TP	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	\$0					
EHB basis or full portion of TAC, [see instructions]	#DIV/0!					
state mandated benefits portion of TAC that are other than EHB	#DIV/0!					
Other benefits portion of TAC	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	\$0					
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0					
Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!					
Total Incurred Claims, payable with issuer funds	\$0	\$0	\$0	\$0	\$0	\$0
Net Amt of Reim	\$0.00					
Net Amt of Risk Adj	\$0.00					
Incurred Claims PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	54297NY0030044	54297NY0030043	54297NY0030042	54297NY0030041	54297NY0030000
Average Rate PMPM	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Member Months	-	-	-	-	-	-
Total Premium (TP)	\$0	\$0	\$0	\$0	\$0	\$0
EHB basis or full portion of TP, [see instructions]	#DIV/0!					
state mandated benefits portion of TP that are other than EHB	#DIV/0!					
Other benefits portion of TP	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	\$0					
EHB basis or full portion of TAC, [see instructions]	#DIV/0!					
state mandated benefits portion of TAC that are other than EHB	#DIV/0!					
Other benefits portion of TAC	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	\$0					
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0					
Insured person, as %	#DIV/0!					
Total Incurred Claims, payable with issuer funds	\$0	\$0	\$0	\$0	\$0	\$0
Net Amt of Reim	\$0					
Net Amt of Risk Adj	\$0					



July 24, 2013

[REDACTED]
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

RE: UnitedHealthcare Insurance Company of New York
NY Individual Conversion Plans
Effective January 2014 – December 2014

Dear [REDACTED]

This rate filing addresses the development of the New York Individual rates for plans written by UnitedHealthcare Insurance Company of New York. The rates are effective from January 2014 to December 2014.

Included in this filing are

- Actuarial Certification
- Actuarial Memorandum
- Section I – Supporting Exhibits 1, 7, 8, & 9
- Section II - Rate Manual
- Section III – HIOS Forms

Should you have any questions or need any additional information, please contact me at [REDACTED]
[REDACTED] or at [REDACTED]

Sincerely,

[REDACTED]



July 24, 2013

Mr. [REDACTED]
Deputy Chief Actuary
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

RE: UnitedHealthcare Insurance Company of New York
NY Individual Conversion Plans
Effective January 2014 – December 2014

Dear [REDACTED]

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Should you have any questions or need any additional information, please contact me at [REDACTED]
[REDACTED]

Sincerely,

[REDACTED]

UnitedHealthcare Insurance Company of New York

NEW YORK INDIVIDUAL RATE MANUAL

Rates Effective January 1, 2014

UnitedHealthcare Insurance Company of New York

NEW YORK INDIVIDUAL RATE MANUAL

<u>Rate and Annual Rate Change</u>	<u>PAGE(S)</u>
Area Definitions	1
Base Medical Rates By County - Q1 - Q4	2 - 3
Rates for Dependent to Age 29 Rider	4

County	DFS Rating Region
Albany	Albany Area
Columbia	Albany Area
Fulton	Albany Area
Greene	Albany Area
Montgomery	Albany Area
Rensselaer	Albany Area
Saratoga	Albany Area
Schenectady	Albany Area
Schoharie	Albany Area
Warren	Albany Area
Washington	Albany Area
Niagara	Buffalo Area
Orleans	Buffalo Area
Erie	Buffalo Area
Genesee	Buffalo Area
Wyoming	Buffalo Area
Chautauqua	Buffalo Area
Cattaraugus	Buffalo Area
Allegany	Buffalo Area
Delaware	Mid-Hudson Area
Dutchess	Mid-Hudson Area
Orange	Mid-Hudson Area
Putnum	Mid-Hudson Area
Sullivan	Mid-Hudson Area
Ulster	Mid-Hudson Area
Bronx	New York City Area
Kings	New York City Area
New York	New York City Area
Queens	New York City Area
Richmond	New York City Area
Rockland	New York City Area
Westchester	New York City Area
Monroe	Rochester Area
Wayne	Rochester Area
Livingston	Rochester Area
Ontario	Rochester Area
Yates	Rochester Area
Seneca	Rochester Area
Broome	Syracuse Area
Onondaga	Syracuse Area
Tioga	Syracuse Area
Cortland	Syracuse Area
Cayuga	Syracuse Area
Tompkins	Syracuse Area
Schuyler	Syracuse Area
Chemung	Syracuse Area
Steuben	Syracuse Area
Jefferson	Utica/Watertown Area
Oswego	Utica/Watertown Area
Lewis	Utica/Watertown Area
Madison	Utica/Watertown Area
Oneida	Utica/Watertown Area
Otsego	Utica/Watertown Area
Chenango	Utica/Watertown Area
Herkimer	Utica/Watertown Area
Clinton	Utica/Watertown Area
Essex	Utica/Watertown Area
Franklin	Utica/Watertown Area
Hamilton	Utica/Watertown Area
St. Lawrence	Utica/Watertown Area
Suffolk	Long Island Area
Nassau	Long Island Area

NY Standard Bronze								
In Network - \$3,000/\$6,000 Deductible, 50%/50% coinsurance with a \$6,350/\$12,700 Out-of-Pocket Maximum								
Rx Plan - \$10/\$35/\$70								
	Albany Area	Buffalo Area	Mid-Hudson Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Long Island Area
1st Quarter 2014 Rates:								
Single rate	\$730.04	\$687.57	\$897.29	\$730.04	\$768.67	\$743.39	\$712.03	\$867.15
Parent / Child(ren) rate	\$1,241.07	\$1,168.87	\$1,525.39	\$1,241.07	\$1,306.74	\$1,263.76	\$1,210.45	\$1,474.16
Couple rate	\$1,460.08	\$1,375.14	\$1,794.58	\$1,460.08	\$1,537.34	\$1,486.78	\$1,424.06	\$1,734.30
Family rate	\$2,080.61	\$1,959.57	\$2,557.28	\$2,080.61	\$2,190.71	\$2,118.66	\$2,029.29	\$2,471.38
Child Only rate	\$300.78	\$283.28	\$369.68	\$300.78	\$316.69	\$306.28	\$293.36	\$357.27
1st Quarter 2013 Rates:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Dollar Amount Change								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Percent Change:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA

NY Standard Silver								
In Network - \$2,000/\$4,000 Deductible, \$30/\$50 Copayment after deductible, 70%/30% coinsurance with a \$5,500/\$11,000 Out-of-Pocket Maximum								
Rx Plan - \$10/\$35/\$70								
	Albany Area	Buffalo Area	Mid-Hudson Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Long Island Area
1st Quarter 2014 Rates:								
Single rate	\$856.06	\$806.25	\$1,052.18	\$856.06	\$901.36	\$871.72	\$834.94	\$1,016.84
Parent / Child(ren) rate	\$1,455.30	\$1,370.63	\$1,788.71	\$1,455.30	\$1,532.31	\$1,481.92	\$1,419.40	\$1,728.63
Couple rate	\$1,712.12	\$1,612.50	\$2,104.36	\$1,712.12	\$1,802.72	\$1,743.44	\$1,669.88	\$2,033.68
Family rate	\$2,439.77	\$2,297.81	\$2,998.71	\$2,439.77	\$2,568.88	\$2,484.40	\$2,379.58	\$2,897.99
Child Only rate	\$352.70	\$332.18	\$433.50	\$352.70	\$371.36	\$359.15	\$344.00	\$418.94
1st Quarter 2013 Rates:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Dollar Amount Change								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Percent Change:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA

NY Standard Gold								
In Network - \$600/\$1,200 Deductible, \$25/\$40 Copayment after deductible, 80%/20% coinsurance with a \$4,000/\$8,000 Out-of-Pocket Maximum								
Rx Plan - \$10/\$35/\$70								
	<u>Albany Area</u>	<u>Buffalo Area</u>	<u>Mid-Hudson Area</u>	<u>New York City Area</u>	<u>Rochester Area</u>	<u>Syracuse Area</u>	<u>Utica/Watertown Area</u>	<u>Long Island Area</u>
1st Quarter 2014 Rates:								
Single rate	\$1,012.43	\$953.53	\$1,244.38	\$1,012.43	\$1,066.00	\$1,030.95	\$987.45	\$1,202.58
Parent / Child(ren) rate	\$1,721.13	\$1,621.00	\$2,115.45	\$1,721.13	\$1,812.20	\$1,752.62	\$1,678.67	\$2,044.39
Couple rate	\$2,024.86	\$1,907.06	\$2,488.76	\$2,024.86	\$2,132.00	\$2,061.90	\$1,974.90	\$2,405.16
Family rate	\$2,885.43	\$2,717.56	\$3,546.48	\$2,885.43	\$3,038.10	\$2,938.21	\$2,814.23	\$3,427.35
Child Only rate	\$417.12	\$392.85	\$512.68	\$417.12	\$439.19	\$424.75	\$406.83	\$495.46
1st Quarter 2013 Rates:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Dollar Amount Change								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Percent Change:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA

NY Standard Platinum								
In Network - \$15/\$35 Copayment, 90%/10% coinsurance with a \$2,000/\$4,000 Out-of-Pocket Maximum								
RX Plan - \$10/\$30/\$60								
	<u>Albany Area</u>	<u>Buffalo Area</u>	<u>Mid-Hudson Area</u>	<u>New York City Area</u>	<u>Rochester Area</u>	<u>Syracuse Area</u>	<u>Utica/Watertown Area</u>	<u>Long Island Area</u>
1st Quarter 2014 Rates:								
Single rate	\$1,194.76	\$1,125.25	\$1,468.48	\$1,194.76	\$1,257.98	\$1,216.61	\$1,165.28	\$1,419.15
Parent / Child(ren) rate	\$2,031.09	\$1,912.93	\$2,496.42	\$2,031.09	\$2,138.57	\$2,068.24	\$1,980.98	\$2,412.56
Couple rate	\$2,389.52	\$2,250.50	\$2,936.96	\$2,389.52	\$2,515.96	\$2,433.22	\$2,330.56	\$2,838.30
Family rate	\$3,405.07	\$3,206.96	\$4,185.17	\$3,405.07	\$3,585.24	\$3,467.34	\$3,321.05	\$4,044.58
Child Only rate	\$492.24	\$463.60	\$605.01	\$492.24	\$518.29	\$501.24	\$480.10	\$584.69
1st Quarter 2013 Rates:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Dollar Amount Change								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA
Percent Change:								
Single rate	NA	NA	NA	NA	NA	NA	NA	NA
Parent / Child(ren) rate	NA	NA	NA	NA	NA	NA	NA	NA
Couple rate	NA	NA	NA	NA	NA	NA	NA	NA
Family rate	NA	NA	NA	NA	NA	NA	NA	NA
Child Only rate	NA	NA	NA	NA	NA	NA	NA	NA

UnitedHealthcare Insurance Company of New York
New York Individual
Dependent to Age 29 Rider
Proprietary & Confidential - FOIL Protection Requested

Form # UHIC_CONV_COC_2014

The rate for this optional "make available" rider is calculated as a percentage of the medical & pharmacy rate on tiers which include dependents. There is no charge for the rider on non-dependent tiers.

<u>Tier</u>	<u>Percent of medical & pharmacy rate</u>
	Raise age from
	26 to 29
Single	25.10%
Parent/Child(ren)	25.10%
Couple	25.10%
Family	25.10%



UnitedHealthcare Insurance Company of New York.

New York Individual Conversion Plans
Rates Effective January 1, 2014 – December 31, 2014

ACTUARIAL CERTIFICATION

I,  am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

To the best of my knowledge and based upon the information and data available to me, I certify that:

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) 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 Clarification
 - 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
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.



July 24, 2013

UnitedHealthcare



UnitedHealthcare Insurance Company of New York.

New York Individual Conversion Plans
Rates Effective January 1, 2014 – December 31, 2014

ACTUARIAL CERTIFICATION

I, [REDACTED], am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

To the best of my knowledge and based upon the information and data available to me, I certify that:

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) 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 Clarification
 - 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
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.

[REDACTED]

July 24, 2013