

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: NY SG ALIC 1q13 to 4q13
Project Name/Number: NY SG ALIC 1q13 to 4q13/

Filing at a Glance

Company: Aetna Life Insurance Company
Product Name: NY SG ALIC 1q13 to 4q13
State: New York
TOI: H21 Health - Other
Sub-TOI: H21.000 Health - Other
Filing Type: Rate Adjustment pursuant to Section 3231(e)(1)
Date Submitted: 08/24/2012
SERFF Tr Num: AETN-128494178
SERFF Status: Submitted to State
State Tr Num:
State Status:
Co Tr Num:

Implementation: 01/01/2013
Date Requested:
Author(s): Xiaoping Hu, Caitlyn Prescott, Brian Diiorio
Reviewer(s):
Disposition Date:
Disposition Status:
Implementation Date:

State Filing Description:

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General Information

Project Name: NY SG ALIC 1q13 to 4q13
 Project Number:
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Employer
 Filing Status Changed: 08/24/2012
 State Status Changed:
 Created By: Caitlyn Prescott
 Corresponding Filing Tracking Number:

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small
 Overall Rate Impact:
 Deemer Date:
 Submitted By: Caitlyn Prescott

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:
 NY SG ALIC rate filing for 1q13 to 4q13.

Company and Contact

Filing Contact Information

Xiaoping Hu, ACTUARIAL CONSULTANT HuX@Aetna.com
 980 Jolly Road 215-775-6739 [Phone]
 M.S. U12S
 Blue Bell, PA 19422

Filing Company Information

Aetna Life Insurance Company	CoCode: 60054	State of Domicile: Connecticut
151 Farmington Avenue	Group Code: 1	Company Type:
Hartford, CT 06156	Group Name:	State ID Number:
(860) 273-7546 ext. [Phone]	FEIN Number: 06-6033492	

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
Aetna Life Insurance Company	\$0.00		

State Specific

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1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): Yes, Aetna Health Insurance Company of New York AETN-128619230 and Aetna Health Inc. (NY) AETN-128619160
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.): Blanket
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.): Rate Only
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.): Yes, Prior Approval Rate Adjustment
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes, AETN-128589860; State Tracking Number: 2012070203

SERFF Tracking #:

AETN-128494178

State Tracking #:

Company Tracking #:

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Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 3.000%
Effective Date of Last Rate Revision: 07/01/2012
Filing Method of Last Filing: SERFF

Company Rate Information

Table with 9 columns: 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). Row 1: Aetna Life Insurance Company, Increase, 5.000%, 5.000%, \$18,805,969, 3,830, \$160,092,546, %, %

Table with 10 columns: Product Type, HMO, PPO, EPO, POS, HSA, HDHP, FFS, Other. Rows: Covered Lives (29,636), Policy Holders (3,830)

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Filing Company:

Aetna Life Insurance Company

Rate Review Detail

COMPANY:

Company Name: Aetna Life Insurance Company
HHS Issuer Id: 17210
Product Names: Aetna Preferred Provider Organization
Aetna Fee for Service
Aetna Exclusive Provider Organization

Trend Factors:

FORMS:

New Policy Forms:

Affected Forms:

Other Affected Forms: GR-STATHCRGrp NY 01

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 331,598
Benefit Change: None
Percent Change Requested: Min: 5.0 Max: 5.0 Avg: 5.0

PRIOR RATE:

Total Earned Premium: 160,092,546.21
Total Incurred Claims: 133,083,706.84
Annual \$: Min: 282.91 Max: 806.59 Avg: 439.16

REQUESTED RATE:

Projected Earned Premium: 178,898,514.79
Projected Incurred Claims: 147,989,082.01
Annual \$: Min: 312.12 Max: 835.33 Avg: 481.11

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Actuarial Memorandum/Actuarial Certification		
Comments:			
Attachment(s):			
2-ALIC Memo.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)		
Comments:			
Attachment(s):			
ALIC Checklist.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Final Notice of Proposed Rate Adjustment		
Comments:			
Attachment(s):			
2013 NY Subscriber Letter TRAD Approved Rate Notice.pdf			
NY PS Letter-SG Customer ALL PLANS.pdf			
NY SUBSCRIBER SUMMARY OF RENEWAL RATES 2.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Rate Summary Worksheet		
Comments:			
Attachment(s):			
RateSummaryTemplate-NY SG ALIC 1Q13.pdf			
RateSummaryTemplate-NY SG ALIC 1Q13.xls			

Item Status:**Status Date:**

SERFF Tracking #:

AETN-128494178

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New York

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Satisfied - Item:	Standard Exhibit 1 - General Information		
Comments:			
Attachment(s):			
Standard_Exhibit_1_ALIC 1q13-4q13.pdf			
Standard_Exhibit_1_ALIC 1q13-4q13.xls			

Item Status:**Status Date:**

Satisfied - Item:	Standard Exhibit 2 - Summary of Average Claim Trend and Administrative Expenses		
Comments:			
Attachment(s):			
Standard_Exhibit_2_ALIC 1q13-4q13.pdf			
Standard_Exhibit_2_ALIC 1q13-4q13.xls			

Item Status:**Status Date:**

Satisfied - Item:	Standard Exhibit 4 - Part B - Summary of Proposed Percentage Rate Changes		
Comments:			
Attachment(s):			
Standard_Exhibit_4B_ALIC 1q13-4q13.pdf			
Standard_Exhibit_4B_ALIC 1q13-4q13.xls			

Item Status:**Status Date:**

Satisfied - Item:	Standard Exhibit 5 - Part B - Distribution of Contracts Affected by Proposed Rate Adjustments		
Comments:			
Attachment(s):			
Standard_Exhibit_5B_ALIC 1q13-4q13.pdf			
Standard_Exhibit_5B_ALIC 1q13-4q13.xls			

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Item Status:

Status Date:

Satisfied - Item:	Standard Exhibit 6 - Summary of Policy Form and Product Changes		
Comments:			
Attachment(s):	Standard_Exhibit_6_ALIC 1q13-4q13.xls Standard_Exhibit_6_ALIC 1q13-4q13.pdf		

Item Status:

Status Date:

Satisfied - Item:	Standard Exhibit 7 - Historical Data		
Comments:			
Attachment(s):	Standard_Exhibit_7_ALIC 1q13-4q13.xls Standard_Exhibit_7_ALIC 1q13-4q13.pdf		

Item Status:

Status Date:

Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):	1-ALIC Cover Letter.pdf		

Item Status:

Status Date:

Satisfied - Item:	Form Documents for new plans		
Comments:	We have included the forms and approvals as required because we have included rates for 2 additional plans (EPO 6 HSA and EPO 6 HSA MHP).		
Attachment(s):	ALICfInal Sec 11 Medical NY.pdf form approval.tif S-12 EPO NY.pdf		

**Aetna Life Insurance Company
Actuarial Memorandum**

This filing pertains to Aetna Life Insurance Company forms: GR-STATHCRGrp 01 NY. Its purpose is to provide the benefit descriptions and Small Group premium rates for the various plan options offered under this product.

We have attached copies of all pages of our small group rate manual. Please note that pages containing rates have been provided for all 4 quarters governed by this filing. The rates filed include all previously approved PPACA adjustments, which excludes the Women’s Preventive Health mandated benefits. We will submit a separate filing to address Women’s Preventive Health benefits. In addition to the proposed quarterly and annual rate adjustments, the rate adjustments for the preceding 24 months are summarized in the following table and apply to all products governed in this filing:

Effective Date	Implemented Rate Increases	
	Quarterly	Annual
01/01/2011	2.50%	15.00%
04/01/2011	3.00%	10.70%
07/01/2011	3.00%	8.70%
10/01/2011	0.00%	8.70%
01/01/2012	3.00%	9.30%
04/01/2012	3.00%	9.30%
07/01/2012	3.00%	9.30%
10/01/2012	0.00%	9.30%
Effective Date	Proposed Rate Increases	
	Quarterly	Annual
01/01/2013	5.00%	11.40%
04/01/2013	2.70%	11.10%
07/01/2013	2.70%	10.70%
10/01/2013	2.70%	13.70%

Our pricing model makes the following adjustments to normalize the premium and claims and assure the numerator and denominator of the loss ratio calculation are based on the same populations and mix of plan designs:

- We utilized Aetna Small Group, community rated NY EPO and MC experience for the period 02/01/11 through 01/31/12 with run-out through 04/30/12 in order to project claims for this filing. No adjustments were made for large claims. There have been no changes in tier relationships, the single conversion factor, or area factors.
- The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality.

- Premium and claim data is credible for understanding baseline experience, but not necessarily credible for developing and forecasting trends. As a result, we provide trend experience for 3 similar blocks of business. The medical trend assumptions are based on our large group and small group experience. For this rate filing, we have used 11.2% as the projected change in medical cost. We believe our trend assumption is a reasonable estimate based on the results of these 3 blocks of business.
- As a result of recent market stabilization pool submissions, the credit from this regulation is 0.5% of premium.
- The current premium levels by renewal cohort are carried forward using filed rate changes on each cohort renewal month.
- We then look at projected calendar year loss ratios and renewal cohort loss ratios, and a rate increase is chosen in order to exceed New York's minimum 82% loss ratio and achieve our target renewal cohort loss ratio and achieve an 82.2% renewal cohort loss ratio as directed by the NY DOI. Based on these pricing assumptions we expect this to generate losses as shown on Exhibit A.

The expected loss ratio including breakdown of the non-claims expense component is included in Exhibit A. The non-claim expense components indicated on Exhibit A and Standard Exhibit 2 are consistent with the 2011 Department of Health and Human Services Medical Loss Ratio Reporting Form on a percentage of premium basis.

The attached exhibits 7, 7A, 7B, 7C, 7D, and 7E illustrate the historical experience, demonstrate the calculation of standardized premium, detail the development of the proposed rate increases, and provide detail on our most recent medical and unit cost trends. Standardized premium is the sum product of premium PMPM, member months, and the cumulative rate increase. Exhibit 7A includes the detailed calculation by DOS month.

We are adding the NY OA EPO 6 HSA Compatible plan and the corresponding Mental Health Parity version of the plan to our current portfolio. This plan is similar to the NY OA EPO 5 HSA Compatible plan, with the only difference being that the NY OA EPO 6 HSA Compatible plan has 100% coinsurance. We priced the NY OA EPO 6 HSA Compatible plan to be 5% higher than the NY OA EPO 5 HSA Compatible plan based on expected costs using our internal pricing model. The already approved contract language in the GR-9N form includes the new 100 % coinsurance benefit option being added.

Aetna Life Insurance Company
Actuarial Certification

I, William R. Jones, am an actuary and employee of Aetna Inc. and a member of the American Academy of Actuaries.

I have examined the underlying records and/or summaries, reviewed the assumptions and methods used in their development, and did such tests and calculations as I considered necessary. I certify that, to the best of my knowledge, the attached memorandum reflects the rating impact for the new plans. I further certify that this filing is in compliance with all applicable laws and regulations of the State of New York, Actuarial Standard of Practice No. 8, the expected loss ratio requirements of the State of New York, the benefits are reasonable in relation to the premiums charged, and the rates are not unfairly discriminatory.



William R. Jones, F.S.A., M.A.A.A.
Northeast & SGI Head Actuary
[August 1, 2012](#)

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

As of 5/18/2012

Use this Checklist for all rate adjustment filings submitted pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law. One of the following two SERFF filing type codes must be used to properly denote such a filing. A rate submission with the wrong filing type code will be rejected and will need to be resubmitted with the correct filing type code.

Rate Adjustment Pursuant to Section 3231(e)(1): This filing type is used for Article 42 insurers that are submitting a rate adjustment only filing for a hospital and/or medical coverage (including Medicare Supplemental insurance) for small groups and individuals under the Section 3231(e)(1) prior approval process. This filing type cannot be used for form filings, initial rate filings, or by Article 43 Corporations or Health Maintenance Organizations (HMOs).

Rate Adjustment Pursuant to Section 4308(c): This filing type is used for Article 43 Corporations and HMOs that are submitting a rate adjustment only filing for any policy form that uses a community rating structure. This includes hospital and/or medical policy forms, or separate stand-alone dental policy forms, that are not required to be community rated but for which the corporation voluntarily community rates. “Community rating” means a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation. This also includes the HMO portion of large group Point of Service business where an approved experience rating formula is not used. This filing code cannot be used for form filings, initial rate filings, or by commercial insurers.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) can include an expansion of an existing rate table to include new benefit options (such as rates for additional copays or deductibles) provided that: (a) the already approved contract language includes the new benefit options being added, (b) the actuarial memorandum clearly identifies the new benefit options being added and provides appropriate actuarial support for the new rates, and (c) approved contract language pages and the Department’s approval letter are included with the rate filing documenting that the benefit options being added are included in the already approved contract language. No Section 3231(e)(1) or Section 4308(c) rate adjustment filing can include rates that require contract language approval where such approval has not already been received.

A change to existing rating region differentials is a rate adjustment filing pursuant to Section 3231(e)(1) or Section 4308(c). A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot reflect an expansion to a new service area. A service area expansion, and the rate applicable to that new service area, must be submitted as a separate rate filing using the “Normal Pre-Approval” SERFF filing type code. A Section 3231(e)(1) or Section 4308(c) filing cannot be used to withdraw from a service area.

If a company wishes to eliminate some of its approved benefit options included in the current rate manual, this cannot be done pursuant to a Section 3231(e)(1) or Section 4308(c) rate adjustment application. Such elimination is to be implemented by submitting a form and rate filing using the “Normal Pre-Approval” SERFF filing type code and the filing is to include a revised statement of variables for the benefit options that are available along with revised rate manual pages reflecting the revised benefit options.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot 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. Once a new rate has been approved (for a new policy form or for a revision to an existing policy form), such new rate can be incorporated into the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing.

The “Normal Pre-Approval” SERFF filing type code triggers the traditional Department review (generally by the Albany Health Bureau unit) and would be used for all form and rate filings, form only filings, experience rating formula filings, or commercial insurer rate only filings other than filings submitted pursuant to Section

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

3231(e)(1), or Article 43 Corporation and HMO rate only filings other than filings submitted pursuant to Section 4308(c). The “Normal Pre-Approval” SERFF filing type code would also be used for old individual medical policy forms that are not community rated. Rate revisions for products subject to Section 3231(e)(1) or 4308(c) incorporated into a form and rate filing that adjusts an existing policy form for a change in benefit language can only reflect rate changes due to the benefit revision and can not reflect any adjustment for experience or trend. A “Normal Pre-Approval” SERFF type filing for a product subject to Section 3231(e)(1) or 4308(c) can not include rolling rate tables that extend beyond the period included in the most recently approved or pending Section 3231(e)(1) or Section 4308(c) rate adjustment submission (for example, the last rate adjustment submission included quarterly rolling rate tables for each calendar quarter of 2012; a benefit revision is submitted January 2012 to be effective July 1, 2012; this form and rate filing can include rolling rate tables for third and fourth quarter 2012, but not beyond fourth quarter 2012).

New or revised commission schedules or broker fee schedules must first be placed on file using a rate filing with a “Normal Pre-Approval” SERFF filing type code. Once the new or revised schedule has been placed on file, any rate impact can be included with the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing and the change and its impact on the premium rates is to be discussed in the actuarial memorandum.

It is recommended that a Section 3231(e)(1) or Section 4308(c) rate filing application be submitted at least 150 days before the proposed effective date, however, in determining how far in advance to submit such a rate filing, the company should consider: the time needed to load final rates into its computer system; produce the final rate notice, which is to be sent at least 60 days before the scheduled rate change effective date of the renewal cohort; the 60 days the Department has to review the material; and the time the clock may be stopped while the company responds to issues raised by the Department about the rate filing.

It is recommended that a rate adjustment submission not be submitted more than 180 days prior to the proposed rate effective date. It is recommended that a rate adjustment submission 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. If a company can not send the required final notice at least 60 days in advance of the rate change date for a particular renewal cohort, then the rate change implementation date for such renewal cohort will need to be deferred. Contract terms will dictate whether the rate change can be deferred to a later implementation date for that renewal cohort (e.g., for the July 2012 renewal cohort, deferring the rate change to August 2012, while retaining the next rate change date as July 2013), or deferring implementation of the newly approved rates to a later renewal cohort (e.g., assuming quarterly rolling rates are used: renewing the July 2012 renewal cohort using the previously approved second quarter 2012 rate tables, and implementing the newly approved rates with the August 2012 renewal cohort).

Each attachment to the rate adjustment application must be compatible with the following software: Microsoft Word 2003, Microsoft Excel 2003, or Adobe Acrobat 9.

When an attachment is submitted via SERFF as other than an Adobe Acrobat PDF file, another copy of that attachment is to also be included in Adobe Acrobat PDF file format. This can occur when one of the standard exhibits is required to be submitted as an Excel workbook, or when an appendix/attachment to the actuarial memorandum is submitted in other than PDF format. Failure to include a PDF version of each attachment will result in an objection letter being sent for the missing material and the rate submission will be tolled while waiting for the missing material to be submitted.

The rate manual and the year over year exhibit (if distinct versions are used) are to be attached to the Rate Schedule tab of an initial SERFF filing. All other attachments are to be attached to the Supporting Documentation tab of the initial SERFF filing.

An “amendment” to a SERFF filing, as described beginning on page 183 of the SERFF Industry Manual (available online via SERFF), is used when the amendment is not in response to an objection letter. For example: the filer has decided to add a schedule item; the filer has noticed an error in one of the originally submitted schedule items and is submitting a correction before the error is raised in an objection letter. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, year over year exhibit, etc.) needs to be amended, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be corrected.

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Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

A revision to a previously submitted schedule item made in response to an objection letter is to use the “Revising Schedule Items” process described beginning page 170 of the SERFF Industry Manual. This is the method that is to be used when any schedule item needs to be revised in response to an objection letter, including a revised rate manual to be submitted in response to the Department’s decision. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, year over year exhibit, etc.) needs to be revised in response to an objection letter, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be revised.

NOTE: A new section, Public Disclosure of the Rate Application, has been added at the end of the checklist. If the applicant chooses to submit a redacted version of the rate application for posting on the Department’s website, see the guidance there.

NOTE: Parts I and II of the HHS Preliminary Justification are now required for all market segments and for all section 3231(e)(1) or 4308(c) rate submissions. See the section “HHS Preliminary Justification Parts I and II” below for guidance.

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
DEFINITIONS		<ul style="list-style-type: none"> a. Company refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing. b. A company’s commercial book of business includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus. c. Loss ratio refers to incurred claims divided by earned premiums for a given period of time. Incurred claims <u>includes</u> the impact of the Standard Direct Pay and Healthy New York stop loss pools, Regulation 146 (11 NYCRR 361), covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including “quality improvement expenses” or “community benefit expenses”. Earned premiums <u>do not include</u> any adjustment for assessments or taxes. d. Market segment refers to large group, small group, sole proprietor, direct pay, Healthy New York, Medicare Supplemental, etc. Small group is as defined in New York Insurance Law and Regulation. e. Product street name refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department. f. Rate applicability period refers to the length of time in which the rates in a rate table are assumed to remain in effect. <ul style="list-style-type: none"> (i) Example 1: A non-rolling rate table is developed to be effective January 1, 2012 and is expected to be revised January 1, 2013. The rate applicability 	N/A

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		<p>period for this table is January 1, 2012 through December 31, 2012.</p> <p>(ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2012 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2012 (mid renewal date) through February 14, 2013. If all policyholders must have a first of the month effective date, then the rate applicability period would be considered as February 1, 2012 through January 31, 2013.</p> <p>g. Standardized earned premium is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable pursuant to Regulation 146 or pursuant to a loss ratio report have no impact on the earned premiums or standardized earned premiums shown in Exhibit 7 or in the rate development analysis.</p> <p>(i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3rd and 4th quarters 2012 and 1st and 2nd quarters 2013. The 2nd quarter 2012 rates have already been approved. Therefore, the 2nd quarter 2012 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2nd quarter 2012 rate level. If the 2nd quarter 2012 rate table included a 2% increase due to the addition of a new benefit that is being added to all policyholders at renewal, the standardization for periods prior to April 1, 2012 would not reflect this 2% increase since the incurred claims for this earlier period did not reflect this additional benefit.</p> <p>(ii) Example: An insurance company uses a quarterly rolling rate structure and has been raising rates 4% each quarter as of the beginning of a new quarter. The first quarter 2011 rate for plan design A is \$100, the first quarter 2012 rate is \$116.99, and the second quarter 2012 rate is \$121.67. These increases reflect no revision to the underlying covered benefits. The second quarter 2012 rate table is the standard rate level. Contract X was paying \$100 per month for January-December 2011. At renewal January 1, 2012, the premium was scheduled to increase to \$116.99 but a change to plan design B occurred that reduced the premium by 5% to \$111.14 for January 2012 and later. The second quarter 2012 rate for plan design A is \$121.67 and the second quarter 2012 rate for plan design B is \$115.58 (\$121.67 x 0.95). The earned premium for this contract for each month from January through December 2011 is standardized to the second quarter 2012 level by adjusting by 121.67/100.00, and the</p>	
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		<p align="center">January 2012 earned premium is standardized to the second quarter 2012 level by adjusting by 115.58/111.14.</p>	
<p>ROLLING RATE STRUCTURE</p>		<ul style="list-style-type: none"> a. Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates). b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period. c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates). 	<p>Rate/Rule Schedule ALIC Rate Manual.pdf</p>
<p>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</p>		<ul style="list-style-type: none"> a. Beginning with rate adjustment filings that include rate tables to be effective January 1, 2012 or later, the rate adjustment filing must include all community rated policy forms within a given market segment (such as all small group products) whether or not a premium rate adjustment is requested for a particular product or rider in that market segment. All entities within the same holding company system are to submit filings for a given market segment at the same time; the filings can be submitted under different SERFF filings, but all the applicable filings must be submitted within a total of seven calendar days. b. A company can revise a previously approved non-rolling rate table provided that: <ul style="list-style-type: none"> (i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or (ii) The proposed effective date of the rate table is at least 6 months after the effective date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and all policyholders that received a final 60 day notice about the approved rates from the previously approved rate adjustment filing have also received the rate change approved from the previously approved rate adjustment filing. c. A company can revise rate tables included in a previously approved rolling rate filing provided that: (i) the rate tables being revised were never implemented, (ii) the first two quarterly rate tables, or the first six monthly rate tables, included in the previously approved rate adjustment filing are not revised, and (iii) policyholders in the renewal cohort(s) affected by the change to the previously approved rate tables did not receive a final 60 day notice informing them of the approved rates from the previously approved rate adjustment filing. The revised rate adjustment filing must include a year's worth of rates as discussed in the "Rolling Rate Structure" section above. (Example: A rolling rate filing was submitted and approved that included quarterly rolling rate tables for 1st, 2nd, 3rd 	<p>Rate/Rule Schedule ALIC Rate Manual.pdf</p>

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		and 4 th quarter of 2012. The company can not revise the 1 st and 2 nd quarter 2012 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3 rd and 4 th quarter 2012 and 1 st and 2 nd quarter 2013.) The Department may waive these requirements if the company can demonstrate to the Superintendent’s satisfaction that the solvency of the corporation is threatened.	
STANDARD EXHIBITS 1 - 7	Introduction	Exhibits 1 through 7 must be submitted as part of each rate adjustment application. All exhibits, except Exhibit 3, must be submitted as a Microsoft Excel file and as an Adobe PDF file. For Exhibits 1-2 and 4-7 the supplied workbook must be used. Only use the first tab of each Excel workbook for data entry.	
Exhibit 1		<p>General information about the rate adjustment submission.</p> <ul style="list-style-type: none"> a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit. b. Indicate the company type using the drop down list: Article 42 Accident and Health company (A&H – 42), HMO (HMO – 44), Article 42 Life company (Life – 42), Article 41 property/casualty company (P&C – 41), and Article 43 Non-Profit Medical and Dental Indemnity or Health and Hospital Service Corporations (Not for Profit – 43). c. Indicate the organization type (Org Type), for profit or not for profit, by using the drop down list. d. Item D – the “new rate effective date” must be a realistic implementation date given the review time allowed the Department and the requirement of the 60 day final rate notice. This date would usually be the first date the proposed rates would affect renewing policyholders. So a 1/1/2013 effective date would imply that the first renewal cohort affected by the rate submission would be January 2013. e. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected. f. This exhibit must be submitted as an Excel file and as an Adobe PDF file. 	<p>Supporting Documentation Standard Exhibit 1 ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 1 ALIC 1q13-4q13.xls</p>
Exhibit 2		<p>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</p> <ul style="list-style-type: none"> a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert more rows as needed. Only use the first tab for data entry. b. Use a separate row to enter information for each combination of market segment/rating pool included in this rate adjustment application. Use the drop down list to enter the market segment. Enter a description of the rating pool in the column indicated; if the rating pools vary by rating region, the rating pool identifier should include a region identifier. All market segments of Healthy New York are usually combined into one rating pool and in that case choose as market 	<p>Supporting Documentation Standard Exhibit 2 ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 2 ALIC 1q13-4q13.xls</p>

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		<p>segment HNY-IND or HNY-SG based on which subpopulation has the most membership.</p> <p>c. Information is for medical base plans and all associated riders combined.</p> <p>d. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rate applicability period.</p> <p>e. The administrative expense components incorporated into the proposed rates are to be entered as a percentage of gross premium and as a per member per month amount.</p> <p>f. Enter the data for the rate period included in this rate adjustment filing. This refers to the various non-claim expense components included in the proposed rates and the average annualized claim trend assumed.</p> <p>g. Enter the data for the rate period included in the immediately prior rate adjustment filing (i.e., a section 3231(e)(1) or 4308(c) rate adjustment filing). This refers to the various non-claim expense components included in the proposed rates submitted with this prior filing and the average annualized claim trend assumed in this prior filing. If there is no immediately prior rate adjustment filing, enter the data assumed in the initial or prior form and rate filing.</p>	
<p>Exhibit 3</p>		<p>Narrative Summary.</p> <p>a. The format of the exhibit is illustrative, but must include the required material. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. If submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>b. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company’s policyholders and subscribers to help them understand why a rate increase is needed.</p> <p>c. The narrative summary will be a public document.</p> <p>d. It is suggested that once reviewed by the Department, the company post the narrative summary to a location on its website that is publicly available, that is, a location that can be viewed without the need for entering a user ID and password. Links should be provided on key pages of the company’s website so that the information may be easily located. Any change(s) to the narrative summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified. Narrative summaries should remain on the company’s website for at least 12 months past the proposed effective date of the rate submission.</p> <p>e. The narrative summary should include, but not be limited to, the following</p>	<p>Supporting Documentation Standard Exhibit 3 ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 3 ALIC 1q13-4q13.xls</p>

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		<p>information:</p> <ul style="list-style-type: none"> (i) The name of the company submitting the rate adjustment request, the NAIC code number for the company, and the SERFF number for the rate application. (ii) A summary of the proposed rate adjustments. (iii) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect policyholders in a certain market segment (e.g., small group), or with certain products (indicate the “street name” of the products affected), or only a certain renewal cohort (e.g., policyholders renewing from period mm/dd/yyyy – mm/dd/yyyy). (iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples: <ul style="list-style-type: none"> (a) Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy. (b) A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder’s next anniversary on or after mm/dd/yyyy. (v) The number of policyholders and members affected by the proposed rate adjustments. This can be aggregated across all market segments and products included in the rate adjustment submission. (vi) An explanation, in plain language, as to why it is necessary to request such rate change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type. <p>Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p>	
<p>Exhibit 4</p>		<p>Summary of Proposed Percentage Rate Change to Existing Rate.</p> <ul style="list-style-type: none"> a. There are four different versions of this exhibit as indicated below. Not all versions may be required for a given rate filing. <ul style="list-style-type: none"> (i) Part A – Base Medical Plan information when a <u>Non-Rolling</u> Rate Structure is used. (ii) Part B – Base Medical Plan information when a <u>Rolling</u> Rate Structure is used. (iii) Part C – Drug Rider information when a <u>Non Rolling</u> Rate Structure is used. (iv) Part D – Drug Rider information when a <u>Rolling</u> Rate Structure is used. b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment filing. Use the drop down list to enter the market segment. c. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for 	<p>Supporting Documentation Standard Exhibit 4B ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 4B ALIC 1q13-4q13.xls</p>

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		<p>data entry.</p> <p>d. This exhibit is to summarize the proposed percentage rate changes. The percentage rate change is the percentage change from the rate the subscriber is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which are not being revised by the current rate application) to the proposed rate that this subscriber would be paying at the subscriber's next rate change date according to the new rate application.</p> <p>Example 1: the rate structure is quarterly rolling rates, has a 12 month rate guarantee period, and the rate adjustment application is for second quarter 2013 issues and renewals. The rate change would be the percentage change from the second quarter 2012 rates to proposed second quarter 2013 rates.</p> <p>Example 2: the rate application includes quarterly rolling rates for each quarter of calendar year 2013. The prior rate application included quarterly rolling rates for each quarter of 2012. Rates include a 12 month rate guarantee period. The current rate application is submitted July 2012 before all the third and fourth quarter 2012 renewals have taken place. The proposed percentage change for fourth quarter 2013 would be the change from the fourth quarter 2012 rates to the proposed fourth quarter 2013 rates.</p> <p>e. If the subscriber will need to change to a different plan design at renewal (i.e., a required change from the current plan design whether mandated by a government entity or not, but not due to the discontinuation of the current policy form or discontinuation of a particular plan design), a supplement to Exhibit 4 is to be included. The supplemental exhibit is to indicate (i) a high level summary of the difference in covered benefits and cost sharing between the current and replacement plan, and (ii) the estimated pricing percentage change due solely to the difference in the plan designs between the replacement plan and the existing plan. This supplemental exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file; if submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>f. The weighted averages may be based on membership or contract as used in Standard Exhibit 5 instead of premium volume.</p> <p>g. The values entered should follow the organization of the rate manual. If the drug rate is included with the rates in the medical rate table, the combined result is entered in Part A and/or Part B. If the drug rate is a separate rate table associated with a drug rider, then the medical changes are shown in Part A and/or Part B and the drug rider changes are shown in Part C and/or Part D.</p> <p>h. Parts A and B summarize the proposed changes for the base medical rate tables and excludes the impact of all optional riders. The lowest and highest values indicate for a given market segment, region, policy form, product combination the</p>	
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		<p>lowest percentage change that applies to a renewing subscriber/contract holder and the highest percentage change that applies to a renewing subscriber/contract holder. This difference could be due to different percentage changes proposed by rating tier or by plan design within a particular product.</p> <p>Example: The rate adjustment application is only for small group PPO and within this product there are only two product designs. The proposed rate changes for design A are: employee only = 10%, employee+child(ren) = 8%, employee+spouse = 13% and employee+family = 11%. The proposed rate change for design B are: employee only = 9%, employee+child(ren) = 7%, employee+spouse = 12% and employee+family = 10%. The lowest change proposed is 7% and the highest change proposed is 13%. The weighted average change would reflect the distribution of contracts by plan design and rating tier.</p> <p>i. Parts C and D summarize the proposed changes just for the traditional drug riders. <u>Exclude</u> minor drug related riders such as a rider to include oral contraceptives. All the drug riders available with a given base medical product can be aggregated into one row.</p> <p>Example 1: Drug riders D1 to D99 are available with the PPO product. The proposed changes on the drug riders vary from 10% to 16%. There would be one row for the PPO policy form/product. The lowest change proposed is 10% and the highest change proposed is 16%. The weighted average change would reflect the distribution of contracts by plan design and rating tier.</p> <p>Example 2: As in Example 1, but drug riders HD1-HD19 are available with the HSA high deductible PPO product. There would be another row for the high deductible PPO policy form/product indicating the lowest, highest, and weighted average changes among the HD1-HD19 drug riders.</p> <p>j. A separate row should be completed for each market segment. If the percentage rate change for sole proprietor is different from small group, then a separate market segment of sole proprietor is to be reported.</p> <p>k. Where rate changes differ by rating region within a market segment, separate rows are to be used by market segment/rating region combination.</p> <p>l. Separate information should be submitted for each rolling rate table of a rolling rate structure. For example: if a calendar quarterly rolling rate structure is used and the rate adjustment filing includes proposed rate tables for first, second, third and fourth quarters 2013, separate information should be entered in Parts B and D for the impact of the first quarter 2013 rate changes, the impact of the second quarter 2013 rate changes, the impact of the third quarter 2013 rate changes, and the impact of the fourth quarter 2013 rate changes.</p>	
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<p>Exhibit 5</p>		<p>Distribution of Contracts Affected by the Proposed Rate Adjustments.</p> <ol style="list-style-type: none"> a. There are two different versions of this exhibit as indicated below. Not all versions may be required for a given rate submission. <ol style="list-style-type: none"> (i) Part A – for use with <u>Non-Rolling</u> Rate Structures. (ii) Part B – for use with <u>Rolling</u> Rate Structures. b. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for data entry. c. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. Use the drop down list to enter the market segment. d. This exhibit indicates the distribution of the proposed rate changes for each market segment, rating region and product, as well as the weighted average rate change impact for that segment/region/product combination. If the same percentage rate change applies to each rating region, then a separate break out by rating region is not necessary and the results can be shown for all rating regions combined. e. The distribution basis can be by number of contracts or by number of members – fill in the applicable column. The same basis is to be used for all products within a given rate adjustment submission. Enter the applicable counts in the appropriate column (members column or contracts column), and replace the “mm/dd/yyyy” placeholder with the applicable “as of” date for the counts entered. The Weighted Average % should be developed based on the distribution of contracts or members for that market segment/rating region/product. At the end of each market segment enter a Market Segment Total row indicating the member/contract counts in total and by rate change column and the Weighted Average % for all rating regions/products in that market segment combined. f. The percentage rate change reflects the expected change in premium rate that would apply to that subscriber/contract holder on that subscriber/contract holder’s next rate change date according to the new rate application. This would reflect the percentage rate change from the rate the contract holder is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application) to the proposed rate that this contract holder would be paying at the contract holder’s next rate change date according to the new rate application The rate change reflects the impact of the base medical plans and all riders applicable to that contract. g. Enter in Part A the information for the various products that use a <u>non-rolling</u> rate structure. h. Enter in Part B the information for the various products that use a <u>rolling</u> rate structure. Separate rows are to be used for each rolling rate cohort. For example, if 	<p>Supporting Documentation Standard Exhibit 5B ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 5B ALIC 1q13-4q13.xls</p>
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		<p>the rate submission is for quarterly rolling rate tables for first, second, third and fourth quarter 2013, then separate rows would be used to enter information for each of these four quarters. The distribution shown for a particular quarter would reflect only those policyholders renewing in that particular quarter.</p>	
<p>Exhibit 6</p>		<p>Summary of Policy Form and Product Changes.</p> <ol style="list-style-type: none"> a. This exhibit summarizes all rate changes filed pursuant to sections of the New York Insurance Law other than Section 3231(e)(1) or Section 4308(c) that impact the policyholders affected by this rate adjustment filing and which affect the percentage changes shown on Exhibits 4 or 5. b. The format of the exhibit is fixed. Insert additional rows as needed. Only use the first tab for data entry. Use the drop down list to enter the filing status. Leave the Approval Date column blank for any filing that has not yet been approved. This exhibit must be submitted as an Excel file and also as an Adobe PDF file. c. List all rate filings that have been approved since the prior Section 3231(e)(1) or Section 4308(c) rate filing that impact the percentage rate change of the policyholders affected by this rate adjustment filing. The actuarial memorandum should include a brief description of such changes, when the changes were implemented, and the impact on the rate changes in Exhibits 4 and 5. d. List all rate filings currently pending with the Department that if approved would impact the percentage rate change of the policyholders affected by this rate adjustment submission. This includes any pending request to discontinue a policy form, product, or plan design option. 	<p>Supporting Documentation Standard Exhibit 6 ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 6 ALIC 1q13-4q13.xls</p>
<p>Exhibit 7</p>		<p>Historical Data by Each Policy Form Included in the Rate Adjustment Filing.</p> <ol style="list-style-type: none"> a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert additional rows as needed. Only use the first tab for data entry. b. Indicate the company name, the NAIC code number for that entity, and the SERFF filing number for the applicable rate filing in the spaces indicated. c. Use a separate row for each base medical policy form belonging to a rating pool (i.e., a permitted aggregation of base medical policy forms). Data is to be shown for each base medical policy form included in the rate adjustment filing even if no rate adjustment is proposed for that base medical policy form. Then add another row for the rating pool total and indicate an appropriate rating pool identifier in the first column. Skip a line and then enter similar data for the next rating pool. d. Indicate the form number for each base medical policy form, the product name as in the rate manual, the street product name, and the rating pool identifier (the rating pool identifier should include a region identifier if rating pools vary by region). 	<p>Supporting Documentation Standard Exhibit 7 ALIC 1q13-4q13.pdf</p> <p>Standard Exhibit 7 ALIC 1q13-4q13.xls</p>

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		<p>Refer to Section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for the requirements to aggregate substantially similar policy forms for small group policy forms and for individual policy forms.</p> <p>e. Indicate for each base medical policy form if the policy form aggregation has changed from the previous rate filing. If yes, the actuarial memorandum must include an explanation of the change, the rationale for the change, and the percentage rate impact this change has on this policy form and on the policy forms previously aggregated with this policy form.</p> <p>f. The effective date of rate change refers to the proposed effective date of the non-rolling rate table, and/or the proposed effective date of the earliest rolling rate period of a rolling rate structure.</p> <p>g. The rate guarantee period refers to a non-rolling rate table and/or to the first rate table of a rolling rate structure. (If the rate guarantee period for the rolling rate structure is not the same for each rolling rate period, the actuarial memorandum must discuss this and explain why the length of the rate guarantee periods are not the same.)</p> <p>h. The weighted average rate change percentage proposed (from the rate currently charged the policyholder [or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application] to the proposed rate to be charged to that same cohort of policyholders) for the indicated base medical policy form, including all associated riders. The weighting should be consistent with how the average changes were calculated in Standard Exhibit 5 (i.e., based on members or contracts). For a rolling rate structure, enter the result for the first rate table in the rolling rate structure. (Example: a quarterly rolling rate filing was submitted that includes rolling rate tables for the 1st, 2nd, 3rd, and 4th quarters of 2013. Rates are for a 12 month period. Indicate the average rate change percentage from the 1st quarter of 2012 rate tables to the 1st quarter 2013 rate tables.)</p> <p>i. For the number of policyholders affected and the number of covered lives affected by this rate filing, indicate the effect of all the rate tables of a rolling rate structure included in the rate filing (but not more than 12 months of issues and renewals if more than 12 months of rolling rate tables are included in the rate filing). For group business, “policyholders” is referring to the number of groups, not the number of subscribers or contracts.</p> <p>j. The expected loss ratio is the loss ratio incorporated into the proposed rate tables for each base medical policy form (and the entire rating pool) and includes the impact of associated riders and reflects the impact of the proposed rate changes. Loss ratio is calculated on a New York statewide basis. For a rolling rate structure, enter the expected loss ratio incorporated into the rate tables of the first rolling rate</p>	
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		<p>period of the rolling rate structure.</p> <p>k. The experience entered for the three indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.</p> <p>(i) Each experience period is to be for 12 months (or shorter if a new form).</p> <p>(ii) The ending date of the recent experience period cannot be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing is for a non-rolling rate table to be effective July 1, 2013. The recent experience period cannot have an ending date earlier than June 30, 2012, i.e., 12 months prior to July 1, 2013.).</p> <p>(iii) The first prior period is the immediately prior 12 month experience period (or shorter period if a new form). The second prior period is the immediately prior 12 month experience period (or shorter if a new form) prior to the first prior period.</p> <p>(iv) The incurred claims for each of the three experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of the incurred claims.</p> <p>(v) Loss ratio report refunds or refunds pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.</p> <p>l. Enter the average annual composite medical trend assumption used in the proposed rate development for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown, as well as any other component such as for case mix or intensity (identify and discuss and justify any such other component in the actuarial memorandum along with the utilization component and unit cost component).</p> <p>m. The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods.</p> <p>n. If the rating differential between the New York rating regions is being revised with</p>	
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		<p>this rate filing, separate rows are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined, and the rating pool identifier is to include a rating region identifier.</p>	
ACTUARIAL MEMORANDUM	11NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	Supporting Documentation 2-ALIC Memo.pdf
Justification of Rates	<p>§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b) 11NYCRR 360.11</p>	<ul style="list-style-type: none"> a. Description of proposed changes in rates, including the following: <ul style="list-style-type: none"> (i) The member (or contract) weighted average proposed percentage change over the current rates charged to each renewal cohort of policyholders for each base medical policy form, including the impact of all associated riders available to that policy form (or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application). This is to be shown for each non-rolling rate table and/or each rolling rate table included in the rate filing. (The percentage change is comparable to the percentage change developed for Standard Exhibit 5.) Include comparable information for percentage rate changes implemented during the prior 24 months. (ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3rd quarter 2013. The change from each of the 2nd quarter 2013 rolling rate tables to the corresponding 3rd quarter 2013 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated. (iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment filing, indicate the aggregate (medical plus riders) percentage change between the successive non-rolling rate tables. For a rolling rate structure, indicate the aggregate (medical plus riders) percentage change between each of the successive rolling rate tables (e.g., for a quarterly rolling rate structure, the percentage change between each of the successive 	All items are addressed in the Supporting Documentation and Rate/Rule Schedule.

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		<p>quarterly rate tables).</p> <ul style="list-style-type: none"> (iv) The percentage change due to any change in the expected loss ratio incorporated into the proposed rate tables from the prior rate filing for such base medical policy form or rider. Indicate the expected loss ratio incorporated into the current rate tables, the expected loss ratio incorporated into the proposed rate tables, the impact on the percentage change in items (i) and (ii) above due to this revision in the expected loss ratio, and the reason(s) and justification for the change in the pricing expected loss ratio. (v) The percentage change due to any change to the tier structure relationships included in this rate filing and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes. (vi) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate filing, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes. (vii) The percentage change due to variance in the prior incurred claim cost per member per month estimate and the impact of such variance on the percentage changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an exhibit showing how this variance and the percentage impact of this variance were developed. (viii) Changes to any of the rating differentials between the various rating regions included in this rate filing. If the rating differential between the rating regions was changed, include (a) a listing of the composition of each rating region, (b) the percentage change impact on each such rating region, and (c) justification for each such change between the rating region differentials. If the composition of any rating region is being changed with this filing, indicate (a) the current and proposed composition of the affected rating regions, (b) the percentage change impact on each of the affected rating regions, and (c) justification for the proposed change in the rating region composition. <ul style="list-style-type: none"> b. If new benefit options are being added to an existing rate table (such as additional copays or deductibles): (a) clearly indicate the additions being made, (b) include in the actuarial memorandum, a statement that the already approved contract language includes the new benefit options being added, (c) provide appropriate actuarial justification for the additional rating factors, and (d) submit a copy of the approved contract language pages and a copy of the Department’s approval letter and clearly indicate how the approved contract language covers the new benefit options being added to the existing rate table. c. Include the following (year over year exhibit): <ul style="list-style-type: none"> (i) For each non-rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change from 	
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		<p>the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission.</p> <p>(ii) For each rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change for each renewal cohort from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission. (Example: the rate submission includes new rate tables for third and fourth quarter 2013 and first and second quarter 2014. Rates are for 12 month periods. Show the rates for the third quarter 2012, the proposed rates for the third quarter 2013, and the dollar and percentage change from third quarter 2012 to the proposed third quarter 2013 rates. Show a similar table for the proposed fourth quarter 2013, and first and second quarter 2014 rates as well.)</p> <p>d. Discuss the standard premium development used in Standard Exhibit 7. See discussion above on Standard Exhibit 7.</p> <p>e. Discuss the source data used to develop the projected incurred claims for the renewal rate applicability period.</p> <p>(i) If the source data is actual claims experience, the experience period is to be at least 12 months long, and the unpaid claim reserve is to be based on at least 3 months of claims run-out beyond the end of the experience period.</p> <p>(ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data.</p> <p>(iii) Discuss the credibility of such source data.</p> <p>(iv) Include an exhibit showing the source data and indicate all adjustments made to this source data to develop the projected incurred claims for the renewal rate applicability period. Provide this detail for each non-rolling rate table included in the rate filing, and/or for the first rate table of each rolling rate structure included in the rate filing (for base medical rate tables and for rider rate tables) for each permitted aggregation of policy forms (i.e., rating pool). Provide justification for each such adjustment.</p> <p>f. Indicate the assumed annualized claim trend projection factors used to project the source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure) for each product within each permitted policy form aggregation (i.e., rating pool).</p> <p>(i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend.</p>	
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		<ul style="list-style-type: none"> (ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components. (iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period. <p>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</p> <ul style="list-style-type: none"> (i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for a rolling rate structure, how the percentage change from the existing 2nd quarter 2013 rate table to the proposed 3rd quarter 2013 rate table was developed for each rating element in the proposed rate table.) This demonstration must clearly show how the proposed rate change was developed from the projected source data, current rate level, and expected loss ratio. Provide justification for the percentage change proposed. (ii) For each subsequent rate table of a rolling rate structure, show how the change between each of the successive rate tables was developed (e.g., the change from the 3rd quarter 2013 rate table to the 4th quarter 2013 rate table). Provide justification for these changes between the rolling rate tables. (iii) Clearly show how the proposed rate development, as applicable, reflects recoveries from the standard direct pay and Healthy New York stop loss pools (New York Insurance Law Sections 4321-a, 4322-a, and 4327), and discuss how the recovery amounts used were developed. (iv) Clearly show how the proposed rate development, as applicable, reflects payments to, or receipts from, the Department Regulation 146 (11 NYCRR 361) and New York Insurance Law Section 3233 marketing stabilization pool. Clearly discuss how the corporation has been complying with 11 NYCRR 361 (Regulation 146), Section 361.6(g), and include in the rate application any new plan pursuant to Section 361.6(g)(2)(i). Such discussion should include an exhibit showing how all monies received from the Regulation 146 pool from calendar years 2007 to date have been used to benefit consumers pursuant to the requirements of Section 361.6(g). (v) Discuss if the source data includes any very large claims on an individual, how such large claims have been handled, and any internal mechanism to pool large claims across more than the rating pool that contained the large claim. Clearly show how the rate development, if applicable, reflects this internal mechanism 	
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		<p>for pooling large claims.</p> <ul style="list-style-type: none">h. If the percentage rate change by benefit option differs within a particular policy form (or rider form), include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option. Any assumed variation in utilization by benefit option within a particular policy form (or rider form) must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the policy form, and cannot be based on differences due to age, sex, health status or industry among the members selecting the different benefit options.i. If the percentage rate change by policy form differs within a permitted aggregation of policy forms, include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options among the aggregated policy forms, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option within the aggregated policy forms. Any assumed variation in utilization between policy forms within a permitted aggregation of policy forms must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the permitted aggregation of policy forms, and cannot be based on differences due to age, sex, health status or industry among the members selecting a particular benefit option within the aggregated policy forms.j. If the percentage rate change by rating region differs, the default assumption is that the rating regions are not aggregated for rate setting purposes. In order for a company to claim that certain rating regions are aggregated for rate setting purposes, it is necessary to include an actuarial demonstration that the rate changes were developed assuming the same insured population in each of the aggregated rating regions, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members in each of the aggregated rating regions.k. Discuss any significant change in the non claim expense components indicated on Standard Exhibit 2 between the prior rate adjustment filing and this rate adjustment filing, including any item where the \$mpm value exceeds \$1 and where the \$mpm value changed by more than 10% between the prior filing and the current filing. Discuss the source for the non-claim expense components indicated on Standard Exhibit 2 for the current rate filing and, for the percentage of gross premium values, how the proposed rate change was reflected in the development of those percentage of gross premium factors (e.g., as premiums increase the	
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		percentage of premium should decrease for an expense that is not directly tied to premium). Discuss any revision to the expense allocation basis that has occurred since the last rate adjustment filing.	
Minimum Loss Ratio Requirements	§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)	<ul style="list-style-type: none"> a. The minimum loss ratio for community rated products, other than the official Medicare Supplemental products, is as specified in Section 3231(e)(1)(B) or 4308(c)(3)(A) of the New York Insurance Law, as amended by Chapter 107 of the Laws of 2010. b. The minimum loss ratio for the official Medicare Supplemental products is: <ul style="list-style-type: none"> (i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance Law, as amended by Chapter 107 of the Laws of 2010; and (ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52). 	<p>Supporting Documentation 2-ALIC Memo.pdf</p> <p>Rate/Rule Schedule ALIC Rate Manual.pdf</p>
Actuarial Certification	11NYCRR 52.40(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 incorporated into the proposed rate tables meets the minimum requirement of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions. Specify the expected loss ratio incorporated into the proposed rate tables for each permitted aggregation of policy forms within each permitted aggregation of rating regions. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	<p>Supporting Documentation 2-ALIC Memo.pdf</p>
REVISED RATE MANUAL PAGES	11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)	<p>Rate Manual.</p> <ul style="list-style-type: none"> a. Table of contents. b. Rate pages, including a page indicating the composition of each rating region. c. Insurer/corporation name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts, as applicable. g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual, to the extent applicable. j. Expected loss ratio(s). 	<p>Rate/Rule Schedule ALIC Rate Manual.pdf</p>

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<p>NOTICES TO POLICYHOLDERS Initial & Final</p>	<p>§3231(e)(1)(A) §4308(c)(2) Circular Letter No. 12 (2011)</p>	<p>a. As indicated in Circular Letter No. 12 (2011), a draft of the initial notice should be submitted for review by the Department prior to the rate adjustment submission. This draft should be submitted via SERFF using the “Prior Approval Prefiling” filing type code. (It is strongly recommended that the company also include a draft of the Narrative Summary in this pre-filing submission.)</p> <p>b. Include with the rate adjustment filing a sample copy of the initial written notice sent to policyholders and subscribers/contract holders of the proposed rate adjustment submitted to the Department of Financial Services.</p> <p>(i) Section 3231(e)(1) and Section 4308(c) of the New York Insurance Law require that the initial notice be sent on or before the date the rate application is submitted to the Department.</p> <p>(ii) If different notices are used for different products or different rating regions, submit a sample for each such product and/or each such rating region.</p> <p>c. Include with the rate adjustment filing a sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.</p>	<p>Supporting Documentation SG Plan Sponsor Proposed Rate Filing Notification REVISED 726.pdf</p> <p>SG Plan Subscriber Proposed Rate Filing Notification REVISED 726.pdf</p> <p>2013 NY Subscriber Letter TRAD Approved Rate Notice.pdf</p> <p>NY PS Letter-SG Customer ALL PLANS.pdf</p> <p>NY SUBSCRIBER SUMMARY OF RENEWAL RATES 2.pdf</p>
<p>HHS PRELIMINARY JUSTIFICATION PARTS I AND II</p>	<p>PPACA §1003</p>	<p>a. For every rate submission pursuant to section 3231(e)(1) or section 4308(c) of the New York Insurance Law, the insurer is to submit Parts I and II of the U.S. Department of Health and Human Services (HHS) Preliminary Justification, whether or not such justification material is required to be submitted to HHS.</p> <p>b. This requirement applies to large group community rated products as well as to small group and individual products, and to non-grandfathered and grandfathered products, but this requirement does not apply to a product type that would never require such justification material to be submitted to HHS (for example: Medicare Supplemental products, stand-alone dental products).</p> <p>c. The justification material is to be prepared using the template and instructions provided by HHS.</p>	<p>N/A</p>
<p>PUBLIC DISCLOSURE OF THE RATE APPLICATION</p>		<p>Posting a Redacted Version of the Rate Adjustment Application to the Department’s Website.</p> <p>a. A redacted version of this rate application will be posted to the Department’s website to aid consumers’ understanding of the reason(s) for the requested rate change(s).</p> <p>b. The Department will accept redaction of only the following information in the rate application:</p> <p>(i) personally identifiable information, including names and contact information of actuaries or other individuals, including those who work for the health plan, a consulting firm, or the Department, that are contained in the application; and</p> <p>(ii) information that identifies in reasonably precise terms specific provider</p>	<p>N/A</p>

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		<p>reimbursement rates contained in contracts between the health plan and a particular provider or formally affiliated provider group. Information that discloses trend, even specific trend, will <i>not</i> qualify for redaction. For example, if an insurer has a single pharmacy benefit manager (PBM), information about generic, brand and specialty drug costs per member will be disclosed. However, information about per unit dispensing fees paid to the PBM, or the level of rebates received, may be redacted.</p> <p>c. In order to expedite the posting of the redacted application to the Department’s website, the company is to attach within SERFF as a PDF file the redacted version of each document submitted with the application, including the completed checklist, all of the standard exhibits, the actuarial memorandum plus any attachments or appendices, the rate manuals and year over year exhibits, as well as any other documentation submitted. A redacted attachment/file should be clearly labeled as a redacted version.</p> <p>d. The redacted version of the application that will be posted to the Department’s website will be constructed by the Department and will not be submitted to the insurer for prior review. <i>Where a document is attached to SERFF without a clearly labeled redacted version in PDF format, it will be assumed that no redactions are requested and the unredacted version of the document will be posted to the website as filed.</i></p>	
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Small Group Underwriting
3 Independence Way, Suite 400
Princeton, NJ 08540

<Date>

<Subscriber first> <Subscriber last>

<Address>

<City>, <ST> <ZIP>

<Group ID>

Dear Aetna Member:

Notice of approved rate increase

We may have previously sent you notice of a proposed rate increase that we filed with the New York Department of Financial Services (formerly the New York State Insurance Department) for your **Small Group plan** offered by Aetna Life Insurance Company. Your final rate increase for the plan included with this renewal is shown on the attached renewal rate exhibit.

We've attached a summary of renewal rates

The resulting monthly premium charge to your employer is shown in the attached summary of renewal rates. Your employer determines how much you contribute towards these premium amounts. These monthly premiums will be effective <January 1, 2013>.

While we try to give you the most accurate information possible, your final rate may differ, based on the enrollment census, benefits plan design and other features your employer selects upon renewal.

What you need to do next

If you have questions about your contribution amounts (e.g., payroll deductions), please feel free to contact Member Services at the number located on your ID card. Plan representatives are available to assist you from 8 a.m. to 5 p.m. You may also contact us by logging into Aetna Navigator™, our secure member website at www.aetna.com, or call us at 1-888-802-3862.

Thank you for choosing us for your health insurance needs.

Enclosure: Summary of renewal rates



Small Group Underwriting
3 Independence Way, Suite 400
Princeton, NJ 08540

<Date>

<Plan sponsor first> <Plan sponsor last>

<Title>

<Company Name>

<Address>

<City>, <ST> <ZIP>

<Group ID>

Attention New York Plan Sponsor:

Notice of approved rate increase

We may have previously sent you notice of a proposed rate increase that we filed with the New York Department of Financial Services (formerly the New York State Insurance Department) for your Small Group plan(s) offered by Aetna Health Inc., Aetna Health Insurance Company of New York, and Aetna Life Insurance Company. Your final rate increase for the plan included with this renewal is shown on the attached renewal rate exhibit.

We've attached a summary of renewal rates

The resulting monthly premium is shown in the attached summary of renewal rates. The summary includes current monthly rates, renewal rates and the percentage change between the two, and the effective date of the rate change.

While we try to give you the most accurate information possible, your final rate may differ, based on the enrollment census, benefits plan design and other features you select upon renewal.

What you need to do next

Many factors are considered in the request and approval of health insurance premium rates. You have the right to shop around.

If you choose to continue your Aetna coverage, there's nothing you need to do now. We will include the new rates in your renewal bill.

For more information, please contact your insurance broker of record. If you do not use a broker, contact our Renewal Specialist Team at 1-888-277-1053 (option 5). We can review your approved rate or help you explore other health insurance options.

Thank you for choosing us for your health insurance needs.

Enclosure: Subscriber letter

Aetna Small Business Health Plan Options Summary of Renewal Rates

<Rating areas listed>

RATES EFFECTIVE <00/00/00 - 00/00/00>

Plan Options	Current Monthly Premium - Pharmacy Plan \$15/\$35/\$70 Mail Order: \$30/\$70/\$140					
	Single:	Employee/ Spouse:	Parent/Child (26 dep age):	Family (26 dep age):	Parent/Child (30 dep age):	Family (30 dep age):
<Plan Name>	<\$0.00>	<\$0.00>	<\$0.00>	<\$0.00>	<\$0.00>	<\$0.00>

RATES EFFECTIVE <00/00/00 - 00/00/00>

Plan Options	Renewal Monthly Premium - Pharmacy Plan \$15/\$35/\$70 Mail Order: \$30/\$70/\$140					
	Single:	Employee/ Spouse:	Parent/Child (26 dep age):	Family (26 dep age):	Parent/Child (30 dep age):	Family (30 dep age):
<Plan Name>	<\$0.00>	<\$0.00>	<\$0.00>	<\$0.00>	<\$0.00>	<\$0.00>

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Health Inc., Aetna Health Insurance Company of New York, Aetna Life Insurance Company and its affiliates (Aetna).

(Rating Area <00 - Plan)

14.32.339.1-NY

Per the instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY.
The other cells are auto-populated.

A. Base Period Data

Start Period: 02/01/2011 End Period: 01/31/2012

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	331,598	\$ 26,986,609.87	\$ 24,043,384.82	\$ 2,943,225.05	\$ 8.88	\$ 72.51	\$ 81.38
Outpatient	331,598	\$ 13,735,026.89	\$ 9,489,777.07	\$ 4,245,249.82	\$ 12.80	\$ 28.62	\$ 41.42
Professional	331,598	\$ 41,026,366.76	\$ 26,639,195.13	\$ 14,387,171.63	\$ 43.39	\$ 80.34	\$ 123.72
Prescription Drugs	331,598	\$ 29,379,911.41	\$ 22,574,447.02	\$ 6,805,464.39	\$ 20.52	\$ 68.08	\$ 88.60
Other	331,598	\$ 37,613,548.76	\$ 27,704,393.25	\$ 9,909,155.51	\$ 29.88	\$ 83.55	\$ 113.43
Capitation	331,598	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Total	331,598	\$ 148,741,463.69	\$ 110,451,197.29	\$ 38,290,266.40	\$ 115.47	\$ 333.09	\$ 448.56

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 01/01/2012 End Period: 12/31/2012

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.1022	\$ 89.70	\$ 78.37	0.1262
Outpatient	1.1022	\$ 45.65	\$ 30.93	0.3224
Professional	1.1022	\$ 136.37	\$ 86.84	0.3632
Prescription Drugs	1.1022	\$ 97.65	\$ 73.59	0.2465
Other	1.1022	\$ 125.02	\$ 90.31	0.2777
Capitation	1.1022	\$ 0.00	\$ 0.00	0.0000
Total		\$ 494.39	\$ 360.04	0.27

B2. Claims Projection for Future Rate

Start Period: 01/01/2013 End Period: 12/31/2013

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.1123	\$ 99.77	\$ 87.73	0.1207
Outpatient	1.1123	\$ 50.78	\$ 34.63	0.3181
Professional	1.1123	\$ 151.68	\$ 97.20	0.3592
Prescription Drugs	1.1123	\$ 108.62	\$ 82.37	0.2417
Other	1.1123	\$ 139.06	\$ 101.09	0.2731
Capitation	1.1123	\$ 0.00	\$ 0.00	0.0000
Total		\$ 549.92	\$ 403.02	0.27

B3. Medical Trend Breakout

Factor	Impact
Utilization	46.9227%
Unit Cost	35.2634%
Other Factors	17.8138%

C. Components of Current and Future Rates

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 403.02	85.06%	\$ 378.96	92.91%	\$ 24.07	36.48%
2. Administrative Costs	\$ 65.66	13.86%	\$ 50.60	12.41%	\$ 15.06	22.83%
3. Underwriting Gain/Loss	\$ 5.14	1.08%	\$ (21.71)	-5.32%	\$ 26.84	40.69%
4. Total Rate	\$ 473.82	100.00%	\$ 407.86	100.00%	\$ 65.97	100.00%
5. Overall Rate Increase		16.17%				

D. Components of Rate Increase

Claims Components	Impact on Rate	Percent
1. Inpatient	\$ 8.80	36.58%
2. Outpatient	\$ 3.47	14.44%
3. Professional	\$ 9.75	40.53%
4. Prescription Drugs	\$ 8.27	34.35%
5. Other	\$ 10.14	42.15%
6. Capitation	\$ 0.00	0.00%
7. Cost Share	\$ 2.54	10.57%
8. Correction of Prior Net Claims Estimate	\$ (18.92)	-78.61%
9. Total	\$ 24.07	100.00%
Claims Restatement for Current Rate Period		
8.a. Prior Net Claims Estimate for Current Rate Period	\$ 378.96	
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 360.04	

E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	New Form	Requested	Implemented
2012	N	10.7812%	7.0669%
2011	N	9.2377%	8.9018%
2010	N	0.3322%	0.3322%

F. Range and Scope of Proposed Increase

Number of Covered Individuals	29,636	Threshold Rate Increase	13.5203%
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Range of Rate Increase	
Minimum % Increase	12.7049%
Maximum % Increase	16.8296%

State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Attachment RateSummaryTemplate-NY SG ALIC 1Q13.xls is not a PDF document and cannot be reproduced here.

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Aetna Life Insurance Company</u> Company submitting the rate adjustment request 151 Farmington Ave. <u>Hartford, CT 06156</u> Company mailing address	<u>A&H - 42</u> Company Type	<u>For Profit</u> Org. Type	<u>60054</u> Company NAIC Code
B.	Contact Person: <u>Caitlyn Prescott, Sr. Actuarial Consultant</u> Rate filing contact person name, title	<u>(860) 273-0159</u> Contact phone number	<u>PrescottC@aetna.com</u> Contact Email address	
C.	Actuarial Contact (If different from above): <u>Xiaoping Hu, Actuary</u> Actuary name, title	<u>(215) 775-6739</u> Actuary phone number	<u>HuX@aetna.com</u> Actuary Email address	
D.	New Rate Information (See Note #1): <u>January 1, 2013 to December 31, 2013</u> New rate applicability period	_____ New rate effective date	<u>01/01/2013</u>	<u>AETN-128494178</u> SERFF Tracking Number
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): <u>Small Group</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>No</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>All Small Group NY policyholders. Notification sent August 24, 2012</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</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>Yes, AETN-128589860; State Tracking Number: 2012070203</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.

State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

Attachment Standard_Exhibit_1_ALIC 1q13-4q13.xls is not a PDF document and cannot be reproduced here.

EXHIBIT 2: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT AND PRIOR RATE ADJUSTMENT FILINGS

Company Name: Aetna Life Insurance Company

NAIC Code: 60054

SERFF Number: AETN-128494178

		Data Item for Specified Rating Pool																												
		For the period included in this rate adjustment filing																												
1. Market Segment	2. Description of rating pool within the market segment	3. Period assumed - beginning date (MM/DD/YYYY)	4. Period assumed - ending date (MM/DD/YYYY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
SG	ALIC	01/01/13	12/31/13	11.20%	0.13%	0.59%	7.12%	1.60%	0.00%	3.76%	13.20%	2.97%	0.01%	0.225%	1.60%	35.00%	-1.26%	16.52%	0.71	3.19	38.39	8.64	0.00	20.28	71.21	16.00	0.06	8.64	-6.79	89.12

EXHIBIT 2: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT AND PRIOR RATE ADJUSTMENT FILINGS

		Data Item for Specified Rating Pool																												
		For the rate period included in the immediately prior rate adjustment filing (or initial form & rate filing)																												
1. Market Segment	18. Period assumed - beginning date (MM/DD/YYYY)	19. Period assumed - ending date (MM/DD/YYYY)	20. Average annual claim trend assumed	21.1 Regulatory authority licenses and fees, including New York State 332 assessment	21.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	21.3 Commissions and broker fees - as a % of gross premium	21.4 Premium Taxes - as a % of gross premium	21.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	21.6 Other administrative expenses as a % of gross premium	21.7 Subtotal columns 21.1 through 21.6	22. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	23. State income tax component as a % of gross premium	23.1 State income tax rate assumed (eg 3%)	24. Federal income tax component - as a % of gross premium	24.1 Federal income tax rate assumed (eg 30%)	25. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	26. Subtotal lines 21.7 + 22 + 23 + 24 + 25	27.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	27.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	27.3 Commissions and broker fees - as \$mpm	27.4 Premium Taxes - as \$mpm	27.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	27.6 Other administrative expenses as \$mpm	27.7 Subtotal lines 27.1 through 27.6	28. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	29. State income tax component - as \$mpm	30. Federal income tax component - as \$mpm	31. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	32. Subtotal columns 27.7 through 31	
SG	XX	01/01/12	12/31/12	11.20%	0.13%	0.59%	7.12%	1.60%	0.00%	3.76%	13.20%	3.43%	0.01%	0.225%	1.85%	35.00%	-1.26%	17.23%	0.63	2.85	34.35	7.74	0.00	18.15	63.73	16.54	0.06	8.94	(6.08)	83.18

State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

Attachment Standard_Exhibit_2_ALIC 1q13-4q13.xls is not a PDF document and cannot be reproduced here.

EXHIBIT 4 - PART B: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

-- for Base Medical Plan with ROLLING Rate Structure

Aetna Life Insurance Company
Company submitting the rate adjustment request

60054
Company NAIC Code

AETN-128494178
SERFF tracking number

- => Use this Exhibit for the base medical plan type policy forms/products with ROLLING rate structure that are included in the rate adjustment submission.
- => This form must be submitted as an Excel file and as a PDF file.
- => The format of this exhibit is discussed below. Insert more rows as needed. Only use the first tab for data entry.
- =>
 - Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan.
- => The effective date is the earliest date that the proposed new rate would become effective if approved. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure.)
- => The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- => Provide a list of proposed rate changes for each base medical plan type, by product name/street name. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => The "proposed rate change" is just for the base medical product, excluding the impact of any riders.
 - Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
 - Highest should be the largest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
 - The weighted average should reflect the average using the distribution of contracts within each base medical product; the impact of riders is not included.

Base Medical Plan Rolling Rate Products

SERFF# AETN-128494178

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Proposed Percentage Rate Change		
							Lowest	Highest	Weighted Avg
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12	NY OA MC 3	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12	NY OA MC 4	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible	NY OA MC 3 HSA Compatible	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12	NY OA EPO 1	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12	NY OA EPO 2	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12	NY OA EPO 3	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12	NY OA EPO 4	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12	NY OA EPO 5	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12	NY OA EPO 6	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 HSA Compatible	NY OA EPO 3 HSA Compatible	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 MHP	NY OA MC 3 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12 MHP	NY OA MC 4 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12	NY Indemnity 1	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	01/01/2013	Jan - Mar 2013	11.39%	11.39%	11.39%

Base Medical Plan Rolling Rate Products

SERFF# AETN-128494178

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Proposed Percentage Rate Change		
							Lowest	Highest	Weighted Avg
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12	NY OA EPO 4	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12	NY OA EPO 5	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12	NY OA EPO 6	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible	NY OA EPO 5 HSA Compatible	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 MHP	NY OA MC 3 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12 MHP	NY OA MC 4 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12	NY Indemnity 1	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible MHP	NY OA EPO 2 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible MHP	NY OA EPO 4 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	13.74%	13.74%	13.74%

EXHIBIT 4 - PART B: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

-- for Base Medical Plan with ROLLING Rate Structure

Aetna Life Insurance Company
Company submitting the rate adjustment request

60054
Company NAIC Code

- => Use this Exhibit for the base medical plan type policy forms/products with ROLLING rate structure that are included in the rate adjustment submission.
- => This form must be submitted as an Excel file and as a PDF file.
- => The format of this exhibit is discussed below. Insert more rows as needed. Only use the first tab for data entry.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan.
- => The effective date is the earliest date that the proposed new rate would become effective if approved. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure.)
- => The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- => Provide a list of proposed rate changes for each base medical plan type, by product name/street name. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => The "proposed rate change" is just for the base medical product, excluding the impact of any riders.
 - Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
 - Highest should be the largest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
 - The weighted average should reflect the average using the distribution of contracts within each base medical product; the impact of riders is not included.

Base Medical Plan Rolling Rate Products

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Rate Change due Solely to Added Benefits
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12	NY OA MC 3	01/01/2013	Jan - Mar 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12	NY OA MC 4	01/01/2013	Jan - Mar 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible	NY OA MC 3 HSA Compatible	01/01/2013	Jan - Mar 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12	NY OA EPO 1	01/01/2013	Jan - Mar 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12	NY OA EPO 2	01/01/2013	Jan - Mar 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12	NY OA EPO 3	01/01/2013	Jan - Mar 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12	NY OA EPO 4	01/01/2013	Jan - Mar 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12	NY OA EPO 5	01/01/2013	Jan - Mar 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12	NY OA EPO 6	01/01/2013	Jan - Mar 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible	NY OA EPO 5 HSA Compatible	01/01/2013	Jan - Mar 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 MHP	NY OA MC 3 MHP	01/01/2013	Jan - Mar 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12 MHP	NY OA MC 4 MHP	01/01/2013	Jan - Mar 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	01/01/2013	Jan - Mar 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	01/01/2013	Jan - Mar 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	01/01/2013	Jan - Mar 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	01/01/2013	Jan - Mar 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	01/01/2013	Jan - Mar 2013	2.12%

Base Medical Plan Rolling Rate Products

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Rate Change due Solely to Added Benefits
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	01/01/2013	Jan - Mar 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	01/01/2013	Jan - Mar 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	01/01/2013	Jan - Mar 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12	NY Indemnity 1	01/01/2013	Jan - Mar 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	01/01/2013	Jan - Mar 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	01/01/2013	Jan - Mar 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	01/01/2013	Jan - Mar 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible MHP	NY OA EPO 2 HSA Compatible MHP	01/01/2013	Jan - Mar 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible MHP	NY OA EPO 4 HSA Compatible MHP	01/01/2013	Jan - Mar 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12	NY OA MC 3	04/01/2013	Apr - Jun 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12	NY OA MC 4	04/01/2013	Apr - Jun 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible	NY OA MC 3 HSA Compatible	04/01/2013	Apr - Jun 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12	NY OA EPO 1	04/01/2013	Apr - Jun 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12	NY OA EPO 2	04/01/2013	Apr - Jun 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12	NY OA EPO 3	04/01/2013	Apr - Jun 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12	NY OA EPO 4	04/01/2013	Apr - Jun 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12	NY OA EPO 5	04/01/2013	Apr - Jun 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12	NY OA EPO 6	04/01/2013	Apr - Jun 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible	NY OA EPO 5 HSA Compatible	04/01/2013	Apr - Jun 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 MHP	NY OA MC 3 MHP	04/01/2013	Apr - Jun 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12 MHP	NY OA MC 4 MHP	04/01/2013	Apr - Jun 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	04/01/2013	Apr - Jun 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	04/01/2013	Apr - Jun 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	04/01/2013	Apr - Jun 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	04/01/2013	Apr - Jun 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	04/01/2013	Apr - Jun 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	04/01/2013	Apr - Jun 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	04/01/2013	Apr - Jun 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	04/01/2013	Apr - Jun 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12	NY Indemnity 1	04/01/2013	Apr - Jun 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	04/01/2013	Apr - Jun 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	04/01/2013	Apr - Jun 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	04/01/2013	Apr - Jun 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible MHP	NY OA EPO 2 HSA Compatible MHP	04/01/2013	Apr - Jun 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible MHP	NY OA EPO 4 HSA Compatible MHP	04/01/2013	Apr - Jun 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12	NY OA MC 3	07/01/2013	Jul - Sep 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12	NY OA MC 4	07/01/2013	Jul - Sep 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible	NY OA MC 3 HSA Compatible	07/01/2013	Jul - Sep 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12	NY OA EPO 1	07/01/2013	Jul - Sep 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12	NY OA EPO 2	07/01/2013	Jul - Sep 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12	NY OA EPO 3	07/01/2013	Jul - Sep 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12	NY OA EPO 4	07/01/2013	Jul - Sep 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12	NY OA EPO 5	07/01/2013	Jul - Sep 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12	NY OA EPO 6	07/01/2013	Jul - Sep 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible	NY OA EPO 5 HSA Compatible	07/01/2013	Jul - Sep 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 MHP	NY OA MC 3 MHP	07/01/2013	Jul - Sep 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12 MHP	NY OA MC 4 MHP	07/01/2013	Jul - Sep 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	07/01/2013	Jul - Sep 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	07/01/2013	Jul - Sep 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	07/01/2013	Jul - Sep 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	07/01/2013	Jul - Sep 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	07/01/2013	Jul - Sep 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	07/01/2013	Jul - Sep 2013	2.12%

Base Medical Plan Rolling Rate Products

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Rate Change due Solely to Added Benefits
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	07/01/2013	Jul - Sep 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	07/01/2013	Jul - Sep 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12	NY Indemnity 1	07/01/2013	Jul - Sep 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	07/01/2013	Jul - Sep 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	07/01/2013	Jul - Sep 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	07/01/2013	Jul - Sep 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible MHP	NY OA EPO 2 HSA Compatible MHP	07/01/2013	Jul - Sep 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible MHP	NY OA EPO 4 HSA Compatible MHP	07/01/2013	Jul - Sep 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12	NY OA MC 3	10/01/2013	Oct - Dec 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12	NY OA MC 4	10/01/2013	Oct - Dec 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible	NY OA MC 3 HSA Compatible	10/01/2013	Oct - Dec 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12	NY OA EPO 1	10/01/2013	Oct - Dec 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12	NY OA EPO 2	10/01/2013	Oct - Dec 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12	NY OA EPO 3	10/01/2013	Oct - Dec 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12	NY OA EPO 4	10/01/2013	Oct - Dec 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12	NY OA EPO 5	10/01/2013	Oct - Dec 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12	NY OA EPO 6	10/01/2013	Oct - Dec 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible	NY OA EPO 5 HSA Compatible	10/01/2013	Oct - Dec 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 MHP	NY OA MC 3 MHP	10/01/2013	Oct - Dec 2013	1.88%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 4-12 MHP	NY OA MC 4 MHP	10/01/2013	Oct - Dec 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	2.34%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	10/01/2013	Oct - Dec 2013	1.77%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	10/01/2013	Oct - Dec 2013	1.99%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	10/01/2013	Oct - Dec 2013	1.91%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	10/01/2013	Oct - Dec 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	10/01/2013	Oct - Dec 2013	2.12%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	10/01/2013	Oct - Dec 2013	2.21%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	2.72%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12	NY Indemnity 1	10/01/2013	Oct - Dec 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	10/01/2013	Oct - Dec 2013	2.20%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	10/01/2013	Oct - Dec 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	10/01/2013	Oct - Dec 2013	2.46%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 2-12 HSA Compatible MHP	NY OA EPO 2 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	2.14%
GR-STATHCRGrp 01 NY	SG	ALL	NY OA EPO 4-12 HSA Compatible MHP	NY OA EPO 4 HSA Compatible MHP	10/01/2013	Oct - Dec 2013	2.46%

State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

Attachment Standard_Exhibit_4B_ALIC 1q13-4q13.xls is not a PDF document and cannot be reproduced here.

EXHIBIT 5 - PART B: DISTRIBUTION OF CONTRACTS AFFECTED BY PROPOSED RATE ADJUSTMENTS for ROLLING Rate Structured Products

Company Name: Aetna Life Insurance Company
 NAIC Code: 60054
 SERFF Tracking #: AETN-128494178

Instructions:

- 1) The percentage rate change reflects the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
- 2) The effective date is the earliest date that the proposed new rate would become effective if approved. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure)
- 3) The distribution is by number of members or number of contracts. The Company should fill in the appropriate column below (members or contracts) and replace the mm/dd/yy placeholder with the applicable as of date.
- 4) The Weighted Average Percentage should be developed based on the distribution of contracts or members for that market segment/product and for the market segment in total.
- 5) Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- 6) Under each market segment, the table should provide the distribution by broad product type (e.g., HMO, POS, EPO, PPO, Indemnity, High Deductible/Consumer Driven, Medicare Supplement, etc.).
- 7) Provide distribution information for each rolling rate cohort of a rolling rate structure contract affected by this rate submission (e.g., by quarter of renewal for a quarterly rolling rate structure).
- 8) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
- 9) After each effective period/market segment combination there should be a market segment total row. Enter Total in the "Product" column, the sum of the counts in the various columns, and the market segment weighted avg %.
- 10) This exhibit must be submitted as an Excel file and a PDF file.

FOR ROLLING RATE STRUCTURE PRODUCTS - Distribution of Rolling Rate Contracts by Proposed Rate Adjustment by Each Rolling Rate Cohort

SERFF#: AETN-128494178

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of mm/dd/yyyy	Total # of Contracts as of mm/dd/yyyy	Number of (*) with Proposed Percentage Rate Change at Renewal												
								Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher		
								01/01/2013	Jan - Mar 2013	SG	RA01-RA12, RA14-RA15	MC	11.4%	N/A	2,806	0	0	0	0	2,806
01/01/2013	Jan - Mar 2013	SG	RA01-RA12, RA14-RA15	EPO	11.4%	N/A	2,457	0	0	0	0	2,457	0	0	0	0	0	0	0	0
01/01/2013	Jan - Mar 2013	SG	RA01-RA12, RA14-RA15	Indemnity		N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0
01/01/2013	Jan - Mar 2013	SG	RA01-RA12, RA14-RA15	HSA	11.4%	N/A	1,025	0	0	0	0	1,025	0	0	0	0	0	0	0	0
01/01/2013	Jan - Mar 2013	Market Segm			11.4%	N/A	6,288	0	0	0	0	6,288	0	0	0	0	0	0	0	0

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of mm/dd/yyyy	Total # of Contracts as of mm/dd/yyyy	Number of (*) with Proposed Percentage Rate Change at Renewal												
								Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher		
								04/01/2013	Apr - Jun 2013	SG	RA01-RA12, RA14-RA15	MC	11.1%	N/A	2,016	0	0	0	0	2,016
04/01/2013	Apr - Jun 2013	SG	RA01-RA12, RA14-RA15	EPO	11.1%	N/A	1,376	0	0	0	0	1,376	0	0	0	0	0	0	0	0
04/01/2013	Apr - Jun 2013	SG	RA01-RA12, RA14-RA15	Indemnity		N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0
04/01/2013	Apr - Jun 2013	SG	RA01-RA12, RA14-RA15	HSA	11.1%	N/A	568	0	0	0	0	568	0	0	0	0	0	0	0	0
04/01/2013	Apr - Jun 2013	Market Segm			11.1%	N/A	3,960	0	0	0	0	3,960	0	0	0	0	0	0	0	0

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of mm/dd/yyyy	Total # of Contracts as of mm/dd/yyyy	Number of (*) with Proposed Percentage Rate Change at Renewal												
								Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher		
								07/01/2013	Jul - Sep 2013	SG	RA01-RA12, RA14-RA15	MC	10.7%	N/A	1,429	0	0	0	0	1,429
07/01/2013	Jul - Sep 2013	SG	RA01-RA12, RA14-RA15	EPO	10.7%	N/A	936	0	0	0	0	936	0	0	0	0	0	0	0	0
07/01/2013	Jul - Sep 2013	SG	RA01-RA12, RA14-RA15	Indemnity		N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0
07/01/2013	Jul - Sep 2013	SG	RA01-RA12, RA14-RA15	HSA	10.7%	N/A	478	0	0	0	0	478	0	0	0	0	0	0	0	0
07/01/2013	Jul - Sep 2013	Market Segm			10.7%	N/A	2,843	0	0	0	0	2,843	0	0	0	0	0	0	0	0

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of mm/dd/yyyy	Total # of Contracts as of mm/dd/yyyy	Number of (*) with Proposed Percentage Rate Change at Renewal												
								Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher		
								10/01/2013	Oct - Dec 2013	SG	RA01-RA12, RA14-RA15	MC	13.7%	N/A	1,667	0	0	0	0	1,667
10/01/2013	Oct - Dec 2013	SG	RA01-RA12, RA14-RA15	EPO	13.7%	N/A	1,053	0	0	0	0	1,053	0	0	0	0	0	0	0	0
10/01/2013	Oct - Dec 2013	SG	RA01-RA12, RA14-RA15	Indemnity		N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10/01/2013	Oct - Dec 2013	SG	RA01-RA12, RA14-RA15	HSA	13.7%	N/A	681	0	0	0	0	681	0	0	0	0	0	0	0	0
10/01/2013	Oct - Dec 2013	Market Segm			13.7%	N/A	3,401	0	0	0	0	3,401	0	0	0	0	0	0	0	0

State: New York**Filing Company:** Aetna Life Insurance Company**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other**Product Name:** NY SG ALIC 1q13 to 4q13**Project Name/Number:** NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

Attachment Standard_Exhibit_5B_ALIC 1q13-4q13.xls is not a PDF document and cannot be reproduced here.

Attachment Standard_Exhibit_6_ALIC 1q13-4q13.xls is not a PDF document and cannot be reproduced here.

EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: Aetna Life Insurance Company

NAIC Code: 60054

SERFF Number: AETN-128494178

Instructions:

- This Exhibit summarizes all benefit/rate changes filed under sections other than §3231(e)(1)/4308(c) that impact the rate tables in this filing.
- The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- Enter filing status (approved or pending) using the drop down list. For pending files leave the approval date blank.
- Extend the worksheet to add more rows as needed. Only use the first tab for data entry.

List of rate filings that have been approved since the prior §3231(e)(1) or §4308(c) rate filing or are currently pending with the Department, which impact the rate tables in this filing.

Filing Status	SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
Approved	AENX-G127651429	2011090128	09/26/2011	GR-9N S-10-35 02,	Diagnostic X-ray and Lab	Application of different cost-sharing to x-ray and lab	01/06/2012
Approved	AENX-G128091031	2012020092	02/14/2012	GR-9N 30-015 06	PPO/Traditional	Provide more flexibility for termination of dependents coverage	04/11/2012
Approved	AENX-G127193959	2011060018	06/01/2011	GR-9N 08-029 02	PPO	Compliance with NY S 1803 (Dialysis treatment)	08/15/2011
Approved	AENX-G127384563	2011080169	08/24/2011	GR-29N -5-03 04, G	GENERAL PROVISIONS	Retroactive terminations and premium rebate allocations	12/01/2011
Approved	AENX-G127877968	2011120064	12/08/2011	GR-9N 32-005 03	PPO/Traditional	Adds HRC required rescission	01/12/2012
Approved	AENX-G127181527	2011050189	05/23/2011	GR-9N 31-020 02, G	PPO/Traditional	Revises extension of benefits provision	08/24/2011
Approved	AENX-G127877968	2011120064	12/08/2011	GR-9N-APPEALS 0	Grievances and Appeals	To comply with NY law and HCR	01/10/2012
Approved	AENX-G128173319	2012030128	03/15/2012	GR-9N 13-010 04	Pharmacy	List of drugs that require precertification	05/30/2012

State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

Attachment Standard_Exhibit_7_ALIC 1q13-4q13.xls is not a PDF document and cannot be reproduced here.

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

Company Name: Aetna Life Insurance Company

NAIC Code: 60054

SERFF Number: AETN-128494178

Data Item for Specified Base Medical Policy Form														
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]	8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	9. Rate guarantee period incorporated into rate tables (months) (e.g., 12, for a 12 month rate guarantee period; or 0, if no rate guarantee period.)	10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders)	11. Number of policyholders affected by rate change. (For group business this is number of groups.)	12. Number of covered lives affected by rate change	13. Expected NY statewide loss ratio for base medical policy form including associated riders
GR-STATHCRGrp 01 NY	EPO MC Indemnity	EPO MC Indemnity	SG ALIC	01/01/13	SG	EPO	Yes	No	Open	12	11.69%	3,830	29,636	82.2%

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

		Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)																					
1a. Base medical policy form number	1b. Product Name as in Rate Manual	14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period (\$)	14.5 Standardized earned premiums for experience period (\$)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	14.11 Earned premiums for experienc e period (\$mpm)	14.12 Standardiz ed premiums for experienc e period (\$mpm)	14.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	14.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	14.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	14.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	14.17 Administrativ e expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	14.18 Ratio: Col 14.7/ Col 14.4 (Incurred Claims / Standardize d Earned Premiums)	14.19 Ratio: Col 14.7/ Col 14.5 (Incurred Claims / Standardize d Earned Premiums)	14.20 Ratio:Col 14.10/ Col 14.4 (Administrat ion Expenses / Earned Premiums)	14.21 Ratio: (Col 14.8 + Col 14.9 + Col 14.10) / Col 14.4	
GR- STATHCRGrp 01 NY	EPO MC Indemnity	XX	02/01/11	01/31/12	331,598	141,644,345	163,632,335	112,825,069	114,450,739	0	(443,829)	18,696,694	427.16	493.47	340.25	345.15	0.00	(1.34)	56.38	0.808	0.699	0.132	0.937

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

		First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)																					
1a. Base medical policy form number	1b. Product Name as in Rate Manual	15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period (\$)	15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	15.11 Earned premiums for experience period (\$mpm)	15.12 Standardized premiums for experience period (\$mpm)	15.13 Paid claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	15.14 Incurred claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	15.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	15.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	15.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	15.18 Ratio: Col 15.7/ Col 15.4 (Incurred Claims / Earned Premiums)	15.19 Ratio: Col 15.7/ Col 15.5 (Incurred Claims / Standardized Earned Premiums)	15.20 Ratio: Col 15.10/ Col 15.4 (Administrative Expenses / Earned Premiums)	15.21 Ratio: (Col 15.7 + Col 15.9 + Col 15.10) / Col 15.4	
GR-STATHCRGrp 01 NY	EPO MC Indemnity	XX	02/01/10	01/31/11	438,332	172,060,487	235,763,544	159,086,276	152,638,982	0	(13,804,815)	22,711,547	392.53	537.87	362.94	348.23	0.00	(31.49)	51.81	0.887	0.647	0.132	0.939

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

		Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)																				
1a. Base medical policy form number	1b. Product Name as in Rate Manual	16.1 Beginning date of the experience period (MM/DD/Y Y)	16.2 Ending Date of the experienc e period (MM/DD/Y Y)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	16.10 Administrativ e expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.11 Earned premiums for experienc e period (\$mpm)	16.12 Standardiz ed premiums for experienc e period (\$mpm)	16.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	16.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	16.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	16.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	16.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	16.18 Ratio: Col 16.7/ Col 16.4 (Incurred Claims / Standardiz ed Earned Premiums)	16.19 Ratio: Col 16.7/ Col16.5 (Incurred Claims / Standardiz ed Earned Premiums)	16.20 Ratio:Col 16.10/ Col16.4 (Administr ation Expenses / Earned Premiums)	16.21 Ratio: (Col 16.7 + Col 16.9 + Col 16.10) /Col 16.4
GR- STATHCRGrp 01 NY	EPO MC X Indemnity X	02/01/09	01/31/10	683,572	252,241,078	436,814,086	243,451,433	240,934,284	0	(4,816,341)	33,295,182	369.00	639.02	356.15	352.46	0.00	(7.05)	48.71	0.955	0.552	0.132	1.068

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

		Annualized Medical Trend Factors Assumed in Rate Development (%)					Ratios: Most Recent Experience Period to First Prior Period						Ratios: First Prior Period to Second Prior Period						Ratio: Standard Premium to Earned Premium					
1a. Base medical policy form number	1b. Product Name as in Rate Manual	17.1 All benefits combined, composite	17.2 Due to utilization	17.3 Due to unit cost	17.4 Due to case mix/intensity/other	18.1 Member months	18.2 Earned premiums (\$pmpm)	18.3 Standardized premiums (\$pmpm)	18.4 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$pmpm)	18.5 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$pmpm)	18.6 Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) (\$pmpm)	19.1 Member months	19.2 Earned premiums (\$pmpm)	19.3 Standardized premiums (\$pmpm)	19.4 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$pmpm)	19.5 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$pmpm)	19.6 Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) (\$pmpm)	20.1 Most Recent Experience Period	20.2 First Prior Experience Period	20.3 Second Prior Experience Period				
GR-STATHCRGrp 01 NY	EPO MC Indemnity	XX	11.20%	5.08%	3.82%	1.93%	XX	0.756	1.088	0.917	0.937	0.991	1.088	XX	0.641	1.064	0.842	1.019	0.988	1.064	XX	1.155	1.370	1.732

Exhibit 7B: Development of Rate Action

	Period	Most Recent Experience
Earned Premium	02/2011-01/2012	141,644,345
Standardized Premium	To 4Q12	163,632,335
Completed Paid Claims	02/2011-01/2012	114,450,739
MSP Subsidy	02/2011-01/2012	(443,829)
MSP Adjusted Claims	02/2011-01/2012	114,006,910

	1Q13	2Q13	3Q13	4Q13
Quarterly Premium Trend	5.0%	2.7%	2.7%	2.7%
Cumulative Premium Trend	1.0500	1.0784	1.1075	1.1374
Claims Trend	1.1120	1.1120	1.1120	1.1120
Claim Trend Months	24.50	27.50	30.50	33.50
ProjPrem	171,813,952	176,452,929	181,217,158	186,110,021
ProjPaidClaims	142,150,768	145,973,965	149,899,990	153,931,606
ProjMSP%	0.5%	0.5%	0.5%	0.5%
ProjMSP	859,070	882,265	906,086	930,550
ProjMSPClaims	141,291,698	145,091,701	148,993,904	153,001,056
LossRatio	82.2%	82.2%	82.2%	82.2%
Expenses	4.5%	4.5%	4.5%	4.5%
Premium Taxes	1.6%	1.6%	1.6%	1.6%
Commissions	7.1%	7.1%	7.1%	7.1%
Total Administrative Expenses	13.2%	13.2%	13.2%	13.2%
Pre-tax Profit	4.6%	4.6%	4.6%	4.6%
FIT/SIT	1.6%	1.6%	1.6%	1.6%
AFIT profit	2.96%	2.96%	2.97%	2.97%
Total	100.0%	100.0%	100.0%	100.0%

FIT = Federal Income Tax

SIT = State Income Tax

Exhibit 7C: Small Group Trend - Traditional

	Data through March 2012				AVG 12	
	Medical				PMPM	Rolling 12
	Med MM	Rx MM	PMPM	Rx PMPM		
200901	49,454	49,441	532.77	90.58		
200902	49,512	49,501	474.12	85.49		
200903	49,975	49,964	558.42	97.83		
200904	50,425	50,415	577.23	103.99		
200905	50,485	50,475	565.45	98.84		
200906	50,914	50,904	632.68	108.92		
200907	50,297	50,288	626.44	104.49		
200908	49,398	49,389	566.27	105.62		
200909	48,463	48,455	605.58	105.32		
200910	47,896	47,888	640.33	110.87		
200911	47,079	47,071	599.59	110.86		
200912	46,110	46,102	613.12	119.04	685.68	
201001	42,689	42,679	618.22	117.25	694.61	
201002	40,817	40,809	630.28	113.59	709.74	
201003	38,748	38,740	689.53	136.89	722.51	
201004	36,920	36,912	698.32	158.05	735.29	
201005	35,218	35,210	665.32	143.02	746.81	
201006	32,187	32,179	789.10	158.81	759.87	
201007	30,837	30,829	713.43	152.12	769.37	
201008	29,552	29,544	721.97	165.89	786.82	
201009	27,695	27,690	660.91	156.48	796.75	
201010	26,725	26,720	712.09	156.94	806.22	
201011	25,899	25,894	692.34	162.14	820.15	
201012	24,781	24,775	654.72	174.27	831.05	21.2%
201101	24,250	24,244	828.52	161.87	852.32	22.7%
201102	24,072	24,066	659.38	156.80	862.28	21.5%
201103	23,704	23,698	701.20	184.98	868.00	20.1%
201104	23,495	23,489	754.89	170.68	873.43	18.8%
201105	23,336	23,330	781.45	178.19	887.03	18.8%
201106	22,981	22,975	707.81	197.26	882.00	16.1%
201107	22,844	22,838	714.40	164.23	883.44	14.8%
201108	22,807	22,806	807.16	181.66	891.21	13.3%
201109	22,944	22,943	727.77	187.43	900.23	13.0%
201110	22,943	22,942	797.13	181.73	909.52	12.8%
201111	22,987	22,985	836.43	186.49	923.86	12.6%
201112	23,463	23,462	739.18	179.64	931.84	12.1%

Historical Average Trend

13.1%

Adjustment

-1.9%

Trend

11.2%

Exhibit 7C: Small Group Trend - HMO/POS

	Data through March 2012				AVG 12	
	Med MM	Rx MM	Medical PMPM	Rx PMPM	PMPM	Rolling 12
200901	4,740	4,337	385.27	61.25		
200902	4,778	4,375	339.03	64.58		
200903	4,963	4,534	420.95	75.08		
200904	4,995	4,550	484.01	75.75		
200905	5,064	4,606	367.95	74.89		
200906	5,128	4,687	484.89	87.68		
200907	5,114	4,650	514.95	86.68		
200908	5,100	4,614	451.21	77.26		
200909	5,139	4,645	485.51	74.03		
200910	5,320	4,830	452.08	83.58		
200911	5,301	4,803	496.56	88.64		
200912	5,426	4,913	425.74	77.16	513.87	
201001	5,434	4,898	498.81	80.81	524.52	
201002	5,542	5,002	505.80	72.75	538.33	
201003	5,656	5,139	608.54	97.82	556.40	
201004	5,767	5,242	560.28	77.99	563.40	
201005	5,910	5,395	589.87	82.66	582.64	
201006	6,030	5,492	746.28	86.34	606.24	
201007	6,023	5,487	711.08	85.82	623.73	
201008	6,157	5,628	720.56	83.49	647.21	
201009	6,212	5,681	712.02	84.49	667.12	
201010	6,370	5,847	755.68	92.56	693.55	
201011	6,532	6,015	579.80	86.29	699.11	
201012	6,844	6,314	635.53	88.74	716.07	39.3%
201101	6,934	6,427	689.74	76.27	730.83	39.3%
201102	7,063	6,552	615.35	75.59	738.29	37.1%
201103	7,232	6,722	749.91	89.16	750.16	34.8%
201104	7,489	6,993	630.33	86.09	755.12	34.0%
201105	7,577	7,098	769.69	86.40	770.71	32.3%
201106	7,872	7,407	833.00	96.09	781.34	28.9%
201107	7,791	7,341	659.06	90.42	777.34	24.6%
201108	7,782	7,341	734.94	92.91	780.04	20.5%
201109	7,891	7,464	700.07	80.44	779.03	16.8%
201110	7,907	7,489	768.20	98.46	781.95	12.7%
201111	8,143	7,716	627.09	96.79	785.12	12.3%
201112	8,391	7,956	731.42	88.11	792.87	10.7%

Historical Average Trend

16.3%

Adjustment

-5.1%

Trend

11.2%

Exhibit 7C: Large Group Trend HMO

	Data through March 2012				AVG 12	
	Medical				PMPM	Rolling 12
	Med MM	Rx MM	PMPM	Rx PMPM		
May-09	43,102	18,020	368.40	35.14		
Jun-09	42,550	17,488	409.11	38.49		
Jul-09	42,246	17,281	399.33	38.08		
Aug-09	42,047	17,158	369.19	38.73		
Sep-09	41,965	17,139	332.06	37.70		
Oct-09	41,877	17,102	376.82	40.53		
Nov-09	41,676	16,900	326.95	39.75		
Dec-09	41,569	16,850	329.38	41.68		
Jan-10	36,204	14,386	323.34	78.08		
Feb-10	36,174	14,364	351.94	56.69		
Mar-10	35,779	13,996	436.16	82.09		
Apr-10	35,672	13,914	372.91	84.41	386.10	
May-10	35,557	13,807	399.49	77.61	389.65	
Jun-10	35,390	13,666	424.33	70.76	391.13	
Jul-10	35,526	13,465	401.80	65.05	391.68	
Aug-10	35,030	13,236	370.98	71.76	392.80	
Sep-10	34,590	12,922	393.56	71.83	399.22	
Oct-10	34,534	12,939	407.63	69.34	402.49	
Nov-10	34,253	12,745	367.96	69.64	407.56	
Dec-10	34,255	12,870	387.42	79.59	414.37	
Jan-11	28,517	11,086	437.93	75.72	423.24	
Feb-11	28,466	11,113	423.37	69.02	429.46	
Mar-11	28,419	11,118	505.64	83.02	433.71	
Apr-11	28,319	11,027	459.89	78.32	440.33	14.0%
May-11	28,191	10,944	443.52	88.49	444.06	14.0%
Jun-11	28,066	10,887	445.22	86.63	445.93	14.0%
Jul-11	27,947	10,713	433.44	88.15	449.40	14.7%
Aug-11	27,899	10,701	445.08	84.43	456.50	16.2%
Sep-11	27,920	10,684	402.40	86.42	458.36	14.8%
Oct-11	27,768	10,546	421.79	85.92	460.48	14.4%
Nov-11	27,671	10,474	412.89	85.30	465.90	14.3%
Dec-11	27,523	10,371	425.81	85.78	470.20	13.5%

Historical Average Trend

14.7%

Adjustment

-3.5%

Trend

11.2%

Exhibit 7D: Unit Cost Trend

Line Of Business	Product	Reimbursement Type	DOS	FI Only	
CP	ACAS	ALL	Apr-12	0	
	Reimb. Type		2012	2013	Average
	Facility		Latest Estimate	Latest Estimate	Estimate
New York	Total		6.40%	6.20%	6.30%

	Reimb. Type		2012	2013	Average
	Physician		Latest Estimate	Latest Estimate	Estimate
New York	Total		0.86%	1.51%	1.18%

	Reimb. Type		2012	2013	Average
	Total		Latest Estimate	Latest Estimate	Estimate
New York	Total		3.68%	3.96%	3.82%

Weights

Facility:	55%
Physician:	45%

EXHIBIT 7: LISTING OF ALL COMMERCIAL AND MEDICARE PRODUCTS SOLD BY THE COMPANY

Company Name: Aetna Life Insurance Company

NAIC Code: 60054

SERFF Tracking Number: AETN-128494178

Instructions:

- The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- Market segment is: Large Group, Small Group, Individual, Healthy New York, Medicare Supplement (official benefit designs), Medicare Advantage, and Medicare Part D Drugs.
- Product type is a broad category such as HMO, POS, EPO, PPO, Indemnity Fee For Service, Consumer Driven/High Deductible, Medicare Supplement, etc.
- Use the drop down list for entries of Market Segment and Product Type or enter other applicable items.
- Extend the worksheet to add more rows as needed.

New #	Market Segment	Policy Form Number	Product Name as in Rate Manual	Product Street Name	Product Type
14013767	Small Group	GR-STATHCRGrp 01 NY	NY OA MC 3-12	NY OA MC 3	MC
14013768	Small Group	GR-STATHCRGrp 01 NY	NY OA MC 4-12	NY OA MC 4	MC
14013769	Small Group	GR-STATHCRGrp 01 NY	NY OA MC 3-12 HSA Compatible	NY OA MC 3 HSA Compatible	HSA High Deductible Plans
14013770	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 1-12	NY OA EPO 1	EPO
14013771	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 2-12	NY OA EPO 2	EPO
14013772	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 3-12	NY OA EPO 3	EPO
14013773	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 4-12	NY OA EPO 4	EPO
14013774	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 5-12	NY OA EPO 5	EPO
14013775	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 6-12	NY OA EPO 6	EPO
14013776	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 5-12 HSA Compatible	NY OA EPO 5 HSA Compatible	HSA High Deductible Plans
14013777	Small Group	GR-STATHCRGrp 01 NY	NY OA MC 3-12 MHP	NY OA MC 3 MHP	MC
14013778	Small Group	GR-STATHCRGrp 01 NY	NY OA MC 4-12 MHP	NY OA MC 4 MHP	MC
14013779	Small Group	GR-STATHCRGrp 01 NY	NY OA MC 3-12 HSA Compatible MHP	NY OA MC 3 HSA Compatible MHP	HSA High Deductible Plans
14013780	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 1-12 MHP	NY OA EPO 1 MHP	EPO
14013781	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 2-12 MHP	NY OA EPO 2 MHP	EPO
14013782	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 3-12 MHP	NY OA EPO 3 MHP	EPO
14013783	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 4-12 MHP	NY OA EPO 4 MHP	EPO
14013784	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 5-12 MHP	NY OA EPO 5 MHP	EPO
14013785	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 6-12 MHP	NY OA EPO 6 MHP	EPO
14013786	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 5-12 HSA Compatible MHP	NY OA EPO 5 HSA Compatible MHP	HSA High Deductible Plans
14013763	Small Group	GR-STATHCRGrp 01 NY	NY Indemnity 1-12	NY Indemnity 1	Indemnity FFS
14013766	Small Group	GR-STATHCRGrp 01 NY	NY Indemnity 1-12 MHP	NY Indemnity 1 MHP	Indemnity FFS
14013761	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 2-12 HSA Compatible	NY OA EPO 2 HSA Compatible	HSA High Deductible Plans
14013762	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 4-12 HSA Compatible	NY OA EPO 4 HSA Compatible	HSA High Deductible Plans
14013764	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 2-12 HSA Compatible MHP	NY OA EPO 2 HSA Compatible MHP	HSA High Deductible Plans
14013765	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 4-12 HSA Compatible MHP	NY OA EPO 4 HSA Compatible MHP	HSA High Deductible Plans
new	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 6-12 HSA Compatible	NY OA EPO 6-12 HSA Compatible	HSA High Deductible Plans
new	Small Group	GR-STATHCRGrp 01 NY	NY OA EPO 6-12 HSA Compatible MHP	NY OA EPO 6-12 HSA Compatible MHP	HSA High Deductible Plans



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August 1, 2012

Mr. Gary Teitel, Assistant Chief Actuary
New York State Insurance Department
25 Beaver Street - Health Bureau
New York, NY 10004-2319

Re: Aetna Life Insurance Company - Small Group
GR-STATHCRGrp 01 NY

Mr. Teitel:

Submitted for your review is a rate filing for Aetna Life Insurance Company's Small Group market segment for the state of New York. As we have in the past, we will work with the New York State Insurance Department to make sure these rate changes comply with all state regulations.

The proposed quarterly and annual rate adjustments are summarized in the following table and apply to all products governed in this filing:

Effective Date	Proposed Rate Increases		Policyholders	Members
	Quarterly	Annual		
01/01/2013	5.0%	11.4%	6,288	11,595
04/01/2013	2.7%	11.1%	3,960	6,742
07/01/2013	2.7%	10.7%	2,843	5,131
10/01/2013	2.7%	13.7%	3,401	6,168

The proposed rate adjustments would take effect on the policyholder's next anniversary on or after the effective dates in the table above. The number of policyholders affected by the proposed rate adjustment is 16,492 as of 04/30/2012.

The requested rates for Aetna's Small Group EPO and MC plans are directly related to medical claim trend due to changes in unit costs and utilization. Trends were based on a review of large group data and small group data over the period August 2009 – December 2011. The table below reflects our cost trends:

Utilization Trend	Unit Cost Trend	Other Trend	Total Trend
5.1%	3.8%	1.9%	11.2%

Utilization represents the number of services per member per year. Increase in Unit Cost represents the change in dollar amount per claim. Increases in Unit Cost reflect changes in our contracted rates and prescription drug costs as well as the price escalation due to usage of more intensive services or expensive technologies. Other trend represents deductible leveraging. Deductible leveraging occurs when the rate of change in deductibles is less than the rate of change in total medical costs. This results in the rate of change in insurer plan cost exceeding the rate of change in total medical costs. For this rate filing, we have used 11.2% as the projected change in medical cost.

Our pricing projection and the resulting rate increases assume that 82.2% of premium is used for medical care. New York state law requires that at least 82% of premium must be used to pay medical member costs. The remaining 17.8% are used for administrative expenses, profit, and taxes. Administrative costs include (but are not limited to) customer service, processing and paying claims, medical management programs, maintaining our provider networks, and complying with State and Federal regulations.

Aetna takes our commitment to our customers seriously. We have taken a number of steps to try to keep our products as affordable as possible, such as:

- Reducing our administrative costs by cutting back on the number of plan designs we offer, focusing only on the most popular plans that meet the needs of the majority of our members.
- Developing relationships with health care providers that provide incentives for the quality of care they provide, and not the quantity.
- Creating medical management programs which address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

We are also dedicated to increasing transparency within the health care system, as well as helping our members best utilize the plans that they have. Members can also access Aetna Navigator, our secure member website, which allows members to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's Plan for Your Health website aims to educate all consumers—not just Aetna members—on how to take advantage of their health care benefits.

If you have any questions, please do not hesitate to call me at (860) 273-6254.

Sincerely,



William R. Jones, F.S.A., M.A.A.A.
 Northeast & SGI Head Actuary
JonesWR@aetna.com

Enclosures

[WHAT THE PLAN COVERS]
[Major][Comprehensive][PPO][Gatekeeper PPO] [EPO] [LIMITED]
Medical Expense Insurance

[Once you reach the basic medical plan maximums, the major medical plan will provide coverage.]

Many [preventive and] routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Wellness

[Routine Physical Exams]

Covered expenses include charges made by [your **physician, primary care physician**] for routine physical exams for persons age 19 or more. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children from birth through [age 18] also include:

- An initial **hospital** check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.]

[Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Services and supplies furnished by an **out-of-network provider**.]

[Important Reminder

Refer to the[<i>Summary of Benefits</i>]for details about deductibles, coinsurance , benefit maximums and frequency and age limits for physical exams, if applicable.]

Preventive Health Care Services

This plan will pay for charges for preventive health care services provided in connection with a routine physical exam of a dependent child under 19 years of age, as follows. These charges are not subject to deductible or any lifetime maximum benefit. These services may be provided in a **hospital** or **physician's** office.

An initial hospital checkup and well-child visits scheduled in accordance with the prevailing standards of a national association of pediatric physicians designated by the New York State commissioner of health.

At each visit, services in accordance with the prevailing clinical standards of the designated association, including:

- A medical history;
- a complete physical examination;
- developmental assessment;
- anticipatory guidance;
- appropriate immunizations;
- laboratory tests.

All necessary immunizations recommended by the Advisory Committee on Immunizations Practices of the U.S. Public Health Service and the Department of Health of The State of New York, and in accordance with the minimum benefits mandated by the State of New York.

Not covered are charges for:

- Services which are covered to any extent under any other part of the plan;
- Services for diagnosis or treatment of a suspected or identified illness or disease;
- Medicines or drugs;
- Appliances, equipment or supplies;
- Premarital exams; dental exams; hearing exams; or exams related in any way to employment.

[Routine] Cancer Screening

The plan will pay for charges incurred for routine cancer screening, as follows:

Mammograms:

- Upon recommendation of a **physician**, a mammogram at any age for females having a history of breast cancer or who have a first degree relative with a prior history of breast cancer;
- A single baseline mammogram for covered females aged 35 through 39; and
- An annual mammogram for covered females aged 40 or older.

One gynecological exam, including Pap smear, every twelve months.

The following coverage for diagnostic screening of prostatic cancer:

- Standard diagnostic tests, including but not limited to a digital rectal exam and one prostate specific antigen (PSA) test at any age for males having a prior history of prostate cancer; and
- An annual standard diagnostic examination, including but not limited to a digital rectal examination and a prostate specific antigen test for males age 50 or more who are asymptomatic and for males age 40 or more with a family history of prostate cancer or other prostate cancer risk factors.

Fecal occult blood test, sigmoidoscopy, colonoscopy, double contrast barium enema.

Any age limits shown above do not apply to any person who is at high risk for the cancer being screened.

Early Intervention Services Expenses

The plan will pay the following charges even though they may not be incurred in connection with an **injury or disease**. Benefits are payable on the same basis as any other sickness. They are included only for a dependent child:

- Until September 1 of the calendar year in which the child attains the age of 3 years; if the child is born between January 1 and August 31 of that calendar year.
- Until January 2 of the calendar year following the calendar year the child attains the age of 3 years; if the child is born between September 1 and December 31 of the preceding calendar year.

The dependent child must be certified by the New York Department of Health as eligible to participate in the Early Intervention Program. You must submit proof of such qualification with the initial claim.

Early Intervention Services Expenses

These are the charges incurred for Early Intervention Services.

Early Intervention Services: These are services, designed to offer a comprehensive array of educational, developmental, health and social services to eligible infants, children and their families as specified in program regulations. They include, but are not limited to, the following:

- Speech and language therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease or injury.
- Clinical psychological tests or treatment.
- Skilled nursing services, on a part-time or intermittent basis, given by an **R.N.** or by an **L.P.N.**

Not more than the Early Intervention Services Calendar Year Maximum will be payable for Early Intervention Services Expenses incurred by a person in any one calendar year.

Not more than the Early Intervention Services Lifetime Maximum will be payable for Early Intervention Services Expenses incurred by a person during the person's lifetime.

Benefits paid for early intervention services will not be applied against any maximum lifetime or annual limits specified in this Booklet-Certificate. However, visit limitations and other terms and conditions of the Booklet-Certificate will continue to apply to early intervention services. Visits used for Early Intervention Services will not reduce the number of visits otherwise available under the coverage for such services.

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Family Planning Services

Covered expenses include charges for certain family planning services, even though not provided to treat an **illness** or **injury**. Refer to the *Summary of Benefits* for the frequency limits that apply to these services, if not specified below.

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

[The plan does **not** cover the reversal of voluntary sterilization procedures, including related follow-up care.]

Also see section on maternity and infertility related expenses on a later page.

Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- **Routine** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. [A routine eye exam does not include a contact lens exam.]
- [Contact lens exam: The plan covers a contact lens exam. A contact lens exam is an eye exam performed for the sole purpose of fitting contact lenses.]

[The plan covers charges for one routine eye exam and one contact lens exam in any 36 consecutive month period.]

[Limits

Unless specified above, the benefit plan does not cover charges for a service or supply furnished by other than a **network provider**.]

[Coverage is subject to the calendar year **deductibles, copays** and **coinsurance** percentages shown in your *Summary of Benefits*.]

Vision Care Supplies

You and each of your covered dependents are eligible for the following **covered expenses** for prescription lenses and frames, or prescription contact lenses:

Charges for

- [One] pair of eyeglasses (lenses and frames) during any [24-month] period; or
- [One pair of hard contact lenses during any 24-month period or
- Disposable contact lenses

up to the vision supply maximum listed on your *Summary of Benefits*].

[If contact lenses are required to correct visual acuity to 20/40 or better in the better eye, and that correction cannot be obtained with conventional lenses, or if aphakic lenses are prescribed after cataract surgery has been performed, the maximum benefit payable during a covered family member's lifetime for all such contact and aphakic lenses is \$200.]

[Important Reminder

Refer to the <i>Summary of Benefits</i> for information about the maximums that apply to vision care supplies.]

[Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before you coverage ended, and the exam included refraction;
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in prescription; and
- No other expenses for vision care supplies were incurred in the previous period of 24 months in a row.]

Routine Hearing Exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** [certified as an otolaryngologist or otologist]; or
- An audiologist who:
 - Is legally qualified in audiology; or
 - Holds a certificate of [Clinical Competence in Audiology from the American Speech and Hearing Association] (in the absence of any applicable licensing requirements); and
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

[The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.]

[All **covered expenses** for the routine hearing exam are subject to the **deductible, copay** and **coinsurance**.]

Physician Services

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- [Immunizations for infectious disease, but not if solely for your employment or travel,]
- Allergy testing and allergy injections; and
- Charges made by a qualified **physician** for a second surgical opinion on the need for surgery; and 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. [The opinion may be rendered by either a **network** or a **non-network** specialist.]

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

[Important Reminder

Certain procedures need to be precertified by Aetna . Refer to <i>How the Plan Works</i> for more information about precertification].
--

Hospital Expenses

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. [Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.]

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

[**Covered expenses** include hospital charges for other services and supplies provided, such as:

- **Ambulance** services
- **Physicians** and surgeons.
- Operating, **cytoscopic** and recovery rooms.
- Intensive or special care facilities **and equipment**.
- Administration of blood and blood derivatives, but not the cost of the blood or blood product.
- Radiation therapy, **chemotherapy**.
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy.
- Radiological services, **electrocardiographs, electroencephalographs**, laboratory testing and diagnostic services.
- Medications, **sera, biologicals and vaccines**.
- Intravenous (IV) preparations, **visualizing dyes**.
- Discharge planning.
- **Dressings and casts.**]

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for:

- Covered services and supplies provided by the outpatient department of a **hospital**;
- **Hospital** services rendered within 24 hours after an accidental injury; and
- X-ray and lab tests in the outpatient department of the **hospital**, to the extent such services would be provided if an inpatient.

[Important Reminders

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

Hospital admissions need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

(NOTE: The duration and any stay for patients undergoing a lymph node dissection or lumpectomy for treatment of breast cancer, or a mastectomy, will be as determined by the attending physician, in consultation with the patient.)

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your **stay**. [**Covered expenses** for these charges are payable at the out-of-network benefit level if the provider has not contracted with **Aetna**, even if the facility is in the **Aetna** network.]

Refer to the *Summary of Benefits* for your **deductible**, copay and **coinsurance** and maximum benefit limits.]

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room [staff] **physicians** services;
- **Hospital** nursing staff services; and
- [Staff] radiologists and pathologists services.

Please contact [your **PCP**] [a **network provider**] [**physician**] after receiving treatment for an **emergency medical condition**.

[Important Reminder

If you visit a hospital emergency room for a non-emergency condition, the plan will [pay a reduced benefit] [will not cover your expenses], as shown in the [<i>Summary of Benefits</i>]. No other plan benefits will pay for non-emergency care in the emergency room.]

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an urgent condition.

Your coverage includes:

- [Use of emergency room facilities;
- Use of urgent care facilities;
- [Staff] **physicians** services;
- Nursing staff services; and
- [Staff] radiologists and pathologists services.]

Please contact [your **PCP**] [a **network provider**] [**physician**] after receiving treatment of an urgent condition.

If you visit an **urgent care provider** for a non-urgent condition, the plan will [pay a reduced benefit] [will not cover your expenses], as shown in the [*Summary of Benefits*].

Alternatives to Hospital Stays

Outpatient Surgery [and Physician Services]

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- [An office-based surgical facility of a **physician** or **dentist**];
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** [; or in an office-based surgical facility; and
- The surgery is not normally performed in a **physician's** or **dentist's** office].

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital, surgery center** or office-based surgical facility on the day of the procedure;
- [The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.]

Limitations

Not covered under this plan are charges made for:

- [The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.]
- A **stay** in a **hospital**.

[Also refer to Outpatient Pre-operative Testing under Diagnostic and Pre-operative Testing.]
--

Birth Center [and Physician Services]

Covered expenses include charges made by a **birth center** for services and supplies related to your care in a **birth center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

[**Covered expenses** also include charges made:

- By an operating **physician** for:
 - Delivery;
 - Pre- and post-natal care; and
 - Administering an anesthetic.
- By a **physician** for administering an anesthetic (other than a local anesthetic).]

Limitations

Unless specified above, not covered under this benefit are charges:

- [For the services of a **physician** who renders technical assistance to the operating **physician**.]
- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Maternity Expenses* for information about other **covered expenses** related to maternity care.]

[Ambulatory Care

Covered expenses include charges incurred for ambulatory care in a **hospital's** outpatient department of in a **physician's** office. Ambulatory care includes: services for diagnostic X-rays; laboratory and pathological examinations; physical and radiation therapy; services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy.

The services and supplies must be:

- Related to and necessary for treatment or diagnosis of your **illness or injury**;
- Ordered by a **physician**;
- In the case of physical therapy, furnished for the same illness or injury for which you were hospitalized or for surgery (care must start no later than 6 months after discharge from the **hospital** or surgery and is limited to 365 days following surgery or discharge from the **hospital**).]

Home Health Care

Covered expenses include charges for home health care services when ordered by a **physician** provided:

- The charges are made by a **home health care agency**; and
- The care is given under a **home health care plan**; and
- The care is given to you in your home while you are homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by a **R.N.** or by a **L.P.N.**
- Part-time intermittent home health aide services provided in conjunction with and in direct support of patient care.
- Physical, occupational and speech therapy.
- Medical supplies, prescription drugs and medications and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you been confined in a **hospital** or **skilled nursing facility** (as defined in Title XVIII of the Social Security Act).

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit. Each 4 hours of home health aide services is one visit.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's [or your domestic partner's] family.
- [Transportation.]
- Services that are for **custodial care**.

[Important Reminders
The plan does not cover custodial care , even if care is provided by a nursing professional, and family members or other caretakers provide the necessary care.
[Home health care needs to be precertified by Aetna. Refer to <i>How the Medical Plan Works</i> for details about precertification .
Refer to the Summary of Benefits for details about home health care visit maximums.]

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Skilled Nursing Facility

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the [*Summary of Benefits*], including:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

[The **stay** must start during a Convalescent Period. A convalescent period starts on the first day of your **stay** if you:

- Had a **hospital stay** [of at least 3 days in a row], while covered under this plan, for treatment of an **illness** or **injury**;
- Start your **stay** in a **skilled nursing facility** within [14] days after discharge from the **hospital**;
- Need **skilled nursing facility** services to recover from the condition that caused the **hospital stay**; and
- Further hospitalization would otherwise be necessary

A convalescent period ends when you have not been confined in a **hospital, skilled nursing facility**, or other place giving nursing care for 90 days in a row.]

[Important Reminder

Refer to the *Summary of Benefits* for details about **skilled nursing facility** maximums.

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *Using Your Medical Plan* for details about **precertification**].

Limitations

Unless specified above, not covered under this benefit are charges for:

- Charges made for the treatment of:
 - [Drug addiction;
 - Alcoholism;
 - Senility;
 - Mental retardation; or
 - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.]

Skilled Nursing Care

Covered expenses include charges by a **R.N.**, **L.P.N.** or nursing agency for outpatient skilled nursing care.

This is care by a visiting **R.N.**, **L.P.N.** to perform specific skilled nursing tasks. [One outpatient visit is equal to a period of up to 2 hours.]

[The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**; or
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.]

Limitations

Unless specified above, not covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
 - [Transportation;
 - Meal preparation;
 - Vital sign charting;
 - Companionship activities;
 - Bathing;
 - Feeding;
 - Personal grooming;
 - Dressing;
 - Toileting; and
 - Getting in/out of bed or a chair.]
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility [, provided the care can adequately be provided by the facility's general nursing staff, if it were fully staffed.]

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

[Facility Expenses

The charges made by a **hospital, hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.]

[Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** [for up to eight hours a day];
- Part-time or intermittent home health aide services to care[for you up to eight hours a day].
- Medical social services under the direction of a **physician**. These include but are not limited to:
 - Assessment of your social, emotional and medical needs, and your home and family situation;
 - Identification of available community resources; and
 - Assistance provided to you to obtain resources to meet your assessed needs.
- [Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies.
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.]

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- [A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
 - Physical and occupational therapy;
 - Part time or intermittent home health aide services for your care up to eight hours a day;
 - Medical supplies;
 - **Prescription drugs**;
 - Psychological counseling; and
 - Dietary counseling.]

Limitations

Unless specified above, not covered under this benefit are charges for:

- [Daily **room and board** charges over the **semi-private room rate**.
- **More than [5] visits for** bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.]

[Important Reminders

Refer to the <i>Summary of Benefits</i> for details about hospice care maximums.

Inpatient hospice care and home health care must be precertified by Aetna . Refer to <i>How the Plan Works</i> for details about precertification].
--

Other Covered Health Care Expenses

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with covered surgical procedure[]; and

[Option 1:

- To treat the following **illness** or **injury** or alleviate chronic pain: Aetna considers needle acupuncture (manual or electroacupuncture) **medically necessary** for *any* of the following indications:

[Postoperative and chemotherapy-induced nausea and vomiting; or

Nausea of pregnancy; or

Postoperative dental pain; or

Temporomandibular disorders (TMD); or

Migraine headache; or

Pain from osteoarthritis of the knee or hip (adjunctive therapy)]

[Option 2

- To treat an illness, injury or to alleviate chronic pain.]

[Important Reminder

Refer to the [<i>Summary of Benefit</i>] or details about the acupuncture benefit maximum.]

Ambulance Service

Covered expenses include the following:

Emergency Transportation

Covered expenses include charges made by an ambulance service, issued a certificate to operate under the New York Public Health Law, for **prehospital emergency medical services**. Payment under the Plan will be payment in full for the services provided. An ambulance service that is so reimbursed by the Plan will not seek any reimbursement from, or have any recourse against you, except for the collection of [**copays, coinsurance or deductibles** for which you are responsible under the Plan.]

“Prehospital emergency medical services” means the prompt evaluation and treatment of an emergency medical condition, and/or non-airborne transportation of a covered person from the place where he or she is injured or stricken by illness to the **hospital** where treatment is given. If the person utilizes non-airborne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the covered person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others’ in serious jeopardy; (2) serious impairment to such covered person’s bodily functions; (3) serious dysfunction of any bodily organ or part of such covered person; or (4) serious disfigurement of such covered person.

Non-Emergency Transportation

Covered expenses include charges by a professional ambulance service for the necessary non-emergency transfer of a covered person via ground ambulance or a medical van.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.]

Enteral Formulas

Covered expenses include charges incurred for enteral formulas for home use and modified solid food products that are low in protein or which contain protein, which are prescribed by a **physician** for the treatment of certain diseases which include, but are not limited to:

- inherited diseases of amino acid or organic acid metabolism;
- Crohn's disease;
- gastroesophageal reflux with failure to thrive;
- disorders of gastrointestinal motility;
- multiple, severe food allergies.

Bone Mineral Density Measurements or Tests, Drugs and Devices

Covered expenses include charges incurred for bone mineral density measurements or tests, including drugs and devices, for individuals(a) meeting the criteria under the federal Medicare program or the National Institutes of Health; or (b) previously diagnosed as having osteoporosis or a family history of osteoporosis; or (c) with symptoms or conditions indicative of the presence or of significant risk of osteoporosis; or (d) on a prescribed drug regimen posing a significant risk of osteoporosis; or (e) with lifestyle factors to such a degree posing a significant risk of osteoporosis; or (f) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Bone mineral density measurements or tests, drugs and devices include those covered under the federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including dual energy X-ray absorptiometry.

Diagnostic, Genetic and Preoperative Testing

[Outpatient] Diagnostic Lab Work [and Radiological Services]

Covered expenses include charges for radiological services other lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. [You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**.] The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

[Genetic Testing]

Aetna considers genetic testing **medically necessary** to establish a molecular diagnosis of an inheritable disease when:

- The person displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); *and*
- The result of the test will directly impact the treatment being delivered.

Covered expenses include the following

- Charges made by a **physician** and lab for the test once per lifetime.
- Charges made by a genetic counselor to interpret the test results and evaluate treatment, once per lifetime.]

[Important Note
Refer to the Summary of Benefits for details about any deductible, coinsurance and maximum that applies to outpatient diagnostic testing, lab and radiological services.]

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital, surgery center**[, **physician** or licensed diagnostic laboratory] provided the charges for the surgery are **covered expenses** and:

- The tests are related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Reservations for a bed or for an operating room were made prior to the tests;
- The tests are completed [within 7 days] before your surgery;
- The tests are performed on an outpatient basis;
- The tests would be covered if you were an inpatient in a **hospital**;
- The tests are not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

[Important Reminders

If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will *not* be covered.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment: Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item].

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **DME** includes equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have a **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment **does not** include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is Aetna's.

[Important Reminders

Refer to the <i>Summary of Benefits</i> for details about durable medical and surgical equipment deductible, coinsurance and benefit maximums.]
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Experimental or Investigational Treatment

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided *all* of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria;
- [The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center;] and
- You are treated in accordance with protocol.

[Maternity Expenses]

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- [48 hours] after a vaginal delivery; and
- [96 hours] after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

If the mother is discharged earlier, the plan will pay for [two] post-delivery home visits by a health care provider.] This [will not be subject to any **deductible** or **copay** and] will not count toward the maximum number of visits under the home health care benefit.

Covered expenses for a **birthing center** are described under Alternatives to **Hospital Care**.

Note: **Covered expenses** also include services and supplies provided for circumcision.]

Prescription Drugs

Covered expenses include charges made for outpatient **prescription drugs** [and insulin] when prescribed in writing by a **physician** to treat an **illness** or **injury**. [The plan covers both **generic** and **brand-name prescription drugs**.]

Also covered will be charges for a prescription drug for the treatment of a certain type of cancer if the drug has been prescribed for treatment of a cancer for which it has not been approved by the federal Food and Drug Administration, but the drug is recognized for the treatment of the specific type of cancer in one of the standard reference compendia, or in medical literature.

Unless specified above, not covered under this benefit are charges for:

[any outpatient prescription drug covered [or excluded from coverage] under Aetna's prescription drug plan in accordance with the prescription drug coverage and exclusions sections of this Booklet-Certificate or any separately issued Booklet-Certificate].

[Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of **illness** or **injury** or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes [, but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made and fitted for you.]

The plan will not cover expenses and charges for, or expenses related to:

- [Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, [unless required for the treatment of or to prevent complications of diabetes[; or if the orthopedic shoe is an integral part of a covered leg brace]; or
- Trusses, corsets, and other support .]

Short-Term Rehabilitation Therapy Services

Covered expenses included charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on the [*Summary of Benefits*]. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- [A **hospital, skilled nursing facility, or hospice facility**];
- [A **home health care agency**]; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

[Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.]

[Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the [*Summary of Benefits*]. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet-Certificate**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, [provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure]. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries** [, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function].
- Speech therapy is covered for non-chronic conditions and acute **illnesses** and **injuries** [and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts,

speaking words and forming sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.]

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function. [Cognitive therapy is covered as part of your [Physical] [Occupational] Therapy benefit and the visit limit for [Occupational] [Physical] Therapy applies to this benefit.]

A "visit" consists of no more than [one] hour[s] of therapy. Refer to the [*Summary of Benefits*] for the visit maximum that applies to the plan. **Covered expenses** include charges for [two] therapy visits of no more than [one] hour[s] in a 24-hour period.

The therapy should follow a specific treatment plan that:

- [Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- If you are **homebound**, therapy services may be provided in your home.]

[Important Reminder

Refer to the <i>Summary of Benefits</i> for details about the short-term rehabilitation therapy maximum benefit].

Unless specifically covered above, not covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by [an employer];
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from: **illness; injury;** or congenital defect;
- [Services provided during a **stay** in a **hospital, skilled nursing facility, or hospice facility except as stated above;**]
- [Services provided by a **home health care agency;**]
- Services not performed by a **physician** or under the direct supervision of a **physician;**
- Medical treatment. This applies whether or not benefits have been paid under that section];
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family [or your domestic partner];
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive [or Cosmetic] Surgery and Supplies

Covered expenses include charges made by a **physician, hospital** [, or **surgery center**] for reconstructive services and supplies, including:

- [Surgery to correct the result of an accidental **injury** provided the surgery occurs no more than [24] months after the **injury**. For a covered child, surgery will be covered up to age 18 or up to [24] months after the injury, whichever period is longer. Injuries that occur during surgical procedures or medical treatments are not considered accidental injuries, even if unplanned or unexpected.
- Surgical implantation or attachment of covered prosthetic devices.
- Surgery to correct a gross anatomical defect present at birth. The surgery will be covered if - the defect results in severe facial disfigurement or significant functional impairment of a body part; and the purpose of the surgery is to improve function.]
- Reconstructive surgery which is incidental to or follows surgery for trauma, infection or other diseases of the involved part, or necessary due to a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Reconstructive Breast Surgery

Covered expenses include (i) reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. (ii) **surgery on the other breast to make it symmetrical with the reconstructed breast; and (iii) physical therapy to treat complications of mastectomy, including lymph edema, in as manner determined by you and your attending physician.**

[Important Reminders
[For services and supplies involving cleft lip or cleft palate, refer to the <i>Specialized Care</i> section, Treatment of Cleft Lip or Palate for coverage details.]

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise medically necessary based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

[Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for Infusion Therapy by:

- A free-standing facility;
- The outpatient department of a **Hospital**; or
- A **physician** in his/her office or in your home.

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are **Medically Necessary** for your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with Infusion Therapy and any medical supplies, equipment and nursing services required to support the Infusion Therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- [Blood transfusions;]
- [Any service or supply furnished by an **Out-of-network Provider**.]

Coverage is subject to the maximums, if any, shown on the [Summary of Benefits].

Coverage for inpatient infusion therapy is provided under the Inpatient Hospital & Skilled Nursing Facility Benefits section of this Booklet-Certificate.

[Benefits payable for Infusion Therapy will not count toward any applicable **Home Health Care** maximums.]

[Important Reminders

Refer to the <i>Summary of Benefits</i> for details on your deductible, coinsurance and maximum benefit limits.]]
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Services Provided by a Center for Eating Disorders

Covered expenses include charges made by a comprehensive care center for eating disorders to provide a coordinated, individualized plan of care for individuals with eating disorders, including all necessary non-institutional, institutional and practitioner services and treatments, from initial patient screening and evaluation to treatment , follow-up care and support.

Eating disorder includes, but is not limited to: conditions such as anorexia nervosa, bulimia and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, or other medical and mental health diagnostic references generally accepted for standard use by the medical and mental health fields.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment and training for the treatment diabetes :

Services

Diabetes self-management education given by a **physician** (or any other licensed health care provider), including information on proper diets. Coverage is limited to visits made upon diagnosis of diabetes, where a **physician** diagnoses a significant change in the patient's symptoms or condition which requires changes in the patient's self-management, or where reeducation or refresher education is necessary.

Supplies

- Insulin ;
- Insulin pumps and accessories;
- Syringes;
- Injections aids for the visually impaired;
- Test strips for glucose monitoring and visual reading and urine testing strips ;
- Blood glucose monitors, including those for the visually impaired ;
- Lancets;
- Insulin infusion devices;
- Oral agents for controlling blood sugar;
- Cartridges for the visually impaired;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.
- Any additional equipment and related supplies as may be medically necessary for the treatment of diabetes.

End of Life Care

Covered expenses include charges incurred by a covered person who has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified the patient's attending physician) for acute care services at an acute care facility specializing in the treatment of terminally ill patients. The person's attending **physician**, in consultation with the medical director of such facility, must determine that the patient's care would be appropriately provided by such facility. The facility must be licensed pursuant to New York State's public health law, or by the state in which it is located.

In the event Aetna disagrees with the admission of or provision or continuation of care of the covered person by the facility, and Aetna initiates an expedited external appeal, such admission of, provision of, or continuation of the care by the facility will not be denied, and Aetna continue to provide coverage until a decision is rendered. The decision will be binding on all parties.

Treatment of Infertility

Basic Infertility Services

The plan will include charges made by a **physician** to diagnose and treat a correctable medical condition where the medical condition results in **infertility**.

Comprehensive Infertility Services

The plan covers charges made for **hospital**, surgical and medical care which would correct malformation, disease or dysfunction resulting in **infertility**. The **infertility** must not be caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.

Covered expenses will include, but are not limited to, the following services or supplies:

- Ovulation induction;
- Artificial insemination;
- Ultrasound;
- Post-coital test;
- Hysterosalpinogram;
- Laparoscopy;
- Sono-hysteroqram;
- Blood tests;
- Endometrial biopsy;
- Hysteroscopy;
- Semen analysis;
- Testis biopsy; and
- [**Prescription** drugs.]

Limitations

[Not covered are charges for:

- Purchases of donor sperm and any charges for the storage of any sperm;
- The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrieval, transfers or gestational carriers;
- Charges associated with cryopreservation, or storage of cryopreserved embryos, including but not limited to office visits, hospital charges, ultrasounds and lab tests.
- Reversal of elective sterilization;
- Sex change procedures;
- Cloning;
- Gestational carrier programs (surrogate parenting) for you or the gestational carrier;
- Prescription drugs used for the treatment of an excluded treatment or procedure, including injectable medications;
- Home ovulation prediction kits;
- In-vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; and intracytoplasmic sperm injection;
- Frozen embryo transfers; including thawing;

- Procedures deemed experimental in accordance with the standards of the American Society for Reproductive Medicine;
- Services and supplies obtained without **precertification**.

[Important Reminder

- If you fail to obtain any necessary referrals or preauthorization from Aetna, charges incurred [will not be covered][will be paid at a reduced rate]. [You will be responsible for full payment of the services.]

Refer to the *Summary of Coverage* for details about [the **copays, deductibles** and maximums that apply to these services.]

[Advanced Reproductive Technology (ART) Benefits

Covered expenses include charges for advanced reproductive technology for the treatment of infertility, if all of the following tests are met:

- A condition that is a demonstrated cause of infertility has been recognized by a gynecologist or infertility specialist.
- The procedures are not performed during an inpatient **stay** in a **hospital**, or any other facility.
- FSH levels are less than, or equal to, 19miU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal), or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

[Covered expenses for ART include:

- In-vitro fertilization (IVF);
- Zygote intra-fallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery;
- Care associated with a donor IVF program. This includes fertilization and culture;]
- [Charges for obtaining the sperm of a covered partner are covered if both the man and the woman are covered by the plan.]

[All ART infertility services must be:

- [Precertified] by Aetna's Infertility Care Management Unit.]

[Important Reminder

- If you fail to obtain services through a network provider or to get any necessary referrals or any required precertification from Aetna, charges [will not be covered][will be paid at a reduced rate]. [You will be responsible for full payment of the services.]

Refer to the *Summary of Coverage* for details about [the **copays, deductibles** and maximums that apply to these services.]]

Limitations

[Not covered are charges for:

- purchases of donor sperm and any charges for storage of any sperm;
- the purchase of donor eggs and any charges associated with the care of the donor required for donor egg retrievals, transfers or gestational carriers;
- charges associated with cryopreservation, or storage of cryopreserved embryos, including but not limited to, office visits, **hospital** charges, ultrasounds and lab tests;
- Reversal of elective sterilization;
- Charges for or related to artificial insemination;

- Gestational carrier programs (surrogate parenting) for you or the gestational carrier;
- Prescription drugs, including injectable infertility medications;
- Home ovulation prediction kits;
- Frozen embryo transfers, including thawing;
- Services and supplies obtained without the necessary referrals, or claims authorizations from the Infertility Unit or the Patient Management Unit.]

[Important Reminder

Refer to the *Summary of Coverage* for details about [the **copays, deductibles** and maximums that apply to these services.]]

Marriage, Family and Child Counseling

Covered expenses include charges made by a **physician**, marriage, family or child counselor for marriage, family and child counseling services, even if the counseling is not in connection with diagnosis or treatment of an **injury** or **illness**.

[Important Reminder

Refer to the <i>Summary of Benefits</i> for details about the maximums that apply to counseling services.]
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Limits

Unless specified above, not covered under this benefit are counseling services for, or related to, the following:

- [Family planning;
- Genetics;
- Sex education;
- Career or job;
- Sexual dysfunction or inadequacy;
- Gender identity disorder;
- Sex change surgery; or
- Financial or debt planning.]

Speech Loss or Impairment

The plan covers the following charges made by a **physician** to diagnose or treat the loss or impairment of speech:

- [Diagnostic speech evaluation to determine if, and to what extent, your ability to speak is lost or impaired;
- Rehabilitative speech and language therapy to restore or improve your ability to speak; and
- Speech and language therapy to treat delays in speech development resulting from **illness, injury** or birth defect.]

Unless specified above, benefits are not payable under this provision for:

- Services and supplies that a school system is required by law to provide;
- Special education to teach you, if your ability to speak has been lost or impaired, to function without that ability. This includes (but is not limited to) lessons in sign language.
- Speaking aids or training in the use of such aids.

Treatment of Jaw Joint Disorder

When the condition is determined to be medical in nature, the plan covers charges made by a **physician, hospital or surgery center** for the diagnosis [and][or] surgical [and non-surgical (not involving cutting)] treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as Temporomandibular Joint Dysfunction (TMJ) Syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as Myofascial Pain Dysfunction (MPD).

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a **jaw joint disorder**.

Treatment of Cleft Lip or Palate [of Dependent Children Under Age 18]

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre- and post-operative care provided by a **physician**;
- Oral prosthesis treatment, [including obturators and orthotic devices, speech and feeding appliances;]
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures [by dentures] or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- [Cleft orthodontic therapy;]
- [Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;]
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- [Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;]
- Psychological assessment and counseling;
- Genetic assessment and counseling for [you, your dependent child and the child's parents;]
- [Hearing aids;]
- [Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.]

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, not covered under this benefit are:

- [Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Speech aids and training in the use of speech aids; and
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)]

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Treatment of [Alcoholism, Drug Abuse and Mental Disorders]

Covered expenses include charges made for the treatment of [alcoholism, drug abuse and mental disorders] by **physicians** and **behavioral health providers**.

[Mental Disorders]

Covered expenses include charges made for the treatment of mental disorders by **physicians** and **behavioral health providers**.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, or physician's or behavioral health provider's** office for the treatment of mental disorders as follows:

[Definitions]

Biologically Based Mental Illness: A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia.

Children with Serious Emotional Disturbances: Persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- Serious suicidal symptoms or other life-threatening self-destructive behaviors;
- Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Coverage for Biologically-based Mental Illness and for Children with Serious Emotional Disturbances Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate**, and other services and supplies provided during your **stay** in a **hospital** or **psychiatric hospital**.

Outpatient Treatment

- **Covered expenses** include charges for treatment received in a facility issued an operating certificate by the Commissioner of Mental Health, a facility operated by the Office of Mental Health, a licensed psychiatrist, psychologist or clinical social worker, or a professional corporation or university faculty practice corporation.

Coverage for Other Than Biologically-based Mental Illness and for Children with Serious Emotional Disturbances Inpatient Treatment

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate**, and other services and supplies provided during your **stay** in a **hospital** or **psychiatric hospital**.

Outpatient Treatment

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Covered expenses include charges for treatment received in a facility issued an operating certificate by the Commissioner of Mental Health, a facility operated by the Office of Mental Health, a licensed psychiatrist, psychologist or clinical social worker, or a professional corporation or university faculty practice corporation. The covered expenses are as follows:

- Expenses for crisis intervention services: (these are services rendered in connection with an unforeseen clinical condition which requires prompt action, since without such action the person may be at risk of injuring him or herself or others; or the person is at risk of substantial deterioration).
- Expenses for any other services rendered by and charged for by a facility issued an operating certificate by the Commissioner of Mental Health, a facility operated by the Office of Mental Health, a licensed psychiatrist, psychologist or clinical social worker, or a professional corporation or university faculty practice corporation.]

One inpatient hospitalization day may be exchanged for 2 partial hospitalization visits.

Not Covered

- Expenses incurred while incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth.
- Expenses incurred solely because such services are ordered by a court.
- Expenses for services deemed cosmetic in nature.

Remember: inpatient care and partial **hospitalizations** must be [**precertified**] by **Aetna**. Refer to *How the Plan Works* for more information about [**precertification**].

The *Summary of Benefits* shows the benefits payable and any applicable maximums

[Alcoholism and Drug Abuse]

Covered expenses include charges made for the treatment of [alcoholism and drug abuse] by **physicians** and **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

The *Summary of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of [alcoholism and drug abuse].

Inpatient

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital** or **residential treatment facility**, appropriately licensed by the Department of Health or its equivalent.

Coverage includes detoxification and rehabilitation services.:

Outpatient

The plan covers outpatient treatment of [alcohol or drug abuse.]

Remember: inpatient and partial- hospitalization care must be [precertified] by Aetna . Refer to <i>How the Plan Works</i> for more information about [precertification] .
--

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of [alcohol or drug abuse].

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

One day of partial confinement will count as one outpatient visit for the treatment of [alcohol or drug abuse].

Remember: inpatient and partial-hospitalization care must be [precertified] by Aetna. Refer to *How the Plan Works* for more information about [precertification].

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician** [, a **dentist** and **hospital**] for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out [: teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth;] cysts, tumors, or other diseased tissues.
- [Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.]
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

[**Hospital** services and supplies received for a **stay** required because of the person's condition.]

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

- (a) Natural teeth damaged, lost, or removed; or
- (b) Other body tissues of the mouth fractured or cut due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

[The treatment must be completed in the calendar year of the accident or in the next calendar year.]

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **Covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Covered expenses include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

- Impacted teeth. The plan covers oral surgery to remove:
 - Teeth partly or completely impacted in the bone of the jaw;
 - Teeth that will not erupt through the gum; and
 - Other teeth that cannot be removed without removing bone.
- Accidental **injuries** and other trauma. The plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state, but only if the services take place no later than [24] months after the **injury**.

If a child needs oral surgery as the result of accidental **injury** or trauma, surgery may be postponed until a certain level of growth has been achieved.

Note: Trauma which occurs as a result of biting or chewing is *not* considered accidental **injury**, even if it is unplanned or unexpected.

Pathology. The plan covers removal of tumors and cysts requiring pathological examination.

Radiation treatment. The plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

Anatomical defects. The plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

[Related dental services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth;
- The first placement of dentures or bridgework to replace lost teeth; and
- Orthodontic therapy to preposition teeth; and

Dental implants are *not* covered.]

Healthy Outlook [Disease Management] Program

Healthy Outlook is a [disease management] program for covered persons with one or more of the following chronic conditions:

- [• Asthma;
- Congestive heart failure;
- Coronary artery disease;
- Diabetes.]

A “participant” in this program is a covered person:

- Who has volunteered to participate; or
- Who has been identified by:
 - their attending **physician** or other health care provider; or
 - **Aetna**; or
 - the policyholder; and
- Who is approved by **Aetna** as a participant.

Any:

- Visit calendar year maximum; or
- Day calendar year maximum; or
- Visit lifetime maximum; or
- Day lifetime maximum.

under this plan will not be reduced.

However, any:

- Dollar calendar year maximum; or
- Dollar lifetime maximum.

under this plan will be reduced.

All such **covered expenses** will reduce the overall Lifetime Maximum Benefit under this plan.

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Readability Statistics

Counts	
Words	11535
Characters	64290
Paragraphs	975
Sentences	446
Averages	
Sentences per Paragraph	1.4
Words per Sentence	16.0
Characters per Word	5.2
Readability	
Passive Sentences	20%
Flesch Reading Ease	36.9
Flesch-Kincaid Grade Level	11.8

OK

Coverage includes:

- Treatment in a hospital for the medical
- "Medical complications" include detox cirrhosis of the liver, delirium tremens:
- Treatment in a hospital is covered only treatment facility section.

Outpatient

The plan covers outpatient treatment of [alcohol]

The plan covers partial hospitalization services (day) provided in a facility or program for the intensive treatment of alcohol or drug abuse. You would need inpatient if you were not admitted.

Remember: inpatient and partial-hospitalization care must be [precertified] by Aetna. Refer to *How the Plan Works* for more information about [precertification].

Partial Confinement Treatment

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State: New York

Filing Company: Aetna Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: NY SG ALIC 1q13 to 4q13

Project Name/Number: NY SG ALIC 1q13 to 4q13/

Supporting Document Schedules

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Aetna Life Insurance Company EPO [Limited] Medical Expense Coverage Summary of Benefits		
PLAN FEATURES	[IN NETWORK]	[OUT- OF-NETWORK]
[[Calendar] Year Deductible*	[\$100-10,000]	Not applicable
[Individual Deductible*	[\$100-10,000]	Not applicable
[Family Deductible*	[\$100-30,000]	Not applicable
[Per Admission Copayment	[\$0-50 per day up to] [1-5 days] [\$0-5000]]	Not applicable
[Deductible Waiver [Applies to the benefits listed in Deductible Waiver Provision of this Summary][Applies to all benefits]	[Deductible waived for first [\$0-500] per [calendar] year, then [50-100%]]	Not applicable
[First Dollar Benefit: The Plan pays 100% of covered medical expenses up to the first dollar maximum shown below. [Refer to the Expense Insurance Provision Section of this Summary for a list of the First Dollar Benefits.]		Not applicable
Individual Amount	[\$500-10,000]	
Family Amount	[\$1,000-20,000]	
[Common Accident Deductible	[\$100-\$10,000]	Not applicable
[Separate Accident Benefit	[100% deductible waived]	Not applicable
[Maximum per calendar year]	[\$100-1,000]	

[*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.]

Summary of Benefits (Continued)

[Plan [Coinsurance] [Payment] [Out-of-Pocket] Limit [Includes] [Excludes] [plan deductible] [copayments] [precertification penalties]

[Individual Plan [Coinsurance] [Payment] [Out-of-Pocket] Limit:

- [For [in-network] expenses: [\$0-20,000].]

[Family Plan [Coinsurance] [Payment] [Out-of-Pocket] Limit.

- For [in-network] expenses: [\$0-60,000].]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
[[Calendar][Year Maximum Benefit Per Person]	[\$25,000-unlimited]	Not applicable
[Lifetime Maximum Benefit per person]	[\$25,000-unlimited]	Not applicable
[Lifetime Maximum Benefit Automatic Yearly Restoration]	[\$1000- \$50,000]	Not applicable

Coinsurance listed in the [Summary] below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance percentage. You are responsible for full payment of any non-covered expenses you incur.

[ALL COVERED EXPENSES ARE SUBJECT TO THE [CALENDAR] YEAR DEDUCTIBLE UNLESS OTHERWISE NOTED IN THE SUMMARY BELOW.]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[[Routine] Physical Exams</i> <i>[Adults] [and] [Children] [only].</i> <i>[Includes coverage for immunizations]]</i></p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Benefit per [calendar year] [12 consecutive month period]]</p>	<p>[\$50-unlimited]</p>	
<p><i>[Preventive Care Services]</i></p>	<p>100% per visit [after calendar year deductible]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Routine Hearing Exam]</i>	[[50-100%] per visit [after calendar year deductible]] [[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per [calendar year] [6-24 consecutive month period]]	[\$100- unlimited]	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>Routine Cancer Screening (age and maximum limits do not apply to any person at high risk the cancer being screened)]</i>		
<i>[Routine Mammography</i>	[[50-100%] per visit [after calendar year deductible]] [[\\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per Mammography]	[\$50-unlimited]	
[Maximum visits per [calendar year] [12 consecutive month period]]	[1-2 visits]	
Diagnostic Screening for Cancer	[[50-100%] per visit [after calendar year deductible]] [[\\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
[Maximum visits per [calendar year] [12-24 consecutive month period]]	[1-2 visits]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Routine Gynecological Exams, including Pap Smears]</i></p>	<p>[[50-100%] per test [after calendar year deductible]]</p> <p>[[\$0-75] per test copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Tests per [calendar year] [12-24 consecutive month period]]</p>	<p>[1-2 tests]</p>	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p>[Fecal Occult Blood Test [age 40 and over]]</p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Sigmoidoscopy Age [40-50] and over]</p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Tests per [1-5] consecutive year period]</p>	<p>[1-2 tests]</p>	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p>[Double Contrast Barium Enema (DCBE)] [Age [40-50] and over]]</p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Benefit per [1-5] consecutive year period]</p>	<p>[[1-2 visits]</p>	
<p>[Colonoscopy] age [40-50] and over]</p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Benefit Maximum per [2-10] consecutive year period]</p>	<p>[1-2 tests]</p>	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Eye Examinations</i> (including refraction)]	[[50-100%] per visit [after calendar year deductible]] [[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per [calendar year] [12 consecutive month period]]		
[(under age [19])]	[1 exam every [6-24] consecutive months]	
[(age [19] and older)]	[1 exam every [6-24] consecutive months]	
<i>[Vision Care Supplies]</i>	[[50-100%] [after calendar year deductible]] [No deductible applies.]	[Not Covered]
[Maximum Benefit for All Vision Supplies]	[\$50-1000]	
<i>[Eyeglass Frames [(including prescription lenses)]]</i>	[[50-100%] [after calendar year deductible]] [after \$0-75 per item copay] [No deductible applies.]	[Not Covered]
[Maximum Benefit [every [6-24] consecutive months]]	[1 set] [\$50 - \$500]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Prescription Lenses]</i>	[[50-100%] [after calendar year deductible] [after \$0-75 copay per pair] [No deductible applies.]	[Not Covered]
[Maximum Benefit [every [12-24] consecutive months]]	[1-2 pair] [\$25 - \$500]	
<i>[Prescription Contact Lenses]</i>	[[50-100%] [after calendar year deductible] [after \$0-75 copay per item] [No deductible applies.]	[Not Covered]
[Maximum Benefit [every [12-24] consecutive months]]	[\$50-500]	
<i>[Aphakic lenses]</i> prescribed after cataract surgery. The maximum benefit payable per person, per lifetime for all such contact and aphakic lenses]	[50-100%] [after [calendar] year deductible]	[Not Covered]
[Maximum Benefit per lifetime]	[\$100-1000]	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
PHYSICIAN SERVICES		
<p><i>[Physician Office Visits (non-surgical)]</i></p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p><i>[Office Visits to [Primary Care Physician][General Practitioner/Family Practitioner]</i> [Office visits (non-surgical) to non-specialist]]</p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]]</p>

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Specialist Office Visits][All specialists except those specifically listed in this schedule.]</i></p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p><i>[Physician Office Visits- [Surgery]]</i></p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Physician Services for Inpatient Facility and Hospital Visits]</i></p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p><i>[Administration of Anesthesia]</i></p>	<p>[[50-100%] per procedure [after calendar year deductible]]</p> <p>[[[\$0-75] copay per procedure [after calendar year deductible] [then the plan pays [50-100%]]]</p> <p>[An amount equal to [the lesser of [20-50%] of the amount paid for the procedure and [\$250-2000] copay per visit]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Benefit]</p>	<p>[\$200-unlimited]</p>	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Allergy Testing [and Treatment]]</i>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]]
<i>[Allergy Injections]</i>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]]
<i>Second medical opinions 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.</i>	<p>[100% [after the [calendar year] deductible]]</p> <p>[\$0-75 per visit [after the calendar year deductible]]</p> <p>[No deductible applies]</p>	[Not covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Immunizations when not part of the physical exam]</i></p>	<p>[[50-100%] per visit [after calendar year deductible]]</p> <p>[[\$0-75] visit copay [after calendar year deductible] [then plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]]</p>
<p><i>[[First] Prenatal Visit[s]]</i></p>	<p>[[50-100%] [after the deductible]]</p> <p>[\$0-\$75 visit copay] [after the deductible] [all visits thereafter covered [50-100%]]</p> <p>[No deductible applies]</p>	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>Emergency Medical Services</i>		
<i>[Hospital Emergency Facility]</i>	[50-100%][after calendar year deductible] [[\$0-150] copay per visit] [after the deductible] [then the plan pays [50-100%]] [No deductible applies]	[50-100%] [after calendar year deductible] [[\$0-150] deductible per visit] [after the deductible] [then the plan pays [50-100%]] [No deductible applies]
<i>[Non-Emergency Care in a Hospital Emergency Room]</i>	[50-100%] [after calendar year deductible] [[\$0-250] copay per visit] [after the deductible] [then the plan pays [50-100%]] [Not covered]	[50-90%] [after calendar year deductible] [[\$0-250] deductible per visit] [after the deductible] [then the plan pays [50-100%]] [Not covered]
<p>A separate [hospital] emergency room [deductible] [copay] applies for each visit to an emergency room for emergency care. If you are admitted to a hospital as an inpatient immediately following a visit to an emergency room, your deductible is waived.</p> <p>[Covered expenses that are applied to the emergency room [deductible] [copay] cannot be applied to any other [deductible][copay] under your plan. Likewise, covered expenses that are applied to any of your plan’s other [deductibles] [copays] cannot be applied to the emergency room [deductible][copay].</p>		
<i>Urgent Care Services</i>		
<i>[Urgent Medical Care (at a non-hospital free standing facility)]</i>	[50-100%][after calendar year deductible] [[\$0-150] copay per visit] [after the deductible] [then the plan pays [50-100%]] [No deductible applies]	[50-100%] [after calendar year deductible] [[\$0-150] deductible per visit] [after the deductible] [then the plan pays [50-100%]] [No deductible applies]
<i>[Non-Urgent Use of Urgent Care Provider (at a non-hospital free standing facility)]</i>	[50-100%] [after calendar year deductible] [[\$0-250] copay per visit] [after the deductible] [then the plan pays [50-100%]] [Not covered]	[50-90%] [after calendar year deductible] [[\$0-250] deductible per visit] [after the deductible] [then the plan pays [50-100%]] [Not covered]

Summary of Benefits (Continued)

<p>A separate urgent care [deductible][copay] applies for each visit to an urgent care provider for urgent care. If you are admitted to a hospital as an inpatient immediately following a visit to an urgent care provider, this [deductible][copay] is waived.</p> <p>[Covered expenses that are applied to the urgent care [deductible][copay] cannot be applied to any other [deductible][copay] under your plan. Likewise, covered expenses that are applied to your plan's other [deductibles][copays] cannot be applied to the urgent care [deductible][copay].]</p>		

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Outpatient] Diagnostic Lab [and Radiologic] Services, and Gebrtic and Preoperative Testing</i>		
<i>[Performed at a Hospital Outpatient Facility]</i>	<p>[[50-100%] per procedure [after calendar year deductible]]</p> <p>[[\$0-75] per procedure copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]]
<i>[Performed at a facility other than Hospital Outpatient Facility]</i>	<p>[[50-100%] per procedure [after calendar year deductible]]</p> <p>[[\$0-75] per procedure copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>Outpatient Surgery</i>		
<i>[Performed in a Physician's Office]</i>	<p>[[50-100%] per visit/surgical procedure [after calendar year deductible]]</p> <p>[[\$0-75] per visit/surgical procedure copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]
<i>[Performed at a Hospital Outpatient Facility]</i>	<p>[[50-100%] per visit/surgical procedure [after calendar year deductible]]</p> <p>[[\$0-75] per visit/surgical procedure copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Performed at a Surgery Center or Facility other than a Hospital Outpatient Facility]</i></p>	<p>[[50-100%] [after calendar year deductible]]</p> <p>[[\$0-75] per visit/surgical procedure copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>INPATIENT FACILITY EXPENSES</i>		
<i>[Birthing Center]</i>	<p>[[50-100%] per admission [after calendar year deductible]]</p> <p>[[\$0-1,000] per admission copay [after calendar year deductible] then the plan pays [50-100%]]</p> <p>[[\$0-500] copay per day for up to [1-5] days [after calendar year deductible] [then the plan pays [50-100%] for [the first] [1-5] days, then plan pays [50-100%]] thereafter, per admission]</p> <p>[No deductible applies.]</p>	[Not covered.]
<i>Hospital Expenses</i> [Room and Board] [(including maternity)]	<p>[[50-100%] per admission [after calendar year deductible]]</p> <p>[[\$0-1,000] per continuous admission copay [after calendar year deductible] then the plan pays [50-100%]]</p> <p>[[\$0-500] copay [per continuous confinement][per day for up to [1-5] days] [after calendar year deductible] [then the plan pays [50-100%] for [the first] [1-5] days, then plan pays [50-100%]] thereafter, per admission]</p> <p>[No deductible applies.]</p>	[Not Covered]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
[<i>Hospital Facility Expenses (other than Room and Board)</i>]	[[50-100%] [after the deductible] [per admission]] [No deductible applies.]	[Not Covered]
[<i>Skilled Nursing Facility</i>]	[[50-100%] per admission [after calendar year deductible]] [[\$0-1,000] per continuous admission copay [after calendar year deductible] then the plan pays [50-100%]] [[\$0-500] copay [per continuous confinement][per day for up to [1-5] days] [after calendar year deductible] [then the plan pays [50-100%] for [the first] [1-5] days, then plan pays [50-100%]] thereafter, per admission] [No deductible applies.]	[Not Covered]
[Maximum Days per calendar year] [12 consecutive month period]]	[60 - unlimited days]	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>SPECIALTY BENEFITS</i>		
<i>Ambulatory Care</i>	[[50-100%] per visit [after calendar year deductible]] [[\\$0-75] per visit copay [after calendar year deductible] then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
<i>[Home Health Care (Outpatient)]</i>	[[75-100%] per visit [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
[Maximum Visits per [calendar year] [condition] [365 consecutive day period]]	[40-unlimited visits]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Private Duty Nursing [Outpatient][and Inpatient]</i>	[[50-100%] per visit [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per visit]	[\$50- unlimited]	
[Maximum Visit Limit per [calendar year] [365 consecutive day period]]	[[0-70] Private Duty Nursing Shifts. Eight (8) hours equal one shift.] [20-unlimited visits]	
<i>[Skilled Nursing Care Outpatient]</i>	[[50-100%] per visit [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
[Maximum Visit Limit per [calendar year] [365 consecutive day period]]	[20-unlimited]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>Hospice Benefits</i>		
<p><i>[Hospice Care –Facility Expenses (Room & Board)]</i></p>	<p>[[50-100%] per admission [after calendar year deductible]]</p> <p>[[$\\$0$-1,000] per continuous admission copay [after calendar year deductible] then the plan pays [50-100%]]</p> <p>[[$\\$0$-500] copay [per continuous confinement][per day for up to [1-5] days] [after calendar year deductible] [then the plan pays [50-100%] for [the first] [1-5] days, then [50-100%]] thereafter, per admission]</p> <p>[No deductible applies.]</p>	<p>[Not Covered.]</p>

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Hospice Care – Other Expenses during a stay]</i>	[[50-100%] per admission [after the deductible]] [No deductible applies.]	
<i>[Hospice Outpatient Visits]</i>	[[50-100%] per visit [after calendar year deductible]] [No deductible applies.]	[Not Covered]
[Maximum days per [calendar year] [condition] [365 consecutive day period]]	[210-unlimited days, [5-10] visits for bereavement counseling]	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of a correctable medical condition causing the infertility.	Payable on the same basis as any other [disease or injury], in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Not Covered
<i>Comprehensive Infertility Expenses</i>	[[50-100%] per visit [after the calendar year deductible]] [[[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]]] [No deductible applies.]	[Not Covered]
<i>[Advanced Reproductive Technology (ART) Expenses]</i>	[[50-100%] per visit [after the calendar year deductible]] [[[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per [calendar year] [365 consecutive day benefit period] [condition]]	[\$1,500-100,000]	
[Maximum per lifetime*] [Aetna will take into consideration all of the following, whether past or present: <ul style="list-style-type: none"> • Services received while covered under a plan of benefits offered by Aetna or one of its affiliated companies; • Services received while covered under a plan of benefits on an individual or group basis, whether insured or self-insured, offered by any other carrier; and • Services received while no plan coverage was provided. 	[\$2,000-100,000] [One course of treatment in a person's lifetime. (A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.)]	
[*Does not apply toward the plan [coinsurance][out-of-pocket] limit.]		

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[MENTAL DISORDERS]</i>		
<i>[Coverage for Biologically-Based Mental Illness and Children with Serious Emotional Disturbances]</i>		
<i>Inpatient</i>	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Summary to determine what the plan pays.	[Not Covered]
One inpatient hospitalization day may be exchanged for 2 partial hospitalization visits.		
<i>Outpatient</i>	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Summary to determine what the plan pays.	[Not Covered]
<i>Coverage for other than Biologically-Based Mental Illness and Children with Serious Emotional Disturbances]</i>		
<i>Inpatient</i>	<p>[[50-100%] per admission [after the [calendar] year deductible]]</p> <p>[[50-100%] per continuous admission copay [after [calendar] year deductible] then the plan pays [50-100%]]</p> <p>[[50-100%] copay [per continuous confinement][per day for up to [1-5] days] [after [calendar] year deductible] then the plan pays [50-100%] for [the first] [1-5] days, then the plan pays [50-100%] thereafter, per admission]</p> <p>[No deductible applies.]</p>	[Not Covered]

Summary of Benefits (Continued)

Maximum Benefit per [calendar year]	[30-unlimited] days[*]	[Not Covered]
One inpatient hospitalization day may be exchanged for 2 partial hospitalization visits.		
<i>Outpatient</i>	<p>[[50-100%] per visit [after the [calendar] year deductible]]</p> <p>[[(\$0-75] per visit copay [after [calendar] year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	[Not Covered]
Maximum visits per[calendar year]	[20–Unlimited] visits [*]	[Not Covered]]
[*Benefits provided for treatment of Biologically based Mental Illness and Children with Serious Emotional Disturbances will count against and reduce these benefits.]		
[Crisis Intervention Services]	[3 visits, \$60 per visit]	[Not Covered]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
[SUBSTANCE ABUSE] [<i>Chemical Dependency</i>] [<i>Substance Abuse</i>] [<i>Alcoholism</i>][, and] [<i>Drug Abuse/Addiction treatment expenses</i>]		
<i>[Inpatient Detoxification]</i>	<p>[[50-100%] per admission [after the [calendar] year deductible]]</p> <p>[[[\$0-1,000] per continuous admission copay] [after [calendar] year deductible] then the plan pays [50-100%]]</p> <p>[[[\$0-500] copay [per continuous confinement]][per day for up to [1-5] days] [after [calendar] year deductible] then the plan pays [50-100%] for [the first] [1-5] days, then the plan pays [50-100%] thereafter, per admission]</p> <p>[No deductible applies.]</p>	[Not Covered]
[Maximum Days/admissions per [calendar year]]	[7 –unlimited days]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Inpatient Rehabilitation]</i></p>	<p>[[50-100%] per admission [after the [calendar] year deductible]]</p> <p>[[[\$0-1,000] per continuous admission copay] [after [calendar] year deductible] then the plan pays [50-100%]]</p> <p>[[[\$0-500] copay [per continuous confinement][per day for up to [1-5] days] [after [calendar] year deductible] then the plan pays [50-100%] for [the first] [1-5] days, then the plan pays [50-100%] thereafter, per admission]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Days/admissions per [calendar year]]</p>	<p>[30 –unlimited days]</p>	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Outpatient Rehabilitation]</i>	[[50-100%] per visit [after the [calendar] year deductible]] [[\$0-75] per visit copay [after [calendar] year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
[Maximum Visits per [calendar year]]	[[60 –365] visits, at least 20 for family members.]	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>OTHER COVERED HEALTH EXPENSES</i>		
<i>[Acupuncture]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
<i>Enteral Formulas</i>	[[50-100%] [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
<i>Bone Mineral Density Measurements or tests</i>	[[50-100%] [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
<i>Maternity Expenses</i>	Payable on the same basis as any other [disease or injury], in accordance with the type of expense incurred. Refer to other sections of this Summary to determine what the plan pays.	[Not Covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Ambulance Service]</i>		
<i>[Emergency Transportation (air, water or ground)]</i>	[50-100%] [after deductible] [[\$0-50] [per trip copay] [after calendar year deductible] [then the plan pays [50-100%] [No deductible applies.]	[Not Covered]
<i>[Non-Emergency Transportation (ground)]</i>	[50-100%] [after calendar year deductible] [[\$0-50] [per trip copay] [after calendar year deductible] [then the plan pays [50-100%] [No deductible applies.]	[Not covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Diabetic Equipment, Supplies and Education]</i></p>	<p>[[50-100%] [after the calendar year deductible] per visit/prescription]</p> <p>[[\$0-75] per visit/prescription copay [after the calendar year deductible] [then the plan pays 50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Durable Medical and Surgical Equipment]</i>	[[50-100%] [after the calendar year deductible] per item] [No deductible applies.]	[Not Covered]
[Maximum Benefit per [calendar year] [condition] [12 consecutive month period]]	[\$2,500-10,000]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Jaw Joint Disorder Treatment]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
<i>[Marriage, Family and Child Counseling]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
<i>[Prescription Drugs</i>		
[Diabetic Supplies and Insulin [Only]]	[50-100%] per prescription or refill [, after the calendar year deductible] [No deductible applies.]	[Not Covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
[Maximum Benefit per [calendar year[[12-24 consecutive month period]]	[\$100-unlimited]	
<i>[Prosthetic Devices]</i>	<p>[50-100%] per item after the calendar year deductible]</p> <p>[\$0-75] copay per prescription or refill] [after the [calendar] year deductible [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p> <p>[Deductible waived for first [\$0-500] per [calendar] year, then [50-100%] per item]</p>	[Not covered]
<i>Reconstructive [or Cosmetic] Surgery and Supplies</i>	<p>[50-100%] after the calendar year deductible]</p> <p>[No deductible applies.]</p>	[Not Covered]
<i>Reconstructive Breast Surgery</i>	<p>[50-100%] after the calendar year deductible]</p> <p>[No deductible applies.]</p>	[Not Covered]
<i>Treatment of Cleft Lip or Cleft Palate [For Dependent Children Under Age 18]</i>	<p>[50-100%] after the calendar year deductible]</p> <p>[No deductible applies.]</p>	[Not Covered]

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Outpatient Therapies]</i>		
<i>[Chemotherapy]</i>	[[50-100%] per visit [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
<i>End of Life Care</i>	Payable on the same basis as any other [disease or injury], in accordance with the type of expense incurred. Refer to other sections of this Summary to determine what the plan pays.	[Not Covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Infusion Therapy] [Performed in a Physicians Office or Home Care]]</i></p>	<p>[[50-100%] per visit [after the calendar year deductible]]</p> <p>[[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p><i>[Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility]</i></p>	<p>[[50-100%] per visit [after the calendar year deductible]]</p> <p>[[\$0-500] per visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Benefit per visit]</p>	<p>[\$20-1,000]</p>	
<p>[Maximum Benefit per [calendar year] [60- 365]consecutive day benefit period] [condition]]</p>	<p>[\$1,000-5,000]</p>	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Radiation Therapy]</i>	[[50-100%] per visit [after the calendar year deductible]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per visit]	[\$50-unlimited]	

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Short Term Outpatient Rehabilitation Therapies]</i>		
[Physical Therapy] [,] [Occupational Therapy] [Speech Therapy] [Cardiac Therapy] [Cognitive Therapy] [Pulmonary] and other Therapies	[[50-100%] per visit [after the calendar year deductible]] [[\\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per visit]	[\$50-500]	
[Maximum visits per [calendar year] [60-365 consecutive day benefit period] [condition]]	[[60-Unlimited] [combined for all outpatient rehabilitation therapies]	
<i>[Physical Therapy]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
[Maximum Benefit per visit]	[\$50-500]	
[Maximum visits per [calendar year] [60-365 consecutive day benefit period] [condition]]	[[60-Unlimited] [combined for all outpatient rehabilitation therapies]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Outpatient Occupational Therapy]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
[Maximum Benefit per visit]	[\$50-500]	
[Maximum visits per [calendar year] [60-365 consecutive day benefit period] [condition]]	[60-Unlimited] [combined for all outpatient rehabilitation therapies]	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<p><i>[Outpatient [Physical] [, [and]] Occupational] [, and] [Speech] Therapy combined</i></p>	<p>[[50-100%] per visit [after the calendar year deductible]]</p> <p>[[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]]</p> <p>[No deductible applies.]</p>	<p>[Not Covered]</p>
<p>[Maximum Benefit per visit]</p>	<p>[\$50-500]</p>	
<p>[Maximum visits per [calendar year] [60-365 consecutive day benefit period] [condition]]</p>	<p>[60- unlimited] combined [Physical] [, [and]] [Occupational] [, and] [Speech] Therapy visits</p>	

Summary of Benefits (Continued)

PLAN FEATURES	[IN NETWORK]	[OUT OF NETWORK]
<i>[Speech Loss or Impairment]</i>	[[50-100%] per visit [after the calendar year deductible]] [[\$0-75] per visit copay [after calendar year deductible] [then the plan pays [50-100%]] [No deductible applies.]	[Not Covered]
<i>[Healthy Outlook Program]</i>	[[50-100%] per visit [after the calendar year deductible]] [No deductible applies.]	[Not Covered]