

SERFF Tracking #:

GRPH-129013157

State Tracking #:

2013050230

Company Tracking #:2013 0503 GHI INDIVIDUAL OFF
EXCHANGE**State:** New York**Filing Company:** Group Health Incorporated**TOI/Sub-TOI:** H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense**Product Name:** GHI HIX OFF Exchange Ind**Project Name/Number:** GHI Off Exchange Individual/DPC-OX-100 et al

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		GHI Individual Rate Manual 2014 Approved		New		GHI DP Rate Manual 2014 Approved 0813.pdf,

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Proposed Rates

Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Platinum	Standard	HD900 PLATINUM	Off	0.888	Downstate	Ind	\$852.26
Platinum	Standard	HD900 PLATINUM	Off	0.888	Downstate	Ind + Sp	\$1,704.52
Platinum	Standard	HD900 PLATINUM	Off	0.888	Downstate	Parent + Chld(rn)	\$1,448.84
Platinum	Standard	HD900 PLATINUM	Off	0.888	Downstate	Family	\$2,428.94
Platinum	Standard	HD900 PLATINUM	Off	0.888	Downstate	Child Only	\$351.13
Platinum	Standard	HD900 PLATINUM	Off	0.888	Long Island	Ind	\$918.01
Platinum	Standard	HD900 PLATINUM	Off	0.888	Long Island	Ind + Sp	\$1,836.02
Platinum	Standard	HD900 PLATINUM	Off	0.888	Long Island	Parent + Chld(rn)	\$1,560.62
Platinum	Standard	HD900 PLATINUM	Off	0.888	Long Island	Family	\$2,616.33
Platinum	Standard	HD900 PLATINUM	Off	0.888	Long Island	Child Only	\$378.22
Platinum	Standard	HD900 PLATINUM	Off	0.888	Albany	Ind	\$796.85
Platinum	Standard	HD900 PLATINUM	Off	0.888	Albany	Ind + Sp	\$1,593.70
Platinum	Standard	HD900 PLATINUM	Off	0.888	Albany	Parent + Chld(rn)	\$1,354.65
Platinum	Standard	HD900 PLATINUM	Off	0.888	Albany	Family	\$2,271.02
Platinum	Standard	HD900 PLATINUM	Off	0.888	Albany	Child Only	\$328.30
Platinum	Standard	HD900 PLATINUM	Off	0.888	Buffalo	Ind	\$737.26
Platinum	Standard	HD900 PLATINUM	Off	0.888	Buffalo	Ind + Sp	\$1,474.52
Platinum	Standard	HD900 PLATINUM	Off	0.888	Buffalo	Parent + Chld(rn)	\$1,253.34
Platinum	Standard	HD900 PLATINUM	Off	0.888	Buffalo	Family	\$2,101.19
Platinum	Standard	HD900 PLATINUM	Off	0.888	Buffalo	Child Only	\$303.75
Platinum	Standard	HD900 PLATINUM	Off	0.888	Mid-Hudson	Ind	\$873.13
Platinum	Standard	HD900 PLATINUM	Off	0.888	Mid-Hudson	Ind + Sp	\$1,746.26
Platinum	Standard	HD900 PLATINUM	Off	0.888	Mid-Hudson	Parent + Chld(rn)	\$1,484.32
Platinum	Standard	HD900 PLATINUM	Off	0.888	Mid-Hudson	Family	\$2,488.42
Platinum	Standard	HD900 PLATINUM	Off	0.888	Mid-Hudson	Child Only	\$359.73
Platinum	Standard	HD900 PLATINUM	Off	0.888	Rochester	Ind	\$720.23
Platinum	Standard	HD900 PLATINUM	Off	0.888	Rochester	Ind + Sp	\$1,440.46
Platinum	Standard	HD900 PLATINUM	Off	0.888	Rochester	Parent + Chld(rn)	\$1,224.39
Platinum	Standard	HD900 PLATINUM	Off	0.888	Rochester	Family	\$2,052.66
Platinum	Standard	HD900 PLATINUM	Off	0.888	Rochester	Child Only	\$296.73
Platinum	Standard	HD900 PLATINUM	Off	0.888	Syracuse	Ind	\$771.34
Platinum	Standard	HD900 PLATINUM	Off	0.888	Syracuse	Ind + Sp	\$1,542.68
Platinum	Standard	HD900 PLATINUM	Off	0.888	Syracuse	Parent + Chld(rn)	\$1,311.28
Platinum	Standard	HD900 PLATINUM	Off	0.888	Syracuse	Family	\$2,198.32
Platinum	Standard	HD900 PLATINUM	Off	0.888	Syracuse	Child Only	\$317.79
Platinum	Standard	HD900 PLATINUM	Off	0.888	Utica	Ind	\$805.42
Platinum	Standard	HD900 PLATINUM	Off	0.888	Utica	Ind + Sp	\$1,610.84
Platinum	Standard	HD900 PLATINUM	Off	0.888	Utica	Parent + Chld(rn)	\$1,369.21
Platinum	Standard	HD900 PLATINUM	Off	0.888	Utica	Family	\$2,295.45
Platinum	Standard	HD900 PLATINUM	Off	0.888	Utica	Child Only	\$331.83

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Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Downstate	Ind	\$894.87
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Downstate	Ind + Sp	\$1,789.74
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Downstate	Parent + Chld(rn)	\$1,521.28
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Downstate	Family	\$2,550.38
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Long Island	Ind	\$963.91
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Long Island	Ind + Sp	\$1,927.82
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Long Island	Parent + Chld(rn)	\$1,638.65
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Long Island	Family	\$2,747.14
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Albany	Ind	\$836.69
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Albany	Ind + Sp	\$1,673.38
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Albany	Parent + Chld(rn)	\$1,422.37
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Albany	Family	\$2,384.57
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Buffalo	Ind	\$774.12
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Buffalo	Ind + Sp	\$1,548.24
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Buffalo	Parent + Chld(rn)	\$1,316.00
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Buffalo	Family	\$2,206.24
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Mid-Hudson	Ind	\$916.79
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Mid-Hudson	Ind + Sp	\$1,833.58
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Mid-Hudson	Parent + Chld(rn)	\$1,558.54
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Mid-Hudson	Family	\$2,612.85
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Rochester	Ind	\$756.24
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Rochester	Ind + Sp	\$1,512.48
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Rochester	Parent + Chld(rn)	\$1,285.61
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Rochester	Family	\$2,155.28
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Syracuse	Ind	\$809.91
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Syracuse	Ind + Sp	\$1,619.82
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Syracuse	Parent + Chld(rn)	\$1,376.85
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Syracuse	Family	\$2,308.24
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Utica	Ind	\$845.69
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Utica	Ind + Sp	\$1,691.38
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Utica	Parent + Chld(rn)	\$1,437.67
Platinum	Age 29	HD900 PLATINUM	Off	0.888	Utica	Family	\$2,410.22

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Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Gold	Standard	HD1800 GOLD	Off	0.782	Downstate	Ind	\$716.19
Gold	Standard	HD1800 GOLD	Off	0.782	Downstate	Ind + Sp	\$1,432.38
Gold	Standard	HD1800 GOLD	Off	0.782	Downstate	Parent + Chld(rn)	\$1,217.52
Gold	Standard	HD1800 GOLD	Off	0.782	Downstate	Family	\$2,041.14
Gold	Standard	HD1800 GOLD	Off	0.782	Downstate	Child Only	\$295.07
Gold	Standard	HD1800 GOLD	Off	0.782	Long Island	Ind	\$771.45
Gold	Standard	HD1800 GOLD	Off	0.782	Long Island	Ind + Sp	\$1,542.90
Gold	Standard	HD1800 GOLD	Off	0.782	Long Island	Parent + Chld(rn)	\$1,311.47
Gold	Standard	HD1800 GOLD	Off	0.782	Long Island	Family	\$2,198.63
Gold	Standard	HD1800 GOLD	Off	0.782	Long Island	Child Only	\$317.84
Gold	Standard	HD1800 GOLD	Off	0.782	Albany	Ind	\$669.64
Gold	Standard	HD1800 GOLD	Off	0.782	Albany	Ind + Sp	\$1,339.28
Gold	Standard	HD1800 GOLD	Off	0.782	Albany	Parent + Chld(rn)	\$1,138.39
Gold	Standard	HD1800 GOLD	Off	0.782	Albany	Family	\$1,908.47
Gold	Standard	HD1800 GOLD	Off	0.782	Albany	Child Only	\$275.89
Gold	Standard	HD1800 GOLD	Off	0.782	Buffalo	Ind	\$619.56
Gold	Standard	HD1800 GOLD	Off	0.782	Buffalo	Ind + Sp	\$1,239.12
Gold	Standard	HD1800 GOLD	Off	0.782	Buffalo	Parent + Chld(rn)	\$1,053.25
Gold	Standard	HD1800 GOLD	Off	0.782	Buffalo	Family	\$1,765.75
Gold	Standard	HD1800 GOLD	Off	0.782	Buffalo	Child Only	\$255.26
Gold	Standard	HD1800 GOLD	Off	0.782	Mid-Hudson	Ind	\$733.74
Gold	Standard	HD1800 GOLD	Off	0.782	Mid-Hudson	Ind + Sp	\$1,467.48
Gold	Standard	HD1800 GOLD	Off	0.782	Mid-Hudson	Parent + Chld(rn)	\$1,247.36
Gold	Standard	HD1800 GOLD	Off	0.782	Mid-Hudson	Family	\$2,091.16
Gold	Standard	HD1800 GOLD	Off	0.782	Mid-Hudson	Child Only	\$302.30
Gold	Standard	HD1800 GOLD	Off	0.782	Rochester	Ind	\$605.24
Gold	Standard	HD1800 GOLD	Off	0.782	Rochester	Ind + Sp	\$1,210.48
Gold	Standard	HD1800 GOLD	Off	0.782	Rochester	Parent + Chld(rn)	\$1,028.91
Gold	Standard	HD1800 GOLD	Off	0.782	Rochester	Family	\$1,724.93
Gold	Standard	HD1800 GOLD	Off	0.782	Rochester	Child Only	\$249.36
Gold	Standard	HD1800 GOLD	Off	0.782	Syracuse	Ind	\$648.19
Gold	Standard	HD1800 GOLD	Off	0.782	Syracuse	Ind + Sp	\$1,296.38
Gold	Standard	HD1800 GOLD	Off	0.782	Syracuse	Parent + Chld(rn)	\$1,101.92
Gold	Standard	HD1800 GOLD	Off	0.782	Syracuse	Family	\$1,847.34
Gold	Standard	HD1800 GOLD	Off	0.782	Syracuse	Child Only	\$267.05
Gold	Standard	HD1800 GOLD	Off	0.782	Utica	Ind	\$676.84
Gold	Standard	HD1800 GOLD	Off	0.782	Utica	Ind + Sp	\$1,353.68
Gold	Standard	HD1800 GOLD	Off	0.782	Utica	Parent + Chld(rn)	\$1,150.63
Gold	Standard	HD1800 GOLD	Off	0.782	Utica	Family	\$1,928.99
Gold	Standard	HD1800 GOLD	Off	0.782	Utica	Child Only	\$278.86

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Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Gold	Age 29	HD1800 GOLD	Off	0.782	Downstate	Ind	\$752.00
Gold	Age 29	HD1800 GOLD	Off	0.782	Downstate	Ind + Sp	\$1,504.00
Gold	Age 29	HD1800 GOLD	Off	0.782	Downstate	Parent + Chld(rn)	\$1,278.40
Gold	Age 29	HD1800 GOLD	Off	0.782	Downstate	Family	\$2,143.20
Gold	Age 29	HD1800 GOLD	Off	0.782	Long Island	Ind	\$810.02
Gold	Age 29	HD1800 GOLD	Off	0.782	Long Island	Ind + Sp	\$1,620.04
Gold	Age 29	HD1800 GOLD	Off	0.782	Long Island	Parent + Chld(rn)	\$1,377.03
Gold	Age 29	HD1800 GOLD	Off	0.782	Long Island	Family	\$2,308.56
Gold	Age 29	HD1800 GOLD	Off	0.782	Albany	Ind	\$703.12
Gold	Age 29	HD1800 GOLD	Off	0.782	Albany	Ind + Sp	\$1,406.24
Gold	Age 29	HD1800 GOLD	Off	0.782	Albany	Parent + Chld(rn)	\$1,195.30
Gold	Age 29	HD1800 GOLD	Off	0.782	Albany	Family	\$2,003.89
Gold	Age 29	HD1800 GOLD	Off	0.782	Buffalo	Ind	\$650.54
Gold	Age 29	HD1800 GOLD	Off	0.782	Buffalo	Ind + Sp	\$1,301.08
Gold	Age 29	HD1800 GOLD	Off	0.782	Buffalo	Parent + Chld(rn)	\$1,105.92
Gold	Age 29	HD1800 GOLD	Off	0.782	Buffalo	Family	\$1,854.04
Gold	Age 29	HD1800 GOLD	Off	0.782	Mid-Hudson	Ind	\$770.43
Gold	Age 29	HD1800 GOLD	Off	0.782	Mid-Hudson	Ind + Sp	\$1,540.86
Gold	Age 29	HD1800 GOLD	Off	0.782	Mid-Hudson	Parent + Chld(rn)	\$1,309.73
Gold	Age 29	HD1800 GOLD	Off	0.782	Mid-Hudson	Family	\$2,195.73
Gold	Age 29	HD1800 GOLD	Off	0.782	Rochester	Ind	\$635.50
Gold	Age 29	HD1800 GOLD	Off	0.782	Rochester	Ind + Sp	\$1,271.00
Gold	Age 29	HD1800 GOLD	Off	0.782	Rochester	Parent + Chld(rn)	\$1,080.35
Gold	Age 29	HD1800 GOLD	Off	0.782	Rochester	Family	\$1,811.18
Gold	Age 29	HD1800 GOLD	Off	0.782	Syracuse	Ind	\$680.60
Gold	Age 29	HD1800 GOLD	Off	0.782	Syracuse	Ind + Sp	\$1,361.20
Gold	Age 29	HD1800 GOLD	Off	0.782	Syracuse	Parent + Chld(rn)	\$1,157.02
Gold	Age 29	HD1800 GOLD	Off	0.782	Syracuse	Family	\$1,939.71
Gold	Age 29	HD1800 GOLD	Off	0.782	Utica	Ind	\$710.68
Gold	Age 29	HD1800 GOLD	Off	0.782	Utica	Ind + Sp	\$1,421.36
Gold	Age 29	HD1800 GOLD	Off	0.782	Utica	Parent + Chld(rn)	\$1,208.16
Gold	Age 29	HD1800 GOLD	Off	0.782	Utica	Family	\$2,025.44

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Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Silver	Standard	HD2000 SILVER	Off	0.686	Downstate	Ind	\$609.27
Silver	Standard	HD2000 SILVER	Off	0.686	Downstate	Ind + Sp	\$1,218.54
Silver	Standard	HD2000 SILVER	Off	0.686	Downstate	Parent + Chld(rn)	\$1,035.76
Silver	Standard	HD2000 SILVER	Off	0.686	Downstate	Family	\$1,736.42
Silver	Standard	HD2000 SILVER	Off	0.686	Downstate	Child Only	\$251.02
Silver	Standard	HD2000 SILVER	Off	0.686	Long Island	Ind	\$656.27
Silver	Standard	HD2000 SILVER	Off	0.686	Long Island	Ind + Sp	\$1,312.54
Silver	Standard	HD2000 SILVER	Off	0.686	Long Island	Parent + Chld(rn)	\$1,115.66
Silver	Standard	HD2000 SILVER	Off	0.686	Long Island	Family	\$1,870.37
Silver	Standard	HD2000 SILVER	Off	0.686	Long Island	Child Only	\$270.38
Silver	Standard	HD2000 SILVER	Off	0.686	Albany	Ind	\$569.66
Silver	Standard	HD2000 SILVER	Off	0.686	Albany	Ind + Sp	\$1,139.32
Silver	Standard	HD2000 SILVER	Off	0.686	Albany	Parent + Chld(rn)	\$968.42
Silver	Standard	HD2000 SILVER	Off	0.686	Albany	Family	\$1,623.53
Silver	Standard	HD2000 SILVER	Off	0.686	Albany	Child Only	\$234.70
Silver	Standard	HD2000 SILVER	Off	0.686	Buffalo	Ind	\$527.05
Silver	Standard	HD2000 SILVER	Off	0.686	Buffalo	Ind + Sp	\$1,054.10
Silver	Standard	HD2000 SILVER	Off	0.686	Buffalo	Parent + Chld(rn)	\$895.99
Silver	Standard	HD2000 SILVER	Off	0.686	Buffalo	Family	\$1,502.09
Silver	Standard	HD2000 SILVER	Off	0.686	Buffalo	Child Only	\$217.14
Silver	Standard	HD2000 SILVER	Off	0.686	Mid-Hudson	Ind	\$624.18
Silver	Standard	HD2000 SILVER	Off	0.686	Mid-Hudson	Ind + Sp	\$1,248.36
Silver	Standard	HD2000 SILVER	Off	0.686	Mid-Hudson	Parent + Chld(rn)	\$1,061.11
Silver	Standard	HD2000 SILVER	Off	0.686	Mid-Hudson	Family	\$1,778.91
Silver	Standard	HD2000 SILVER	Off	0.686	Mid-Hudson	Child Only	\$257.16
Silver	Standard	HD2000 SILVER	Off	0.686	Rochester	Ind	\$514.88
Silver	Standard	HD2000 SILVER	Off	0.686	Rochester	Ind + Sp	\$1,029.76
Silver	Standard	HD2000 SILVER	Off	0.686	Rochester	Parent + Chld(rn)	\$875.30
Silver	Standard	HD2000 SILVER	Off	0.686	Rochester	Family	\$1,467.41
Silver	Standard	HD2000 SILVER	Off	0.686	Rochester	Child Only	\$212.13
Silver	Standard	HD2000 SILVER	Off	0.686	Syracuse	Ind	\$551.42
Silver	Standard	HD2000 SILVER	Off	0.686	Syracuse	Ind + Sp	\$1,102.84
Silver	Standard	HD2000 SILVER	Off	0.686	Syracuse	Parent + Chld(rn)	\$937.41
Silver	Standard	HD2000 SILVER	Off	0.686	Syracuse	Family	\$1,571.55
Silver	Standard	HD2000 SILVER	Off	0.686	Syracuse	Child Only	\$227.19
Silver	Standard	HD2000 SILVER	Off	0.686	Utica	Ind	\$575.78
Silver	Standard	HD2000 SILVER	Off	0.686	Utica	Ind + Sp	\$1,151.56
Silver	Standard	HD2000 SILVER	Off	0.686	Utica	Parent + Chld(rn)	\$978.83
Silver	Standard	HD2000 SILVER	Off	0.686	Utica	Family	\$1,640.97
Silver	Standard	HD2000 SILVER	Off	0.686	Utica	Child Only	\$237.22

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Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Silver	Age 29	HD2000 SILVER	Off	0.686	Downstate	Ind	\$639.73
Silver	Age 29	HD2000 SILVER	Off	0.686	Downstate	Ind + Sp	\$1,279.46
Silver	Age 29	HD2000 SILVER	Off	0.686	Downstate	Parent + Chld(rn)	\$1,087.54
Silver	Age 29	HD2000 SILVER	Off	0.686	Downstate	Family	\$1,823.23
Silver	Age 29	HD2000 SILVER	Off	0.686	Long Island	Ind	\$689.08
Silver	Age 29	HD2000 SILVER	Off	0.686	Long Island	Ind + Sp	\$1,378.16
Silver	Age 29	HD2000 SILVER	Off	0.686	Long Island	Parent + Chld(rn)	\$1,171.44
Silver	Age 29	HD2000 SILVER	Off	0.686	Long Island	Family	\$1,963.88
Silver	Age 29	HD2000 SILVER	Off	0.686	Albany	Ind	\$598.14
Silver	Age 29	HD2000 SILVER	Off	0.686	Albany	Ind + Sp	\$1,196.28
Silver	Age 29	HD2000 SILVER	Off	0.686	Albany	Parent + Chld(rn)	\$1,016.84
Silver	Age 29	HD2000 SILVER	Off	0.686	Albany	Family	\$1,704.70
Silver	Age 29	HD2000 SILVER	Off	0.686	Buffalo	Ind	\$553.40
Silver	Age 29	HD2000 SILVER	Off	0.686	Buffalo	Ind + Sp	\$1,106.80
Silver	Age 29	HD2000 SILVER	Off	0.686	Buffalo	Parent + Chld(rn)	\$940.78
Silver	Age 29	HD2000 SILVER	Off	0.686	Buffalo	Family	\$1,577.19
Silver	Age 29	HD2000 SILVER	Off	0.686	Mid-Hudson	Ind	\$655.39
Silver	Age 29	HD2000 SILVER	Off	0.686	Mid-Hudson	Ind + Sp	\$1,310.78
Silver	Age 29	HD2000 SILVER	Off	0.686	Mid-Hudson	Parent + Chld(rn)	\$1,114.16
Silver	Age 29	HD2000 SILVER	Off	0.686	Mid-Hudson	Family	\$1,867.86
Silver	Age 29	HD2000 SILVER	Off	0.686	Rochester	Ind	\$540.62
Silver	Age 29	HD2000 SILVER	Off	0.686	Rochester	Ind + Sp	\$1,081.24
Silver	Age 29	HD2000 SILVER	Off	0.686	Rochester	Parent + Chld(rn)	\$919.05
Silver	Age 29	HD2000 SILVER	Off	0.686	Rochester	Family	\$1,540.77
Silver	Age 29	HD2000 SILVER	Off	0.686	Syracuse	Ind	\$578.99
Silver	Age 29	HD2000 SILVER	Off	0.686	Syracuse	Ind + Sp	\$1,157.98
Silver	Age 29	HD2000 SILVER	Off	0.686	Syracuse	Parent + Chld(rn)	\$984.28
Silver	Age 29	HD2000 SILVER	Off	0.686	Syracuse	Family	\$1,650.12
Silver	Age 29	HD2000 SILVER	Off	0.686	Utica	Ind	\$604.57
Silver	Age 29	HD2000 SILVER	Off	0.686	Utica	Ind + Sp	\$1,209.14
Silver	Age 29	HD2000 SILVER	Off	0.686	Utica	Parent + Chld(rn)	\$1,027.77
Silver	Age 29	HD2000 SILVER	Off	0.686	Utica	Family	\$1,723.02

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Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Bronze	Standard	HD6300 BRONZE	Off	0.582	Downstate	Ind	\$513.32
Bronze	Standard	HD6300 BRONZE	Off	0.582	Downstate	Ind + Sp	\$1,026.64
Bronze	Standard	HD6300 BRONZE	Off	0.582	Downstate	Parent + Chld(rn)	\$872.64
Bronze	Standard	HD6300 BRONZE	Off	0.582	Downstate	Family	\$1,462.96
Bronze	Standard	HD6300 BRONZE	Off	0.582	Downstate	Child Only	\$211.49
Bronze	Standard	HD6300 BRONZE	Off	0.582	Long Island	Ind	\$552.92
Bronze	Standard	HD6300 BRONZE	Off	0.582	Long Island	Ind + Sp	\$1,105.84
Bronze	Standard	HD6300 BRONZE	Off	0.582	Long Island	Parent + Chld(rn)	\$939.96
Bronze	Standard	HD6300 BRONZE	Off	0.582	Long Island	Family	\$1,575.82
Bronze	Standard	HD6300 BRONZE	Off	0.582	Long Island	Child Only	\$227.80
Bronze	Standard	HD6300 BRONZE	Off	0.582	Albany	Ind	\$479.95
Bronze	Standard	HD6300 BRONZE	Off	0.582	Albany	Ind + Sp	\$959.90
Bronze	Standard	HD6300 BRONZE	Off	0.582	Albany	Parent + Chld(rn)	\$815.92
Bronze	Standard	HD6300 BRONZE	Off	0.582	Albany	Family	\$1,367.86
Bronze	Standard	HD6300 BRONZE	Off	0.582	Albany	Child Only	\$197.74
Bronze	Standard	HD6300 BRONZE	Off	0.582	Buffalo	Ind	\$444.06
Bronze	Standard	HD6300 BRONZE	Off	0.582	Buffalo	Ind + Sp	\$888.12
Bronze	Standard	HD6300 BRONZE	Off	0.582	Buffalo	Parent + Chld(rn)	\$754.90
Bronze	Standard	HD6300 BRONZE	Off	0.582	Buffalo	Family	\$1,265.57
Bronze	Standard	HD6300 BRONZE	Off	0.582	Buffalo	Child Only	\$182.95
Bronze	Standard	HD6300 BRONZE	Off	0.582	Mid-Hudson	Ind	\$525.89
Bronze	Standard	HD6300 BRONZE	Off	0.582	Mid-Hudson	Ind + Sp	\$1,051.78
Bronze	Standard	HD6300 BRONZE	Off	0.582	Mid-Hudson	Parent + Chld(rn)	\$894.01
Bronze	Standard	HD6300 BRONZE	Off	0.582	Mid-Hudson	Family	\$1,498.79
Bronze	Standard	HD6300 BRONZE	Off	0.582	Mid-Hudson	Child Only	\$216.67
Bronze	Standard	HD6300 BRONZE	Off	0.582	Rochester	Ind	\$433.79
Bronze	Standard	HD6300 BRONZE	Off	0.582	Rochester	Ind + Sp	\$867.58
Bronze	Standard	HD6300 BRONZE	Off	0.582	Rochester	Parent + Chld(rn)	\$737.44
Bronze	Standard	HD6300 BRONZE	Off	0.582	Rochester	Family	\$1,236.30
Bronze	Standard	HD6300 BRONZE	Off	0.582	Rochester	Child Only	\$178.72
Bronze	Standard	HD6300 BRONZE	Off	0.582	Syracuse	Ind	\$464.59
Bronze	Standard	HD6300 BRONZE	Off	0.582	Syracuse	Ind + Sp	\$929.18
Bronze	Standard	HD6300 BRONZE	Off	0.582	Syracuse	Parent + Chld(rn)	\$789.80
Bronze	Standard	HD6300 BRONZE	Off	0.582	Syracuse	Family	\$1,324.08
Bronze	Standard	HD6300 BRONZE	Off	0.582	Syracuse	Child Only	\$191.41
Bronze	Standard	HD6300 BRONZE	Off	0.582	Utica	Ind	\$485.11
Bronze	Standard	HD6300 BRONZE	Off	0.582	Utica	Ind + Sp	\$970.22
Bronze	Standard	HD6300 BRONZE	Off	0.582	Utica	Parent + Chld(rn)	\$824.69
Bronze	Standard	HD6300 BRONZE	Off	0.582	Utica	Family	\$1,382.56
Bronze	Standard	HD6300 BRONZE	Off	0.582	Utica	Child Only	\$199.87

GHI
Rates Effective 1/1/2014

Proposed Rates

Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	2014
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Downstate	Ind	\$538.99
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Downstate	Ind + Sp	\$1,077.98
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Downstate	Parent + Chld(rn)	\$916.28
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Downstate	Family	\$1,536.12
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Long Island	Ind	\$580.57
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Long Island	Ind + Sp	\$1,161.14
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Long Island	Parent + Chld(rn)	\$986.97
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Long Island	Family	\$1,654.62
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Albany	Ind	\$503.95
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Albany	Ind + Sp	\$1,007.90
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Albany	Parent + Chld(rn)	\$856.72
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Albany	Family	\$1,436.26
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Buffalo	Ind	\$466.26
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Buffalo	Ind + Sp	\$932.52
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Buffalo	Parent + Chld(rn)	\$792.64
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Buffalo	Family	\$1,328.84
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Mid-Hudson	Ind	\$552.18
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Mid-Hudson	Ind + Sp	\$1,104.36
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Mid-Hudson	Parent + Chld(rn)	\$938.71
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Mid-Hudson	Family	\$1,573.71
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Rochester	Ind	\$455.48
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Rochester	Ind + Sp	\$910.96
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Rochester	Parent + Chld(rn)	\$774.32
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Rochester	Family	\$1,298.12
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Syracuse	Ind	\$487.82
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Syracuse	Ind + Sp	\$975.64
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Syracuse	Parent + Chld(rn)	\$829.29
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Syracuse	Family	\$1,390.29
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Utica	Ind	\$509.37
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Utica	Ind + Sp	\$1,018.74
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Utica	Parent + Chld(rn)	\$865.93
Bronze	Age 29	HD6300 BRONZE	Off	0.582	Utica	Family	\$1,451.70

GHI
Individual Off Exchange Products
Form Name and Number

Product Name	Form Name	Form Number
HD900 PLATINUM	Contract of Insurance Form	DPC-OX-100
HD900 PLATINUM	Age 29 Rider	DPC-OXR-A29
HD900 PLATINUM	Child Only	DPC-OXC-100
HD1800 GOLD	Contract of Insurance Form	DPC-OX-100
HD1800 GOLD	Age 29 Rider	DPC-OXR-A29
HD1800 GOLD	Child Only	DPC-OXC-100
HD2000 SILVER	Contract of Insurance Form	DPC-OX-100
HD2000 SILVER	Age 29 Rider	DPC-OXR-A29
HD2000 SILVER	Child Only	DPC-OXC-100
HD6300 BRONZE	Contract of Insurance Form	DPC-OX-100
HD6300 BRONZE	Age 29 Rider	DPC-OXR-A29
HD6300 BRONZE	Child Only	DPC-OXC-100

GHI
Individual Off Exchange Products
Region and Area Factors

<u>Region</u>	<u>Area Factor</u>
Downstate	0.955
LongIsland	1.029
Albany	0.893
Buffalo	0.826
Mid_Hudson	0.979
Rochester	0.807
Syracuse	0.865
Utica	0.903

GHI
Individual Off Exchange Products
Expected Loss Ratios

HD900 PLATINUM	92.2%
HD1800 GOLD	92.1%
HD2000 SILVER	91.9%
HD6300 BRONZE	91.7%

OFF EXCHANGE: Underwritten: GHI	Platinum
Product Type:	EPO
Ind/Fam Deductible (Med/Hosp/Vision/Rx)	\$900/\$1800 (per cal/yr/ policy year.)
Ind/Fam Maximum OOP (incl Ded):	\$900/\$1800
Rx included in Deductible:	Yes
Rx included in OOP maximum:	Yes
Q4 Deductible Carry Over	No
PCP Visit (injury or illness)	0% coinsurance per visit
Specialist Visit	0% coinsurance per visit
Inpatient Facility/SNF/Hospice	0% coinsurance per admission
Outpatient Facility - Surgery, including free-standing surgicenters	0% coinsurance per visit
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	0% coinsurance per visit
Emergency Room - Facility charge (INN/ONN)	0% coinsurance (waived if admitted as an inpatient)
Emergency room visit - Physician charge	0% coinsurance per visit
Urgent Care (INN)	0% coinsurance per visit
Observation Stay	0% coinsurance (waived if admitted as inpatient)
Anesthesia	0% coinsurance
Emergent Ambulance	0% coinsurance per visit
Non-Emergent Ambulance Hosp to Facility Transfer	Covered in Full
PT/OT/ST (Rehabilitative & Habilitative)	0% coinsurance per visit
DME/Medical Supplies	0% Coinsurance
Hearing Aids	0% Coinsurance
Eyewear	0% Coinsurance
Exercise Facility Reimbursement	<p>Subscriber reimbursed at the lesser of \$200 or actual cost of membership per six-month period and 50 visits. Subscriber's spouse reimbursed at the lesser of \$100 or actual cost of membership per six-month period and 50 visits.</p> <p>* Incentive not applied to OOP or Deductible</p>

SERVICE	LIMIT/Note	IP Fac	OP Fac	Prof
Outpatient Services				
PCP Office Visits (Injury or Illness)	No Limit	N/A	N/A	0% Coinsurance
Specialist Visits	No Limit	N/A	N/A	0% Coinsurance
Outpatient Facility or Ambulatory Surgery	No Limit	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	N/A
Outpatient Surgery Physician/Surgical Services	No Limit	N/A	N/A	Surgeon 0% Coinsurance
Outpatient Diagnostic and Routine Laboratory/Pathology/Routine Imaging (X-rays)/Imaging (CAT/PET/MRI)	No Limit	N/A	0% Coinsurance	N/A

Appendix B
GHI Platinum

Radiation Therapy	No Limit	N/A	0% Coinsurance	0% Coinsurance
Home Health Care Services	Coverage is limited to 60 visits per calendar year.	N/A	0% Coinsurance	0% Coinsurance
Hemodialysis/Renal dialysis	No Limit	N/A	0% Coinsurance	0% Coinsurance
Out of Network Dialysis	Limit is 10 visits. Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	N/A	0% Coinsurance	0% Coinsurance
Chemotherapy	No Limit	N/A	0% Coinsurance	0% Coinsurance
Preadmission Testing	No Limit	N/A	0% Coinsurance	0% Coinsurance
Autologous Blood Banking	Only in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury.	N/A	0% Coinsurance	N/A
Outpatient Rehabilitation Services/Habilitation Services (PT, OT, ST)	ST: 60 visits per calendar year OT/PT: 120 visits per calendar year	N/A	0% Coinsurance	0% Coinsurance
Chiropractic Care	No Limit	N/A	N/A	0% Coinsurance
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home. Orthotics are excluded * See Model Language	N/A	N/A	0% Coinsurance
Prosthetic Devices - External	2 external prosthetic device per lifetime *Coverage for external repairs or replacement in adults. - Coverage for wigs made from human hair if member is allergic to synthetic wig materials. To determine if this can be configured **Additional coverage for external device replacement for children for devices that have been outgrown - Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy)	N/A	N/A	0% coinsurance (for devices)
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Infertility Treatment	Unlimited / Member must be between ages of 21 and 44 * Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Includes correctable medical conditions leading to infertility ** Advanced infertility is not covered	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	Surgeon 0%Coinsurance
Infertility Treatment	Provider visits and non surgical services under infertility treatment	N/A	0% Coinsurance	0% Coinsurance

Appendix B
GHI Platinum

Termination of Pregnancy	Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules	N/A	OP Amb Surgery Coinsurance	Surgeon 0% Coinsurance
Elective Termination of Pregnancy	One per calendar year Limit Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules ****(to discuss configuration of therapeutic vs elective; re: limits and differentiating via specific codes on claims - with Med Mgmt and Claims)	N/A	OP Amb Surgery Coinsurance	Surgeon 0% Coinsurance
Diabetic supplies	No Limit	N/A	N/A	0% Coinsurance / 30 day supply
Diabetic drugs (including insulin)	No Limit	N/A	N/A	0% Coinsurance / 30 day supply
Diabetic education and self-management	No Limit	N/A	N/A	0% Coinsurance
Allergy testing and treatment; Allergy shots	No Limit	N/A	N/A	0% Coinsurance
ABA treatment for Autism Spectrum Disorder	Actuarial equivalence to 680 hours per year annual ABA limit	N/A	N/A	0% Coinsurance
Assistive Communication Devices for Autism Spectrum Disorder		N/A	N/A	0% Coinsurance per device
Emergency Services		IP Fac	OP Fac	Prof
Emergency Room Services	No Limit. Copay waived if admitted as IP	N/A	0% Coinsurance	0% Coinsurance
Observation Stay	Copay waived if admitted as IP Note: If ER and Obs. Stay, only one copay.	N/A	0% Coinsurance	N/A
Urgent Care Centers or Facilities	INN Coverage Only	N/A	0% Coinsurance	Urgent Care 0% Coinsurance for "freestanding" Urgent Care (e.g., "doc in a box"). 0% cost sharing for Urgent Care physicians
Emergency Transportation/Ambulance	No Limit Covers Land, Air and Water	0% Coinsurance		
Non Emergent Transportation/Ambulance	No Limit (Hospital to Facility transfer only) Land and Air only; Ambulette is excluded.	Covered in Full		
Hospitalization		IP Fac	OP Fac	Prof
Inpatient Hospital Services	No Limit*	0% Coinsurance	N/A	N/A

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GHI Platinum

Inpatient Physician and Surgical Services	No Limit	N/A	N/A	Surgeon coinsurance on surgeon claim. \$0 cost sharing on all other IP professional svcs
Skilled Nursing Facility	Skilled Nursing limited to 200 days per calendar year*	0% Coinsurance	N/A	\$0 cost sharing on all SNF professional services
Delivery and all Inpatient Services for Maternity Care	No Limit (covers mother and newborn combined)*	0% Coinsurance	N/A	Surgeon coinsurance on maternity delivery. Only one copay per pregnancy (e.g., covers delivery and post-natal svcs.)
Inpatient Rehabilitation Services	Inpatient rehabilitation therapy is covered for consecutive 60-day period, for physical, speech and occupational therapies when hospitalization would otherwise be necessary and the member must require skilled care on a daily basis, which is not primarily custodial and can only be provided on an inpatient basis. Admission must begin within six(6) months inpatient hospital stay or outpatient surgical procedure Copay not taken if member readmitted w/in 90 days for same or related condition. Cardiac and Pulmonary Rehab is not covered.	0% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Bariatric Surgery	No Limit*	0% Coinsurance	0% Coinsurance	Surgeon 0% Cost Sharing. \$0 cost sharing on all other IP professional svcs
Mental Health and Substance Abuse Disorder Services		IP Fac	OP Fac	Prof
Mental/Behavioral Health Outpatient Services	No Limit Includes 20 OP visits for family counseling are covered.	N/A	0% Coinsurance	0% Coinsurance
Mental/Behavioral Health Inpatient Services	No Limit*	0% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Substance Abuse Disorder Outpatient Services	No Limit	N/A	0% Coinsurance	0% Coinsurance
Substance Abuse Disorder Inpatient Services	No Limit*	0% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Laboratory and Imaging Services		IP Fac	OP Fac	Prof
Diagnostic Test (X-Ray and Lab Work)	No Limit Note: only 1 copay applies and does not apply of claims for X-ray interpretation.	N/A	0% Coinsurance	0% Coinsurance
Imaging (CT/PET Scans, MRI)	No Limit Note: This does not apply to claims for interpretation of imaging	N/A	0% Coinsurance	0% Coinsurance
Preventive and Wellness Services		IP Fac	OP Fac	Prof
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. \$0 cost sharing for ACA preventive svcs and other \$0 cost sharing NYS mandates.	N/A	Covered in Full	Covered in Full

Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Pediatric Vision		IP Fac	OP Fac	Prof
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	One exam per 12 month period. Up to age 19 end of month.	N/A	N/A	0% Coinsurance
Prescription Lenses	Must provide coverage for eye exam, lenses and frames (once in any 12 month period) and contact lenses (only when deemed medically necessary)	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Contact Lenses	in lieu of frames	N/A	N/A	0% Coinsurance
Other Services		IP Fac	OP Fac	Prof
Hospice Services (includes End of Life Care)	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member. For End of Life Care - Non-Par providers are covered. ** Refer to model language for rules	0% Coinsurance	0% Coinsurance	0% Coinsurance
Family Planning - Contraceptive drugs and devices, tubal ligations	No Limit * Women's Wellness mandate	N/A	N/A	Covered in Full
Vasectomies-Office		N/A	N/A	0% Coinsurance
Vasectomies-Outpatient/ Amb Surgery		N/A	0% Coinsurance	Surgeon 0% Coinsurance
Hearing Evaluations/testing	No Limit	N/A	N/A	0% Coinsurance
Hearing Aids	Limited to a single purchase for one or both ears (including repair/replacement) every three years.	N/A	N/A	0% Coinsurance
Outpatient Cardiac and Pulmonary Therapy	No limits in Model Language.	N/A	0% Coinsurance	0% Coinsurance
Second Opinion (surgical)	Second surgical opinion on the need for surgery.	N/A	N/A	0% Coinsurance
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer. <u>Copay applies to Par and Non Par</u>	N/A	N/A	0% Coinsurance
Transplants	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition * Solely for transplants for surgeries determined to be non-experimental and non-investigational.	0% Coinsurance	N/A	Surgeon 0% Coinsurance. \$0 cost sharing on all other IP professional svcs

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GHI Platinum

<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*<u>Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</u></p>	<p>0% Coinsurance</p>	<p>N/A</p>	<p>Surgeon 0% Coinsurance. \$0 cost sharing on all other IP professional svcs</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*<u>Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</u></p>	<p>N/A</p>	<p>0% Coinsurance</p>	<p>Surgeon 0% Coinsurance</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*<u>Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</u></p>	<p>N/A</p>	<p>N/A</p>	<p>0% Coinsurance</p>

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GHI Platinum

Infusion Therapy		N/A	N/A	0% Coinsurance
Infusion Therapy	No limit	N/A	0% Coinsurance	0% Coinsurance
Anesthesia (all settings)	No limit	0% Coinsurance	0% Coinsurance	0% Coinsurance
Prescription Drugs		IP Fac	OP Fac	Prof
Enteral Formulas	No Limit Note: Follows current practice for MM and Pharmacy	N/A	N/A	N/A
Retail: Tier 1/Generic: 0% Coinsurance Tier 2/Formulary Brand: 0% Coinsurance Tier 3/Non-Formulary: 0% Coinsurance *Mail Order up to 90 day supply: 2.5x the 30 day supply cost sharing	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Specialty Drugs: 0% Coinsurance	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Off Label Cancer Drugs: 0% Coinsurance	30 day supply	N/A	N/A	N/A

(1) Pediatric Dental removed since standalone

OFF EXCHANGE: Underwritten: GHI	Gold
Product Type:	EPO
Ind/Fam Deductible (Med/Hosp/Vision/Rx)	\$1800/\$3600 (per cal/yr/ policy year.)
Ind/Fam Maximum OOP (incl Ded):	\$2200/\$4400
Rx included in Deductible:	Yes
Rx included in OOP maximum:	Yes
Q4 Deductible Carry Over	No
PCP Visit (injury or illness)	10% coinsurance per visit
Specialist Visit	10% coinsurance per visit
Inpatient Facility/SNF/Hospice	10% coinsurance per admission
Outpatient Facility - Surgery, including free-standing surgicenters	10% coinsurance per visit
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	10% coinsurance per visit
Emergency Room - Facility charge (INN/ONN)	10% coinsurance (waived if admitted as an inpatient)
Emergency room visit - Physician charge	10% coinsurance per visit
Urgent Care (INN)	10% coinsurance per visit
Observation Stay	10% coinsurance (waived if admitted as inpatient)
Anesthesia	10% coinsurance
Emergent Ambulance	10% coinsurance per visit
Non-Emergent Ambulance Hosp to Facility Transfer	Covered in Full
PT/OT/ST (Rehabilitative & Habilitative)	10% coinsurance per visit
DME/Medical Supplies	10% Coinsurance
Hearing Aids	10% Coinsurance
Eyewear	10% Coinsurance
Exercise Facility Reimbursement	<p>Subscriber reimbursed at the lesser of \$200 or actual cost of membership per six-month period and 50 visits. Subscriber's spouse reimbursed at the lesser of \$100 or actual cost of membership per six-month period and 50 visits.</p> <p>* Incentive not applied to OOP or Deductible</p>

SERVICE	LIMIT/Note	IP Fac	OP Fac	Prof
Outpatient Services				
PCP Office Visits (Injury or Illness)	No Limit	N/A	N/A	10% Coinsurance
Specialist Visits	No Limit	N/A	N/A	10% Coinsurance
Outpatient Facility or Ambulatory Surgery	No Limit	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	N/A
Outpatient Surgery Physician/Surgical Services	No Limit	N/A	N/A	Surgeon 10% Coinsurance
Outpatient Diagnostic and Routine Laboratory/Pathology/Routine Imaging (X-rays)/Imaging (CAT/PET/MRI)	No Limit	N/A	10% Coinsurance	N/A

Appendix B
GHI Gold

Radiation Therapy	No Limit	N/A	10% Coinsurance	10% Coinsurance
Home Health Care Services	Coverage is limited to 60 visits per calendar year.	N/A	10% Coinsurance	10% Coinsurance
Hemodialysis/Renal dialysis	No Limit	N/A	10% Coinsurance	10% Coinsurance
Out of Network Dialysis	Limit is 10 visits. Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	N/A	10% Coinsurance	10% Coinsurance
Chemotherapy	No Limit	N/A	10% Coinsurance	10% Coinsurance
Preadmission Testing	No Limit	N/A	10% Coinsurance	10% Coinsurance
Autologous Blood Banking	Only in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury.	N/A	10% Coinsurance	N/A
Outpatient Rehabilitation Services/Habilitation Services (PT, OT, ST)	ST: 60 visits per calendar year OT/PT: 120 visits per calendar year	N/A	10% Coinsurance	10% Coinsurance
Chiropractic Care	No Limit	N/A	N/A	10% Coinsurance
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home. Orthotics are excluded * See Model Language	N/A	N/A	10% Coinsurance
Prosthetic Devices - External	2 external prosthetic device per lifetime *Coverage for external repairs or replacement in adults. - Coverage for wigs made from human hair if member is allergic to synthetic wig materials. To determine if this can be configured **Additional coverage for external device replacement for children for devices that have been outgrown - Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy)	N/A	N/A	10% coinsurance (for devices)
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Infertility Treatment	Unlimited / Member must be between ages of 21 and 44 * Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Includes correctable medical conditions leading to infertility ** Advanced infertility is not covered	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	Surgeon 10%Coinsurance
Infertility Treatment	Provider visits and non surgical services under infertility treatment	N/A	10% Coinsurance	10% Coinsurance

Termination of Pregnancy	Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules	N/A	OP Amb Surgery Coinsurance	Surgeon 10% Coinsurance
Elective Termination of Pregnancy	One per calendar year Limit Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules ****(to discuss configuration of therapeutic vs elective; re: limits and differentiating via specific codes on claims - with Med Mgmt and Claims)	N/A	OP Amb Surgery Coinsurance	Surgeon 10% Coinsurance
Diabetic supplies	No Limit	N/A	N/A	10% Coinsurance / 30 day supply
Diabetic drugs (including insulin)	No Limit	N/A	N/A	10% Coinsurance / 30 day supply
Diabetic education and self-management	No Limit	N/A	N/A	10% Coinsurance
Allergy testing and treatment; Allergy shots	No Limit	N/A	N/A	10% Coinsurance
ABA treatment for Autism Spectrum Disorder	Actuarial equivalence to 680 hours per year annual ABA limit	N/A	N/A	10% Coinsurance
Assistive Communication Devices for Autism Spectrum Disorder		N/A	N/A	10% Coinsurance per device
Emergency Services		IP Fac	OP Fac	Prof
Emergency Room Services	No Limit. Copay waived if admitted as IP	N/A	10% Coinsurance	10% Coinsurance
Observation Stay	Copay waived if admitted as IP Note: If ER and Obs. Stay, only one copay.	N/A	10% Coinsurance	N/A
Urgent Care Centers or Facilities	INN Coverage Only	N/A	10% Coinsurance	Urgent Care 10% Coinsurance for "freestanding" Urgent Care (e.g., "doc in a box"). 0% cost sharing for Urgent Care physicians
Emergency Transportation/Ambulance	No Limit Covers Land, Air and Water	10% Coinsurance		
Non Emergent Transportation/Ambulance	No Limit (Hospital to Facility transfer only) Land and Air only; Ambulette is excluded.	Covered in Full		
Hospitalization		IP Fac	OP Fac	Prof
Inpatient Hospital Services	No Limit*	10% Coinsurance	N/A	N/A

Inpatient Physician and Surgical Services	No Limit	N/A	N/A	Surgeon coinsurance on surgeon claim. \$0 cost sharing on all other IP professional svcs
Skilled Nursing Facility	Skilled Nursing limited to 200 days per calendar year*	10% Coinsurance	N/A	\$0 cost sharing on all SNF professional services
Delivery and all Inpatient Services for Maternity Care	No Limit (covers mother and newborn combined)*	10% Coinsurance	N/A	Surgeon coinsurance on maternity delivery. Only one copay per pregnancy (e.g., covers delivery and post-natal svcs.)
Inpatient Rehabilitation Services	Inpatient rehabilitation therapy is covered for consecutive 60-day period, for physical, speech and occupational therapies when hospitalization would otherwise be necessary and the member must require skilled care on a daily basis, which is not primarily custodial and can only be provided on an inpatient basis. Admission must begin within six(6) months inpatient hospital stay or outpatient surgical procedure Copay not taken if member readmitted w/in 90 days for same or related condition. Cardiac and Pulmonary Rehab is not covered.	10% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Bariatric Surgery	No Limit*	10% Coinsurance	10% Coinsurance	Surgeon 10% Cost Sharing. \$0 cost sharing on all other IP professional svcs
Mental Health and Substance Abuse Disorder Services		IP Fac	OP Fac	Prof
Mental/Behavioral Health Outpatient Services	No Limit Includes 20 OP visits for family counseling are covered.	N/A	10% Coinsurance	10% Coinsurance
Mental/Behavioral Health Inpatient Services	No Limit*	10% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Substance Abuse Disorder Outpatient Services	No Limit	N/A	10% Coinsurance	10% Coinsurance
Substance Abuse Disorder Inpatient Services	No Limit*	10% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Laboratory and Imaging Services		IP Fac	OP Fac	Prof
Diagnostic Test (X-Ray and Lab Work)	No Limit Note: only 1 copay applies and does not apply of claims for X-ray interpretation.	N/A	10% Coinsurance	10% Coinsurance
Imaging (CT/PET Scans, MRI)	No Limit Note: This does not apply to claims for interpretation of imaging	N/A	10% Coinsurance	10% Coinsurance
Preventive and Wellness Services		IP Fac	OP Fac	Prof
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. \$0 cost sharing for ACA preventive svcs and other \$0 cost sharing NYS mandates.	N/A	Covered in Full	Covered in Full

Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Pediatric Vision		IP Fac	OP Fac	Prof
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	One exam per 12 month period. Up to age 19 end of month.	N/A	N/A	10% Coinsurance
Prescription Lenses	Must provide coverage for eye exam, lenses and frames (once in any 12 month period) and contact lenses (only when deemed medically necessary)	N/A	N/A	10% coinsurance applies to combined cost of lenses and frames
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.	N/A	N/A	10% coinsurance applies to combined cost of lenses and frames
Contact Lenses	in lieu of frames	N/A	N/A	10% Coinsurance
Other Services		IP Fac	OP Fac	Prof
Hospice Services (includes End of Life Care)	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member. For End of Life Care - Non-Par providers are covered. ** Refer to model language for rules	10% Coinsurance	10% Coinsurance	10% Coinsurance
Family Planning - Contraceptive drugs and devices, tubal ligations	No Limit * Women's Wellness mandate	N/A	N/A	Covered in Full
Vasectomies-Office		N/A	N/A	10% Coinsurance
Vasectomies-Outpatient/ Amb Surgery		N/A	10% Coinsurance	Surgeon 10% Coinsurance
Hearing Evaluations/testing	No Limit	N/A	N/A	10% Coinsurance
Hearing Aids	Limited to a single purchase for one or both ears (including repair/replacement) every three years.	N/A	N/A	10% Coinsurance
Outpatient Cardiac and Pulmonary Therapy	No limits in Model Language.	N/A	10% Coinsurance	10% Coinsurance
Second Opinion (surgical)	Second surgical opinion on the need for surgery.	N/A	N/A	10% Coinsurance
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer. <u>Copay applies to Par and Non Par</u>	N/A	N/A	10% Coinsurance
Transplants	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition * Solely for transplants for surgeries determined to be non-experimental and non-investigational.	10% Coinsurance	N/A	Surgeon 10% Coinsurance. \$0 cost sharing on all other IP professional svcs

<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>10% Coinsurance</p>	<p>N/A</p>	<p>Surgeon 10% Coinsurance. \$0 cost sharing on all other IP professional svcs</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>N/A</p>	<p>10% Coinsurance</p>	<p>Surgeon 10% Coinsurance</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>N/A</p>	<p>N/A</p>	<p>10% Coinsurance</p>

Appendix B
GHI Gold

Infusion Therapy		N/A	N/A	10% Coinsurance
Infusion Therapy	No limit	N/A	10% Coinsurance	10% Coinsurance
Anesthesia (all settings)	No limit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Prescription Drugs		IP Fac	OP Fac	Prof
Enteral Formulas	No Limit Note: Follows current practice for MM and Pharmacy	N/A	N/A	N/A
Retail: Tier 1/Generic: 10% Coinsurance Tier 2/Formulary Brand: 10% Coinsurance Tier 3/Non-Formulary: 10% Coinsurance *Mail Order up to 90 day supply: 2.5x the 30 day supply cost sharing	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Specialty Drugs: 10% Coinsurance	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Off Label Cancer Drugs: 10% Coinsurance	30 day supply	N/A	N/A	N/A

(1) Pediatric Dental removed since standalone

OFF EXCHANGE: Underwritten: GHI	Silver
Product Type:	EPO
Ind/Fam Deductible (Med/Hosp/Vision/Rx)	\$2000/\$4000 (per cal/yr/ policy year.)
Ind/Fam Maximum OOP (incl Ded):	\$6350/\$12700
Rx included in Deductible:	Yes
Rx included in OOP maximum:	Yes
Q4 Deductible Carry Over	No
PCP Visit (injury or illness)	20% coinsurance per visit
Specialist Visit	20% coinsurance per visit
Inpatient Facility/SNF/Hospice	20% coinsurance per admission
Outpatient Facility - Surgery, including free-standing surgicenters	20% coinsurance per visit
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	20% coinsurance per visit
Emergency Room - Facility charge (INN/ONN)	20% coinsurance (waived if admitted as an inpatient)
Emergency room visit - Physician charge	20% coinsurance per visit
Urgent Care (INN)	20% coinsurance per visit
Observation Stay	20% coinsurance (waived if admitted as inpatient)
Anesthesia	20% coinsurance
Emergent Ambulance	20% coinsurance per visit
Non-Emergent Ambulance Hosp to Facility Transfer	Covered in Full
PT/OT/ST (Rehabilitative & Habilitative)	20% coinsurance per visit
DME/Medical Supplies	20% Coinsurance
Hearing Aids	20% Coinsurance
Eyewear	20% Coinsurance
Exercise Facility Reimbursement	<p>Subscriber reimbursed at the lesser of \$200 or actual cost of membership per six-month period and 50 visits. Subscriber's spouse reimbursed at the lesser of \$100 or actual cost of membership per six-month period and 50 visits.</p> <p>* Incentive not applied to OOP or Deductible</p>

SERVICE	LIMIT/Note	IP Fac	OP Fac	Prof
Outpatient Services				
PCP Office Visits (Injury or Illness)	No Limit	N/A	N/A	20% Coinsurance
Specialist Visits	No Limit	N/A	N/A	20% Coinsurance
Outpatient Facility or Ambulatory Surgery	No Limit	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	N/A
Outpatient Surgery Physician/Surgical Services	No Limit	N/A	N/A	Surgeon 20% Coinsurance
Outpatient Diagnostic and Routine Laboratory/Pathology/Routine Imaging (X-rays)/Imaging (CAT/PET/MRI)	No Limit	N/A	20% Coinsurance	N/A

Appendix B
GHI Silver

Radiation Therapy	No Limit	N/A	20% Coinsurance	20% Coinsurance
Home Health Care Services	Coverage is limited to 60 visits per calendar year.	N/A	20% Coinsurance	20% Coinsurance
Hemodialysis/Renal dialysis	No Limit	N/A	20% Coinsurance	20% Coinsurance
Out of Network Dialysis	Limit is 10 visits. Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	N/A	20% Coinsurance	20% Coinsurance
Chemotherapy	No Limit	N/A	20% Coinsurance	20% Coinsurance
Preadmission Testing	No Limit	N/A	20% Coinsurance	20% Coinsurance
Autologous Blood Banking	Only in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury.	N/A	20% Coinsurance	N/A
Outpatient Rehabilitation Services/Habilitation Services (PT, OT, ST)	ST: 60 visits per calendar year OT/PT: 120 visits per calendar year	N/A	20% Coinsurance	20% Coinsurance
Chiropractic Care	No Limit	N/A	N/A	20% Coinsurance
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home. Orthotics are excluded * See Model Language	N/A	N/A	20% Coinsurance
Prosthetic Devices - External	2 external prosthetic device per lifetime *Coverage for external repairs or replacement in adults. - Coverage for wigs made from human hair if member is allergic to synthetic wig materials. To determine if this can be configured **Additional coverage for external device replacement for children for devices that have been outgrown - Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy)	N/A	N/A	20% coinsurance (for devices)
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Infertility Treatment	Unlimited / Member must be between ages of 21 and 44 * Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Includes correctable medical conditions leading to infertility ** Advanced infertility is not covered	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	Surgeon 20%Coinsurance
Infertility Treatment	Provider visits and non surgical services under infertility treatment	N/A	20% Coinsurance	20% Coinsurance

Termination of Pregnancy	Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules	N/A	OP Amb Surgery Coinsurance	Surgeon 20% Coinsurance
Elective Termination of Pregnancy	One per calendar year Limit Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules ****(to discuss configuration of therapeutic vs elective; re: limits and differentiating via specific codes on claims - with Med Mgmt and Claims)	N/A	OP Amb Surgery Coinsurance	Surgeon 20% Coinsurance
Diabetic supplies	No Limit	N/A	N/A	20% Coinsurance / 30 day supply
Diabetic drugs (including insulin)	No Limit	N/A	N/A	20% Coinsurance / 30 day supply
Diabetic education and self-management	No Limit	N/A	N/A	20% Coinsurance
Allergy testing and treatment; Allergy shots	No Limit	N/A	N/A	20% Coinsurance
ABA treatment for Autism Spectrum Disorder	Actuarial equivalence to 680 hours per year annual ABA limit	N/A	N/A	20% Coinsurance
Assistive Communication Devices for Autism Spectrum Disorder		N/A	N/A	20% Coinsurance per device
Emergency Services		IP Fac	OP Fac	Prof
Emergency Room Services	No Limit. Copay waived if admitted as IP	N/A	20% Coinsurance	20% Coinsurance
Observation Stay	Copay waived if admitted as IP Note: If ER and Obs. Stay, only one copay.	N/A	20% Coinsurance	N/A
Urgent Care Centers or Facilities	INN Coverage Only	N/A	20% Coinsurance	Urgent Care 20% Coinsurance for "freestanding" Urgent Care (e.g., "doc in a box"). 0% cost sharing for Urgent Care physicians
Emergency Transportation/Ambulance	No Limit Covers Land, Air and Water	20% Coinsurance		
Non Emergent Transportation/Ambulance	No Limit (Hospital to Facility transfer only) Land and Air only; Ambulette is excluded.	Covered in Full		
Hospitalization		IP Fac	OP Fac	Prof
Inpatient Hospital Services	No Limit*	20% Coinsurance	N/A	N/A

Inpatient Physician and Surgical Services	No Limit	N/A	N/A	Surgeon coinsurance on surgeon claim. \$0 cost sharing on all other IP professional svcs
Skilled Nursing Facility	Skilled Nursing limited to 200 days per calendar year*	20% Coinsurance	N/A	\$0 cost sharing on all SNF professional services
Delivery and all Inpatient Services for Maternity Care	No Limit (covers mother and newborn combined)*	20% Coinsurance	N/A	Surgeon coinsurance on maternity delivery. Only one copay per pregnancy (e.g., covers delivery and post-natal svcs.)
Inpatient Rehabilitation Services	Inpatient rehabilitation therapy is covered for consecutive 60-day period, for physical, speech and occupational therapies when hospitalization would otherwise be necessary and the member must require skilled care on a daily basis, which is not primarily custodial and can only be provided on an inpatient basis. Admission must begin within six(6) months inpatient hospital stay or outpatient surgical procedure Copay not taken if member readmitted w/in 90 days for same or related condition. Cardiac and Pulmonary Rehab is not covered.	20% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Bariatric Surgery	No Limit*	20% Coinsurance	20% Coinsurance	Surgeon 20% Coinsurance. \$0 cost sharing on all other IP professional svcs
Mental Health and Substance Abuse Disorder Services		IP Fac	OP Fac	Prof
Mental/Behavioral Health Outpatient Services	No Limit Includes 20 OP visits for family counseling are covered.	N/A	20% Coinsurance	20% Coinsurance
Mental/Behavioral Health Inpatient Services	No Limit*	20% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Substance Abuse Disorder Outpatient Services	No Limit	N/A	20% Coinsurance	20% Coinsurance
Substance Abuse Disorder Inpatient Services	No Limit*	20% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Laboratory and Imaging Services		IP Fac	OP Fac	Prof
Diagnostic Test (X-Ray and Lab Work)	No Limit Note: only 1 copay applies and does not apply of claims for X-ray interpretation.	N/A	20% Coinsurance	20% Coinsurance
Imaging (CT/PET Scans, MRI)	No Limit Note: This does not apply to claims for interpretation of imaging	N/A	20% Coinsurance	20% Coinsurance
Preventive and Wellness Services		IP Fac	OP Fac	Prof
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. \$0 cost sharing for ACA preventive svcs and other \$0 cost sharing NYS mandates.	N/A	Covered in Full	Covered in Full

Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Pediatric Vision		IP Fac	OP Fac	Prof
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	One exam per 12 month period. Up to age 19 end of month.	N/A	N/A	20% Coinsurance
Prescription Lenses	Must provide coverage for eye exam, lenses and frames (once in any 12 month period) and contact lenses (only when deemed medically necessary)	N/A	N/A	20% coinsurance applies to combined cost of lenses and frames
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.	N/A	N/A	20% coinsurance applies to combined cost of lenses and frames
Contact Lenses	in lieu of frames	N/A	N/A	20% Coinsurance
Other Services		IP Fac	OP Fac	Prof
Hospice Services (includes End of Life Care)	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member. For End of Life Care - Non-Par providers are covered. ** Refer to model language for rules	20% Coinsurance	20% Coinsurance	20% Coinsurance
Family Planning - Contraceptive drugs and devices, tubal ligations	No Limit * Women's Wellness mandate	N/A	N/A	Covered in Full
Vasectomies-Office		N/A	N/A	20% Coinsurance
Vasectomies-Outpatient/ Amb Surgery		N/A	20% Coinsurance	Surgeon 20% Coinsurance
Hearing Evaluations/testing	No Limit	N/A	N/A	20% Coinsurance
Hearing Aids	Limited to a single purchase for one or both ears (including repair/replacement) every three years.	N/A	N/A	20% Coinsurance
Outpatient Cardiac and Pulmonary Therapy	No limits in Model Language.	N/A	20% Coinsurance	20% Coinsurance
Second Opinion (surgical)	Second surgical opinion on the need for surgery.	N/A	N/A	20% Coinsurance
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer. <u>Copay applies to Par and Non Par</u>	N/A	N/A	20% Coinsurance
Transplants	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition * Solely for transplants for surgeries determined to be non-experimental and non-investigational.	20% Coinsurance	N/A	Surgeon 20% Coinsurance. \$0 cost sharing on all other IP professional svcs

<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>20% Coinsurance</p>	<p>N/A</p>	<p>Surgeon 20% Coinsurance. \$0 cost sharing on all other IP professional svcs</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>N/A</p>	<p>20% Coinsurance</p>	<p>Surgeon 20% Coinsurance</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>N/A</p>	<p>N/A</p>	<p>20% Coinsurance</p>

Infusion Therapy		N/A	N/A	20% Coinsurance
Infusion Therapy	No limit	N/A	20% Coinsurance	20% Coinsurance
Anesthesia (all settings)	No limit	20% Coinsurance	20% Coinsurance	20% Coinsurance
Prescription Drugs		IP Fac	OP Fac	Prof
Enteral Formulas	No Limit Note: Follows current practice for MM and Pharmacy	N/A	N/A	N/A
Retail: Tier 1/Generic: 20% Coinsurance Tier 2/Formulary Brand: 20% Coinsurance Tier 3/Non-Formulary: 20% Coinsurance *Mail Order up to 90 day supply: 2.5x the 30 day supply cost sharing	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Specialty Drugs: 20% Coinsurance	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Off Label Cancer Drugs: 20% Coinsurance	30 day supply	N/A	N/A	N/A

(1) Pediatric Dental removed since standalone

OFF EXCHANGE: Underwritten: GHI	Bronze
Product Type:	EPO
Ind/Fam Deductible (Med/Hosp/Vision/Rx)	\$6,300/\$12,600 (per cal/yr/ policy year.)
Ind/Fam Maximum OOP (incl Ded):	\$6,300/\$12,600
Rx included in Deductible:	Yes
Rx included in OOP maximum:	Yes
Q4 Deductible Carry Over	No
PCP Visit (injury or illness)	0% coinsurance per visit
Specialist Visit	0% coinsurance per visit
Inpatient Facility/SNF/Hospice	0% coinsurance per admission
Outpatient Facility - Surgery, including free-standing surgicenters	0% coinsurance per visit
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	0% coinsurance per visit
Emergency Room - Facility charge (INN/ONN)	0% coinsurance (waived if admitted as an inpatient)
Emergency room visit - Physician charge	0% coinsurance per visit
Urgent Care (INN)	0% coinsurance per visit
Observation Stay	0% coinsurance (waived if admitted as inpatient)
Anesthesia	0% coinsurance
Emergent Ambulance	0% coinsurance per visit
Non-Emergent Ambulance Hosp to Facility Transfer	Covered in Full
PT/OT/ST (Rehabilitative & Habilitative)	0% coinsurance per visit
DME/Medical Supplies	0% Coinsurance
Hearing Aids	0% Coinsurance
Eyewear	0% Coinsurance
Exercise Facility Reimbursement	<p>Subscriber reimbursed at the lesser of \$200 or actual cost of membership per six-month period and 50 visits. Subscriber's spouse reimbursed at the lesser of \$100 or actual cost of membership per six-month period and 50 visits.</p> <p>* Incentive not applied to OOP or Deductible</p>

SERVICE	LIMIT/Note	IP Fac	OP Fac	Prof
Outpatient Services				
PCP Office Visits (Injury or Illness)	No Limit	N/A	N/A	0% Coinsurance
Specialist Visits	No Limit	N/A	N/A	0% Coinsurance
Outpatient Facility or Ambulatory Surgery	No Limit	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	N/A
Outpatient Surgery Physician/Surgical Services	No Limit	N/A	N/A	Surgeon 0% Coinsurance
Outpatient Diagnostic and Routine Laboratory/Pathology/Routine Imaging (X-rays)/Imaging (CAT/PET/MRI)	No Limit	N/A	0% Coinsurance	N/A

Appendix B
GHI Bronze

Radiation Therapy	No Limit	N/A	0% Coinsurance	0% Coinsurance
Home Health Care Services	Coverage is limited to 60 visits per calendar year.	N/A	0% Coinsurance	0% Coinsurance
Hemodialysis/Renal dialysis	No Limit	N/A	0% Coinsurance	0% Coinsurance
Out of Network Dialysis	Limit is 10 visits. Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	N/A	0% Coinsurance	0% Coinsurance
Chemotherapy	No Limit	N/A	0% Coinsurance	0% Coinsurance
Preadmission Testing	No Limit	N/A	0% Coinsurance	0% Coinsurance
Autologous Blood Banking	Only in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury.	N/A	0% Coinsurance	N/A
Outpatient Rehabilitation Services/Habilitation Services (PT, OT, ST)	ST: 60 visits per calendar year OT/PT: 120 visits per calendar year	N/A	0% Coinsurance	0% Coinsurance
Chiropractic Care	No Limit	N/A	N/A	0% Coinsurance
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home. Orthotics are excluded * See Model Language	N/A	N/A	0% Coinsurance
Prosthetic Devices - External	2 external prosthetic device per lifetime *Coverage for external repairs or replacement in adults. - Coverage for wigs made from human hair if member is allergic to synthetic wig materials. To determine if this can be configured **Additional coverage for external device replacement for children for devices that have been outgrown - Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy)	N/A	N/A	0% coinsurance (for devices)
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Infertility Treatment	Unlimited / Member must be between ages of 21 and 44 * Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Includes correctable medical conditions leading to infertility ** Advanced infertility is not covered	N/A	OP Fac coinsurance on surgeries done in AmSurg or OP Facility.	Surgeon 0 %Coinsurance
Infertility Treatment	Provider visits and non surgical services under infertility treatment	N/A	0% Coinsurance	0% Coinsurance

Termination of Pregnancy	Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules	N/A	OP Amb Surgery Coinsurance	Surgeon 0% Coinsurance
Elective Termination of Pregnancy	One per calendar year Limit Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules ****(to discuss configuration of therapeutic vs elective; re: limits and differentiating via specific codes on claims - with Med Mgmt and Claims)	N/A	OP Amb Surgery Coinsurance	Surgeon 0% Coinsurance
Diabetic supplies	No Limit	N/A	N/A	0% Coinsurance / 30 day supply
Diabetic drugs (including insulin)	No Limit	N/A	N/A	0% Coinsurance / 30 day supply
Diabetic education and self-management	No Limit	N/A	N/A	0% Coinsurance
Allergy testing and treatment; Allergy shots	No Limit	N/A	N/A	0% Coinsurance
ABA treatment for Autism Spectrum Disorder	Actuarial equivalence to 680 hours per year annual ABA limit	N/A	N/A	0% Coinsurance
Assistive Communication Devices for Autism Spectrum Disorder		N/A	N/A	0% Coinsurance per device
Emergency Services		IP Fac	OP Fac	Prof
Emergency Room Services	No Limit. Copay waived if admitted as IP	N/A	0% Coinsurance	0% Coinsurance
Observation Stay	Copay waived if admitted as IP Note: If ER and Obs. Stay, only one copay.	N/A	0% Coinsurance	N/A
Urgent Care Centers or Facilities	INN Coverage Only	N/A	0% Coinsurance	Urgent Care 0% Coinsurance for "freestanding" Urgent Care (e.g., "doc in a box"). 0% cost sharing for Urgent Care physicians
Emergency Transportation/Ambulance	No Limit Covers Land, Air and Water	0% Coinsurance		
Non Emergent Transportation/Ambulance	No Limit (Hospital to Facility transfer only) Land and Air only; Ambulette is excluded.	Covered in Full		
Hospitalization		IP Fac	OP Fac	Prof
Inpatient Hospital Services	No Limit*	0% Coinsurance	N/A	N/A

Inpatient Physician and Surgical Services	No Limit	N/A	N/A	Surgeon coinsurance on surgeon claim. \$0 cost sharing on all other IP professional svcs
Skilled Nursing Facility	Skilled Nursing limited to 200 days per calendar year*	0% Coinsurance	N/A	\$0 cost sharing on all SNF professional services
Delivery and all Inpatient Services for Maternity Care	No Limit (covers mother and newborn combined)*	0% Coinsurance	N/A	Surgeon coinsurance on maternity delivery. Only one copay per pregnancy (e.g., covers delivery and post-natal svcs.)
Inpatient Rehabilitation Services	Inpatient rehabilitation therapy is covered for consecutive 60-day period, for physical, speech and occupational therapies when hospitalization would otherwise be necessary and the member must require skilled care on a daily basis, which is not primarily custodial and can only be provided on an inpatient basis. Admission must begin within six(6) months inpatient hospital stay or outpatient surgical procedure Copay not taken if member readmitted w/in 90 days for same or related condition. Cardiac and Pulmonary Rehab is not covered.	0% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Bariatric Surgery	No Limit*	0% Coinsurance	0% Coinsurance	Surgeon 0% Cost Sharing. \$0 cost sharing on all other IP professional svcs
Mental Health and Substance Abuse Disorder Services		IP Fac	OP Fac	Prof
Mental/Behavioral Health Outpatient Services	No Limit Includes 20 OP visits for family counseling are covered.	N/A	0% Coinsurance	0% Coinsurance
Mental/Behavioral Health Inpatient Services	No Limit*	0% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Substance Abuse Disorder Outpatient Services	No Limit	N/A	0% Coinsurance	0% Coinsurance
Substance Abuse Disorder Inpatient Services	No Limit*	0% Coinsurance	N/A	\$0 cost sharing for any professional svcs associated with IP admission
Laboratory and Imaging Services		IP Fac	OP Fac	Prof
Diagnostic Test (X-Ray and Lab Work)	No Limit Note: only 1 copay applies and does not apply of claims for X-ray interpretation.	N/A	0% Coinsurance	0% Coinsurance
Imaging (CT/PET Scans, MRI)	No Limit Note: This does not apply to claims for interpretation of imaging	N/A	0% Coinsurance	0% Coinsurance
Preventive and Wellness Services		IP Fac	OP Fac	Prof
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. \$0 cost sharing for ACA preventive svcs and other \$0 cost sharing NYS mandates.	N/A	Covered in Full	Covered in Full

Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Pediatric Vision		IP Fac	OP Fac	Prof
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	One exam per 12 month period. Up to age 19 end of month.	N/A	N/A	0% Coinsurance
Prescription Lenses	Must provide coverage for eye exam, lenses and frames (once in any 12 month period) and contact lenses (only when deemed medically necessary)	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Contact Lenses	in lieu of frames	N/A	N/A	0% Coinsurance
Other Services		IP Fac	OP Fac	Prof
Hospice Services (includes End of Life Care)	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member. For End of Life Care - Non-Par providers are covered. ** Refer to model language for rules	0% Coinsurance	0% Coinsurance	0% Coinsurance
Family Planning - Contraceptive drugs and devices, tubal ligations	No Limit * Women's Wellness mandate	N/A	N/A	Covered in Full
Vasectomies-Office		N/A	N/A	0% Coinsurance
Vasectomies-Outpatient/ Amb Surgery		N/A	0% Coinsurance	Surgeon 0% Coinsurance
Hearing Evaluations/testing	No Limit	N/A	N/A	0% Coinsurance
Hearing Aids	Limited to a single purchase for one or both ears (including repair/replacement) every three years.	N/A	N/A	0% Coinsurance
Outpatient Cardiac and Pulmonary Therapy	No limits in Model Language.	N/A	0% Coinsurance	0% Coinsurance
Second Opinion (surgical)	Second surgical opinion on the need for surgery.	N/A	N/A	0% Coinsurance
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer. <u>Copay applies to Par and Non Par</u>	N/A	N/A	0% Coinsurance
Transplants	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition * Solely for transplants for surgeries determined to be non-experimental and non-investigational.	0% Coinsurance	N/A	Surgeon 0% Coinsurance. \$0 cost sharing on all other IP professional svcs

<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>0% Coinsurance</p>	<p>N/A</p>	<p>Surgeon 0% Coinsurance. \$0 cost sharing on all other IP professional svcs</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>N/A</p>	<p>0% Coinsurance</p>	<p>Surgeon 0% Coinsurance</p>
<p>Oral Surgery</p>	<p>No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition.</p> <p>* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and <u>surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery</u></p> <p>*Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.</p>	<p>N/A</p>	<p>N/A</p>	<p>0% Coinsurance</p>

Appendix B
GHI Bronze

Infusion Therapy		N/A	N/A	0% Coinsurance
Infusion Therapy	No limit	N/A	0% Coinsurance	0% Coinsurance
Anesthesia (all settings)	No limit	0% Coinsurance	0% Coinsurance	0% Coinsurance
Prescription Drugs		IP Fac	OP Fac	Prof
Enteral Formulas	No Limit Note: Follows current practice for MM and Pharmacy	N/A	N/A	N/A
Retail: Tier 1/Generic: 0% Coinsurance Tier 2/Formulary Brand: 0% Coinsurance Tier 3/Non-Formulary: 0% Coinsurance *Mail Order up to 90 day supply: 2.5x the 30 day supply cost sharing	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Specialty Drugs: 0% Coinsurance	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Off Label Cancer Drugs: 0% Coinsurance	30 day supply	N/A	N/A	N/A

(1) Pediatric Dental removed since standalone

GHI

Individual Off Exchange Products Underwriting Guidelines

Family verification

- EmblemHealth will request a Federal 1040 form and/or a marriage certificate to verify the marriage of two individuals with different last names. In addition, EmblemHealth will require a birth certificate and/or Federal 1040 Form as proof that a dependent is eligible for coverage if the dependent has a last name different from the subscriber.

Domestic Partners

Domestic partner coverage is available with EmblemHealth.

- A domestic partner will be treated as a dependent.
- Eligible dependents of the domestic partner may be added.
- Domestic partners are not recognized by the IRS and may not receive tax benefits afforded to non-domestic partners (e.g., Health Savings Accounts).
- Domestic partners must submit the following form to EmblemHealth. This form must be notarized.

EmblemHealth's Declaration of Cohabitation & Financial Interdependence Form (DCFIF). In addition, the partners must also provide three documents showing a similar residence and financial interdependence. The specific list of acceptable documents is shown on the Declaration of Cohabitation & Financial Interdependence Form.

High Deductible Health Plans

- The same member may not have an underlying insured or non-insured plan in conjunction with an HDHP product.
- EmblemHealth will require a signed statement that the deductible is not being funded by the employer or any other first dollar coverage plan.

GHI
Individual Off Exchange Products
Commission Schedule and Fees

Product Name	Commission	General Agent
HD900 PLATINUM	0% of premium	\$0.00
HD1800 GOLD	0% of premium	\$0.00
HD2000 SILVER	0% of premium	\$0.00
HD6300 BRONZE	0% of premium	\$0.00

GHI
Individual Off Exchange Products
Effective January 1, 2014-December 31, 2014

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