

**State:** New York **Filing Company:** Aetna Health Inc. (NY)  
**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only  
- HMO  
**Product Name:** NY SG AHI 1Q15-4Q15  
**Project Name/Number:** NY SG AHI 1Q15-4Q15/

### Filing at a Glance

Company: Aetna Health Inc. (NY)  
Product Name: NY SG AHI 1Q15-4Q15  
State: New York  
TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)  
Sub-TOI: HOrg02G.004F Small Group Only - HMO  
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### General Information

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This filing is for NY SG AHI rates 1Q15-4Q15

### Company and Contact

#### Filing Contact Information

[REDACTED]  
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 [REDACTED]

#### Filing Company Information

Aetna Health Inc. (NY)	CoCode: 95234	State of Domicile: New York
60 Charles Lindbergh Boulevard	Group Code: 1	Company Type:
Suite 105	Group Name:	State ID Number:
Uniondale, NY 11553-3645	FEIN Number: 22-2663623	
(999) 999-9999 ext. [Phone]		

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1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): Yes - ALIC AETN-129585656
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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.): Healthy New York

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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 a group prefilling notification, out-of-state, or a report 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.): 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
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State: New York

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## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Healthy NY Cert of Covarage	OffHIXHNY GR-96816	CER	Initial			OffHIXHNYGR-96816.docx.pdf
2		Healthy NY Rider	OffHIXHNY GR-96816- Contra Rider	POLA	Initial			OffHIXHNYGR-96816-Contra Rider.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

This is Your

**HEALTHY NEW YORK CERTIFICATE OF COVERAGE**

Issued by

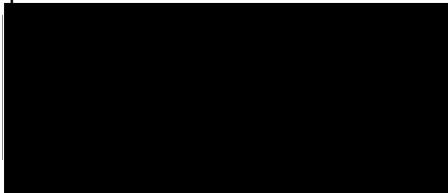
**Aetna Health Inc.**

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Group Contract between Aetna Health Inc. (hereinafter referred to as “We”, “Us”, or “Our”) and the Group contractholder listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

**In-Network Benefits.** This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in our network. Care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Physician before You obtain the services except for services to treat an Emergency or Urgent Condition described in section VI. Except for care for an Emergency Condition described in section VI, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

**READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.**

This Certificate is governed by the laws of New York State.

[  


Chairman, Chief Executive Officer and President]

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## SECTION I

### Definitions

Defined terms will appear capitalized throughout the Certificate.

**Acute:** The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

**Allowed Amount:** The maximum amount on which Our payment is based for Covered Services. See section IV of this Certificate for a description of how the Allowed Amount is calculated.

**Ambulatory Surgical Center:** A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

**Appeal:** A request for Us to review a Utilization Review decision or a Grievance again.

**Balance Billing:** When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

**Certificate:** This Certificate issued by Aetna Health Inc., including the Schedule of Benefits and any attached riders.

**Children:** The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Certificate.

**Coinsurance:** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

**Copayment:** A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

**Cost-Sharing:** Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments, and/or Deductibles.

**Cover, Covered or Covered Services:** The Medically Necessary services paid for or arranged for You by Us under the terms and conditions of this Certificate.

**Deductible:** The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

**Dependents:** The Subscriber's Spouse and Children.

**Durable Medical Equipment (DME):** Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

**Emergency Condition:** A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

**Emergency Department Care:** Emergency Services You get in a Hospital emergency department.

**Emergency Services:** A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

**Exclusions:** Health care services that We do not pay for or Cover.

**External Appeal Agent:** An entity that has been certified by the Department of Financial Services to perform external appeals in accordance with New York law.

**Facility:** A Hospital; ambulatory surgery Facility; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to article 27-J of the public health law; an institutional Provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other Provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If You receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint

Commission on Accreditation of Healthcare Organizations (“JCAHO”) to provide a chemical abuse treatment program.

**Grievance:** A complaint that You communicate to Us that does not involve a Utilization Review determination.

**Group:** The employer or party that has entered into an Agreement with Us.

**Habilitation Services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

**Health Care Professional:** An appropriately licensed, registered or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

**Home Health Agency:** An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

**Hospice Care:** Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

**Hospital:** A short term, acute, general Hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and

- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

**Hospitalization:** Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

**Hospital Outpatient Care:** Care in a Hospital that usually doesn't require an overnight stay.

**Medically Necessary:** See section II of this Certificate for the definition.

**Medicare:** Title XVIII of the Social Security Act, as amended.

**Member:** The Subscriber and Covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

**Non-Participating Provider:** A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

**Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

**Participating Provider:** A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website [www.aetna.com](http://www.aetna.com) or upon Your request to Us. The list will be revised from time to time by Us.

**Physician or Physician Services:** Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

**Plan Year:** A 12 month calendar year.

**Preauthorization:** A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

**Premium:** The amount that must be paid for Your health insurance coverage.

**Prescription Drugs:** A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill and is on Our Formulary. A Prescription Drug includes a medication

that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

**Primary Care Physician:** A Participating Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who typically is an internal medicine, family practice or pediatric doctor and who directly provides or coordinates a range of health care services for You.

**Provider:** A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), licensed Health Care Professional or Facility licensed, certified or accredited as required by state law.

**Referral:** An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in section VI of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

**Rehabilitation Services:** Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

**Schedule of Benefits:** The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, Preauthorization requirements, Referral requirements and other limits on Covered Services.

**Service Area:** The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the counties of Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Sullivan, Suffolk, Ulster and Westchester.

**Skilled Nursing Facility:** An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare law; or as otherwise determined by Us to meet the standards of any of these authorities.

**Specialist:** A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Spouse:** The person to whom the Subscriber is legally married, including a same sex Spouse and a domestic partner.

**Subscriber:** The person to whom this Certificate is issued.

**UCR (Usual, Customary and Reasonable):** The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

**Urgent Care:** Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent Care may be rendered in a Participating Physician's office or Urgent Care Center.

**Urgent Care Center:** A licensed Facility (except Hospitals) that provides Urgent Care.

**Us, We, Our:** Aetna Health Inc. and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate.

**Utilization Review:** The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

**You, Your:** The Member.

## SECTION II

### How Your Coverage Works

**1. Your Coverage under this Certificate.** Your employer (referred to as the “Group contractholder”) has purchased a Group HMO Contract from Us. We will provide the benefits described in this Certificate to members of the Group, that is, to employees of the Group and their Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

**2. Covered Services.** You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in section XIII of this Certificate; and
- Received while Your Certificate is in force.

**3. Participating Providers.** To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call Member Services.
- Visit our website at [www.aetna.com](http://www.aetna.com).

**4. The Role of Primary Care Physicians.** This Certificate has a gatekeeper, usually known as a Primary Care Physician (PCP). You need a Referral from a PCP before receiving Specialist care from a Participating Provider. See the Schedule of Benefits in Section XIV of this Certificate for Your Cost-Sharing. You may select any Participating PCP who is available from the list of PCPs in the HMO Network. Each Member may select a different PCP. Children covered under this Certificate may designate a Participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as your PCP. See section III of this Certificate for more information about designating a Specialist.

Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;

provided that the Participating Provider discusses the services and treatment plan with Your PCP; agrees to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such

Participating Provider; and agrees to provide services pursuant to a treatment plan (if any) approved by Us.

**5. Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered Services. Your PCP is responsible for requesting Preauthorization for in-network services listed in the Schedule of Benefits in section XIV of this Certificate.

**6. Medical Management.** The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

**7. Care Must Be Medically Necessary.** We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of: Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are

performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See section IX of this Certificate for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

## **8. Important Telephone Numbers and Addresses.**

### **Online –**

Visit our website – [www.aetna.com](http://www.aetna.com)

### **Aetna Navigator –**

[www.aetn navigator.com](http://www.aetn navigator.com)

### **DocFind –**

[www.docfind.com](http://www.docfind.com)

### **Aetna Specialty Rx –**

[www.aetnaspecialtyrx.com](http://www.aetnaspecialtyrx.com)

### **Complaints, Grievances and Utilization Review and Appeals-**

Please call **Aetna** Member Services at the toll-free number on the back of your ID card.

Aetna Customer Resolution Team  
P.O. Box 14462  
Lexington, KY 40512

### **Member Services–**

The **Aetna** Member Services toll-free telephone number appears on the back of your ID card. Representatives are available Monday through Friday 8:00 am to 5:00 pm local time.

### **Mail –**

Aetna  
Attn: Enrollment  
P.O. Box 730  
Blue Bell, PA 19422

## SECTION III

### Access To Care And Transitional Care

#### **Referral to a Non-Participating Provider**

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, Your Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

#### **When a Specialist Can Be Your Primary Care Physician**

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a Non-Participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a Non-Participating Specialist, Covered Services rendered by the Non-Participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

#### **Standing Referral to a Participating Specialist**

If You need ongoing specialty care, You may receive a "standing Referral" to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a "standing Referral." Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a Non-Participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a standing Referral to a Non-Participating Specialist, Covered Services rendered by the Non-Participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

#### **Specialty Care Center**

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a Referral to a

specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation Your PCP or Specialist and You. We will not approve a Referral to a Non-Participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our Network. If We approve a Referral to a Non-Participating specialty care center, Covered Services rendered by the Non-Participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a Participating specialty care center. You will be responsible only for any applicable In-Network Cost-Sharing.

### **When Your Provider Leaves the Network**

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

### **New Members In a Course of Treatment**

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to

Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

## SECTION IV

### Cost-Sharing Expenses And Allowed Amount

**1. Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits in section XIV of this Certificate for Services during each Plan Year before We provide coverage. If You have other than Individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible. However, after Deductible payments for all persons covered under this Certificate; total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

**2. Copayments.** Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in section XIV of this Certificate for Covered Services.

**3. Coinsurance.** Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits in section XIV of this Certificate.

**4. Out-of-Pocket Limit.** When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in section XIV of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If you have other than Individual coverage, the individual Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of Deductibles, Copayments and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year

**5. Allowed Amount.** “Allowed Amount” means the maximum amount we will pay to a Provider for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider

See section VI of the Certificate for the Allowed Amount for an Emergency Condition.

## SECTION V

### Who Is Covered

**Who is Covered Under this Certificate.** You, the Subscriber to whom this Certificate, is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Contract. If You selected one of the following types of coverage, members of Your family may also be covered.

#### Types of Coverage

In addition to Individual coverage, We offer the following types of coverage:

**Individual and Spouse -** If You selected Individual and Spouse coverage, then You and Your Spouse are covered.

**Parent and Child/Children –** If You selected Parent and Child/Children coverage, then You and Your Child or Children, as described below, are covered.

**Family –** If You selected Family coverage, then You and Your Spouse and Your Children, as described below, are covered.

#### Children Covered Under This Certificate

If You selected Parent and Child/Children or Family coverage, “Children” covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the Child turns 26 years of age. However, your employer may have elected to cover dependent children until age 30. Contact your employer for details. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not Covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or Covered Subscriber and all other prospective or Covered Members as they pertain to eligibility for coverage under this Certificate at any time.

### **When Coverage Begins**

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the group's next open enrollment period to add Your Spouse.
4. If You, the Subscriber, have Family or Parent and Child/Children coverage, and have a newborn Child, and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth. If You have Individual or Individual and Spouse coverage, You must notify Us of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 30 days from the date of birth in order for coverage to start at the moment of birth; otherwise Parent and Child/Children or Family coverage begins on the date on which We receive notice.
5. If You, the Subscriber, have Family or Parent and Child/Children coverage, Your adopted newborn Child will be covered from the moment of birth if You notify Us within 30 days of the birth, You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law or other applicable state law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have Individual or Individual and Spouse coverage, You must also notify Us of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 30 days from the date of birth in order for coverage to start at the moment of birth. Otherwise Parent and Child/Children or Family coverage begins on the date on which We receive notice and the premium payment. However, We will not provide Hospital benefits for the newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay.

### **Special Enrollment Periods**

You, Your Spouse or Child, can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment.
2. Termination of the other group health plan.
3. Death of the Spouse.
4. Legal separation, divorce or annulment.
5. Reduction of hours of employment.
6. Employer contributions towards the group health plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Your Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Your Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

### **Domestic Partner Coverage**

This Certificate covers domestic partners of Subscribers as Spouses. If You selected Family coverage, "Children" covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

- a. The affidavit must be notarized and must contain the following:
  - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
  - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
  - The partners have been living together on a continuous basis prior to the date of the application;
  - Neither individual has been registered as a member of another domestic partnership within the last six months; and
- b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
- c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
  - A joint bank account
  - A joint credit card or charge card
  - Joint obligation on a loan
  - Status as an authorized signatory on the partner's bank account, credit card or charge card
  - Joint ownership of holdings or investments
  - Joint ownership of residence
  - Joint ownership of real estate other than residence
  - Listing of both partners as tenants on the lease of the shared residence
  - Shared rental payments of residence (need not be shared 50/50)
  - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
  - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
  - Shared household budget for purposes of receiving government benefits
  - Status of one as representative payee for the other's government benefits
  - Joint ownership of major items of personal property (e.g., appliances, furniture)
  - Joint ownership of a motor vehicle
  - Joint responsibility for child care (e.g., school documents, guardianship)
  - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
  - Execution of wills naming each other as executor and/or beneficiary
  - Designation as beneficiary under the other's life insurance policy
  - Designation as beneficiary under the other's retirement benefits account

- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

## SECTION VI

### Preventive Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Preventive Care.** We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us by calling Member Services or visit Our website at [www.aetna.com](http://www.aetna.com). for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from USPSTF, and immunizations recommended by ACIP.

#### **A. Well-Baby and Well-Child Care**

We Cover well-baby and well-child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance.

#### **B. Adult Annual Physical Examinations**

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive services is available on Our website at [www.aetna.com](http://www.aetna.com). or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

### **C. Adult Immunizations**

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP.

### **D. Well-Woman Examinations**

We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive services is available on Our website at [www.aetna.com](http://www.aetna.com). or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

### **E. Mammograms**

We Cover mammograms for the screening of breast cancer as follows:

- one baseline screening mammogram for women age 35 through 39;
- one baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one preventive screening, per Plan Year, be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than the above schedule.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

### **F. Family Planning & Reproductive Health Services**

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug benefit in Section

VI of the Certificate; Policy, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

### **G. Bone Mineral Density Measurements or Testing**

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to section VI of the Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA”) and items or services with an “A” or “B” rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices.

### **H. Screening for Prostate Cancer**

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance.

## SECTION VI

### **Pre-Hospital Emergency Medical Services and Ambulance Services**

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service. We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

### **Non-Emergency Ambulance Transportation:**

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Participating Hospital to a Participating Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care Facility.
- From an acute Facility to a sub-acute setting.

See the schedule of benefits in section XIV of this Certificate for any Preauthorization requirements for non-emergency transportation.

**Limitations/Terms of Coverage:**

Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not Covered.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

## SECTION VI

### Emergency Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Emergency Services for the treatment of an Emergency Condition.

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition.

We define **Emergency Services** to mean: Evaluation of an Emergency Condition and treatment to keep the condition from getting worse including:

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

### **A. Hospital Emergency Department Visits**

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department.** Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

**Follow-up care or routine care provided in a Hospital emergency department is not Covered.**

### **B. Emergency Hospital Admissions**

In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the telephone number listed on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services at a Non-Participating Hospital at the In-Network Cost-Sharing for as long as Your medical condition prevents Your transfer to a Participating Hospital, unless We authorize continued treatment at the Non-Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will not be Covered See section IX of the Certificate for Your Appeals rights.

### **C. Payments Relating to Emergency Services Rendered**

You are responsible for any Deductible, Coinsurance or Copayment. You will be held harmless for any Non-Participating Provider charges that exceed Your Coinsurance or Copayment.

#### **Urgent Care**

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in Our Service Area.**

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center. You do not need to contact Us prior to, or after Your visit.

We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area.

**If Urgent Care results in an Emergency admission please follow the instructions for Emergency Hospital admissions described above.**

## SECTION VI

### **Outpatient and Professional Services**

(For other than Mental Health and Substance Use )

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Advanced Imaging Services:** We Cover PET scans, MRI, nuclear medicine, and CAT scans.

**Allergy Testing and Treatment:** We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

**Ambulatory Surgery Center:** We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the Center the day the surgery is performed.

**Chemotherapy:** We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug section of this Certificate.

**Chiropractic Services:** We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

**Dialysis:** We Cover dialysis treatments of an acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency,

provided that We have a reasonable opportunity to review Your travel and treatment plans.

- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per Plan Year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

**Habilitation Services:** We Cover Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime.

**Home Health Care:** We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation and Habilitation Services".

**Interruption of Pregnancy:** We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest or fetal malformation. We cover elective abortions for one procedure per Member per Plan Year.

**Infertility Treatment:** We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. Such Coverage is available as follows:

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New

York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sonohystogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.

- Comprehensive Infertility Services . If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- Exclusions and Limitations
  - a. In vitro, GIFT and ZIFT procedures.
  - b. Cost for an ovum donor or donor sperm.
  - c. Sperm storage costs.
  - d. Cryopreservation and storage of embryos.
  - e. Ovulation predictor kits.
  - f. Reversal of tubal ligations. Reversal of vasectomies.
  - g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
  - h. Sex change procedures.
  - i. Cloning.
  - j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
  - k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

**Infusion Therapy.** We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count towards Your home health care visit limit.

**Laboratory Procedures, Diagnostic Testing and Radiology Services:** We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

**Maternity and Newborn Care:** We Cover services for maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy.

In order for services of a nurse midwife to be Covered, the nurse midwife must be licensed pursuant to Article 140 of the Education Law, practicing consistent with Section 6951 of the Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. See section VI of the Certificate for coverage of inpatient maternity care.

We Cover the cost of renting one breast pump per pregnancy for the duration of breast feeding.

**Medications for Use in the Office:** We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

**Office Visits:** We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls. We also Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers.

**Outpatient Hospital Services:** We Cover Hospital services and supplies as described in the Inpatient Hospital section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

**Preadmission Testing:** We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

**Rehabilitation Services:** We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- It is ordered by a Physician; and

Covered speech, physical and occupational therapy services must begin within six months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;

- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

**Second Opinions:**

- Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, 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. You may obtain a second opinion from a Non-participating Provider on an In-Network basis when Your attending Physician provides a written Referral to a Non-Participating Specialist.
- Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- Required Second Surgical Opinion. We may require a second opinion before We Preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
  - a. The second opinion must be given by a board certified Specialist who personally examines You.
  - b. If the first and second opinions do not agree You may obtain a third opinion.
- Second Opinions in other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

**Surgical Services:** We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

.If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

**Oral Surgery:** We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

**Reconstructive Breast Surgery:** We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Implanted breast prostheses following a mastectomy or partial mastectomy are also Covered.

**Other Reconstructive and Corrective Surgery:** We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

- It is performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or
- It is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- It is otherwise Medically Necessary.

**Transplants:** We Cover only those transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

**All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.**

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

## SECTION VI

### Additional Benefits, Equipment And Devices

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Autism Spectrum Disorder:** We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- Assistive Communication Devices. We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We will not Cover items, such as, but not limited to, laptops, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered ; however, We will Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
- Pharmacy Care. We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Certificate.

We will not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Certificate for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to Specialist office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

**Diabetic Equipment, Supplies and Self-Management Education:** We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:

#### Supplies

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices

- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

### Self-Management Education

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
- Upon the referral of Your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

### Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

**Durable Medical Equipment and Braces:** We Cover the rental or purchase of durable medical equipment and braces.

### Durable Medical Equipment

Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not meet the definition of durable medical equipment.

### Braces

We Cover braces that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You).

**Hearing Aids:** We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear during the entire period of time that You are enrolled under this Certificate. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

**Hospice:** Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

**Medical Supplies:** We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g.,

ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. Please see the “Diabetic Supplies, Education and Self-Management” section of this Certificate for a description of diabetic supply Coverage.

**Prosthetics:**

**External Prosthetic Devices:** We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only covered under the pediatric vision benefit in section VI of this Certificate. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

We also Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

**Internal Prosthetic Devices:** We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

## SECTION VI

### Inpatient Services

(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits

**Hospital Services:** We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

**Observation Services:** We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. The services include use of a bed and periodic monitoring by nursing or other licensed staff.

**Inpatient Medical Services:** We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

**Inpatient Stay for Maternity Care.** We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

**Inpatient Stay for Mastectomy Care:** We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period time determined to be medically appropriate by You and Your attending Physician.

**Autologous Blood Banking Services:** We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

**Rehabilitation Services:** We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

1. such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. it is ordered by a Physician; and

Covered Services must begin within six months of the later to occur:

1. the date of the injury or illness that caused the need for the therapy;
2. the date You are discharged from a Hospital where surgical treatment was rendered; or
3. the date outpatient surgical care is rendered.

**Skilled Nursing Facility:** We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment

plan prepared by Your Provider and approved by Us. We Cover up to 200 days, per Plan Year, for non-custodial care.

**End of Life Care:** If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare acute care service rates.
3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

**Limitations/Terms of Coverage:**

1. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.
2. We do not Cover radio, telephone and television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

## SECTION VI

### Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

#### Mental Health Care Services

**Inpatient Services:** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this Certificate. However, Coverage for inpatient services for mental health care is limited to Facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

**Outpatient Services:** We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.

#### Limitations/Terms of Coverage:

1. We will not Cover benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.
2. We will not Cover mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services.
3. We will not Cover services solely because they are ordered by a court.

#### Substance Use Services

**Inpatient Services:** We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

**Outpatient Services:** We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also Cover up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

## SECTION VI

### Prescription Drug Coverage

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

### Covered Outpatient Prescription Drugs

We Cover Medically Necessary Outpatient Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription”;
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider’s scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn’s disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the Infertility section of this Certificate.
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the

treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at [www.aetna.com](http://www.aetna.com). You may also inquire if a specific drug is Covered under this Certificate by contacting us at the number on Your ID card.

### **Refills**

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after  $\frac{3}{4}$  of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in section XIV of this Certificate.

### **Benefit and Payment Information**

1. **Cost-Sharing Expenses:** You are responsible for paying the costs outlined in the Schedule of Benefits in section XIV of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

You have a three tier plan design, which means that Your Out-of-Pocket Expenses will generally be lowest for Prescription Drugs on Tier 1 and highest for Prescription Drugs on Tier 3. Your Out-of-Pocket Expense for Prescription Drugs on Tier 2 will generally be more than for Tier 1 but less than Tier 3.

An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier unless We approve coverage at the higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

1. **Participating Pharmacies:** For Prescription Drugs purchased at a retail or mail order or Designated Participating Pharmacy, You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
  - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.
- (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us by calling Member Services at the number in your ID card or visit our website at [www.aetna.com](http://www.aetna.com) to request approval.

2. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.
3. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs that are included in this program:

- Age related macular edema
- Anemia, neutropenia, thrombocytopenia
- Crohn's Disease
- Cystic Fibrosis
- Cytomegalovirus

- Endocrine disorders/Neurologic disorders such as infantile spasms
- Enzyme Deficiencies/Liposomal Storage Disorders
- Gaucher's Disease
- Growth Hormone
- Hemophilia
- Hepatitis B, Hepatitis C
- Hereditary Angioedema
- HIV/AIDS
- Immune Deficiency
- Immune Modulator
- Infertility
- Iron Overload
- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

5. **Mail Order:** Certain Prescription Drugs may be ordered through Our mail order supplier and You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at [www.aetna.com](http://www.aetna.com) or by calling the Member Services number on Your ID card.

6. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at [www.aetna.com](http://www.aetna.com) or by calling the Member Services number on Your ID card.
7. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in section IX of the Certificate.
8. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply. We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a Participating mail order pharmacy.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website [www.aetna.com](http://www.aetna.com) or by calling Member Services at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to section IX of the Policy.

9. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in section XIV of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under section VI of this Policy.

## **Medical Management**

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

For a list of Prescription Drugs that need Preauthorization, please visit our website at [www.aetna.com](http://www.aetna.com), or call the Member Services number on your ID card. This list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or of any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification. Including a Prescription Drug or related item on the list does not promise coverage under Your Plan. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one type of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. The Prescription Drugs that require preauthorization under the Step Therapy Program are also included on the preauthorization drug list.
3. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at [www.aetna.com](http://www.aetna.com) or call Member Services at the phone number on Your ID Card.

### **Limitations/Terms of Coverage**

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy

that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug, are Medically Necessary, and are obtained from a pharmacy that is approved for compounding.
4. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
4. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies are not Covered under this section but are Covered under other sections of this Certificate.
5. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under section VI of this Certificate.
6. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Certificate.
7. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.
8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
10. Your benefit for insulin, diabetic Prescription Drugs, supplies and equipment is not provided under this section of the Policy and is Covered under section VI of the Certificate.
11. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in

section IX of this Certificate.

12. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.
13. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the Covered Outpatient Prescription Drug Section.

### **General Conditions**

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.
2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

### **Definitions**

Terms used in this section are defined as follows. (Other defined terms can be found in the definitions section of this Certificate).

**Brand-Name Drug:** A Prescription Drug that (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as a "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-Name Drug by Us.

**Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an

organization contracting on Our behalf, to provide specific Prescription Drugs, including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

**Formulary:** The list that identifies those Prescription Drugs for which Coverage may be available under this Policy. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website [www.aetna.com](http://www.aetna.com) or by calling the Member Services number on Your ID card.

**Generic Drug:** A Prescription Drug that (1) is chemically equivalent to a Brand-Name Drug; or (2) that We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as a “generic” by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

**Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

**Participating Pharmacy:** A pharmacy that has:

- entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- has been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

**Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

**Prescription Drug Cost:** The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Plan includes Coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

**Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the Education Law.

## SECTION VI

### Wellness Benefits

#### Exercise Facility Reimbursement

We will partially reimburse the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages, yoga, etc.).

In order to be eligible for reimbursement, You must:

- be an active member of the exercise facility, and
- complete 50 visits in a six-month period.

In order to obtain reimbursement, at the end of the six-month period You must:

- submit a completed reimbursement form; documentation of the visits from the facility.
- a copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form; documentation of the visits and the bill, You will be reimbursed the lesser of \$200 for the Subscriber and \$100 for the Subscriber's Spouse or the actual cost of the membership per six-month period.

## SECTION VI

### Pediatric Vision Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Pediatric Vision Care:** We Cover emergency, preventive and routine vision care for Children up to age 19.

**Vision Examinations:** We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are

Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

**Prescribed Lenses & Frames:** We Cover standard prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

## SECTION VI

### Pediatric Dental Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Pediatric Dental Care:** We Cover the following dental care services for Children up to age 19:

**Emergency Dental Care:** We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

Emergency dental care is not subject to Our Preauthorization.

**Preventive Dental Care:** We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

**Routine Dental Care:** We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

**Endodontics:** We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

**Prosthodontics:** We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth

- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

**Orthodontics:** We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

## SECTION VII

### Exclusions

No Coverage is available under this Certificate for the following:

**Aviation.** We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

**Convalescent and Custodial Care.** We do not Cover services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.

**Cosmetic Services.** We do not Cover cosmetic services, Prescription Drugs, or surgery except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in section IX of this Certificate.

**Coverage Outside of the United States, Canada or Mexico.** We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services to treat Your Emergency Condition.

**Dental Services.** We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the oral surgery or pediatric dental care section of this Certificate.

**Experimental or Investigational Treatment.** We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See section IX of this Certificate for a further explanation of Your Appeal rights.

**Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

**Foot Care.** We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this Certificate. For foot care related to diabetes, see section VI of this Certificate.

**Government Facility.** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

**Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the procedure, treatment, service, or Prescription Drug for which Coverage has been denied, to the extent that such procedure, treatment, service, or Prescription Drug is otherwise Covered under the terms of this Certificate.

**Medicare or Other Governmental Program.** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

**Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

**No-Fault Automobile Insurance.** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

**Services, Drugs, Procedures and Supplies for the treatment of erectile dysfunction for persons required to register as a sex offender.** We do not cover services, drugs, procedures and supplies for the treatment of erectile dysfunction for persons required to register as a sex offender,, in accordance with section 4326(d-1) through (d-3) of the Insurance Law.

**Services Separately Billed by Hospital Employees.** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

**Services Provided by a Family Member.** We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

**Services With No Charge.** We do not Cover services for which no charge is normally made.

**Services not Listed.** We do not Cover services that are not listed in this Certificate as being Covered.

**Vision Services.** We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in section VI of this Certificate.

**Workers' Compensation.** We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

**War.** We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

## SECTION VIII

### Claim Determinations

**Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

**Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at [www.aetna.com](http://www.aetna.com). Completed claim forms should be sent to the address in section II of this Certificate or on Your ID card.

**Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

**Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by N.Y. Public Health Law § 238-a(1).

**Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to section IX of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see section IX of this Certificate.

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

#### Pre-service Claim Determinations.

If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Pre-service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

**Post-service Claim Determinations.**

If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

## SECTION IX

### Grievance

**Grievances.** Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

**Filing a Grievance.** You can contact Us[by phone by calling Member Services, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

**Grievance Determination.** Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim

In writing, within 30 calendar days of receipt of Your Grievance.

**Grievance Appeals.** If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances:  
(A request for a service or treatment that has not yet been provided.)

15 calendar days of receipt of Your Appeal.

Post-Service Grievances:  
(A claim for a service or a treatment that has already been provided.)

30 calendar days of receipt of Your Appeal.

All Other Grievances:  
that are not in relation to a claim or request for service

30 business days of receipt of all necessary information to make a determination

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

**Call the New York State Department of Health at 1-800-206-8125 or write them at:**  
New York State Department of Health  
Corning Tower

Empire State Plaza  
Albany, NY 12237  
[www.health.ny.gov](http://www.health.ny.gov)

If You need assistance filing a Grievance or Appeal You may also contact the state independent  
Consumer Assistance Program at:  
Community Health Advocates  
105 East 22nd Street  
New York, NY. 10011  
Or call toll free: 1-888-614-5400  
Or e-mail [cha@cssny.org](mailto:cha@cssny.org)

## SECTION IX

### Utilization Review

#### Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us or visit our website at [www.aetna.com](http://www.aetna.com).

#### Preauthorization Reviews

If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of receipt of the request.

If We need additional information, We will request it within 3 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

### **Concurrent Reviews**

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

### **Retrospective Reviews**

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

### **Retrospective Review of Preauthorized Services**

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

### **Reconsideration**

If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

### **Utilization Review Internal Appeals**

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an Out-of-Network health service, You, or Your designee, must submit:

- A statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
- Two documents from the available medical and scientific evidence that the Out-of-Network service:
  - (a) Is likely to be more clinically beneficial to You than the alternate In-Network service; and
  - (b) that the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

### **First Level Appeal**

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Expedited Appeals. Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

### **Second level Appeal**

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made.

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business

days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:  
Community Health Advocates  
105 East 22nd Street  
New York, NY. 10011  
Or call toll free: 1-888-614-5400  
Or e-mail [cha@cssny.org](mailto:cha@cssny.org)

## **SECTION IX**

### **External Appeal**

#### **I. YOUR RIGHT TO AN EXTERNAL APPEAL**

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:

- We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
- You file an external appeal at the same time as You apply for an expedited internal Appeal; or
- We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

**II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY**

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in I above.

**III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL**

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the two requirements for an external appeal in I above and Your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by Us; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

#### **IV. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS OUT-OF-NETWORK**

If We have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in I above, and You have requested preauthorization for the Out-of-Network treatment.

In addition, Your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-Network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have a right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-Network to provide the particular health service requested by You.

#### **V. THE EXTERNAL APPEAL PROCESS**

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

## **V. YOUR RESPONSIBILITIES**

**It is Your RESPONSIBILITY to start the external appeal process.** You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

**Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.**

## SECTION X

### Coordination of Benefits

This section applies when you also have group health coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This prevents duplicate payments and overpayments.

#### Definitions

“Allowable expense” is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

“Plan” is other group health coverage with which We will coordinate benefits. The term “plan” includes:

1. Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
2. Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.

3. Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

“Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: (1) the plan has no order of benefits rules or its rules differ from those required by regulation; or (2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

“Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

#### Rules to Determine Order of Payment

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s health care expenses:
  - a. The plan of the parent who has custody will be primary;
  - b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

- c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

#### Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

#### Right to Receive and Release Necessary Information

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

#### Our Right to Recover Overpayment

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

#### Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer;
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

## SECTION XI

### Termination of Coverage

This Certificate will terminate on the date when the New York State Law that establishes the Healthy New York Program is terminated.

Coverage under this Certificate will automatically be terminated on the first of the following to apply. In all cases of termination, unless otherwise noted below, We will provide at least 30 days prior written notice to the Group.

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Subscriber ceases to meet the eligibility requirements for (a) the Healthy New York Program, or (b) as otherwise defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless You have coverage for Dependents. If You have coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the Child turns 26 years of age. However, your employer may have elected to cover dependent children until age 30. Contact your employer for details. For all other Dependents, the date in which the Dependent ceases to be eligible.
6. The end of the month during which the Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
7. If a Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if a Subscriber makes an intentional misrepresentation of material fact in writing on his/her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to a year; Your enrollment under the Certificate.
8. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.

9. If We elect to terminate or cease offering all hospital, surgical and medical expense coverage in the small group market, in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
10. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
11. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.
12. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.
13. Termination due to the termination of the program by the state.
14. Termination due to failure to meet eligibility criteria at the time of annual recertification or failure to recertify.

No termination of coverage shall prejudice the right to a claim for benefits which arose prior to such termination.

See sections XII of this Certificate for Your right to continuation of this coverage and section XII of this Certificate for Your right to conversion to an individual Contract; Policy.

## **SECTION XII – What Happens if You Lose Coverage**

### **Extension of Benefits**

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

#### **When You May Continue Benefits**

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

#### **Termination of Extension of Benefits**

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment);
- With respect to the 12 month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

#### **Limits on Extended Benefits**

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends;
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

## SECTION XII

### Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this [Certificate; Contract; Policy] in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your Covered Children.
2. If You are a Covered Spouse, You may continue coverage if Your coverage ends due to:
  - a. Voluntary or involuntary termination of the Covered employee's employment;
  - b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
  - c. Divorce or legal separation of the Covered employee;
  - d. Death of the Covered employee; or
  - e. The Covered employee becoming entitled to Medicare.
3. If You are a Covered Child, You may continue coverage if Your coverage ends due to:
  - a. Voluntary or involuntary termination of the Covered employee's employment;
  - b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
  - c. Loss of Covered Child status under the plan rules;
  - d. Death of the Covered employee; or

- e. The Covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from Your employer in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group contractholder.

The contractholder can charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after Your coverage would have terminated because of termination of employment;
2. If You are a Covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the employee, divorce or legal separation, the employee's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become Covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See section XII of the Certificate.

### **Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.**

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than four years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group contractholder the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not

available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your Covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one year.

### **Age 29 Dependent Coverage Extensions Young Adult Option**

Your Child may be eligible to purchase his or her own individual coverage under Your Group's contract through the age of 29 if he or she 1) is under the age of 30; 2) is not married; 3) is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; 4) lives, works or resides in New York State or Our Service Area; and 5) is not covered by Medicare. The Child may purchase coverage even if he or she is not financially Dependent on his or her parent(s) and does not need to live with his or her parent(s).

Your Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group contractholder; or Group contractholder's designee receives notice and We receive Premium payment;
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group contractholder or Group contractholder's designee receives notice of election and We receive Premium payment.

You or Your Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. Your Child's children are not eligible for coverage under this option.

## SECTION XII

### Conversion Right To New Contract After Termination

You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

1. **Termination of the Group Contract.** If the Group Contract between Us and the Group Contractholder is terminated as set forth in section XI of this Certificate, and the Group Contractholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as direct payment members.
2. **If You Are No Longer Covered in a Group.** If Your coverage terminates under section XI of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.
3. **On the Death of the Subscriber.** If coverage terminates under section XI of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.
4. **Termination of Your Marriage.** If a Spouse's coverage terminates under section XI of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract; as a direct payment member.
5. **Termination of Coverage of a Child.** If a Child's coverage terminates under section XI of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
6. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under section XI of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.
7. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under section XI of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

**When to Apply for the New Contract.** If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

**The New Contract.** We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Contracts offered by Us. However, the coverage may not be the same as Your current coverage.

**When Conversion is Not Available.** We will not issue You an individual direct payment Contract if the issuance of the new Contract will result in overinsurance or duplication of benefits according to the standards We have on file with the Superintendent of the New York State Department of Financial Services.

## SECTION XIII

### General Provisions

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate; Contract; Policy] does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.
2. **Assignment.** You cannot assign any benefits under this Certificate to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate.
3. **Changes in This Certificate.** We may unilaterally change this Certificate upon renewal, if We give the Group Contractholder 30 days' prior written notice.
4. **Choice of Law.** This Certificate shall be governed by the laws of the State of New York.
5. **Clerical Error.** Clerical error, whether by the Group Contractholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.
6. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate; may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to

Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

7. **Entire Agreement.** This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.
8. **Furnishing Information and Audit.** The Group Contractholder and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group Contractholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to group enrollment at the Group Contractholder's New York office.
9. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.
10. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties. {
11. **Independent Contractors.** Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.
12. **Material Accessibility.** We will give the Group Contractholder identification cards, Certificates, riders, and other necessary materials. It is the Contractholder's responsibility to give you the identification cards, Certificates, riders, and other necessary materials.
13. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.
  - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial

statement which includes a balance sheet and a summary of the receipts and disbursements.

- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with Participating Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

14. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears on our records or to the address of the Group Contractholder. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to the address appearing on Section II.

15. **Premium Refund.** We will give any refund of Premiums, if due, to the Group Contractholder.

16. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

17. **Renewal Date.** The renewal date for the Certificate is the anniversary of the effective date of the Group Contract in each Year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us or the Group Contractholder as permitted by the Certificate, or by You upon 30 days' prior written notice to the

Group Contractholder.

18. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Certificate. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.
19. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.
20. **Severability.** The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate.
21. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or

investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

22. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.
23. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please call Member Services to access these services.
24. **Waiver.** The waiver by any party of any breach of any provision of the Certificate; will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
25. **Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Operating Officer (COO); Chief Executive Officer (CEO); President or a person designated by the COO; CEO; President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the COO, CEO, President or person designated by the COO, CEO, President.
26. **Who Receives Payment under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.
27. **Workers' Compensation Not Affected.** The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.
28. **Your Medical Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or our designee permission to obtain and use

Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.



**Aetna Health Inc.**

**HEALTHY NEW YORK**

**RIDER**

**COVERAGE FOR CONTRACEPTIVE  
DRUGS AND DEVICES, FAMILY PLANNING SERVICES AND INTERRUPTION OF  
PREGNANCY**

1. **General.** This rider amends the benefits of Your Certificate and provides coverage for the following:

- We Cover contraceptive drugs or devices approved by the FDA or Generic Prescription Drug equivalents approved as substitutes by the FDA. The contraceptive drug or device must be prescribed for You by a Provider that is legally authorized to prescribe pursuant to applicable law.

Certain contraceptive drugs and devices may require an office visit, such as drugs or devices that require injection or insertion. Such office visit and contraceptive drugs or devices are not subject to Copayments, annual Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

- We Cover family planning services consisting of counseling on the use of contraceptives and related topics and sterilization procedures for women. Such services are not subject to Copayments, annual Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, annual Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

2. **Other Terms of Coverage.** All other terms, conditions, limitations and exclusions of Your Certificate remain in full force and effect except as specifically modified by this rider.

[

A handwritten signature in black ink, appearing to read "Mark T. Bertolini". The signature is fluid and cursive, with a long horizontal stroke at the end.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President]

**SERFF Tracking #:**

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**Product Name:**

NY SG AHI 1Q15-4Q15

**Project Name/Number:**

NY SG AHI 1Q15-4Q15/

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		NY SG Rate Manual AHI	OffHIXHNYGR-96816-1	New		NY SG Rate Manual - AHI 2015.pdf,

**Aetna Health Inc.**  
**New York Small Group**  
**Premium Rate Manual**

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**Aetna Health Inc.**  
**New York Small Group**  
**Premium Rate Manual**

**General**

The attached pages contain worksheets and instructions for calculating the community rates for the plans available from Aetna Health Inc. (The Health Maintenance Organization of New York, Inc.). This filing is made in accordance with Insurance Law Section 4308 (c) Rate Applications and includes rates for our new products that will be offered effective January 1, 2015.

**Aetna Health Inc.**

**New York Small Group**

**Premium Rate Manual**

The following Steps are used to calculate premium rates.

**1. 2015 Base Rate**

<b>Index Premium Rate</b>
\$513.29

**2. Plan Pricing Values**

Plan Relativity Factor Table – rate factor for each unique plan design.

Base Rate x Plan Relativity Factor = Rate for Unique Plan

The product identifier will identify the plan. For each product identifier, there will be a rate relativity factor.

The plan factors shown on page C-1 reflect the pricing differential for each product.

**3. Standardized Rating Region**

Below is the NY SG rating area factor table - Rate factor to reflect differences in cost by geographic area. Base Rate x Plan Relativity Factor x Area Factor = Rate for that Plan for that Rating Area. The rating regions listed below are based on the required ACA standardized rating regions.

<b>Rating Region</b>	<b>Counties</b>	<b>Area Factor</b>
Region 1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	0.8200
Region 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	0.9000
Region 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	0.8900
Region 4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	1.0000
Region 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	0.7000
Region 6	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	0.7900
Region 7	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	0.8200
Region 8	Nassau, Suffolk	1.0000

**Aetna Health Inc.**

**New York Small Group**

**Premium Rate Manual**

4. **Effective Date Factor table** - premium rate level adjustment factor to reflect differences in cost by effective date.

Renewal / Effective Date	Effective Date factor
1Q15	1.0000
2Q15	1.0264
3Q15	1.0536
4Q15	1.0816

5. **Standardized Census Tiers**

All Aetna New York Individual products will be priced to reflect the tiers and relativities specified by the DFS.

<b>Tier</b>	<b>Relativities</b>
Single	1.00
Single + Spouse	2.00
Single + Child(ren)	1.70
Single + Spouse + Child(ren)	2.85

6. **Dependent Age Adjustment Factor**

For subscribers who choose to have the Dependent Up to Age 30 rider, the additional adjustment to the rate is as follows:

Non-Student Age	Student Age	Single	Parent & Child(ren)	Couple	Family
26	26	1.000	1.000	1.000	1.000
30	30	1.030	1.030	1.030	1.030

The rate for an unmarried young adult who chooses coverage under the Young Adult Option would be equal to the rate that would be paid by the young adult's subscriber/parent if that subscriber were billed as a single member.

**Aetna Health Inc.**

**New York Small Group**

**Premium Rate Manual**

**7. Subscriber Rate**

The subscriber rate is equal to Step 1 x Step 2 x Step 3 x Step 4 or Step 5 x Step 6, rounded to the nearest dollar.

**8. Example of Rate Calculations**

Base Rate \* Plan Factor \* Rating Area Factor \* Effective Date factor \* Tier Factor\* Dep Age Adj. Factor

**Region 1 with NY Gold Healthy NY 600 - January 2015**

Rating Area:	NYRA01							
Plan Name:	NY Gold Healthy NY 600							
Effective Date:	1Q 2015							
Dep Age	Age 26	Age 26	Age 26	Age 26	Age 30	Age 30	Age 30	Age 30
	Single	Couple	Parent	Family	Single	Couple	Parent	Family
Base Rate	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29
Plan Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Area Factor	0.820	0.820	0.820	0.820	0.820	0.820	0.820	0.820
Eff Date Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Tier Factor	1.000	2.000	1.700	2.850	1.000	2.000	1.700	2.850
Dep Age Factor	1.000	1.000	1.000	1.000	1.030	1.030	1.030	1.030
<b>Total Rate</b>	<b>\$420.90</b>	<b>\$841.80</b>	<b>\$715.53</b>	<b>\$1,199.56</b>	<b>\$433.52</b>	<b>\$867.05</b>	<b>\$736.99</b>	<b>\$1,235.55</b>

**Region 4 with NY Gold Healthy NY 600 - April 2015**

Rating Area:	NYRA04							
Plan Name:	NY Gold Healthy NY 600							
Effective Date:	2Q 2015							
Dep Age	Age 26	Age 26	Age 26	Age 26	Age 30	Age 30	Age 30	Age 30
	Single	Couple	Parent	Family	Single	Couple	Parent	Family
Base Rate	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29	\$513.29
Plan Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Area Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Eff Date Factor	1.026	1.026	1.026	1.026	1.026	1.026	1.026	1.026
Tier Factor	1.000	2.000	1.700	2.850	1.000	2.000	1.700	2.850
Dep Age Factor	1.000	1.000	1.000	1.000	1.030	1.030	1.030	1.030
<b>Total Rate</b>	<b>\$526.85</b>	<b>\$1,053.71</b>	<b>\$895.65</b>	<b>\$1,501.53</b>	<b>\$542.66</b>	<b>\$1,085.32</b>	<b>\$922.52</b>	<b>\$1,546.58</b>

Aetna Health, Inc.  
New York Small Group HMO Filing  
SERFF ID: AETN-129591063  
Exhibit B

**New York Small Group HMO Portfolio | Summary of Benefits**

**Contents**

NY GOLD HEALTHY NY ..... 2  
NY GOLD HEALTHY NY RE ..... 4

**Summary of Benefits Covered**

NY GOLD HEALTHY NY

New York

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$600
Family	\$1,200
<b>Coinsurance</b> <i>(Member Responsibility)</i>	20% varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$25 per visit after deductible
<b>Specialist Visit</b>	\$40 per visit after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit after deductible
<b>Emergency Room Services</b>	\$150 per visit after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25 per visit after deductible
<b>Imaging (CT/PET Scans, MRIs)</b>	\$40 per visit after deductible
<b>Rehabilitative Speech Therapy</b>	\$30 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$30 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$40 per visit after deductible
<b>X-rays and Diagnostic Imaging</b>	\$40 per visit after deductible
<b>Skilled Nursing Facility</b>	\$1,000/Admit after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	\$100 per visit after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	\$100 per visit after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	\$0
Family	\$0
<b>Generics</b>	\$10
<b>Preferred Brand Drugs</b>	\$35
<b>Non-Preferred Brand Drugs</b>	\$70
<b>Specialty Drugs (i.e. high-cost)</b>	Same as applicable tier cost share.

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

**User Inputs for Plan Parameters**

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

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

Desired Metal Tier: Gold

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$): \$600.00	\$0.00	
Coinsurance (% , Insurer's Cost Share): 85.44%	79.46%	
OOP Maximum (\$): \$4,000.00		
OOP Maximum if Separate (\$):		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

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

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 79.4%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 79.6%

This product, NY Gold Healthy NY satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.6%.

**Summary of Benefits Covered**

\* Religious exemption plans exclude contraceptives (oral, injectable and devices), contraceptive counseling and voluntary sterilization (tubal ligation and vasectomy).

NY Gold Healthy NY RE

New York

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$600
Family	\$1,200
<b>Coinsurance</b> (Member Responsibility)	20% varies; see below <i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$4,000
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<b>Primary Care Visit to Treat an Injury or Illness</b> (excludes Preventative and X-rays)	\$25 per visit after deductible
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<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25 per visit after deductible
<b>Imaging (CT/PET Scans, MRIs)</b>	\$40 per visit after deductible
<b>Rehabilitative Speech Therapy</b>	\$30 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$30 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$40 per visit after deductible
<b>X-rays and Diagnostic Imaging</b>	\$40 per visit after deductible
<b>Skilled Nursing Facility</b>	\$1,000/Admit after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	\$100 per visit after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	\$100 per visit after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
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Family	\$0
<b>Generics</b>	\$10
<b>Preferred Brand Drugs</b>	\$35
<b>Non-Preferred Brand Drugs</b>	\$70
<b>Specialty Drugs (i.e. high-cost)</b>	Same as applicable tier cost share.

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

Desired Metal Tier: Gold

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$600.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)	85.44%	79.46%				
OOP Maximum (\$)	\$4,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### Options for Additional Benefit Design Limits:

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

### Output

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 79.4%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 79.6%

This product, NY Gold Healthy NY RE satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.6%.

**Plan Relativity Factors**

Table 1 - HMO

New Plan Name	Plan Relativity Factor	Rx Generic	Rx Brand Formulary	Rx Brand Non-Formulary	INN Coins	INN Deductible	INN OOP Max	Primary Copay	Specialist Copay	SPU Copay	Hospital Copay	ER Copay
NY Gold Healthy NY 600	1.000000	\$10	\$35	\$70	20%	\$600	\$4,000	\$25	\$40	\$100	\$1000 / admit	\$150
NY Gold Healthy NY 600 RE	0.985222	\$10	\$35	\$70	20%	\$600	\$4,000	\$25	\$40	\$100	\$1000 / admit	\$150

**Aetna Health Inc.  
New York Small Group**

**Premium Rates**

Monthly rates for effective dates January 1, 2015 through December 31, 2015 are shown in pages D-2 through D-9.

**Aetna Health, Inc.**  
**New York Small Group**

**Rate Summary**

Rate Tables - Medical Plans  
NYRA01

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$420.90	\$715.53	\$841.80	\$1,199.56	\$433.53	\$737.00	\$867.05	\$1,235.55
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$414.68	\$704.95	\$829.36	\$1,181.83	\$427.12	\$726.10	\$854.24	\$1,217.28
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$432.02	\$734.43	\$864.04	\$1,231.26	\$444.98	\$756.46	\$889.96	\$1,268.20
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$425.64	\$723.58	\$851.27	\$1,213.06	\$438.41	\$745.29	\$876.81	\$1,249.45
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$443.46	\$753.89	\$886.93	\$1,263.87	\$456.76	\$776.51	\$913.54	\$1,301.79
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$436.91	\$742.75	\$873.82	\$1,245.19	\$450.02	\$765.03	\$900.03	\$1,282.55
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$455.23	\$773.89	\$910.46	\$1,297.41	\$468.89	\$797.11	\$937.77	\$1,336.33
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$448.50	\$762.45	\$897.01	\$1,278.23	\$461.96	\$785.32	\$923.92	\$1,316.58

**Aetna Health, Inc.  
New York Small Group**

**Rate Summary**

Rate Tables - Medical Plans  
NYRA02

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$461.96	\$785.33	\$923.92	\$1,316.59	\$475.82	\$808.89	\$951.64	\$1,356.09
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$455.13	\$773.73	\$910.27	\$1,297.13	\$468.78	\$796.94	\$937.58	\$1,336.04
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$474.17	\$806.09	\$948.34	\$1,351.38	\$488.40	\$830.27	\$976.79	\$1,391.92
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$467.16	\$794.17	\$934.32	\$1,331.41	\$481.17	\$818.00	\$962.35	\$1,371.35
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$486.73	\$827.44	\$973.45	\$1,387.17	\$501.33	\$852.26	\$1,002.65	\$1,428.79
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$479.53	\$815.21	\$959.07	\$1,366.67	\$493.92	\$839.67	\$987.84	\$1,407.67
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$499.64	\$849.39	\$999.29	\$1,423.98	\$514.63	\$874.87	\$1,029.27	\$1,466.70
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$492.26	\$836.84	\$984.52	\$1,402.94	\$507.03	\$861.95	\$1,014.06	\$1,445.03

**Aetna Health, Inc.  
New York Small Group**

**Rate Summary**

Rate Tables - Medical Plans  
NYRA03

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$456.83	\$776.61	\$913.66	\$1,301.96	\$470.53	\$799.91	\$941.07	\$1,341.02
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$450.08	\$765.13	\$900.15	\$1,282.72	\$463.58	\$788.08	\$927.15	\$1,321.20
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$468.90	\$797.13	\$937.80	\$1,336.36	\$482.97	\$821.04	\$965.93	\$1,376.45
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$461.97	\$785.35	\$923.94	\$1,316.61	\$475.83	\$808.91	\$951.66	\$1,356.11
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$481.32	\$818.24	\$962.64	\$1,371.76	\$495.76	\$842.79	\$991.52	\$1,412.91
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$474.21	\$806.15	\$948.41	\$1,351.49	\$488.44	\$830.33	\$976.86	\$1,392.03
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$494.09	\$839.95	\$988.18	\$1,408.16	\$508.91	\$865.15	\$1,017.83	\$1,450.40
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$486.79	\$827.54	\$973.58	\$1,387.35	\$501.39	\$852.37	\$1,002.79	\$1,428.97

**Aetna Health, Inc.  
New York Small Group**

**Rate Summary**

Rate Tables - Medical Plans  
NYRA04

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$513.29	\$872.59	\$1,026.58	\$1,462.88	\$528.69	\$898.77	\$1,057.38	\$1,506.77
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$505.70	\$859.70	\$1,011.41	\$1,441.26	\$520.87	\$885.49	\$1,041.75	\$1,484.50
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$526.85	\$895.65	\$1,053.71	\$1,501.53	\$542.66	\$922.52	\$1,085.32	\$1,546.58
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$519.07	\$882.41	\$1,038.13	\$1,479.34	\$534.64	\$908.88	\$1,069.27	\$1,523.72
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$540.81	\$919.37	\$1,081.62	\$1,541.30	\$557.03	\$946.95	\$1,114.07	\$1,587.54
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$532.82	\$905.79	\$1,065.63	\$1,518.53	\$548.80	\$932.96	\$1,097.60	\$1,564.09
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$555.16	\$943.77	\$1,110.32	\$1,582.20	\$571.81	\$972.08	\$1,143.63	\$1,629.67
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$546.95	\$929.82	\$1,093.91	\$1,558.82	\$563.36	\$957.71	\$1,126.73	\$1,605.58

**Rate Summary**

Rate Tables - Medical Plans  
NYRA05

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$359.30	\$610.82	\$718.61	\$1,024.01	\$370.08	\$629.14	\$740.17	\$1,054.73
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$353.99	\$601.79	\$707.99	\$1,008.88	\$364.61	\$619.84	\$729.23	\$1,039.15
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$368.80	\$626.96	\$737.59	\$1,051.07	\$379.86	\$645.77	\$759.72	\$1,082.60
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$363.35	\$617.69	\$726.69	\$1,035.54	\$374.25	\$636.22	\$748.49	\$1,066.61
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$378.57	\$643.56	\$757.13	\$1,078.91	\$389.93	\$662.87	\$779.84	\$1,111.28
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$372.97	\$634.05	\$745.94	\$1,062.97	\$384.16	\$653.07	\$768.32	\$1,094.86
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$388.61	\$660.64	\$777.22	\$1,107.54	\$400.27	\$680.46	\$800.54	\$1,140.77
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$382.87	\$650.88	\$765.74	\$1,091.17	\$394.36	\$670.41	\$788.71	\$1,123.91

**Aetna Health, Inc.  
New York Small Group**

**Rate Summary**

Rate Tables - Medical Plans  
NYRA06

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$405.50	\$689.35	\$811.00	\$1,155.67	\$417.67	\$710.03	\$835.33	\$1,190.34
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$399.51	\$679.16	\$799.01	\$1,138.59	\$411.50	\$699.53	\$822.98	\$1,172.75
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$416.21	\$707.56	\$832.43	\$1,186.21	\$428.70	\$728.79	\$857.40	\$1,221.80
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$410.06	\$697.11	\$820.13	\$1,168.68	\$422.36	\$718.02	\$844.73	\$1,203.74
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$427.24	\$726.31	\$854.48	\$1,217.63	\$440.06	\$748.10	\$880.11	\$1,254.16
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$420.92	\$715.57	\$841.85	\$1,199.64	\$433.55	\$737.04	\$867.11	\$1,235.63
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$438.58	\$745.58	\$877.15	\$1,249.94	\$451.74	\$767.95	\$903.46	\$1,287.44
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$432.09	\$734.56	\$864.19	\$1,231.47	\$445.05	\$756.60	\$890.12	\$1,268.41

**Aetna Health, Inc.  
New York Small Group**

**Rate Summary**

Rate Tables - Medical Plans  
NYRA07

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$420.90	\$715.53	\$841.80	\$1,199.56	\$433.53	\$737.00	\$867.05	\$1,235.55
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$414.68	\$704.95	\$829.36	\$1,181.83	\$427.12	\$726.10	\$854.24	\$1,217.28
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$432.02	\$734.43	\$864.04	\$1,231.26	\$444.98	\$756.46	\$889.96	\$1,268.20
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$425.64	\$723.58	\$851.27	\$1,213.06	\$438.41	\$745.29	\$876.81	\$1,249.45
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$443.46	\$753.89	\$886.93	\$1,263.87	\$456.76	\$776.51	\$913.54	\$1,301.79
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$436.91	\$742.75	\$873.82	\$1,245.19	\$450.02	\$765.03	\$900.03	\$1,282.55
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$455.23	\$773.89	\$910.46	\$1,297.41	\$468.89	\$797.11	\$937.77	\$1,336.33
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$448.50	\$762.45	\$897.01	\$1,278.23	\$461.96	\$785.32	\$923.92	\$1,316.58

**Rate Summary**

Rate Tables - Medical Plans  
NYRA08

New Plan Number	Plan Name	Metal Level	Plan	With dependent up to age 26				With dependent up to age 30 rider			
				Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	Couple Premium Rate	Family Premium Rate
				1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015	1Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$513.29	\$872.59	\$1,026.58	\$1,462.88	\$528.69	\$898.77	\$1,057.38	\$1,506.77
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$505.70	\$859.70	\$1,011.41	\$1,441.26	\$520.87	\$885.49	\$1,041.75	\$1,484.50
				2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015	2Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$526.85	\$895.65	\$1,053.71	\$1,501.53	\$542.66	\$922.52	\$1,085.32	\$1,546.58
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$519.07	\$882.41	\$1,038.13	\$1,479.34	\$534.64	\$908.88	\$1,069.27	\$1,523.72
				3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015	3Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$540.81	\$919.37	\$1,081.62	\$1,541.30	\$557.03	\$946.95	\$1,114.07	\$1,587.54
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$532.82	\$905.79	\$1,065.63	\$1,518.53	\$548.80	\$932.96	\$1,097.60	\$1,564.09
				4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015	4Q 2015
14025419	NY Gold Healthy NY 600	Gold	HMO	\$555.16	\$943.77	\$1,110.32	\$1,582.20	\$571.81	\$972.08	\$1,143.63	\$1,629.67
14025537	NY Gold Healthy NY 600 RE	Gold	HMO	\$546.95	\$929.82	\$1,093.91	\$1,558.82	\$563.36	\$957.71	\$1,126.73	\$1,605.58

**List of Small Group Off-Exchange Forms**

HNY (HMO) Certificate and Schedules

OffHIXHNYGR-96816-1-SB

OffHIXHNYGR-96816-1

OffHIXHNYGR-96816-Contraceptive Rider-1

OffHIXHNYGR-96816-Deps Age 29 Rider-1

**Exhibit A  
Projected Loss Ratio**

Without expected credits (21.9% of claims) from the Stop Loss Reimbursement, the Healthy New York projected loss ratio for customers with rate increases effective for the 4 quarters provided in this filing (1Q2015-4Q2015) would be 107.9% (84.3% / (1- 21.9%).

The 2015 projected loss ratio with Federal adjustments is 89.05%. This estimate does not include a credibility adjustment and is based on projected 2015 experience for plans that comply with the ACA market reform requirements. The following table details this calculation.

The target MBR calculated in the traditional way (incurred claims divided by premium) is 84.3%. This is compliant with NY loss ratio requirements of 82%. The following table provides the details of this calculation.

		<b>Small Group</b>	<b>Formula</b>
(a)	Member Months	331,968	
(b)	Premium (pmpm)	\$558.65	
(c)	Medical Cost (pmpm)	\$470.96	
(d)	Medical Benefit Ratio (MBR)	<b>84.3%</b>	= (c) / (b)
(e)	Quality Improvement Action (pmpm)	\$5.03	= (b) x 0.9 % <sup>(1)</sup>
(f)	Taxes and Fees (pmpm)	\$38.12	= (b) x 6.82% <sup>(2)</sup>
(g)	Adjusted Premium (pmpm)	\$520.53	= (b) - (f)
(h)	Adjusted Claims (pmpm)	\$475.99	= (c) + (e)
	<b>Medical Loss Ratio (MLR)</b>	<b>91.44%</b>	= (h) / (g)

(1) Spending on quality improvement activities is estimated to be 0.90% of premium.

(2) Taxes and fees are estimated to be 6.82% of premium.

NOTE: ACA adjustments for QIA and taxes and fees are estimates based on historical experience and projected expenses. Values reflect current actuarial projections and will differ from the final reported MLR.

This projection applies to the products included in this filing and is a standalone calculation for the 2015 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

**Exhibit B**  
**Outline of General Underwriting and Marketing Methods**

Aetna Health Inc. (New York), headquartered in Uniondale, New York, is licensed as a Health Maintenance Organization (HMO) pursuant to Article 44 of the New York State Public Health Law.

Aetna Health Inc. is an Individual Practice (IPA) model HMO that contracts with independent primary care physicians and specialists as well as with hospitals and ancillary providers.

Aetna Health Inc. offers traditional community rated contracts to employer groups, with no preexisting condition limitations or benefit waiting periods. Aetna Health Inc. makes available to these groups only those products and rates filed and approved, and compliant with all insurance laws, regulations and practices in the state of New York.

Aetna Health Inc. only has an HMO license in certain counties. This means that the Healthy New York product in this filing pertains to the following counties only:

Dutchess, Orange, Putnam, Sullivan, Ulster, Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester, Nassau, Suffolk, Broome, Cayuga, Onondaga, Tioga, and Oswego.

**Exhibit C  
Commissions Schedule and Incentive Fees**

Commissions are currently set at 1% of premium.

SERFF Tracking #:

AETN-129591063

State Tracking #:

2014060270

Company Tracking #:

State:

New York

Filing Company:

Aetna Health Inc. (NY)

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

NY SG AHI 1Q15-4Q15

Project Name/Number:

NY SG AHI 1Q15-4Q15/

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Actuarial Memorandum/Actuarial Certification
<b>Comments:</b>	
<b>Attachment(s):</b>	NY SG Actuarial Memo AHI 2015.pdf 1 - NY SG 2015 cover letter AHI.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Actuarial Memorandum and Certifications
<b>Comments:</b>	
<b>Attachment(s):</b>	NY SG Actuarial Memo AHI 2015.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Actuarial Value Calculations
<b>Comments:</b>	
<b>Attachment(s):</b>	NY SG Rate Manual - B_Ex A_NY SG HMO AV and Product Summary 2015.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 11-General Information
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 11 AHI 1Q15-4Q15 serff.xlsx Exhibit 11 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 13-Narrative Summary and Numerical Summary
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 13 AHI - Numerical Summary - filing.pdf Exhibit 13 AHI - Numerical Summary - serff.xlsx Exhibit 13 Narrative Summary - AHI filing.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 14B-Sm Grp Requested Percentage Changes
<b>Comments:</b>	

SERFF Tracking #:

AETN-129591063

State Tracking #:

2014060270

Company Tracking #:

State:

New York

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Aetna Health Inc. (NY)

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

NY SG AHI 1Q15-4Q15

Project Name/Number:

NY SG AHI 1Q15-4Q15/

<b>Attachment(s):</b>	Exhibit 14B AHI 1Q15-4Q15 serff.xlsx Exhibit 14B AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Exhibit 15B-Sm Grp Distribution by Rate Adj Percentages
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 15B AHI 1Q15-4Q15 serff.xlsx Exhibit 15B AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Exhibit 16-Summary of Policy Form & Product Changes
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 16 AHI 1Q15-4Q15 serff.xlsx Exhibit 16 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Exhibit 17-Claims Experience for 2011-13 (Sm Grps)
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 17 AHI 1Q15-4Q15 serff.xlsx Exhibit 17 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Exhibit 18-Index Rate Plan-Design Development
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 18 AHI 1Q15-4Q15 serff.xlsx Exhibit 18 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Exhibit 19-Claim Trend, Admin Expenses & Profit
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 19 AHI 1Q15-4Q15 serff.pdf Exhibit 19 AHI 1Q15-4Q15 serff.xlsx
<b>Item Status:</b>	
<b>Status Date:</b>	

SERFF Tracking #:

AETN-129591063

State Tracking #:

2014060270

Company Tracking #:

State:

New York

Filing Company:

Aetna Health Inc. (NY)

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

NY SG AHI 1Q15-4Q15

Project Name/Number:

NY SG AHI 1Q15-4Q15/

<b>Satisfied - Item:</b>	Exhibit 20-HIOS ID Mapping
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 20 AHI 1Q15-4Q15 serff.xlsx Exhibit 20 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 21A-Hospital Inpatient-Unit Costs
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 21A AHI 1Q15-4Q15 serff.xlsx Exhibit 21A AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 21B-Hospital Outpatient-Unit Costs
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 21B AHI 1Q15-4Q15 serff.xlsx Exhibit 21B AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 22-Utilization Information
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 22 AHI 1Q15-4Q15 serff.xlsx Exhibit 22 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Exhibit 23-Requested 2015 Premium Rates
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit 23 AHI 1Q15-4Q15 serff.xlsx Exhibit 23 AHI 1Q15-4Q15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Initial Notice of Proposed Rate Adjustment
<b>Comments:</b>	

**SERFF Tracking #:**

AETN-129591063

**State Tracking #:**

2014060270

**Company Tracking #:****State:**

New York

**Filing Company:**

Aetna Health Inc. (NY)

**TOI/Sub-TOI:**

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

**Product Name:**

NY SG AHI 1Q15-4Q15

**Project Name/Number:**

NY SG AHI 1Q15-4Q15/

<b>Attachment(s):</b>	DRAFT NY HNY - Rate adjustment notice - objection (Group Certificate Holder final).pdf DRAFT NY HNY- Rate adjustment notice - objection (Group Policyholder final....pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Unified Rate Review Template
<b>Comments:</b>	
<b>Attachment(s):</b>	AE_NY_SG_50138_URRT_OFF_1Q15_v0.xlsm Part II NY SG - AHI.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

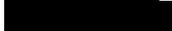
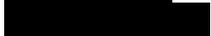
# Actuarial Memorandum and Certification

## General Information

### *Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** New York  
**HIOS Issuer ID:** 50138  
**Market:** Small Group  
**Policy Form:** OffHIXHNYGR-96816-1  
**Effective Date:** 01/01/2015  
**Filing Reference Number:**

### *Company Contact Information:*

**Name:**   
**Telephone Number:**   
**Email Address:** 

## 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms referenced above;
- 3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
- 4) Provide summaries of the benefit details for the products/plan designs referenced by this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in the NY Small Group market by Aetna Life Insurance Company beginning January 1, 2015. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available off the Federally Facilitated Exchange (Off-Exchange) in NY.

This memorandum is being submitted to satisfy federal rate review requirements and to support the development of the rates submitted with this filing. It is not intended to be used for any other purpose.

## 2. Proposed Rate Increase

Monthly premium rates for all ACA-compliant Small Group market products in NY are being revised for effective dates January 1, 2015 through December 31, 2015. Small Group rates are effective for rolling 12 month basis. Rates will increase on quarterly basis due to trend.

### A. Reason for Rate Increase(s):

Rates for these products are updated to reflect the following:

- Impact of medical claim trend (including increases in provider unit costs and increased utilization of medical cost services);
- The projected impact of the federal risk adjustment program that was put in place by the Affordable Care Act.

- Impact of HNY stop loss reimbursement percentage

### 3. Experience Period Premium and Claims

#### A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2013 through December 31, 2013 and paid through March 31, 2014.

#### B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for Small Group business in NY. Based on internal projections and the MLR Annual Reporting Form for Calendar Year 2013, the expected rebate for the Small Group NY Minimum Loss Ratio pool in 2013 is approximately 2.39% of premium. Experience period premium shown in Worksheet 1, Section I reflect an adjustment of this magnitude. Please note the following for additional clarification:

Earned Premium Prior to MLR Rebates:	\$ 6,952,006
Expected CY2013 MLR Rebates:	\$ 165,951
Earned Premium Net of MLR Rebates:	\$ 6,786,055

#### C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. We relied on our corporate data warehouse and medical cost analytics systems, to estimate unit cost and utilization metrics by medical cost category.

A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

### 4. Benefit Categories

The benefit categories used generally align with the Federal instructions dated April 30, 2014. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, while Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses. Other includes home health care, mental health care, medical pharmacy expenses, as well as laboratory and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

### 5. Projection Factors

#### A. Changes in Benefits:

To adjust the experience period PMPM, changes to benefits were applied to reflect differences between the covered benefits in the base 2013 experience data and the 2015 covered benefit level. An adjustment was made to:

- Reflect the value of Essential Health Benefits (EHB) and pediatric dental, as a percentage of the claims.

**B. Changes in Demographics:**

Experience data was normalized for projected changes in the 2015 age/gender mix using Aetna demographic factors.

Experience data was normalized for rating area comparing the current and projected member distributions by county using our company-specific market defined rating area factors.

**C. Trend Factors (Cost/Utilization):**

Anticipated annual trend from the experience period to the rating period for the product line is as follows:

<b>Component</b>	<b>Provider Contract Change</b>	<b>Utilization</b>	<b>Business Mix</b>	<b>Total Trend</b>
Medical	3.9%	4.0%	2.7%	<b>11.0%</b>
Pharmacy	3.7%	7.7%	3.3%	<b>15.3%</b>
Total	3.9%	4.8%	2.8%	<b>11.9%</b>

**a. Medical Trend**

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived after considering the federal risk adjustment program factors and other proprietary models.

**b. Pharmacy Trend**

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

**6. Credibility Manual Rate Development**

**A. Source and Appropriateness of Experience Data Used:**

The source data for our manual rate is the experience incurred from January 13 to December 13 and paid through March 31, 2014 of the HNY plans in the NY Small Group market, excluding Sole proprietor.

7. Paid-to-Allowed Ratio

We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 79.6%.

Tier	Projected Membership Distribution	Actuarial Value
Gold	100.0%	79.6%
Total	100.00%	79.6%

8. Risk Adjustment

We developed a market base rate that represents the average market morbidity expected in 2015. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level.

We included the projected impact of the federal risk adjustment program that was put in place by the Affordable Care Act in this rate filing to adjust our experience period data to the average market morbidity expected in 2015. The impact of risk adjustment in the 2015 NY Small Group marketplace was based on the simulation study conducted by Deloitte on behalf of DFS. Our own analysis of the block indicates stable morbidity and health status, consistent with the data provided to Deloitte, and we do not expect material changes in 2015. Based on these projections of the market in 2015, this adjustment is +10%. This number is derived by combining our current AHI and ALIC book of business experience.

We are projecting a reinsurance premium assessment of \$3.67 per member per month, which has been reflected.

The risk corridors program does not apply to Off-Exchange business.

9. Non-Benefit Expenses and Profit & Risk

The Retention Portion of the Market Base Rate is 15.70%. This was developed from the following items and approximated as shown:

1. Taxes and Fees of 6.82% comprised of:
  - a. Premium Taxes of 1.77%
  - b. Patient Centered Outcomes Research Fund of \$0.20 per member per year, converted to 0.04%
  - c. Reinsurance Contribution of \$3.67 PMPM, converted to 0.66%
  - d. Health Insurer Fee of 3.0%
    - i. 1.95% paid post-tax as the Health Insurer Fee
    - ii. 1.05%, charged as a corporate tax of 35% on the 1.95% pre-tax charge
  - e. Exchange User Fee of 0%.
  - f. Federal Income Tax of 1.35%, assuming 35% tax rate
  - g. Risk Adjustment Program Fee of 0.01%
2. Commissions of 1.02% of premium
3. General Administrative Expenses of \$29.91, converted to 5.35% of premium based upon an expected average premium level.
4. Risk Charge of 2.50%

These prospective expenses are based on historical expense levels and the changes expected with the requirements of PPACA and the Exchange.

### 10. Projected Loss Ratio

Under the current pricing assumption, the average MLR for 2015 using the Federally-prescribed MLR methodology, before any applicable credibility adjustment, is projected to be 91.44%.

The target MBR calculated in the traditional way (incurred claims divided by premium) is 84.3%. This is compliant with NY loss ratio requirements of 82%. The following table provides the details of the calculations.

		<b>Small Group</b>	<b>Formula</b>
(a)	Member Months	331,968	
(b)	Premium (pmpm)	\$558.65	
(c)	Medical Cost (pmpm)	\$470.96	
(d)	Medical Benefit Ratio (MBR)	<b>84.3%</b>	= (c) / (b)
(e)	Quality Improvement Action (pmpm)	\$5.03	= (b) x 0.9 % <sup>(1)</sup>
(f)	Taxes and Fees (pmpm)	\$38.12	= (b) x 6.82% <sup>(2)</sup>
(g)	Adjusted Premium (pmpm)	\$520.53	= (b) - (f)
(h)	Adjusted Claims (pmpm)	\$475.99	= (c) + (e)
	<b>Medical Loss Ratio (MLR)</b>	<b>91.44%</b>	= (h) / (g)

Notes:

(1) The cost of quality improvement action is estimated to be 0.90% of the premium.

(2) Taxes and fees are estimated to be 6.82% of the premium. The components of the 6.82% are listed in Section 9 above.

### 11. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in NY through Aetna Health Inc..

### 12. Index Rate

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, the impact of induced utilization, and the plan's provider network, delivery system characteristics, and utilization management practices. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR Part 156, §156.80(d)(2).

**Small Group Market Trend Adjustments:** The following table (or attached exhibit) illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2015.

Effective Date	Member Distribution	Effective Date factor	Index Rate
1Q15	25%	1.0000	537.96
2Q15	18%	1.0264	552.17
3Q15	22%	1.0536	566.80
4Q15	34%	1.0816	581.84
Total	100%	1.0445	561.89

### 13. Market-Adjusted Index Rate

Exhibit A illustrates the development of the Market Adjusted Index Rate. The Risk Adjustment was discussed previously in section 8. They are developed as multiplicative adjustments to paid claims for the Essential Health Benefits, and are applied as multiplicative adjustments to the index rate, which differs from the basis on which the adjustments were developed by the paid to allowed ratio.

### 14. Plan-Adjusted Index Rates

Exhibit A illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The following briefly describes how each set of adjustments was determined.

#### A. Actuarial Value and Cost Sharing:

We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio.

#### B. Provider Network, Delivery System, and Utilization Management:

There is no network or delivery system changes for this plan.

#### C. Distribution and Administrative Costs:

These are discussed above in Section 9 ‘Non-Benefit Expenses and Profit & Risk’ section. These expense and profit assumptions do not vary by plan.

### 15. Calibration

#### A. Age Curve Calibration:

NY Small Group business is community-rated. There is no demographic factor applied on NY Small Group business.

#### B. Geographic Factor Calibration:

Rating areas are defined by NY Department of Financial Services. We are not changing our rating area factors from 2014 filing.

Exhibit D summarizes the rating area definitions and factors. Exhibit D displays the projected membership by area and the projected average area factor of 0.982.

16. Trend Factors

NY Small Group business is charging quarterly rates on rolling 12 month basis. The rates development in this pricing mode is for first quarter 2015, applying 24 month of trend from experience period of Calendar Year 2013 to first quarter 2015. The rest of the quarter of 2015 will get quarterly trend increase as listed below.

Effective Date	Effective Date factor
1Q15	1.0000
2Q15	1.0264
3Q15	1.0536
4Q15	1.0816

17. Consumer-Adjusted Premium Rate Development

Rates are determined using member composite rating methodology for NY Small Group business. The tier ratios are prescribed by NY Department of Financial Services.

The premium for each billable member is calculated as:

Calibrated Base Plan Index Rate \* Plan Factor \* Area Factor \* Effective Date Factor \* Tier factor (Single, Couple, Parent/Child(ren), Family)

The resulting rate for each subscriber is rounded to the nearest cents.

18. HNY Stop loss Reimbursement

The HNY plan is a state mandated plan which the state has a stop loss program to over large claims. We have built in the reimbursement amount we expect to receive from the state into pricing as well.

19. AV Metal Values

The AV Metal Values were based on the AV Calculator. Rate Manual Section B lists the AV level of all NY Small Group plans. Adjustments were made to account for plan design features that could not be entered into the AV Calculator and have a material impact on the AV. These adjustments were developed using an acceptable alternative method as outlined in 45 CFR Part 156, §156.135 and as discussed in the accompanying certification regarding the development of the AV metal values.

20. AV Pricing Values

The fixed reference plan (anchor plan) is 50138NY0110003 (NY Gold Healthy NY 600). Benefit factors were developed taking into account the allowable rating characteristics. The resulting plan factors are displayed Exhibit F. We have not adjusted the benefit factors based on morbidity differences or benefit selection.

A plan factor to adjust the market base rate for differences in plan-specific expected claims was calculated. These factors account for differences in benefits, cost sharing, and network design (where applicable). The

benchmark Silver plan is assigned a factor of 1.0. The factors were developed using a proprietary pricing model which relies on:

- a) State- and product-specific service category weights;
- b) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and copays
- c) Utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier.

#### 21. Membership Projections

We assumed that total enrollment will be similar to our current enrollment.

#### 22. Plan Type

HNY plan is HMO based plan.

#### 23. Warning Alerts

Total Incurred Claims, payable with issuer funds, differs between Worksheet 2 and the check from Worksheet 1 since the total on Worksheet 2 excludes the impact of Reinsurance Contributions and Risk Adjustment User Fees, while the check from Worksheet 1 is net of Reinsurance Contributions and Risk Adjustment User Fees.

For the same reason, the Incurred Claims PMPM differs between Worksheet 2 and the Worksheet 1 check.

#### 24. Benefit Design

This filing includes the Health New York standard plan. All plans offered outside the Exchange will include pediatric dental benefits. The plan design is defined by Department of Financial Services.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is summarized in Rate Manual Section B (the benefit and AV screen print file). All benefit and cost sharing parameters comply with NY benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

#### 25. Marketing

As described above, all of these plans will be made available Off Exchange.

#### 26. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

#### 27. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

#### Reliance

While I have reviewed the reasonableness of the assumptions in support of both the preparation of the Part I Unified Rate Review Template and the assumptions in support of the rate development applicable to the

products discussed in this filing, I relied on the expertise of the following noted individuals, along with work products produced at their direction, for the following items:

- URRT Methodology and Data Definitions James Lescoe
- Experience Period MLR Rebates James Lescoe
- Actuarial Value, Modifications, and Benefit Relativities Brian Diiorio
- Supplemental EHB Pricing Heather Waldron/Michael McCormick
- Medical Cost and Utilization Trend Bethany McAleer
- Rx Cost and Utilization Trend Bradley Schoening
- Pediatric Dental Claim Cost Barbara Weber
- Components of Retention/Administrative Fees Jonathan Kunkle
- Value of Network Arrangements Julie Graziadei
- Experience Period Data – Small Group Paul Marlowe

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, Xiaoping Hu am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of NY, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Plan Entities check this title
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 41, Actuarial Communications.
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice and based on the claims expected to be paid for essential health benefits and the expected cost sharing and administrative expenses associated with those benefits.
5. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments were made to reflect benefit features not handled by the AV Calculator, as outlined in the attached certification required by 45 CFR Part 156, §156.135.

  
Aetna Life Insurance Company

June 13, 2014  
\_\_\_\_\_  
Date

**Unique Plan Design - Issuer AV  
Supporting Documentation and Justification**

**State:** NY  
**HIOS Issuer ID:** 50138  
**HIOS Product Ids:** 50138NY011

**HIOS Plan Ids:** 50138NY0110003  
50138NY0110004

**1) Justification for use of Issuer AV:**

Per 156.135, the AV must be certified by member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

- (1) Option 1 - Certify that the plan was entered correctly and not vary materially from standard options entered
- (2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

Aetna benefit plans were analyzed vs the AVC to determined when Option 2 vs Option 1 certification was necessary. Five underlying calculators were built to support population of the OP facility, Specialis ER, Rx generic rows in the AVC and average coinsurance cells. These all support Option 2 certifications. In addition, all Aetna plans were run with coinsurance entered on each row where applicable. This was done even if the unique coinsurance on the row was the same as the average coinsurance in row 11. This methodology prevents the OP facility/physician splitting methodology from being invoked which we do not believe is appropriate for our benefit plans. The output from this consistently applied process reflects our certified Actuarial Values.

**2) Regulatory permitted alternate method used:**

- (2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

**3) Confirmation that only in-network cost sharing including multitier networks, was considered:**

Confirmed. Only in-network cost sharing information was used.

**4) Description of standardized plan population data used:**

Detail of data used for each of the subcalculators is described below in items 5 & 6. All data was based on either the AVC continuance tables, or a national data set which is representative of the SG/IVL p in 2015.

**5) If the method described in 156.135.(b).(2) was used, description of how the benefits were modified to fit the parameters of the AV calculator:**

Average Coinsurance

The 2014/2015 AVC does not appropriately calculate an average coinsurance. Therefore, we calculate and effective average coinsurance across copay and coinsurance rows using the AVC continuance table weights and unit costs. This methodology is similar to that embedded in the 2015 preliminary AVC.

OP Facility Benefit Plan Fit Process

OP facility has two subcategories of OP surg - hospital and OP surg- freestanding. The equivalent coinsurance for each was set as the plan copay divided by the unit cost. The adjusted equivalent coinsu was then calculated for each copay/deduct combination. It was adjusted to account for the portion of cost less than the deduct that was at 0% coinsurance in the model as compared to the portion subject It was validated that these adjusted equivalence factors did not vary materially based on the underlying continuance table used. The average coinsurance of the row was calculated based on the weighting of the internal subcategories.

**6) If the method described in 156.135.(b).(3) was used, description of the data and method used to develop the adjustments:**

For deduct and then copay plans, an adjustment was made for the underlying assumption in the model that plans are copay then deduct. Adjustment was determined based on methodology in the 2015 preliminary AVC.

**Certification Language:**

The development of the actuarial value is based on one of the acceptable alternative methods outlines in 156.135.(b).(2) or 156.135.(b).(3) for those benefits that deviate from the parameters of the AV calculator and have a material impact on the AV.

The analysis was

- (i) conducted by a member of the American Academy of Actuaries
- (ii) performed in accordance with generally accepted actuarial principles and methodologies

Actuary Signature:

Actuary Printed name:

Date:

06/11/2014

**Aetna Health Inc.**  
**HIOS ISSUER ID: 50138**

**Exhibit A**  
**Base Plan Rate and Projected Rate Development**

	<u>Medical+ Rx</u>	<u>Comments</u>
Calendar Year 2013 New York Small Group HMO Allowed Claims PMPM:	\$431.98	
<u>Projection Factors</u>		
EHB Impact:	1.037	Including Pediatric Dental
<u>Change in Demographics</u>	<u>1.001</u>	See Exhibit B
Total	1.039	
Trend (with Benefit Richness Adjustment)	9.5%	Apply for 24 months to trend to 2015Q1
Trend Factor	1.199	
Projected 2015 Individual Allowed Claims PMPM:	\$537.96	
<b>2015Q1 Index Rate:</b>	<b>\$537.96</b>	
Projected ACA Risk Adjustment:	\$53.80	10% of Projected Incurred Claims
<b>Market Adjusted Index Rate</b>	<b>\$591.76</b>	
Projected Paid to Allowed ( Anchor Plan):	0.796	
<b>Projected Incurred Claims:</b>	<b>\$470.96</b>	
Retention Components	15.70%	
<b>Projected Premium:</b>	<b>\$558.68</b>	
Premium calibration factors		
Area	0.982	See Exhibit C
Conversion Factor from PMPM to PEPM	1.155	See Exhibit D
<b>Consumer Adjusted Premium Rates - single rate</b>	<b>\$656.89</b>	
Loss Ratio adjustment	21.9%	
<b>Final HNY single premium rate</b>	<b>513.29</b>	

**Aetna Health Inc.**  
**HIOS ISSUER ID: 50138**

**Exhibit B**  
**Claim Impact due to Demographic Changes**

Age	Current Distribution		Projected Distribution		Demographic Factor	
	Male	Female	Male	Female	Male	Female
0	0.47%	0.49%	0.50%	0.52%	1.050	0.939
1	0.47%	0.39%	0.46%	0.42%	1.050	0.939
2	0.47%	0.45%	0.49%	0.47%	0.601	0.596
3	0.49%	0.44%	0.50%	0.41%	0.601	0.596
4	0.45%	0.48%	0.46%	0.50%	0.601	0.596
5	0.48%	0.44%	0.49%	0.39%	0.570	0.565
6	0.49%	0.48%	0.45%	0.45%	0.570	0.565
7	0.48%	0.52%	0.48%	0.51%	0.570	0.565
8	0.54%	0.49%	0.50%	0.54%	0.570	0.565
9	0.54%	0.51%	0.50%	0.49%	0.570	0.565
10	0.58%	0.51%	0.54%	0.49%	0.578	0.565
11	0.54%	0.54%	0.58%	0.54%	0.578	0.565
12	0.53%	0.46%	0.48%	0.49%	0.578	0.565
13	0.56%	0.54%	0.58%	0.50%	0.578	0.565
14	0.55%	0.51%	0.54%	0.49%	0.578	0.565
15	0.59%	0.54%	0.58%	0.53%	0.606	0.615
16	0.58%	0.54%	0.59%	0.56%	0.606	0.615
17	0.54%	0.56%	0.53%	0.52%	0.606	0.615
18	0.57%	0.60%	0.58%	0.56%	0.606	0.615
19	0.55%	0.55%	0.59%	0.56%	0.606	0.615
20	0.58%	0.59%	0.56%	0.55%	0.451	0.741
21	0.61%	0.63%	0.58%	0.55%	0.451	0.741
22	0.69%	0.67%	0.70%	0.71%	0.451	0.741
23	0.71%	0.77%	0.71%	0.74%	0.451	0.741
24	0.75%	0.86%	0.78%	0.86%	0.451	0.741
25	0.83%	0.97%	0.76%	0.97%	0.460	1.106
26	0.83%	1.05%	0.91%	1.13%	0.460	1.106
27	0.96%	1.13%	0.95%	1.14%	0.460	1.106
28	0.91%	1.07%	0.95%	1.09%	0.460	1.106
29	0.94%	1.10%	0.95%	1.13%	0.460	1.106
30	0.90%	1.09%	0.91%	1.08%	0.519	1.197
31	0.93%	1.06%	0.93%	1.09%	0.519	1.197
32	0.85%	0.98%	0.95%	1.01%	0.519	1.197
33	0.84%	0.96%	0.82%	1.07%	0.519	1.197
34	0.82%	0.91%	0.85%	0.92%	0.519	1.197
35	0.81%	0.95%	0.80%	1.01%	0.630	1.197
36	0.82%	0.85%	0.83%	0.86%	0.630	1.197
37	0.87%	0.87%	0.87%	0.87%	0.630	1.197
38	0.76%	0.86%	0.82%	0.83%	0.630	1.197
39	0.63%	0.84%	0.64%	0.81%	0.630	1.197
40	0.80%	0.85%	0.71%	0.81%	0.790	1.197
41	0.77%	0.80%	0.74%	0.84%	0.790	1.197
42	0.79%	0.83%	0.83%	0.80%	0.790	1.197
43	0.84%	0.86%	0.76%	0.80%	0.790	1.197
44	0.86%	0.98%	0.87%	0.95%	0.790	1.197
45	0.84%	0.85%	0.86%	0.87%	1.000	1.269
46	0.86%	0.90%	0.81%	0.90%	1.000	1.269
47	0.82%	0.93%	0.86%	0.94%	1.000	1.269
48	0.89%	0.91%	0.86%	0.90%	1.000	1.269
49	0.88%	1.01%	0.89%	0.91%	1.000	1.269
50	0.92%	0.93%	0.84%	0.93%	1.370	1.460
51	0.90%	1.03%	0.91%	0.93%	1.370	1.460
52	0.90%	0.99%	0.93%	1.03%	1.370	1.460
53	0.87%	0.88%	0.84%	0.96%	1.370	1.460
54	0.90%	0.92%	0.89%	0.89%	1.370	1.460
55	0.84%	0.89%	0.88%	0.89%	1.757	1.745
56	0.81%	0.94%	0.81%	0.90%	1.757	1.745
57	0.77%	0.86%	0.79%	0.89%	1.757	1.745
58	0.76%	0.87%	0.75%	0.83%	1.757	1.745
59	0.80%	0.90%	0.80%	0.93%	1.757	1.745
60	0.75%	0.78%	0.74%	0.85%	2.218	2.128
61	0.72%	0.74%	0.75%	0.70%	2.218	2.128
62	0.70%	0.81%	0.67%	0.79%	2.218	2.128
63	0.64%	0.70%	0.68%	0.71%	2.218	2.128
64	0.60%	0.67%	0.61%	0.70%	2.218	2.128
65+	1.79%	1.38%	1.79%	1.41%	3.200	2.700

<b>Current Demographic Factor</b>	1.1207
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**Note:**  
Current Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

<b>Projected Demographic Factor</b>	1.1222
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**Note:**  
Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

<b>Claim Impact due to Demographic Changes</b>	1.0014
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**Note:**  
Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Current Demographic Factor

Aetna Health Inc.  
HIOS ISSUER ID: 50138

Exhibit C  
Projected Membership Distribution by County

Rating Area	Counties	Current Membership Distribution	Current Area Factor	Projected Membership Distribution	Projection Area Factor	Pricing Area Factor
1	Albany	0.1%	0.8200	0.1%	0.8200	0.8200
1	Columbia	0.2%	0.8200	0.2%	0.8200	0.8200
1	Fulton	0.0%	0.8200	0.0%	0.8200	0.8200
1	Greene	0.0%	0.8200	0.0%	0.8200	0.8200
1	Montgomery	0.0%	0.8200	0.0%	0.8200	0.8200
1	Rensselaer	0.1%	0.8200	0.1%	0.8200	0.8200
1	Saratoga	0.2%	0.8200	0.2%	0.8200	0.8200
1	Schenectady	0.1%	0.8200	0.1%	0.8200	0.8200
1	Schoharie	0.0%	0.8200	0.0%	0.8200	0.8200
1	Warren	0.1%	0.8200	0.1%	0.8200	0.8200
1	Washington	0.0%	0.8200	0.0%	0.8200	0.8200
2	Allegany	0.0%	0.9000	0.0%	0.9000	0.9000
2	Cattaraugus	0.0%	0.9000	0.0%	0.9000	0.9000
2	Chautauqua	0.0%	0.9000	0.0%	0.9000	0.9000
2	Erie	0.2%	0.9000	0.2%	0.9000	0.9000
2	Genesee	0.0%	0.9000	0.0%	0.9000	0.9000
2	Niagara	0.0%	0.9000	0.0%	0.9000	0.9000
2	Orleans	0.0%	0.9000	0.0%	0.9000	0.9000
2	Wyoming	0.0%	0.9000	0.0%	0.9000	0.9000
3	Delaware	0.1%	0.8900	0.1%	0.8900	0.8900
3	Dutchess	3.3%	0.8900	3.3%	0.8900	0.8900
3	Orange	4.6%	0.8900	4.6%	0.8900	0.8900
3	Putnam	2.0%	0.8900	2.0%	0.8900	0.8900
3	Sullivan	1.4%	0.8900	1.4%	0.8900	0.8900
3	Ulster	1.0%	0.8900	1.0%	0.8900	0.8900
4	Bronx	3.1%	1.0000	3.1%	1.0000	1.0000
4	Kings	13.3%	1.0000	13.3%	1.0000	1.0000
4	New York	22.9%	1.0000	22.9%	1.0000	1.0000
4	Queens	9.4%	1.0000	9.4%	1.0000	1.0000
4	Richmond	2.7%	1.0000	2.7%	1.0000	1.0000
4	Rockland	4.0%	1.0000	4.0%	1.0000	1.0000
4	Westchester	12.4%	1.0000	12.4%	1.0000	1.0000
5	Livingston	0.0%	0.7000	0.0%	0.7000	0.7000
5	Monroe	0.2%	0.7000	0.2%	0.7000	0.7000
5	Ontario	0.0%	0.7000	0.0%	0.7000	0.7000
5	Seneca	0.0%	0.7000	0.0%	0.7000	0.7000
5	Wayne	0.0%	0.7000	0.0%	0.7000	0.7000
5	Yates	0.0%	0.7000	0.0%	0.7000	0.7000
6	Broome	0.1%	0.7900	0.1%	0.7900	0.7900
6	Cayuga	0.1%	0.7900	0.1%	0.7900	0.7900
6	Chemung	0.0%	0.7900	0.0%	0.7900	0.7900
6	Cortland	0.0%	0.7900	0.0%	-	0.7900
6	Onondaga	0.2%	0.7900	0.2%	0.7900	0.7900
6	Schuyler	0.0%	0.7900	0.0%	0.7900	0.7900
6	Steuben	0.1%	0.7900	0.1%	0.7900	0.7900
6	Tioga	0.0%	0.7900	0.0%	0.7900	0.7900
6	Tompkins	0.1%	0.7900	0.1%	0.7900	0.7900
7	Chenango	0.0%	0.8200	0.0%	0.8200	0.8200
7	Clinton	0.0%	0.8200	0.0%	0.8200	0.8200
7	Essex	0.0%	0.8200	0.0%	0.8200	0.8200
7	Franklin	0.0%	0.8200	0.0%	0.8200	0.8200
7	Hamilton	0.0%	0.8200	0.0%	0.8200	0.8200
7	Herkimer	0.0%	0.8200	0.0%	0.8200	0.8200
7	Jefferson	0.0%	0.8200	0.0%	0.8200	0.8200
7	Lewis	0.1%	0.8200	0.1%	0.8200	0.8200
7	Madison	0.0%	0.8200	0.0%	0.8200	0.8200
7	Oneida	0.0%	0.8200	0.0%	0.8200	0.8200
7	Oswego	0.0%	0.8200	0.0%	0.8200	0.8200
7	Otsego	0.0%	0.8200	0.0%	0.8200	0.8200
7	Saint Lawrence	0.0%	0.8200	0.0%	0.8200	0.8200
8	Nassau	10.2%	1.0000	10.2%	1.0000	1.0000
8	Suffolk	7.3%	1.0000	7.3%	1.0000	1.0000

<b>Current Area Normalization Factor</b>	0.9819
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**Note:**  
Current Area Normalization Factor computed as the weighted average of Current Area Factors by current membership distribution.

<b>Projected Area Normalization Factor</b>	0.9819
--	--------

**Note:**  
Projected Area Normalization Factor computed as the weighted average of Current Area Factors by projected membership distribution.

<b>Area Shift Factor</b>	1.0000
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**Note:**  
Area Shift Factor computed as the ratio of the Projected Area Normalization Factor over the Current Area Normalization Factor. Factor represents the impact due to the shift of the population distribution across areas.

<b>Projected Network Factor</b>	0.9819
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**Note:**  
Projected Network Factor computed as the weighted average of Projected Area Factors by projected membership distribution.

<b>Network Shift Factor</b>	1.0000
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**Note:**  
Network Shift Factor computed as the ratio of the Projected Network Factor over the Projected Area Normalization Factor. Factor represents the impact due to network changes from the experience period to rating period.

**Aetna Health Insurance Company  
New York Small Group**

**Exhibit D  
Conersion factor from PMPM to Single Rate**

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Small Group Membership Data  
As of December, 2013

Tier	Subscribers	Members	2014 Tier Factor
Single	27,208	27,208	1.000
Single + Spouse	2,880	5,760	2.000
Single + Child(ren)	2,194	5,929	1.700
Single + Spouse + Child(ren)	4,610	18,637	2.850
Total	36,892	57,534	49,836
Conersion factor from PMPM to Single rate			<b>1.155</b>

**Aetna Life Insurance Company  
New York Small Group**

**Exhibit F  
AV and Plan factors**

NY SG Plan Name	Exchange ON/OFF	Metallic Tier	Actuarial Value	Plan Factors
NY Gold Healthy NY 600	OFF	Gold	79.6%	1.0000
NY Gold Healthy NY 600 RE	OFF	Gold	79.6%	0.9852



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June 13, 2014

Mr. Michel Laverdiere, Chief Actuary  
New York State Insurance Department  
25 Beaver Street - Health Bureau  
New York, NY 10004-2319

Subject: Aetna Health, Inc. of NY  
**SERFF ID: AETN-129591063**

Dear Mr. Laverdiere:

Enclosed for your Department's review and approval please find a rate filing that provides Comprehensive Medical Expense insurance coverage to small group employers of the State of NY.

The purpose of this filing is to provide details of the premium rate development and resulting proposed monthly premium rates for Small Group policies which will be offered off-Exchange in the State of NY by Aetna Health, Inc. of NY (Aetna) for effective dates of January 1, 2015 and later. This filing is being provided to comply with regulatory rate filing requirements and is not intended to be used for other purposes.

The health benefit plans proposed in this filing are existing benefit plans and are in compliance with all state-specific benefit requirements and rating regulations, as well as those associated with Federal Health Care Reform H.R. 3590 – the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010. Additionally, these health benefit plans conform to each respective tier of coverage, defined as Bronze, Silver, Gold, and Platinum. All plans within a tier are expected to achieve an actuarial value consistent with the thresholds established for each tier – 60%, 70%, 80%, and 90%, respectively – approximated within the allowable range of deviation defined as 2 percentage points.

This rate filing is intended for new business issued through the State of NY off-Exchange marketplace effective January 1, 2015.

All products and associated proposed monthly premium rates contained within this rate filing will be available to existing business upon their request. Existing business that is not considered grandfathered under PPACA regulation will be converted to the plans and rates in this filing upon renewal.

Mr. Laverdiere  
June 13, 2014  
Page 2 of 2

This submission includes the following:

- Actuarial Memorandum and Certification,
- NY SG Rate Manual, and
- NY required standard exhibits

We have tried to present this information in a manner that will facilitate your Department's review. If there are changes we can make to improve the process or you would like us to present the information differently in the future, please let us know.

Please feel free to contact me at the above listed telephone number and/or e-mail address if you have any additional questions.

Very truly yours,



Aetna Health Inc

Encl: a/s

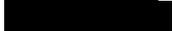
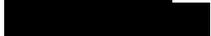
# Actuarial Memorandum and Certification

## General Information

### *Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** New York  
**HIOS Issuer ID:** 50138  
**Market:** Small Group  
**Policy Form:** OffHIXHNYGR-96816-1  
**Effective Date:** 01/01/2015  
**Filing Reference Number:**

### *Company Contact Information:*

**Name:**   
**Telephone Number:**   
**Email Address:** 

## 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms referenced above;
- 3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
- 4) Provide summaries of the benefit details for the products/plan designs referenced by this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in the NY Small Group market by Aetna Life Insurance Company beginning January 1, 2015. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available off the Federally Facilitated Exchange (Off-Exchange) in NY.

This memorandum is being submitted to satisfy federal rate review requirements and to support the development of the rates submitted with this filing. It is not intended to be used for any other purpose.

## 2. Proposed Rate Increase

Monthly premium rates for all ACA-compliant Small Group market products in NY are being revised for effective dates January 1, 2015 through December 31, 2015. Small Group rates are effective for rolling 12 month basis. Rates will increase on quarterly basis due to trend.

### A. Reason for Rate Increase(s):

Rates for these products are updated to reflect the following:

- Impact of medical claim trend (including increases in provider unit costs and increased utilization of medical cost services);
- The projected impact of the federal risk adjustment program that was put in place by the Affordable Care Act.

- Impact of HNY stop loss reimbursement percentage

### 3. Experience Period Premium and Claims

#### A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2013 through December 31, 2013 and paid through March 31, 2014.

#### B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for Small Group business in NY. Based on internal projections and the MLR Annual Reporting Form for Calendar Year 2013, the expected rebate for the Small Group NY Minimum Loss Ratio pool in 2013 is approximately 2.39% of premium. Experience period premium shown in Worksheet 1, Section I reflect an adjustment of this magnitude. Please note the following for additional clarification:

Earned Premium Prior to MLR Rebates:	\$ 6,952,006
Expected CY2013 MLR Rebates:	\$ 165,951
Earned Premium Net of MLR Rebates:	\$ 6,786,055

#### C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. We relied on our corporate data warehouse and medical cost analytics systems, to estimate unit cost and utilization metrics by medical cost category.

A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

### 4. Benefit Categories

The benefit categories used generally align with the Federal instructions dated April 30, 2014. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, while Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses. Other includes home health care, mental health care, medical pharmacy expenses, as well as laboratory and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

### 5. Projection Factors

#### A. Changes in Benefits:

To adjust the experience period PMPM, changes to benefits were applied to reflect differences between the covered benefits in the base 2013 experience data and the 2015 covered benefit level. An adjustment was made to:

- Reflect the value of Essential Health Benefits (EHB) and pediatric dental, as a percentage of the claims.

**B. Changes in Demographics:**

Experience data was normalized for projected changes in the 2015 age/gender mix using Aetna demographic factors.

Experience data was normalized for rating area comparing the current and projected member distributions by county using our company-specific market defined rating area factors.

**C. Trend Factors (Cost/Utilization):**

Anticipated annual trend from the experience period to the rating period for the product line is as follows:

<b>Component</b>	<b>Provider Contract Change</b>	<b>Utilization</b>	<b>Business Mix</b>	<b>Total Trend</b>
Medical	3.9%	4.0%	2.7%	<b>11.0%</b>
Pharmacy	3.7%	7.7%	3.3%	<b>15.3%</b>
Total	3.9%	4.8%	2.8%	<b>11.9%</b>

**a. Medical Trend**

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived after considering the federal risk adjustment program factors and other proprietary models.

**b. Pharmacy Trend**

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

**6. Credibility Manual Rate Development**

**A. Source and Appropriateness of Experience Data Used:**

The source data for our manual rate is the experience incurred from January 13 to December 13 and paid through March 31, 2014 of the HNY plans in the NY Small Group market, excluding Sole proprietor.

7. Paid-to-Allowed Ratio

We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 79.6%.

Tier	Projected Membership Distribution	Actuarial Value
Gold	100.0%	79.6%
Total	100.00%	79.6%

8. Risk Adjustment

We developed a market base rate that represents the average market morbidity expected in 2015. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level.

We included the projected impact of the federal risk adjustment program that was put in place by the Affordable Care Act in this rate filing to adjust our experience period data to the average market morbidity expected in 2015. The impact of risk adjustment in the 2015 NY Small Group marketplace was based on the simulation study conducted by Deloitte on behalf of DFS. Our own analysis of the block indicates stable morbidity and health status, consistent with the data provided to Deloitte, and we do not expect material changes in 2015. Based on these projections of the market in 2015, this adjustment is +10%. This number is derived by combining our current AHI and ALIC book of business experience.

We are projecting a reinsurance premium assessment of \$3.67 per member per month, which has been reflected.

The risk corridors program does not apply to Off-Exchange business.

9. Non-Benefit Expenses and Profit & Risk

The Retention Portion of the Market Base Rate is 15.70%. This was developed from the following items and approximated as shown:

1. Taxes and Fees of 6.82% comprised of:
  - a. Premium Taxes of 1.77%
  - b. Patient Centered Outcomes Research Fund of \$0.20 per member per year, converted to 0.04%
  - c. Reinsurance Contribution of \$3.67 PMPM, converted to 0.66%
  - d. Health Insurer Fee of 3.0%
    - i. 1.95% paid post-tax as the Health Insurer Fee
    - ii. 1.05%, charged as a corporate tax of 35% on the 1.95% pre-tax charge
  - e. Exchange User Fee of 0%.
  - f. Federal Income Tax of 1.35%, assuming 35% tax rate
  - g. Risk Adjustment Program Fee of 0.01%
2. Commissions of 1.02% of premium
3. General Administrative Expenses of \$29.91, converted to 5.35% of premium based upon an expected average premium level.
4. Risk Charge of 2.50%

These prospective expenses are based on historical expense levels and the changes expected with the requirements of PPACA and the Exchange.

### 10. Projected Loss Ratio

Under the current pricing assumption, the average MLR for 2015 using the Federally-prescribed MLR methodology, before any applicable credibility adjustment, is projected to be 91.44%.

The target MBR calculated in the traditional way (incurred claims divided by premium) is 84.3%. This is compliant with NY loss ratio requirements of 82%. The following table provides the details of the calculations.

		<b>Small Group</b>	<b>Formula</b>
(a)	Member Months	331,968	
(b)	Premium (pppm)	\$558.65	
(c)	Medical Cost (pppm)	\$470.96	
(d)	Medical Benefit Ratio (MBR)	<b>84.3%</b>	= (c) / (b)
(e)	Quality Improvement Action (pppm)	\$5.03	= (b) x 0.9 % <sup>(1)</sup>
(f)	Taxes and Fees (pppm)	\$38.12	= (b) x 6.82% <sup>(2)</sup>
(g)	Adjusted Premium (pppm)	\$520.53	= (b) - (f)
(h)	Adjusted Claims (pppm)	\$475.99	= (c) + (e)
	<b>Medical Loss Ratio (MLR)</b>	<b>91.44%</b>	= (h) / (g)

Notes:

(1) The cost of quality improvement action is estimated to be 0.90% of the premium.

(2) Taxes and fees are estimated to be 6.82% of the premium. The components of the 6.82% are listed in Section 9 above.

### 11. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in NY through Aetna Health Inc..

### 12. Index Rate

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, the impact of induced utilization, and the plan's provider network, delivery system characteristics, and utilization management practices. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR Part 156, §156.80(d)(2).

**Small Group Market Trend Adjustments:** The following table (or attached exhibit) illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2015.

Effective Date	Member Distribution	Effective Date factor	Index Rate
1Q15	25%	1.0000	537.96
2Q15	18%	1.0264	552.17
3Q15	22%	1.0536	566.80
4Q15	34%	1.0816	581.84
Total	100%	1.0445	561.89

### 13. Market-Adjusted Index Rate

Exhibit A illustrates the development of the Market Adjusted Index Rate. The Risk Adjustment was discussed previously in section 8. They are developed as multiplicative adjustments to paid claims for the Essential Health Benefits, and are applied as multiplicative adjustments to the index rate, which differs from the basis on which the adjustments were developed by the paid to allowed ratio.

### 14. Plan-Adjusted Index Rates

Exhibit A illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The following briefly describes how each set of adjustments was determined.

#### A. Actuarial Value and Cost Sharing:

We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio.

#### B. Provider Network, Delivery System, and Utilization Management:

There is no network or delivery system changes for this plan.

#### C. Distribution and Administrative Costs:

These are discussed above in Section 9 ‘Non-Benefit Expenses and Profit & Risk’ section. These expense and profit assumptions do not vary by plan.

### 15. Calibration

#### A. Age Curve Calibration:

NY Small Group business is community-rated. There is no demographic factor applied on NY Small Group business.

#### B. Geographic Factor Calibration:

Rating areas are defined by NY Department of Financial Services. We are not changing our rating area factors from 2014 filing.

Exhibit D summarizes the rating area definitions and factors. Exhibit D displays the projected membership by area and the projected average area factor of 0.982.

16. Trend Factors

NY Small Group business is charging quarterly rates on rolling 12 month basis. The rates development in this pricing mode is for first quarter 2015, applying 24 month of trend from experience period of Calendar Year 2013 to first quarter 2015. The rest of the quarter of 2015 will get quarterly trend increase as listed below.

Effective Date	Effective Date factor
1Q15	1.0000
2Q15	1.0264
3Q15	1.0536
4Q15	1.0816

17. Consumer-Adjusted Premium Rate Development

Rates are determined using member composite rating methodology for NY Small Group business. The tier ratios are prescribed by NY Department of Financial Services.

The premium for each billable member is calculated as:

Calibrated Base Plan Index Rate \* Plan Factor \* Area Factor \* Effective Date Factor \* Tier factor (Single, Couple, Parent/Child(ren), Family)

The resulting rate for each subscriber is rounded to the nearest cents.

18. HNY Stop loss Reimbursement

The HNY plan is a state mandated plan which the state has a stop loss program to over large claims. We have built in the reimbursement amount we expect to receive from the state into pricing as well.

19. AV Metal Values

The AV Metal Values were based on the AV Calculator. Rate Manual Section B lists the AV level of all NY Small Group plans. Adjustments were made to account for plan design features that could not be entered into the AV Calculator and have a material impact on the AV. These adjustments were developed using an acceptable alternative method as outlined in 45 CFR Part 156, §156.135 and as discussed in the accompanying certification regarding the development of the AV metal values.

20. AV Pricing Values

The fixed reference plan (anchor plan) is 50138NY0110003 (NY Gold Healthy NY 600). Benefit factors were developed taking into account the allowable rating characteristics. The resulting plan factors are displayed Exhibit F. We have not adjusted the benefit factors based on morbidity differences or benefit selection.

A plan factor to adjust the market base rate for differences in plan-specific expected claims was calculated. These factors account for differences in benefits, cost sharing, and network design (where applicable). The

benchmark Silver plan is assigned a factor of 1.0. The factors were developed using a proprietary pricing model which relies on:

- a) State- and product-specific service category weights;
- b) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and copays
- c) Utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier.

#### 21. Membership Projections

We assumed that total enrollment will be similar to our current enrollment.

#### 22. Plan Type

HNY plan is HMO based plan.

#### 23. Warning Alerts

Total Incurred Claims, payable with issuer funds, differs between Worksheet 2 and the check from Worksheet 1 since the total on Worksheet 2 excludes the impact of Reinsurance Contributions and Risk Adjustment User Fees, while the check from Worksheet 1 is net of Reinsurance Contributions and Risk Adjustment User Fees.

For the same reason, the Incurred Claims PMPM differs between Worksheet 2 and the Worksheet 1 check.

#### 24. Benefit Design

This filing includes the Health New York standard plan. All plans offered outside the Exchange will include pediatric dental benefits. The plan design is defined by Department of Financial Services.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is summarized in Rate Manual Section B (the benefit and AV screen print file). All benefit and cost sharing parameters comply with NY benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

#### 25. Marketing

As described above, all of these plans will be made available Off Exchange.

#### 26. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

#### 27. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

#### Reliance

While I have reviewed the reasonableness of the assumptions in support of both the preparation of the Part I Unified Rate Review Template and the assumptions in support of the rate development applicable to the

products discussed in this filing, I relied on the expertise of the following noted individuals, along with work products produced at their direction, for the following items:

- URRT Methodology and Data Definitions James Lescoe
- Experience Period MLR Rebates James Lescoe
- Actuarial Value, Modifications, and Benefit Relativities Brian Diiorio
- Supplemental EHB Pricing Heather Waldron/Michael McCormick
- Medical Cost and Utilization Trend Bethany McAleer
- Rx Cost and Utilization Trend Bradley Schoening
- Pediatric Dental Claim Cost Barbara Weber
- Components of Retention/Administrative Fees Jonathan Kunkle
- Value of Network Arrangements Julie Graziadei
- Experience Period Data – Small Group Paul Marlowe

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, Xiaoping Hu am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of NY, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Plan Entities check this title
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 41, Actuarial Communications.
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice and based on the claims expected to be paid for essential health benefits and the expected cost sharing and administrative expenses associated with those benefits.
5. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments were made to reflect benefit features not handled by the AV Calculator, as outlined in the attached certification required by 45 CFR Part 156, §156.135.



Aetna Life Insurance Company

June 13, 2014

Date

**Unique Plan Design - Issuer AV  
Supporting Documentation and Justification**

**State:** NY  
**HIOS Issuer ID:** 50138  
**HIOS Product Ids:** 50138NY011

**HIOS Plan Ids:** 50138NY0110003  
50138NY0110004

**1) Justification for use of Issuer AV:**

Per 156.135, the AV must be certified by member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

- (1) Option 1 - Certify that the plan was entered correctly and not vary materially from standard options entered
- (2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

Aetna benefit plans were analyzed vs the AVC to determined when Option 2 vs Option 1 certification was necessary. Five underlying calculators were built to support population of the OP facility, Specialis ER, Rx generic rows in the AVC and average coinsurance cells. These all support Option 2 certifications. In addition, all Aetna plans were run with coinsurance entered on each row where applicable. This was done even if the unique coinsurance on the row was the same as the average coinsurance in row 11. This methodology prevents the OP facility/physician splitting methodology from being invoked which we do not believe is appropriate for our benefit plans. The output from this consistently applied process reflects our certified Actuarial Values.

**2) Regulatory permitted alternate method used:**

- (2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

**3) Confirmation that only in-network cost sharing including multitier networks, was considered:**

Confirmed. Only in-network cost sharing information was used.

**4) Description of standardized plan population data used:**

Detail of data used for each of the subcalculators is described below in items 5 & 6. All data was based on either the AVC continuance tables, or a national data set which is representative of the SG/IVL p in 2015.

**5) If the method described in 156.135.(b).(2) was used, description of how the benefits were modified to fit the parameters of the AV calculator:**

Average Coinsurance

The 2014/2015 AVC does not appropriately calculate an average coinsurance. Therefore, we calculate and effective average coinsurance across copay and coinsurance rows using the AVC continuance table weights and unit costs. This methodology is similar to that embedded in the 2015 preliminary AVC.

OP Facility Benefit Plan Fit Process

OP facility has two subcategories of OP surg - hospital and OP surg- freestanding. The equivalent coinsurance for each was set as the plan copay divided by the unit cost. The adjusted equivalent coinsu was then calculated for each copay/deduct combination. It was adjusted to account for the portion of cost less than the deduct that was at 0% coinsurance in the model as compared to the portion subject It was validated that these adjusted equivalence factors did not vary materially based on the underlying continuance table used. The average coinsurance of the row was calculated based on the weighting of the internal subcategories.

**6) If the method described in 156.135.(b).(3) was used, description of the data and method used to develop the adjustments:**

For deduct and then copay plans, an adjustment was made for the underlying assumption in the model that plans are copay then deduct. Adjustment was determined based on methodology in the 2015 preliminary AVC.

**Certification Language:**

The development of the actuarial value is based on one of the acceptable alternative methods outlines in 156.135.(b).(2) or 156.135.(b).(3) for those benefits that deviate from the parameters of the AV calculator and have a material impact on the AV.

The analysis was

- (i) conducted by a member of the American Academy of Actuaries
- (ii) performed in accordance with generally accepted actuarial principles and methodologies

Actuary Signature:

Actuary Printed name:

Date:

06/11/2014

**Aetna Health Inc.**  
**HIOS ISSUER ID: 50138**

**Exhibit A**  
**Base Plan Rate and Projected Rate Development**

	<u>Medical+ Rx</u>	<u>Comments</u>
Calendar Year 2013 New York Small Group HMO Allowed Claims PMPM:	\$431.98	
<u>Projection Factors</u>		
EHB Impact:	1.037	Including Pediatric Dental
<u>Change in Demographics</u>	<u>1.001</u>	See Exhibit B
Total	1.039	
Trend (with Benefit Richness Adjustment)	9.5%	Apply for 24 months to trend to 2015Q1
Trend Factor	1.199	
Projected 2015 Individual Allowed Claims PMPM:	\$537.96	
<b>2015Q1 Index Rate:</b>	<b>\$537.96</b>	
Projected ACA Risk Adjustment:	\$53.80	10% of Projected Incurred Claims
<b>Market Adjusted Index Rate</b>	\$591.76	
Projected Paid to Allowed ( Anchor Plan):	0.796	
<b>Projected Incurred Claims:</b>	<b>\$470.96</b>	
Retention Components	15.70%	
<b>Projected Premium:</b>	<b>\$558.68</b>	
Premium calibration factors		
Area	0.982	See Exhibit C
Conversion Factor from PMPM to PEPM	1.155	See Exhibit D
<b>Consumer Adjusted Premium Rates - single rate</b>	<b>\$656.89</b>	
Loss Ratio adjustment	21.9%	
<b>Final HNY single premium rate</b>	<b>513.29</b>	

**Aetna Health Inc.**  
**HIOS ISSUER ID: 50138**

**Exhibit B**  
**Claim Impact due to Demographic Changes**

Age	Current Distribution		Projected Distribution		Demographic Factor	
	Male	Female	Male	Female	Male	Female
0	0.47%	0.49%	0.50%	0.52%	1.050	0.939
1	0.47%	0.39%	0.46%	0.42%	1.050	0.939
2	0.47%	0.45%	0.49%	0.47%	0.601	0.596
3	0.49%	0.44%	0.50%	0.41%	0.601	0.596
4	0.45%	0.48%	0.46%	0.50%	0.601	0.596
5	0.48%	0.44%	0.49%	0.39%	0.570	0.565
6	0.49%	0.48%	0.45%	0.45%	0.570	0.565
7	0.48%	0.52%	0.48%	0.51%	0.570	0.565
8	0.54%	0.49%	0.50%	0.54%	0.570	0.565
9	0.54%	0.51%	0.50%	0.49%	0.570	0.565
10	0.58%	0.51%	0.54%	0.49%	0.578	0.565
11	0.54%	0.54%	0.58%	0.54%	0.578	0.565
12	0.53%	0.46%	0.48%	0.49%	0.578	0.565
13	0.56%	0.54%	0.58%	0.50%	0.578	0.565
14	0.55%	0.51%	0.54%	0.49%	0.578	0.565
15	0.59%	0.54%	0.58%	0.53%	0.606	0.615
16	0.58%	0.54%	0.59%	0.56%	0.606	0.615
17	0.54%	0.56%	0.53%	0.52%	0.606	0.615
18	0.57%	0.60%	0.58%	0.56%	0.606	0.615
19	0.55%	0.55%	0.59%	0.56%	0.606	0.615
20	0.58%	0.59%	0.56%	0.55%	0.451	0.741
21	0.61%	0.63%	0.58%	0.55%	0.451	0.741
22	0.69%	0.67%	0.70%	0.71%	0.451	0.741
23	0.71%	0.77%	0.71%	0.74%	0.451	0.741
24	0.75%	0.86%	0.78%	0.86%	0.451	0.741
25	0.83%	0.97%	0.76%	0.97%	0.460	1.106
26	0.83%	1.05%	0.91%	1.13%	0.460	1.106
27	0.96%	1.13%	0.95%	1.14%	0.460	1.106
28	0.91%	1.07%	0.95%	1.09%	0.460	1.106
29	0.94%	1.10%	0.95%	1.13%	0.460	1.106
30	0.90%	1.09%	0.91%	1.08%	0.519	1.197
31	0.93%	1.06%	0.93%	1.09%	0.519	1.197
32	0.85%	0.98%	0.95%	1.01%	0.519	1.197
33	0.84%	0.96%	0.82%	1.07%	0.519	1.197
34	0.82%	0.91%	0.85%	0.92%	0.519	1.197
35	0.81%	0.95%	0.80%	1.01%	0.630	1.197
36	0.82%	0.85%	0.83%	0.86%	0.630	1.197
37	0.87%	0.87%	0.87%	0.87%	0.630	1.197
38	0.76%	0.86%	0.82%	0.83%	0.630	1.197
39	0.63%	0.84%	0.64%	0.81%	0.630	1.197
40	0.80%	0.85%	0.71%	0.81%	0.790	1.197
41	0.77%	0.80%	0.74%	0.84%	0.790	1.197
42	0.79%	0.83%	0.83%	0.80%	0.790	1.197
43	0.84%	0.86%	0.76%	0.80%	0.790	1.197
44	0.86%	0.98%	0.87%	0.95%	0.790	1.197
45	0.84%	0.85%	0.86%	0.87%	1.000	1.269
46	0.86%	0.90%	0.81%	0.90%	1.000	1.269
47	0.82%	0.93%	0.86%	0.94%	1.000	1.269
48	0.89%	0.91%	0.86%	0.90%	1.000	1.269
49	0.88%	1.01%	0.89%	0.91%	1.000	1.269
50	0.92%	0.93%	0.84%	0.93%	1.370	1.460
51	0.90%	1.03%	0.91%	0.93%	1.370	1.460
52	0.90%	0.99%	0.93%	1.03%	1.370	1.460
53	0.87%	0.88%	0.84%	0.96%	1.370	1.460
54	0.90%	0.92%	0.89%	0.89%	1.370	1.460
55	0.84%	0.89%	0.88%	0.89%	1.757	1.745
56	0.81%	0.94%	0.81%	0.90%	1.757	1.745
57	0.77%	0.86%	0.79%	0.89%	1.757	1.745
58	0.76%	0.87%	0.75%	0.83%	1.757	1.745
59	0.80%	0.90%	0.80%	0.93%	1.757	1.745
60	0.75%	0.78%	0.74%	0.85%	2.218	2.128
61	0.72%	0.74%	0.75%	0.70%	2.218	2.128
62	0.70%	0.81%	0.67%	0.79%	2.218	2.128
63	0.64%	0.70%	0.68%	0.71%	2.218	2.128
64	0.60%	0.67%	0.61%	0.70%	2.218	2.128
65+	1.79%	1.38%	1.79%	1.41%	3.200	2.700

<b>Current Demographic Factor</b>	1.1207
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**Note:**  
Current Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

<b>Projected Demographic Factor</b>	1.1222
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**Note:**  
Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

<b>Claim Impact due to Demographic Changes</b>	1.0014
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**Note:**  
Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Current Demographic Factor

Aetna Health Inc.  
HIOS ISSUER ID: 50138

Exhibit C  
Projected Membership Distribution by County

Rating Area	Counties	Current Membership Distribution	Current Area Factor	Projected Membership Distribution	Projection Area Factor	Pricing Area Factor
1	Albany	0.1%	0.8200	0.1%	0.8200	0.8200
1	Columbia	0.2%	0.8200	0.2%	0.8200	0.8200
1	Fulton	0.0%	0.8200	0.0%	0.8200	0.8200
1	Greene	0.0%	0.8200	0.0%	0.8200	0.8200
1	Montgomery	0.0%	0.8200	0.0%	0.8200	0.8200
1	Rensselaer	0.1%	0.8200	0.1%	0.8200	0.8200
1	Saratoga	0.2%	0.8200	0.2%	0.8200	0.8200
1	Schenectady	0.1%	0.8200	0.1%	0.8200	0.8200
1	Schoharie	0.0%	0.8200	0.0%	0.8200	0.8200
1	Warren	0.1%	0.8200	0.1%	0.8200	0.8200
1	Washington	0.0%	0.8200	0.0%	0.8200	0.8200
2	Allegany	0.0%	0.9000	0.0%	0.9000	0.9000
2	Cattaraugus	0.0%	0.9000	0.0%	0.9000	0.9000
2	Chautauqua	0.0%	0.9000	0.0%	0.9000	0.9000
2	Erie	0.2%	0.9000	0.2%	0.9000	0.9000
2	Genesee	0.0%	0.9000	0.0%	0.9000	0.9000
2	Niagara	0.0%	0.9000	0.0%	0.9000	0.9000
2	Orleans	0.0%	0.9000	0.0%	0.9000	0.9000
2	Wyoming	0.0%	0.9000	0.0%	0.9000	0.9000
3	Delaware	0.1%	0.8900	0.1%	0.8900	0.8900
3	Dutchess	3.3%	0.8900	3.3%	0.8900	0.8900
3	Orange	4.6%	0.8900	4.6%	0.8900	0.8900
3	Putnam	2.0%	0.8900	2.0%	0.8900	0.8900
3	Sullivan	1.4%	0.8900	1.4%	0.8900	0.8900
3	Ulster	1.0%	0.8900	1.0%	0.8900	0.8900
4	Bronx	3.1%	1.0000	3.1%	1.0000	1.0000
4	Kings	13.3%	1.0000	13.3%	1.0000	1.0000
4	New York	22.9%	1.0000	22.9%	1.0000	1.0000
4	Queens	9.4%	1.0000	9.4%	1.0000	1.0000
4	Richmond	2.7%	1.0000	2.7%	1.0000	1.0000
4	Rockland	4.0%	1.0000	4.0%	1.0000	1.0000
4	Westchester	12.4%	1.0000	12.4%	1.0000	1.0000
5	Livingston	0.0%	0.7000	0.0%	0.7000	0.7000
5	Monroe	0.2%	0.7000	0.2%	0.7000	0.7000
5	Ontario	0.0%	0.7000	0.0%	0.7000	0.7000
5	Seneca	0.0%	0.7000	0.0%	0.7000	0.7000
5	Wayne	0.0%	0.7000	0.0%	0.7000	0.7000
5	Yates	0.0%	0.7000	0.0%	0.7000	0.7000
6	Broome	0.1%	0.7900	0.1%	0.7900	0.7900
6	Cayuga	0.1%	0.7900	0.1%	0.7900	0.7900
6	Chemung	0.0%	0.7900	0.0%	0.7900	0.7900
6	Cortland	0.0%	0.7900	0.0%	-	0.7900
6	Onondaga	0.2%	0.7900	0.2%	0.7900	0.7900
6	Schuyler	0.0%	0.7900	0.0%	0.7900	0.7900
6	Steuben	0.1%	0.7900	0.1%	0.7900	0.7900
6	Tioga	0.0%	0.7900	0.0%	0.7900	0.7900
6	Tompkins	0.1%	0.7900	0.1%	0.7900	0.7900
7	Chenango	0.0%	0.8200	0.0%	0.8200	0.8200
7	Clinton	0.0%	0.8200	0.0%	0.8200	0.8200
7	Essex	0.0%	0.8200	0.0%	0.8200	0.8200
7	Franklin	0.0%	0.8200	0.0%	0.8200	0.8200
7	Hamilton	0.0%	0.8200	0.0%	0.8200	0.8200
7	Herkimer	0.0%	0.8200	0.0%	0.8200	0.8200
7	Jefferson	0.0%	0.8200	0.0%	0.8200	0.8200
7	Lewis	0.1%	0.8200	0.1%	0.8200	0.8200
7	Madison	0.0%	0.8200	0.0%	0.8200	0.8200
7	Oneida	0.0%	0.8200	0.0%	0.8200	0.8200
7	Oswego	0.0%	0.8200	0.0%	0.8200	0.8200
7	Otsego	0.0%	0.8200	0.0%	0.8200	0.8200
7	Saint Lawrence	0.0%	0.8200	0.0%	0.8200	0.8200
8	Nassau	10.2%	1.0000	10.2%	1.0000	1.0000
8	Suffolk	7.3%	1.0000	7.3%	1.0000	1.0000

<b>Current Area Normalization Factor</b>	0.9819
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**Note:**  
Current Area Normalization Factor computed as the weighted average of Current Area Factors by current membership distribution.

<b>Projected Area Normalization Factor</b>	0.9819
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**Note:**  
Projected Area Normalization Factor computed as the weighted average of Current Area Factors by projected membership distribution.

<b>Area Shift Factor</b>	1.0000
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**Note:**  
Area Shift Factor computed as the ratio of the Projected Area Normalization Factor over the Current Area Normalization Factor. Factor represents the impact due to the shift of the population distribution across areas.

<b>Projected Network Factor</b>	0.9819
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**Note:**  
Projected Network Factor computed as the weighted average of Projected Area Factors by projected membership distribution.

<b>Network Shift Factor</b>	1.0000
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**Note:**  
Network Shift Factor computed as the ratio of the Projected Network Factor over the Projected Area Normalization Factor. Factor represents the impact due to network changes from the experience period to rating period.

**Aetna Health Insurance Company  
New York Small Group**

**Exhibit D  
Conersion factor from PMPM to Single Rate**

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Small Group Membership Data  
As of December, 2013

Tier	Subscribers	Members	2014 Tier Factor
Single	27,208	27,208	1.000
Single + Spouse	2,880	5,760	2.000
Single + Child(ren)	2,194	5,929	1.700
Single + Spouse + Child(ren)	4,610	18,637	2.850
Total	36,892	57,534	49,836
Conersion factor from PMPM to Single rate			<b>1.155</b>

**Aetna Life Insurance Company  
New York Small Group**

**Exhibit F  
AV and Plan factors**

NY SG Plan Name	Exchange ON/OFF	Metallic Tier	Actuarial Value	Plan Factors
NY Gold Healthy NY 600	OFF	Gold	79.6%	1.0000
NY Gold Healthy NY 600 RE	OFF	Gold	79.6%	0.9852

Aetna Health, Inc.  
New York Small Group HMO Filing  
SERFF ID: AETN-129591063  
Exhibit B

**New York Small Group HMO Portfolio | Summary of Benefits**

**Contents**

NY GOLD HEALTHY NY ..... 2  
NY GOLD HEALTHY NY RE ..... 4

**Summary of Benefits Covered**

NY GOLD HEALTHY NY

New York

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$600
Family	\$1,200
<b>Coinsurance</b> <i>(Member Responsibility)</i>	20% varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$25 per visit after deductible
<b>Specialist Visit</b>	\$40 per visit after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit after deductible
<b>Emergency Room Services</b>	\$150 per visit after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25 per visit after deductible
<b>Imaging (CT/PET Scans, MRIs)</b>	\$40 per visit after deductible
<b>Rehabilitative Speech Therapy</b>	\$30 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$30 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$40 per visit after deductible
<b>X-rays and Diagnostic Imaging</b>	\$40 per visit after deductible
<b>Skilled Nursing Facility</b>	\$1,000/Admit after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	\$100 per visit after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	\$100 per visit after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	\$0
Family	\$0
<b>Generics</b>	\$10
<b>Preferred Brand Drugs</b>	\$35
<b>Non-Preferred Brand Drugs</b>	\$70
<b>Specialty Drugs (i.e. high-cost)</b>	Same as applicable tier cost share.

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

**User Inputs for Plan Parameters**

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

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

Desired Metal Tier: Gold

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$): \$600.00	\$0.00	
Coinsurance (%): 85.44%	79.46%	
OOP Maximum (\$): \$4,000.00		
OOP Maximum if Separate (\$):		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

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

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 79.4%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 79.6%

This product, NY Gold Healthy NY satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.6%.

**Summary of Benefits Covered**

\* Religious exemption plans exclude contraceptives (oral, injectable and devices), contraceptive counseling and voluntary sterilization (tubal ligation and vasectomy).

NY Gold Healthy NY RE

New York

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$600
Family	\$1,200
<b>Coinsurance</b> <i>(Member Responsibility)</i>	20%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$25 per visit after deductible
<b>Specialist Visit</b>	\$40 per visit after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit after deductible
<b>Emergency Room Services</b>	\$150 per visit after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25 per visit after deductible
<b>Imaging (CT/PET Scans, MRIs)</b>	\$40 per visit after deductible
<b>Rehabilitative Speech Therapy</b>	\$30 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$30 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$40 per visit after deductible
<b>X-rays and Diagnostic Imaging</b>	\$40 per visit after deductible
<b>Skilled Nursing Facility</b>	\$1,000/Admit after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	\$100 per visit after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	\$100 per visit after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	\$0
Family	\$0
<b>Generics</b>	\$10
<b>Preferred Brand Drugs</b>	\$35
<b>Non-Preferred Brand Drugs</b>	\$70
<b>Specialty Drugs (i.e. high-cost)</b>	Same as applicable tier cost share.

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

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

Desired Metal Tier: Gold

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$600.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)	85.44%	79.46%				
OOP Maximum (\$)	\$4,000.00					
OOP Maximum if Separate (\$)						

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### Options for Additional Benefit Design Limits:

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

### Output

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 79.4%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 79.6%

This product, NY Gold Healthy NY RE satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.6%.

## EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE APPLICATION

**Company Name:** Aetna Health Inc. (NY)  
**NAIC Code:** 95234  
**SERFF Tracking #:** AETN-129591063  
**Market Segment:** **Small Groups Off Exchange**

**A. Insurer Information:** Aetna Health Inc. (NY) HMO - 44 For Profit 95234  
Company submitting the rate adjustment request Company Type Org. Type Company NAIC Code  
151 Farmington Ave. Hartford, CT 06156  
Company mailing address

**B. Contact Person:** [REDACTED] [REDACTED] [REDACTED]  
Rate filing contact person name, title Contact phone number Contact Email address

**C. Actuarial Contact (If different from above):** [REDACTED] [REDACTED] [REDACTED]  
Actuary name, title Actuary phone number Actuary Email address

**D. New Rate Information:** January 1, 2015 to December 31, 2015 01/01/2015  
New rate applicability period New rate effective date SERFF Tracking Number

**E. Market segment included in filing (e.g., Small Group (including Healthy NY Small Group), Individual - only one market segment per rate adjustment filing):** Small Group

**F. Provide responses for the following questions:**

	<b>Response</b>
1. Does this filing include any revision to contract language that is not yet approved? See note (1). If yes, provide a brief description of the contract language changes included in this filing.	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing? If yes, mention these filings on Exhibit 18.	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (2).	All Small Group NY policyholders. Notification will be sent 06/18/2014
4. Have all the required exhibits been submitted with this rate filing? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary and numerical summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF	Yes - SERFF ID: AETN-129584189

**Notes:**

(1) As mentioned in the checklist, this combined non-grandfathered product rate adjustment and form/rate filing can only include minor contract revisions, such as due to changes in the model language, changes to the catastrophic plan due to change in out of pocket maximum, changes to the standard plan designs. Substantial changes need to be submitted as a separate rate and form filing (e.g., a new plan design not replacing an existing plan design, contract language changes not just due to changes in the model language).

(2) §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 filing is submitted to the Department of Financial Services.

**EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY**

**Company** Aetna Health Inc. (NY)  
**NAIC Code:** 95234  
**SERFF Trac** AETN-129591063  
**Market Segment:** Small Groups Off Exchange

- 1) Please complete this Narrative Summary and Numerical Summary for each market segment for which you are submitted a rate filing.
- 2) The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment.
- 3) The purpose of the Narrative Summary is to provide a written explanation to the company's policyholders to help them understand the reasons why a rate increase is needed.
- 4) The purpose of the Numerical Summary is to provide a clear and simple overview of the requested rate adjustment.
- 5) These Summaries will be public documents and will be posted on DFS's website and furnished by DFS to the public upon request.
- 6) The company should submit these Summaries to DFS ten (10) days before submitting a rate adjustment filing.
- 7) A draft of these Summaries and of the Initial Notice must be included in a "Prior Approval Prefiling" submitted to DFS via SERFF.
- 8) Once reviewed by DFS, these Summaries must be posted to a location on its website that is publicly available and accessible without the need for a user ID/password.
- 9) Links should be provided on key pages of the company's website so that the information may be easily located.
- 10) Any change(s) made to the Narrative Summary/Numerical Summary subsequent to the posting must be submitted to DFS with the specific change(s) identified.
- 11) This exhibit must be submitted as an Excel file and as a PDF file.

**A. Average 2014 and 2015 Premium Rates:**

- 1) Average Monthly Premium Rates for Individual Only on Individual Plans and First Quarter Rates for Employee Only on Small Group Plans.
- 2) Premium Rates are Average Arithmetic Premium Rates for All Plans Combined and for all Regions combined.
- 3) Premium Rates are with Through Age 29, with Domestic Partner and with Family Planning Coverage.
- 4) Premium Rates for 2015 should be Consistent with the Premium Rates reflected in Exhibit 23.
- 5) Premium Rates for 2014 should be on a Consistent Basis as the Premium Rates for 2015.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	N/A	\$ 374.03	N/A	N/A	N/A
2015 Premium Rates	N/A	\$ 457.32	N/A	N/A	N/A

22.3%

**B. Weighted Average Annual Percentage Requested Adjustments [Per Exhibit 14A for Individual Plans and Exhibit 14B for Small Group Plans]\*:**

	2014 to 2015
Requested Rate Adjustment	22.3%

**C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [Per Exhibits 4A-4D] [If Applicable]\*:**

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	6.1%	9.55%	N/A

**D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]\*:**

	2011	2012	2013
MLR	98.5%	121.3%	92.7%

**E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2014-15 and Comparable Exhibits for 2013] [If Applicable]\*:**

	2013	2014	2015
Annual Claim Trend Rates	N/A	11.8%	11.9%
Expense Ratios	N/A	15.0%	11.9%
Pre Tax Profit Ratios	N/A	2.0%	3.85%

\* If product was not offered in a particular year, indicate "N/A" in the applicable box.

### Exhibit 13 Narrative Summary

The requested rates for Aetna's Small Group HNY plans are directly related to medical claim trend due to changes in unit costs and utilization. Trends were based on a review of small group data over the period January 2013 – December 2013. The table below reflects our cost trends:

Utilization Trend	Unit Cost Trend	Other Trend	Total Trend
3.9%	4.8%	2.8%	11.9%

-Utilization represents the number of services per member per year across all medical expense categories. 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. Hospital unit cost is projected to increase at 5.7% and physician unit cost is projected to increase at 1.5%.

-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. The deductible leveraging adds 2.8% to our total trend.

-For this rate filing, we have used 11.9% as the projected change in total medical cost

-Our pricing projection and the resulting rate increases assume that 84.3% 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 15.7% 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 innovative new relationships with health care providers that compensate them 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.

This narrative (exhibit 13) will be placed under Aetna.com, which is open to the public.

<http://www.aetna.com/individuals-families-health-insurance/member-guidelines/stateprocess.html>

**EXHIBIT 14 - PART B: SUMMARY OF REQUESTED PERCENTAGE CHANGES TO EXISTING RATES**

**-- for Small Group Medical Plans**

**Company Name:** Aetna Health Inc. (NY)  
**NAIC Code:** 95234  
**SERFF Tracking #:** AETN-129591063  
**Market Segment:** Small Groups Off Exchange

- 1) Use this Exhibit for Small Group Medical Plans.
- 2) The format of this exhibit is discussed below. Insert more rows as needed. Only use the first tab for data entry.
- 3) Market segment refers to the Small Group Plans.
- 4) The requested percentage rate change reflects the expected change in premium rates that would apply to the contract holder on that contract holder's next rate change date for each contract holder within the indicated combination of rating period, metal level, rating region and product name.
- 5) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/metal level when communicating with the DFS). A separate row is to be used for each combination of rating period, metal level, rating region and product name.
- 6) The effective date is the earliest date that the proposed new rate would become effective if approved. Effective Dates for Small Groups are 1/1/15, 4/1/15, 7/1/15 and 10/1/15.
- 7) If the percentage change (lowest and highest and weighted average) are identical for all the rating regions, then separate rows by rating region need not be used, and "All Regions" can be shown in the Rating Region column. If the rate change range information differs by rating region, then separate rows need to be used for each rating region the insurer uses. Rating region names used on this exhibit are to use the standard rating region names developed by DFS (e.g., Albany Area, Buffalo Area, etc.).
- 8) The "requested rate change" includes the impact of any riders (such as: age 29, domestic partner, family planning, pediatric dental, etc.).
- 9) Lowest should be the smallest percentage change that could affect any contract holder due to the submitted rate filing with that rating period, metal level and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
- 10) Highest should be the largest percentage change that could affect any contract holder due to the submitted rate filing with that rating period, metal level and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
- 11) The weighted average percentage should be developed based on annualized premium volume or membership for that rating period, metal level and rating region, including any applicable riders.
- 12) This exhibit must be submitted as an Excel file and as a PDF file.

**Small Group Medical Products**

Market Segment	Effective Date of New Rate	Metal Level	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Small Group	01/01/2015	Gold	99 - All Regions	NY Gold Healthy NY 600	NY Gold Healthy NY 600	22.29%	22.29%	22.29%
Small Group	04/01/2015	Gold	99 - All Regions	NY Gold Healthy NY 600	NY Gold Healthy NY 600	22.42%	22.42%	22.42%
Small Group	07/01/2015	Gold	99 - All Regions	NY Gold Healthy NY 600	NY Gold Healthy NY 600	22.54%	22.54%	22.54%
Small Group	10/01/2015	Gold	99 - All Regions	NY Gold Healthy NY 600	NY Gold Healthy NY 600	22.66%	22.66%	22.66%
Small Group								
Small Group								

**EXHIBIT 15 - PART B: DISTRIBUTION OF CONTRACTS BY REQUESTED PERCENT ADJUSTMENTS FOR SMALL GROUP PRODUCTS**

Company Name: Aetna Health Inc. (NY)  
 NAIC Code: 95234  
 SERFF Tracking #: AETN-129591063  
 Market Segment: Small Groups Off Exchange

**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. Effective Dates for Small Group are 1/1/15, 4/1/15, 7/1/15 and 10/1/15.
- 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 change should be developed based on the distribution of annualized premiums for that Market Segment/Rating Period/Metal Level and for the market segment in total.
- 5) Market segment refers to Small Group market segment.
- 6) Rating region refers to the standard rating regions applicable to this filing. If the percentage change for each plan design does not vary by region, then "All Regions" can be used in the rating region column; otherwise indicate the applicable rating region.
- 7) Under each market segment, the table should provide the distribution by metal level (platinum, gold, silver, bronze).
- 8) Provide distribution information by quarter of renewal.
- 9) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
- 10) After each effective period/market segment combination there should be a market segment total row. Enter the effective period in the applicable column, the sum of the counts in the various columns, and the market segment weighted avg change %.
- 11) This exhibit must be submitted as an Excel file and a PDF file.

**Distribution by Requested Rate Adjustment**

Market Segment	Effective Date	Metal Level	Rating Region	Weighted Avg Change %	Annualized Premiums as of	Total # of Members as of	Total # of Contracts as of	Number of (*) with Requested Percentage Rate Change at Renewal										
								03/31/2014	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%
Small Group	01/01/2015	Gold	99 - All Regions	22.3%	14,728,372	4,194		0	0	0	0	0	0	4,194	0	0	0	0
Small Group																		
Small Group																		





# DED IN RATE ADJUSTMENT FILING

		Most Recent Experience Period (NY statewide experience, base medical policy form +)						
8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change		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 state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)
739	4,194	XX	01/01/13	12/31/13	16,581	6,950,600	8,213,987	6,440,944
		XX						
		XX						

**EXHIBIT 17: HISTORICAL CLAIM DATA BY F**

- associated riders)					(NY statewide exper			
14.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or 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 or the federal risk sharing 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) (\$)		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 (\$)
6,520,831	0	(270,508)	750,758	XX	01/01/12	12/31/12	17,660	6,327,164
				XX				
				XX				

**POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING**

First Prior Experience Period (experience, base medical policy form + associated riders)								
15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	15.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or 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 or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)		16.1 Beginning date of the experience period (mm/dd/yy)	16.2 Ending Date of the experience period (mm/dd/yy)
8,079,425	7,677,445	7,681,195	(281,672)	(755,977)	683,418	XX	01/01/11	12/31/11
						XX		
						XX		

**Second Prior Experience Period**  
**(NY statewide experience, base medical policy form + associated riders)**

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 state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or 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 or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	
18,099	5,655,878	7,358,512	5,570,727	5,572,807	(500,062)	(752,800)	610,911	XX
								XX
								XX

**Exhibit 18 - Index Rate/Plan Design Level Adjustment Worksheet**

Company Name: Aetna Health Inc. (NY)  
 NAIC Code: 95234  
 SERFF Number: \_\_\_\_\_  
 Market Segment : SG

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

Line #	General		
1	Product*		HMO
2	Product ID*		50138NY011
3	Metal Level (or catastrophic)*		Gold
4	AV Metal Value (HHS Calculator)*		0.7958
5	AV Pricing Value (total, risk pool experience based)*		0.7958
6	Plan Type*		HNY
7	Plan Name*		NY Gold Healthy NY
8	HIOS Plan ID*		50138NY0110003
9	Exchange Plan?*		No

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

**Experience Period Index Rate**

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	6,502,092	
10B	Member-Months for Latest Experience Period	16,584	
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	392.07	
11	Average Pricing Actuarial Value reflected in experience period	0.908	
12	<b>AV Adjusted Experience Period Index Rate PMPM (L10C / L11)</b>	<b>431.98</b>	<b>431.98</b>

**Exhibit 18 - Index Rate/Plan Design Level Adjustment Worksheet**

Company Name: Aetna Health Inc. (NY)  
 NAIC Code: 95234  
 SERFF Number: \_\_\_\_\_  
 Market Segment : SG

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

Line #	General		
1	Product*		HMO
2	Product ID*		50138NY011
3	Metal Level (or catastrophic)*		Gold
4	AV Metal Value (HHS Calculator)*		0.7958
5	AV Pricing Value (total, risk pool experience based)*		0.7958

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

13	Impact of adjusting experience period data to EHB benefit level	1.037	
14	Market wide adjustment for changes in provider network **	1.000	
15	Market wide adjustment for fee schedule changes **	1.000	
16	Market wide adjustment for utilization management changes **	1.000	
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000	
18	Impact on risk pool of changes in expected covered membership risk characteristics **	1.100	
19	<b>Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]</b>	<b>1.000</b>	
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000	
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery)	1.000	
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000	
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000	
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.209	
25	Other 1 (Adjustment to Silver Plan level plus Pediatric Dental)	0.796	
26	Other 2 (Conversion factor)	1.155	
27	Other 3 (AgeGender Projection)	1.001	
28	<b>Impact of Market Wide Adjustments (product L13 through L27)</b>	<b>1.269</b>	<b>1.269</b>

\*\* Not Included in Claim Trend Adjustment

**Exhibit 18 - Index Rate/Plan Design Level Adjustment Worksheet**

Company Name: Aetna Health Inc. (NY)  
 NAIC Code: 95234  
 SERFF Number: \_\_\_\_\_  
 Market Segment : SG

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

Line #	General		
1	Product*		HMO
2	Product ID*		50138NY011
3	Metal Level (or catastrophic)*		Gold
4	AV Metal Value (HHS Calculator)*		0.7958
5	AV Pricing Value (total, risk pool experience based)*		0.7958

**Plan Level Adjustments**

29	Pricing actuarial value (without induced demand factor) #	1.000	0.796
30	Pricing actuarial value (only the induced demand factor) #	1.000	0.796
31	Impact of provider network characteristics ##	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.147	1.147
37	Profit/Contribution to surplus margins	1.026	1.026
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000
41	Other 1 (adjust Silver metal level 0.7 to Pricing Anchor 1.0)	1.000	1.257
42	Other 2 (OON impact)	1.000	1.000
43	<b>Impact of Plan Level Adjustments (product L29 through L42)</b>	<b>1.177</b>	<b>0.937</b>

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

## Beyond what is reflected in Market Wide adjustments

44	<b>TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)</b>	<b>645.14</b>	<b>513.38</b>
----	--	---------------	---------------

## EXHIBIT 19 - SUMMARY OF AVERAGE CLA

**Company Name:** Aetna Health Inc. (NY)  
**NAIC Code:** 95234  
**SERFF Number:** AETN-129591063  
**Market Segment:** Small Groups Off Exchan

				For the		
1. Metal Level [drop down menu]	2. On/Off Exchange Designation <u>and</u> Standard/Non Std [drop down menu]	3. Estimated Membership as of 03/31/2014		4.1 Period assumed beginning date (mm/dd/yy)	4.2 Period assumed ending date (mm/dd/yy)	5. Average annual claim trend assumed
Gold	Off Non Std	4,194	XX	01/01/15	12/31/15	11.87%
			XX			
			XX			

# PREMIUM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN

ge

rate period included in this rate adjustment filing							For th	
6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribut ion to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium
1.55%	0.62%	0.98%	1.77%	3.57%	2.97%	11.45%	2.50%	0.00%
						0.00%		
						0.00%		

For the rate period included in this rate adjustment filing

For the rate period included in the

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		14.1 Period assumed - beginning date (mm/dd/yy)	14.2 Period assumed - ending date (mm/dd/yy)	15. Average annual claim trend assumed
8.850%	1.346%	35.00%	0.00%	15.29%	XX	01/01/14	12/31/14	10.30%
				0.00%	XX			
				0.00%	XX			

**prior rate adjustment filing**

**For the rate**

16.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	16.2 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	16.3 Commissions and broker fees - as a % of gross premium	16.4 Premium Taxes - as a % of gross premium	16.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) as a % of gross premium	16.6 Other administrative expenses - as a % of gross premium	16.7 Subtotal columns 20.1 through 20.6
0.61%	0.62%	4.00%	1.66%	3.87%	4.28%	15.04%
						0.00%
						0.00%

period included in the prior rate adjustment filing

17 After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	18 State income tax component - as a % of gross premium	18.1 State income tax rate assumed (eg 3%)	19 Federal income tax component - as a % of gross premium	19.1 Federal income tax rate assumed (eg 30%)	20 Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	21 Subtotal columns 16.7 + 17 + 18 + 19 +20
1.30%	0.18%	8.85%	0.70%	35.00%	-2.02%	15.20%
						0.00%
						0.00%



11 Include Benefits in Addition to EHB? (yes, no)
YES
YES





7.
% Change for Second Prior Year
3.8%
5.0%
2.1%
1.6%
1.6%
2.1%
3.1%
5.1%
6.0%
8.6%
2.1%
2.1%
8.6%
8.6%
8.6%
6.5%
1.6%
1.6%
9.7%
8.7%
7.5%
8.7%
-0.9%
4.7%
4.4%
4.1%
8.7%
-24.6%
2.1%
0.7%
1.6%
9.7%
1.6%
3.7%

**EXHIBIT 22: MEDICAL AND HOSPITAL UTILIZATION DATA FOR SMALL GROUPS**

Company Name: Aetna Health Inc. (NY)  
 NAIC Code: 95234  
 SERFF Number: AETN-129591063  
 Market Segment: Small Groups Off Exchange

Experience Period:	1/1/13 - 12/31/13					
1. Medical and Hospital	2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]
Inpatient Hospital	9,720	\$ 12,714,411	21,394	\$ 1,308.07	0.45	\$ 594.30
Inpatient Mental Health	1,229	\$ 308,734	21,394	\$ 251.21	0.06	\$ 14.43
Inpatient Alcohol and Sub. Abuse	716	\$ 102,257	21,394	\$ 142.82	0.03	\$ 4.78
Newborn Birth Services	412	\$ 1,256,221	21,394	\$ 3,049.08	0.02	\$ 58.72
Primary Care	49,281	\$ 3,499,810	21,394	\$ 71.02	2.30	\$ 163.59
Physician Specialty Services	111,445	\$ 16,705,745	21,394	\$ 149.90	5.21	\$ 780.86
Ambulatory Surgery	7,877	\$ 4,837,291	21,394	\$ 614.10	0.37	\$ 226.11
Other Professional Services	5,125	\$ 230,660	21,394	\$ 45.01	0.24	\$ 10.78
Special Therapies	18,298	\$ 626,587	21,394	\$ 34.24	0.86	\$ 29.29
Out-of-Area Other	-	\$ -	21,394		0.00	\$ -
Emergency Room	2,657	\$ 457,998	21,394	\$ 172.37	0.12	\$ 21.41
Outpatient Mental Health	10,646	\$ 926,449	21,394	\$ 87.02	0.50	\$ 43.30
Outpatient Drug & Alcohol Treatment	791	\$ 78,400	21,394	\$ 99.11	0.04	\$ 3.66
Dental (excluding Orthodontia)	196	\$ 40,969	21,394	\$ 209.02	0.01	\$ 1.91
Pharmacy	-	\$ -	21,394		0.00	\$ -
Durable Medical Equipment	86,502	\$ 1,808,453	21,394	\$ 20.91	4.04	\$ 84.53
Home Health Care	34,650	\$ 1,755,410	21,394	\$ 50.66	1.62	\$ 82.05
Transportation -Emergent	2,688	\$ 287,460	21,394	\$ 106.94	0.13	\$ 13.44
Diagnostic Testing, Lab & X-Ray	267,692	\$ 7,672,368	21,394	\$ 28.66	12.51	\$ 358.62
Family Planning	-	\$ -	21,394		0.00	\$ -
Vision Care (incl. eyeglasses)	10,302	\$ 981,890	21,394	\$ 95.31	0.48	\$ 45.90
Pharmacy( (Non Prescription Drugs)	247,457	\$ 4,686,626	21,394	\$ 18.94	11.57	\$ 219.06
Speech & Hearing	2,604	\$ 104,533	21,394	\$ 40.14	0.12	\$ 4.89
Other Medical	1,313	\$ 2,341,686	21,394	\$ 1,783.46	0.06	\$ 109.46
<b>Total Medical &amp; Hospital</b>	<b>871,601</b>	<b>\$ 61,423,957</b>	<b>21,394</b>	<b>\$ 70.47</b>	<b>40.74</b>	<b>\$ 2,871.08</b>

1/1/12 - 12/31/12					
2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]
6,325	\$ 10,426,979	15,018	\$ 1,648.53	0.42	\$ 694.30
1,046	\$ 217,096	15,018	\$ 207.55	0.07	\$ 14.46
652	\$ 88,987	15,018	\$ 136.48	0.04	\$ 5.93
429	\$ 1,219,804	15,018	\$ 2,843.37	0.03	\$ 81.22
32,368	\$ 2,392,921	15,018	\$ 73.93	2.16	\$ 159.34
80,156	\$ 12,384,511	15,018	\$ 154.51	5.34	\$ 824.64
6,406	\$ 3,169,401	15,018	\$ 494.76	0.43	\$ 211.04
2,016	\$ 225,564	15,018	\$ 111.89	0.13	\$ 15.02
14,663	\$ 464,402	15,018	\$ 31.67	0.98	\$ 30.92
-	\$ -	15,018		-	\$ -
1,788	\$ 280,663	15,018	\$ 156.97	0.12	\$ 18.69
7,458	\$ 728,874	15,018	\$ 97.73	0.50	\$ 48.53
595	\$ 75,797	15,018	\$ 127.39	0.04	\$ 5.05
114	\$ 22,967	15,018	\$ 201.46	0.01	\$ 1.53
-	\$ -	15,018		-	\$ -
73,860	\$ 1,447,865	15,018	\$ 19.60	4.92	\$ 96.41
37,312	\$ 1,799,293	15,018	\$ 48.22	2.48	\$ 119.81
2,759	\$ 236,277	15,018	\$ 85.64	0.18	\$ 15.73
181,299	\$ 4,718,536	15,018	\$ 26.03	12.07	\$ 314.19
-	\$ -	15,018		-	\$ -
7,515	\$ 707,556	15,018	\$ 94.15	0.50	\$ 47.11
203,466	\$ 3,782,496	15,018	\$ 18.59	13.55	\$ 251.86
2,062	\$ 88,473	15,018	\$ 42.91	0.14	\$ 5.89
1,838	\$ 1,814,879	15,018	\$ 987.42	0.12	\$ 120.85
664,127	\$ 46,293,340	15,018	\$ 69.71	44.22	\$ 3,082.52

1/1/11 - 12/31/11

2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]
5,823	\$ 7,358,433	11,212	\$ 1,263.68	0.52	\$ 656.30
674	\$ 152,044	11,212	\$ 225.58	0.06	\$ 13.56
962	\$ 50,288	11,212	\$ 52.27	0.09	\$ 4.49
273	\$ 553,787	11,212	\$ 2,028.52	0.02	\$ 49.39
23,641	\$ 1,788,656	11,212	\$ 75.66	2.11	\$ 159.53
66,790	\$ 10,184,567	11,212	\$ 152.49	5.96	\$ 908.36
4,056	\$ 2,412,639	11,212	\$ 594.83	0.36	\$ 215.18
2,011	\$ 158,175	11,212	\$ 78.66	0.18	\$ 14.11
12,131	\$ 469,243	11,212	\$ 38.68	1.08	\$ 41.85
-	\$ -	11,212		-	\$ -
1,603	\$ 186,741	11,212	\$ 116.49	0.14	\$ 16.66
5,970	\$ 650,076	11,212	\$ 108.89	0.53	\$ 57.98
451	\$ 57,166	11,212	\$ 126.75	0.04	\$ 5.10
110	\$ 22,369	11,212	\$ 203.36	0.01	\$ 2.00
-	\$ -	11,212		-	\$ -
76,126	\$ 1,262,248	11,212	\$ 16.58	6.79	\$ 112.58
42,994	\$ 2,021,633	11,212	\$ 47.02	3.83	\$ 180.31
2,176	\$ 212,912	11,212	\$ 97.85	0.19	\$ 18.99
100,344	\$ 3,278,176	11,212	\$ 32.67	8.95	\$ 292.38
-	\$ -	11,212		-	\$ -
6,289	\$ 576,184	11,212	\$ 91.62	0.56	\$ 51.39
138,533	\$ 3,327,740	11,212	\$ 24.02	12.36	\$ 296.80
1,745	\$ 72,488	11,212	\$ 41.54	0.16	\$ 6.47
4	\$ 1,495,114	11,212	\$ 373,778.41	0.00	\$ 133.35
492,706	\$ 36,290,679	11,212	\$ 73.66	43.94	\$ 3,237



Healthy New York Plan  
Mailstop U12S  
980 Jolly Road, Bldg 1  
Blue Bell, PA 19422



<Date>

<Subscriber first> <Subscriber last>

<Address1> <Address2>

<City>, <ST> <ZIP>

Control # <Control>, Group ID <PSUID>

**Re: Notice of Proposed Premium Rate Change**

**NY Gold Healthy NY and Health Insurance Oversight System (HIOS) identification number**

Dear Member:

Aetna Health Inc. is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your group premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

**Proposed Premium Rate Changes**

If approved, the following table reflects the rate increases we have requested for plans renewing during each of the following quarters for your community rated small group plan offered by Aetna Health Inc. These rate increases are intended to be effective upon your renewal on or after January 1, 2015.

<Plan Name> offered by Aetna Life Insurance Company:

<u>Renewal Date</u>	<u>Increase</u>	<u>Renewal Date</u>	<u>Increase</u>
1st Quarter, 2015:	00.0%	3 <sup>rd</sup> Quarter, 2015:	00.0%
2nd Quarter, 2015:	00.0%	4th Quarter, 2015:	00.0%

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features that your group policyholder selects on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

**Why We Are Requesting a Rate Change**

Every year, we spend considerable time evaluating both medical cost history and rates to ensure we account for the current cost trends in the plan premium. The requested increase is directly related to two main drivers: the overall rising cost of health care services in New York, and the projected impact of the federal risk adjustment program that was put in place by the Affordable Care Act.

These changes have required us to request a rate increase with the Department of Financial Services for all current and new community rated small group customers.

### **30-day Comment Period**

You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Aetna Health Inc. for additional information at:

Aetna  
Healthy New York Plan  
Mailstop U12S  
980 Jolly Road, Bldg 1  
Blue Bell, PA 19422  
1-866-386-1371 (option 1)  
[www.Aetna.com](http://www.Aetna.com)

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services  
Health Bureau – Premium Rate Adjustments  
1 State Street  
New York, NY, 10004  
Email: [premiumrateincreases@dfs.ny.gov](mailto:premiumrateincreases@dfs.ny.gov).  
DFS Website: [www.dfs.ny.gov/healthinsurancepremiums](http://www.dfs.ny.gov/healthinsurancepremiums)

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Aetna Health Inc.
2. The name of your plan, which is <Plan Name>
3. Indicate you have Small Group coverage
4. Your HIOS identification number, which is [Insert the HIOS ID #]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Aetna will also review any comments and answer any questions you may have concerning these proposed rate changes, including the start and conclusion of the 30-day comment period. Please feel free to contact Member Services at 1-866-386-1371 (option 1). 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](http://www.aetna.com).

### **Plain English Summary of Rate Change**

We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

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).

Aetna website: <http://www.aetna.com/individuals-families-health-insurance/member-guidelines/stateprocess.html>

DFS website: [www.dfs.ny.gov/healthinsurancepremiums](http://www.dfs.ny.gov/healthinsurancepremiums)

**Notice of Approved Premium Rate**

After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,  
Aetna

Aetna  
Healthy New York Plan  
Mailstop U12S  
980 Jolly Road, Bldg 1  
Blue Bell, PA 19422



<Date>

<Plan sponsor first> <Plan sponsor last>

<Title>

<Company Name>

<Address>

<City>, <ST> <ZIP>

<Group ID>

**Re: Notice of Proposed Premium Rate Change**

**NY Gold Healthy NY and <Health Insurance Oversight System (HIOS) identification number>**

Dear Plan Sponsor:

Aetna Health Inc. is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

**Proposed Premium Rate Changes**

If approved, the following table reflects the rate increases we have requested for plans renewing during each of the following quarters for your community rated small group plan offered by Aetna Health Inc. These rate increases are intended to be effective upon your renewal on or after January 1, 2015.

<Plan Name> offered by Aetna Health Inc.:

<u>Renewal Date</u>	<u>Increase</u>	<u>Renewal Date</u>	<u>Increase</u>
1st Quarter, 2015:	00.0%	3 <sup>rd</sup> Quarter, 2015:	00.0%
2nd Quarter, 2015:	00.0%	4th Quarter, 2015:	00.0%

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features you select on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

## Why We Are Requesting a Rate Change

Every year, we spend considerable time evaluating both medical cost history and rates to ensure we account for the current cost trends in the plan premium. The requested increase is directly related to two main drivers: the overall rising cost of health care services in New York, and the projected impact of the federal risk adjustment program that was put in place by the Affordable Care Act.

These changes have required us to request a rate increase with the Department of Financial Services for all current and new community rated small group customers.

## 30-day Comment Period

You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Aetna Health Inc. for additional information at:

Aetna  
Healthy New York Plan  
Mailstop U12S  
980 Jolly Road, Bldg 1  
Blue Bell, PA 19422  
1-866-386-1371 (option 1)  
[www.Aetna.com](http://www.Aetna.com)

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services  
Health Bureau – Premium Rate Adjustments  
1 State Street  
New York, NY, 10004  
Email: [premiumrateincreases@dfs.ny.gov](mailto:premiumrateincreases@dfs.ny.gov).  
DFS Website: [www.dfs.ny.gov/healthinsurancepremiums](http://www.dfs.ny.gov/healthinsurancepremiums)

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Aetna Health Inc.
2. The name of your plan, which is <Plan Name>
3. Indicate you have Small Group coverage
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### **Notice of Approved Premium Rate**

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Sincerely,  
Aetna

Enclosure: Subscriber letter

**Aetna Health Inc.**  
**New York Small Group**  
**Aetna Health Maintenance Organization**

**Summary**

Aetna is filing rates for Small Group plans in New York. This filing proposes to raise average premium rates by 22.3%.

**Who is affected?**

The rates will apply to policies that start or renew from January 2015 through December 2015. Approximately 4,000 members are enrolled in plans to which the new rates will apply. Some plans in this market may not be available for renewal. Members in those plans will be able to enroll in the new plans included in this filing.

**Why We Need to Increase Premiums**

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 11.9%, excluding the effect of benefit changes described below. Medical costs go up mainly for two reasons – providers raise their prices and members get more medical care.

For Small Employers in New York, some examples of increasing medical costs we have experienced in the last 12 months include:

- The cost for an inpatient hospital admission has increased 7.3%.
- Expenses for emergency treatment have increased 14.8%.
- Expenses related to Physician services have gone up 7.4%.
- Outpatient mental health costs have gone up 7.9%.

**What Else Affects Our Request to Increase Premiums**

Several requirements related to the Affordable Care Act (ACA) also impact these rates. These include:

- Enhanced network access standards – which limit our ability to control the cost and quality of medical care
- Changes to required taxes and fees

**Will Premiums for All Small Groups Increase 22.3%?**

No, the 22.3% is an average. Some premiums will increase by less or even go down. Others will increase by more than the average. The exact rate change will depend on what benefit plan the group chooses, when the group's contract renews, the family size for enrolling employees, and where in New York the group is located.

Changes in the premium that members pay will also depend on whether the current policy complies with ACA requirements that took effect on January 1, 2014, and the impact of changes in government tax subsidies.

**How does this request align to Minimum Loss Ratio Requirements (MLR)?**

These rates are expected to produce an MLR equal to or above the 80% requirement for Small Group business. Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR turns out to be less than 80%, rebates will be issued to members in accordance with the law.

Aetna makes significant investments that benefit our members that the government does not allow us to use in this calculation. These investments include customer service, and health quality activities like disease management programs, as well as the development of new information technologies.

**What is Aetna doing to keep premiums affordable?**

Aetna is taking a number of steps to keep our products as affordable as possible and to address the underlying cost of health care. These actions include:

- Developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care and not the quantity of services.
- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

Aetna is also dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them 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.