Filing at a Glance

Company:	North Shore-LIJ CareConnect Insurance Company, Inc.
Product Name:	Prior Approval Individual On Exchange
State:	New York
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Prior Approval Exchange Form & Rate Filing
Date Submitted:	06/12/2014
SERFF Tr Num:	NSCC-129574144
SERFF Status:	Assigned
State Tr Num:	2014060169
State Status:	
Co Tr Num:	001
Implementation Date Requested:	01/01/2015
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *North Shore-LIJ CareConnect Insurance Company, Inc.*

TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *Prior Approval Individual On Exchange*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact: -1.3%

Deemer Date:
Submitted By: [redacted]

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 06/13/2014
State Status Changed:
Created By: [redacted]
Corresponding Filing Tracking Number: NSCC-129585411

PPACA: Not PPACA-Related

PPACA Notes: null

Exchange Intentions: This filing is to update rates for On-Exchange Individual Products that were prior approved for 2015 calendar year.

Filing Description:

We propose to lower rates for Prior Approved On Exchange Individual plans by a weighted average of 1.3% for calendar year 2015. We also intend to implement plan changes as required by law in New York State and the ACA. This filing corresponds directly to the filing with SERFF Tracking Number NSCC-129585411.

Company and Contact

Filing Contact Information

[redacted]
2200 Northern Blvd
East Hills, NY 11548

[redacted]

Filing Company Information

North Shore-LIJ CareConnect
Insurance Company, Inc.
2200 Northern Blvd
East Hills, NY 11548
[redacted]

CoCode: 15309
Group Code: 4793
Group Name:
FEIN Number: 46-2270382

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York?

Yes/No (If Yes, enter which one.): No

4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is a group prefiling 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).]: Yes - Prior Approval Rate Adjustment

6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No

7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No

8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No

9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No

10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary, a draft initial notification letter, and a draft numerical summary associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

State: New York **Filing Company:** North Shore-LIJ CareConnect Insurance Company, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Prior Approval Individual On Exchange
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: Decrease
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
North Shore-LIJ CareConnect Insurance Company, Inc.	Decrease	%	%				%	%

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum/Actuarial Certification
Comments:	
Attachment(s):	Individual ON 2015 Memo and Attachments.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Individual ON 2015 Memo and Attachments.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	STANDARD AV CALCULATIONS 2015 04-25-2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 11-General Information
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 11.pdf Prior Approval Individual On Exchange Exhibit 11.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 13-Narrative Summary and Numerical Summary
Comments:	
Attachment(s):	Prio Approval Individual On Exchange Exhibit 13.pdf Prio Approval Individual On Exchange Exhibit 13.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 14A-Indiv Requested Percentage Changes
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 14A.pdf Prior Approval Individual On Exchange Exhibit 14A.xlsx

State: New York **Filing Company:** North Shore-LIJ CareConnect Insurance Company, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Prior Approval Individual On Exchange
Project Name/Number: /

Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 15A-Indiv Distribution by Rate Adj Percentages
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 15A.pdf Prior Approval Individual On Exchange Exhibit 15A.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 16-Summary of Policy Form & Product Changes
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 16.pdf Prior Approval Individual On Exchange Exhibit 16.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 18-Index Rate Plan-Design Development
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 18.xlsx Prior Approval Individual On Exchange Exhibit 18.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 19-Claim Trend, Admin Expenses & Profit
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 19.pdf Prior Approval Individual On Exchange Exhibit 19.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 20-HIOS ID Mapping
Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 20.pdf Prior Approval Individual On Exchange Exhibit 20.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 23-Requested 2015 Premium Rates

State: New York **Filing Company:** North Shore-LIJ CareConnect Insurance Company, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Prior Approval Individual On Exchange
Project Name/Number: /

Comments:	
Attachment(s):	Prior Approval Individual On Exchange Exhibit 23.pdf Prior Approval Individual On Exchange Exhibit 23.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Initial Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	Template - INDIVIDUAL Rate adjustment notice.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	2015 Individual Market URRT 060314.pdf 2015 Individual Market URRT 060314.xlsm
Item Status:	
Status Date:	

North Shore LIJ CareConnect | Insuring better health

North Shore-LIJ CareConnect Insurance Company, Inc.

Individual On-Exchange Plans

Prior Approval Adjustment Filing

2015 Premium Rates

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GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

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

State: New York

HIOS Issuer ID: 82483

Market: Individual

Effective Date: January 1, 2015

COMPANY CONTACT INFORMATION

Primary Contact Name: [redacted]

Primary Contact Telephone Number: [redacted]

Primary Contact E-mail Address: [redacted]

PURPOSE

The purpose of this actuarial memorandum is to provide certain information related to the submission of North Shore-LIJ CareConnect Insurance Company, Inc.'s (NS-LIJ CC's) rate filing, including support for the values entered into the Part 1 Unified Rate Review Template and New York State Department of Financial Services' Exhibit 18 "Index Rate/Plan Design Adjustment Worksheet", which supports compliance with the market rating rules and reasonableness of applicable rate changes.

ACTUARIAL QUALIFICATIONS

I, Craig Winkler, am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

PROPOSED RATE INCREASE(S)

The proposed rates for individual plans to be offered for sale on New York State's Health Benefit Exchange are presented in Attachment A. We are requesting an overall rate decrease of 1.3%:

Rate Component	Area 8 (Long Island)	Area 4 (New York City)
Trend	2.0%	2.0%
Capitation Contract Correction	(2.9%)	(2.9%)
Change in Net Reinsurance Recoveries	3.8%	3.8%
Provider Contract Change	2.0%	(4.0%)
Improved Medical Management	(5.0%)	(5.0%)
Total	**0.0%**	**(6.3%)**

	Area 8	Area 4	Total
Rate Request	0.0%	(6.3%)	(1.3%)
Membership Weight	80%	20%	100%

All the plans shown in Attachment A are plans that were also offered for sale in the New York Health Benefits Exchange effective January 1, 2014. We used the following methodology to develop these rates.

Underlying Claims Experience: As NS-LIJ CC does not have any 2013 claims experience on which to base its premium rating, we carried forward the development from our 2014 rate filing.

Trend: We expect a 2% utilization trend for 2015 and expect that 2015 contracted rates will remain at 2014 levels.

Capitated Contracts: The 2014 rates were built assuming our capitated contracts applied to all members, when in fact, they only apply to children <19 years old. This correction results in a 2.9% reduction to our rates.

Net Reinsurance Recoveries: The change in the 2015 reinsurance parameters relative to the parameters used in our 2014 pricing results in a 3.8% increase to our rates.

Provider Contract Change: 2015 provider reimbursement rates are different from those assumed in our 2014 pricing.

Medical Management: We are expecting savings from the following:

- Reduced inpatient readmissions,
- Reduced Emergency room visits, and
- Better generic and specialty pharmacy management

The premium rates reflect the taxes and fees for 2015 noted below in the Taxes and Fees Section.

The rate development is based on generally accepted actuarial principles for community-rated blocks of business.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. We are a newly licensed insurer in New York State with no claims experience in 2013, therefore, the premium rates presented are 100% manually rated.

BENEFIT CATEGORIES

As we have no 2013 claim experience and the categorization from our previous filing appears sound, we carried forward the same relative relationship of the benefit categories used in our previous filing.

CREDIBILITY MANUAL RATE DEVELOPMENT

As we are a newly licensed health insurer in New York with no 2013 claims experience and considering the actuarial soundness of the development of the manual rates from the 2014 filing, we are making no changes to the development from our 2014 filing, other than those noted on page 5.

Source and Appropriateness of Experience Data Used: We used the same underlying data used in last year's rate filing, which is data from a national consulting firm, as the basis for NS-LIJ's manual rate development. The costs for our individual book of business, therefore, continue to assume utilization 10% higher than for our small group book of business.

Conversion Factor: A conversion factor is required to convert the premium from a PMPM basis to a single premium basis. As we have no experience from 2013, we are making no changes to the conversion factor developed in our 2014 filing. We continue to use a factor of 1.288. Refer to Attachment D for the development of this factor.

Standard Rating Regions: We are filing rates for both Long Island Area (Region 8) and New York City Area (Region 4). Based on the contract differences noted above, our area factors are:

Area	Factor
Area 4	0.937
Area 8	1.000

Inclusion of Capitation Payments: The following services will be paid on a capitated basis and were added to our premiums, by metal level tier, as indicated in our agreements with vendors.

- Pediatric dental
- Pediatric vision

CREDIBILITY OF EXPERIENCE

As we have no 2013 experience on which to base our premium rating, our premium rates are 100% manual rated.

PAID TO ALLOWED RATIO

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

RISK ADJUSTMENT AND REINSURANCE

PROJECTED RISK ADJUSTMENT PMPM

Consistent with our 2014 filing, we did not make any specific adjustment to reflect payments into, or from, the individual risk pool.

PROJECTED ACA REINSURANCE RECOVERIES NET OF REINSURANCE PREMIUM

The premium rates for each plan are reduced by the value of the expected recoveries for that plan.

To evaluate the change in the reinsurance parameters for 2015 relative to those of 2014 at the plan level, we used a cumulative probability distribution from a national consulting firm.

To estimate the market-wide impact of the transitional reinsurance program we multiplied the plan specific value by the projected member months for each plan. We assume that we will receive 100% of the value of these recoveries.

We estimate the net market-wide PMPM impact of the transitional reinsurance program to be:

Assessment	$3.67
Recoveries	($14.10)
Net Impact	($10.43)

NON-BENEFIT EXPENSES AND PROFIT & RISK

ADMINISTRATIVE EXPENSE LOAD

As a new plan, our initial fixed administrative costs will need to be amortized over several years in order to be competitive. Our proposed rates reflect an average loss ratio of 82.9%, i.e. a 17.1% load for administration, taxes and fees.

PROFIT (CONTRIBUTION TO SURPLUS) & RISK MARGIN

The proposed rates do not reflect an allowance for profit margin. We anticipate making a loss in our second year.

TAXES AND FEES

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

Contributions to the Federal Transitional Reinsurance Program	$3.67 PMPM
Patient Centered Outcomes Research Fee	$2.00 PMPY
Risk Adjustment User Fee	$0.96 PMPY
Health Insurance Provider Fee	0.0%*
New York State Exchange User Fee	0.0%*
New York State Premium Tax	1.3%*

* Percent of premium

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

PROJECTED LOSS RATIO

Under section 4308(c)(3)(A) of New York Insurance Law, the expected minimum loss ratio for an individual contract form cannot be less than 82%. The target pricing loss ratios for NS-LIJ CC's 2015 individual products are all at least 82% and on average is 82.9%. One minus the target loss ratio reflects the percent of administrative load. The table below shows the loss ratio by plan.

Metal Level	Loss Ratios
Catastrophic	82.0%
Bronze	82.0%
Silver	83.0%
Gold	83.0%
Platinum	83.0%

INDEX RATE

As we have no 2013 experience, we have no experience period index rate.

The projection period index rate is the projected allowed claims PMPM for the Essential Health Benefits (EHB), as shown in Section III of Worksheet 1 of the URRT. The index rate was calculated by taking a weighted average of the EHB allowed claims for each of the individual plans that we intend to offer for sale on the Health Benefit Exchange and off-Exchange. The plan index rates were weighted based on projected member months by plan.

We offer the following state mandated benefits and riders but no other non-EHB benefits.

- Elective abortion
- Dependent through age 29 rider

MARKET ADJUSTED INDEX RATE

The market adjusted index rate is the index rate plus the net reinsurance amount described above.

CALIBRATION

The Plan Adjusted Rates need to be multiplied by the geographic calibration factor before applying the area factors noted above. The table below derives our geographic calibration factor.

Area	Distribution	Factor
Area 4	.20	0.937
Area 8	.80	1.000
Calibration Factor:		0.987

AV METAL VALUES

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

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

AV PRICING VALUES

The URRT requires the calculation of an AV Pricing Value for each plan based on a comparison to a fixed reference plan. Our fixed reference plan is a 100% coverage plan with dependents through age 25.

The AV pricing values are developed using industry standard data from a national consulting firm.

MEMBERSHIP PROJECTIONS

We used several avenues to gather intelligence to develop the membership projections:

- Analysis of the existing market to identify areas of opportunity
- Survey data provided by the Department of Financial Services
- Actual sales to date

Using the above, we are projecting the following Silver CSR membership:

Silver CSR Level	Membership
200 -250% FPL	272
150-200% FPL	744
100-150% FPL	219

TERMINATED PRODUCTS

Not applicable.

WARNING ALERTS

UNIFIED RATE REVIEW TEMPLATE

Not Applicable.

ACTUARIAL CERTIFICATION

I, [redacted] am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification.

I certify that to the best of my knowledge:

- The submission is in compliance with all applicable laws and regulations of the State of New York
- The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

  ASOP No. 5, Incurred Health and Disability Claims

  ASOP No. 8, Regulatory Filings for Health Plan Entities

  ASOP No. 12, Risk Classification

  ASOP No. 23, Data Quality

  ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

  ASOP No. 41, Actuarial Communications

- The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York
- The benefits are reasonable in relation to the premium charged
- The rates are not unfairly discriminatory
- The projected index rate is:

  In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1))

  Developed in compliance with the applicable Actuarial Standards of Practice

  Reasonable in relation to the benefits provided and the population anticipated to be covered

  Neither excess nor deficient

- The index rate was generated at each plan level with only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)

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

- The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all non-standard plans. The State of New York provided the AV Metal Values for the standard plans.

The Part 1 Unified Rate Review Template and Exhibit 18 do not demonstrate the process used by NS-LIJ to develop the rates presented in this actuarial memorandum. Rather they represent information required by Federal and State regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the index rate is developed in accordance with Federal and State regulation and used consistently and only adjusted by the allowable modifiers.

Signed:

[redacted]

Name: [redacted]

Title: [redacted]

Date: June 10, 2014

Attachment A

North Shore-LIJ CareConnect Insurance Company, Inc.

2015 Individual Exchange Plans Rating Manual

2015 Premium Rates

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual

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North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual On-Exchange Plans Rating Manual
Premium Rates Effective January 1, 2015
New York City Area (Region 4)

Product Description	Form Number	Premium Per Contract				
		Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only
Base Plans						
Standard Platinum						
Base Plan	NSLIJIE/NSLIJP	$523.00	$1,046.00	$889.00	$1,491.00	
Child Only Plan	NSLIJCOE/NSLIJP					$215.00
Standard Gold						
Base Plan	NSLIJIE/NSLIJG	$455.00	$910.00	$774.00	$1,297.00	
Child Only Plan	NSLIJCOE/NSLIJG					$187.00
Standard Silver						
Base Plan	NSLIJIE/NSLIJS	$402.00	$804.00	$683.00	$1,146.00	
Child Only Plan	NSLIJCOE/NSLIJS					$166.00
Standard Bronze						
Base Plan	NSLIJIE/NSLIJB	$319.00	$638.00	$542.00	$909.00	
Child Only Plan	NSLIJCOE/NSLIJB					$131.00
Catastrophic Coverage						
Base Plan	NSLIJIE/NSLIJC	$175.00	$350.00	$298.00	$499.00	
Silver-CSR						
200-250% FPL	NSLIJIE/NSLIJS200-250	$402.00	$804.00	$683.00	$1,146.00	
150-200% FPL	NSLIJIE/NSLIJS150-200	$402.00	$804.00	$683.00	$1,146.00	
100-150% FPL	NSLIJIE/NSLIJS100-150	$402.00	$804.00	$683.00	$1,146.00	
200-250% FPL Child Only	NSLIJCOE/NSLIJS200-250					$166.00
150-200% FPL Child Only	NSLIJCOE/NSLIJS150-200					$166.00
100-150% FPL Child Only	NSLIJCOE/NSLIJS100-150					$166.00
Indian CSR						
Base Plan	NSLIJIE/NSLIJI	$402.00	$804.00	$683.00	$1,146.00	
Child Only Plan	NSLIJCOE/NSLIJI					$166.00
Riders						
Dependent Age 29 - (Platinum)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$8.00	
Dependent Age 29 - (Gold)	NSLIJIE/NSLIJR29	$4.00	$8.00	$6.00	$11.00	
Dependent Age 29 - (Silver)	NSLIJIE/NSLIJR29	$3.00	$6.00	$6.00	$8.00	
Dependent Age 29 - (Bronze)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$9.00	

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual On-Exchange Plans Rating Manual
Premium Rates Effective January 1, 2015
Long Island Area (Region 8)

Product Description	Form Number	Premium Per Contract				
		Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only
Base Plans						
Standard Platinum						
Base Plan	NSLIJIE/NSLIJP	$558.00	$1,116.00	$949.00	$1,590.00	
Child Only Plan	NSLIJCOE/NSLIJP					$230.00
Standard Gold						
Base Plan	NSLIJIE/NSLIJG	$486.00	$972.00	$826.00	$1,385.00	
Child Only Plan	NSLIJCOE/NSLIJG					$200.00
Standard Silver						
Base Plan	NSLIJIE/NSLIJS	$429.00	$858.00	$729.00	$1,223.00	
Child Only Plan	NSLIJCOE/NSLIJS					$177.00
Standard Bronze						
Base Plan	NSLIJIE/NSLIJB	$341.00	$682.00	$580.00	$972.00	
Child Only Plan	NSLIJCOE/NSLIJB					$140.00
Catastrophic Coverage						
Base Plan	NSLIJIE/NSLIJC	$187.00	$374.00	$318.00	$533.00	
Silver-CSR						
200-250% FPL	NSLIJIE/NSLIJS200-250	$429.00	$858.00	$729.00	$1,223.00	
150-200% FPL	NSLIJIE/NSLIJS150-200	$429.00	$858.00	$729.00	$1,223.00	
100-150% FPL	NSLIJIE/NSLIJS100-150	$429.00	$858.00	$729.00	$1,223.00	
200-250% FPL Child Only	NSLIJCOE/NSLIJS200-250					$177.00
150-200% FPL Child Only	NSLIJCOE/NSLIJS150-200					$177.00
100-150% FPL Child Only	NSLIJCOE/NSLIJS100-150					$177.00
Indian CSR						
Base Plan	NSLIJIE/NSLIJI	$429.00	$858.00	$729.00	$1,223.00	
Child Only Plan	NSLIJCOE/NSLIJI					$177.00
Riders						
Dependent Age 29 - (Platinum)	NSLIJIE/NSLIJR29	$4.00	$8.00	$6.00	$12.00	
Dependent Age 29 - (Gold)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$9.00	
Dependent Age 29 - (Silver)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$8.00	
Dependent Age 29 - (Bronze)	NSLIJIE/NSLIJR29	$2.00	$4.00	$3.00	$6.00	

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Composition of Rating Regions

Region 4 (New York City Area)

Queens
Richmond
New York
Bronx
Kings
Westchester

Region 8 (Long Island Area)

Nassau
Suffolk

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual On-Exchange Plans Rating Manual
Benefit Design Description Grid

Form Number	NSLIJIE / NSLIJP	NSLIJIE / NSLIJG	NSLIJIE / NSLIJS	NSLIJIE / NSLIJS200-250	NSLIJIE / NSLIJS150-200	NSLIJIE / NSLIJS100-150	NSLIJIE / NSLIJB	NSLIJIE / NSLIJC	NSLIJIE / NSLIJI
				Silver - CSR Versions					Indian CSR Zero cost sharing variation
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Catastrophic	Less than or equal to 300% FPL
DEDUCTIBLE (single)	$0	$600	$2,000	$1,200	$250	$0	$3,000	$6,600	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,000	$5,500	$5,200	$2,000	$1,000	$6,350	$6,600	$0
COST SHARING - MEDICAL SERVICES									
Inpatient Facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	50% cost sharing	0% cost sharing	0% cost sharing
	The following applies to the Platinum, Gold, Silver and Silver-CSR Plans: For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery copay which is the same as the surgeon copay if this copay has not already been collected as part of another maternity related claim. There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc. For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn. # The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.								
Outpatient Facility-Surgery, including freestanding surgicenters	$100	$100	$100	$100	$75	$25	50% cost sharing	0% cost sharing	0% cost sharing
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$100	$100	$75	$25	50% cost sharing	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".								
PCP	$15	$25	$30	$30	$15	$10	50% cost sharing	0% cost sharing	0% cost sharing
Specialist	$35	$40	$50	$50	$35	$20	50% cost sharing	0% cost sharing	0% cost sharing
PT/OT/ST - rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	50% cost sharing	0% cost sharing	0% cost sharing
ER	$100	$150	$150	$150	$75	$50	50% cost sharing	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	50% cost sharing	0% cost sharing	0% cost sharing
Urgent Care	$55	$60	$70	$70	$50	$30	50% cost sharing	0% cost sharing	0% cost sharing
DME/Medical supplies	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Eyewear	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing

Form Number	NSLIJIE / NSLIJP	NSLIJIE / NSLIJG	NSLIJIE / NSLIJS	NSLIJIE / NSLIJS200-250	NSLIJIE / NSLIJS150-200	NSLIJIE / NSLIJS100-150	NSLIJIE / NSLIJB	NSLIJIE / NSLIJC	NSLIJIE / NSLIJI
				Silver - CSR Versions					Indian CSR Zero cost sharing variation
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Catastrophic	Less than or equal to 300% FPL
INPATIENT HOSPITAL SERVICES									
Observation stay	ER copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Hospital services - non-maternity	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and well newborn combined)	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Detoxification	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility						50% cost sharing	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility						50% cost sharing	0% cost sharing	0% cost sharing
EMERGENCY MEDICAL SERVICES									
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay) directly from the emergency room						50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Emergency Room visit	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Facility charge - Freestanding urgent care center	Urgent Care copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Free standing urgent care center visit	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case						50% cost sharing	0% cost sharing	0% cost sharing
OUTPATIENT HOSPITAL/FACILITY SERVICES									
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Pre-admission/pre-operative testing	$0 copay						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay						50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
PREVENTIVE & PRIMARY CARE SERVICES									
Allergy testing	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services in this benefit service category.								
Bone density testing									
Cervical cytology									
Colonoscopy screening									
Gynecological exams	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Immunizations									
Mammography									
Prenatal maternity care									
Prostate cancer screening									
Routine exams									
Women's preventive health services									

Form Number	NSLIJIE / NSLIJP	NSLIJIE / NSLIJG	NSLIJIE / NSLIJS	NSLIJIE / NSLIJS200-250	NSLIJIE / NSLIJS150-200	NSLIJIE / NSLIJS100-150	NSLIJIE / NSLIJB	NSLIJIE / NSLIJC	NSLIJIE / NSLIJI
				Silver - CSR Versions					Indian CSR Zero cost sharing variation
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Catastrophic	Less than or equal to 300% FPL
PHYSICIAN/PROFESSIONAL SERVICES									
Inpatient hospital surgery - surgeon	Surgeon copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Second medical opinion for cancer	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)						50% cost sharing	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
ADDITIONAL BENEFITS/SERVICES									
ABA treatment for Autism Specturm Disorder	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per device						50% cost sharing	0% cost sharing	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30 days supply						50% cost sharing	0% cost sharing	0% cost sharing
Diabetic education and self-management	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.								
PEDIATRIC DENTAL SERVICES									
Dental office visit	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
PEDIATRIC VISION SERVICES									
Eye exam visit	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames						50% cost sharing	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
PRESCRIPTION DRUGS									
Generic or Tier 1	$10	$10	$10	$10	$9	$6	$10	0% cost sharing	0% cost sharing
Formulary Brand or Tier 2	$30	$35	$35	$35	$20	$15	$35	0% cost sharing	0% cost sharing
Non-Formulary Brand or Tier 3	$60	$70	$70	$70	$40	$30	$70	0% cost sharing	0% cost sharing
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply									

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Description of Revised Rating Classes, Factors, and Discounts

Not applicable.

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Examples of Rate Calculations

Not applicable.

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Commission Schedule

Broker	2.0% of premium
General Agents	1.0% of premium

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Underwriting Guidelines

Not applicable.

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Expected Loss Ratio

Product Description	Form Number	Expected Loss Ratio
Platinum	NSLIJGE/NSLIJP	83%
Gold	NSLIJGE/NSLIJG	83%
Silver	NSLIJGE/NSLIJS	83%
Bronze	NSLIJGE/NSLIJB	82%
Catastrophic	NSLIJGE/NSLIJB	82%

Attachment B

Quality Improvement Program Description 2015

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North Shore-LIJ CareConnect Overview

Background:

North Shore - LIJCareConnect Insurance Company, Inc. ("CareConnect") is a health insurer that covers members in the state of New York. CareConnect has been licensed by the New York State Department of Financial Services to write accident and health business since January 1, 2014.

Vision Statements

CareConnect's focus is to improve the health and quality of life of Members we serve by designing, implementing and managing a health insurance program that ensures access to and consistent delivery of the highest quality health care services and support.

We are committed to giving our Members access to an established integrated, multi-disciplinary healthcare network

In connection with quality our vision is:

- To empower our Members to live healthy lives, self-manage their chronic diseases, and work in partnership within a comprehensive, structured health system where there is no fear, stigma, or barrier to adequate and appropriate services to maintain optimal quality of life.

- To be the premier healthcare insurance organization in the eyes of our Members, providers, and customers.

- To be the plan of choice for members seeking a health insurance company that is attentive and sensitive to their needs.

- To be an effective partner with providers in serving their patients.

Strategic Overview

CareConnect strives to continuously improve the care and service provided by CareConnect and by our health care delivery system. CareConnect's Quality Improvement Program (QIP) establishes the standards that encompass all quality improvement activities.
Three pillars that support our success in this endeavor are:

1. Clinical quality and excellence
2. Access and affordability
3. Customer service and operational excellence

These pillars are achieved by:

A. Promoting and incorporating quality into CareConnect's organizational structure and processes by:

   1. Facilitating a partnership between Members, providers, and State agencies for the continuous improvement of quality health care delivery;

   2. Clearly defining roles, responsibilities and accountability for the quality program;

   3. Continuously improving communication and education in support of these efforts; and

   4. Considering and facilitating achievement of public health goals in the areas of health promotion and early detection and treatment.

B. Providing effective monitoring and evaluation of patient care and services to ensure that care provided by the CareConnect delivery system meets the requirements of standard medical practice, meets the linguistic and cultural needs of the membership, is administered in the most appropriate setting and is perceived positively by CareConnect Members and health care professionals by:

   1. Evaluating and disseminating clinical and preventive practice guidelines;

   2. Monitoring provider performance against established evidence-based medicine;

   3. Developing guidelines for quality improvement activities (e.g. access and availability, peer review, etc.);

   4. Surveying CareConnect Members' and providers' experience with the quality of care and services provided;

   5. Conducting and analyzing data such as Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Health Providers & Systems (CAHPS®), and Quality Assurance Reporting Requirements (QARR); and developing programs to improve satisfaction and preventive services as identified. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). QARR refers to New York State-specific measures.

   6. Collecting and analyzing data for population specific Quality Improvement (QI) projects;

   7. Developing, defining and maintaining data systems to support quality improvement activities and encourage data-driven decision-making;

   8. Providing culturally proficient care and services in the most appropriate setting; and

9. Providing disease management programs that improve the quality of life for chronically ill members.

C. Ensuring prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up by:

1. Identifying, tracking and monitoring important aspects of care and service, quality indicators, critical incidents, abuse, and concerns about health care services provided to members;

2. Implementing and conducting a comprehensive QIP;

3. Recognizing that opportunities for improvement are unlimited;

4. Providing ongoing feedback to CareConnect Members and providers regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities; and

5. Supporting re-measurement of effectiveness and continued development and implementation of improvement interventions.

D. Coordinating of quality improvement, risk management and patient safety activities by.

1. Aggregating and using data to develop quality improvement activities;

2. Providing a regular means by which risk management and patient safety are included in the development of quality improvement initiatives;

3. Identifying, developing and monitoring key aspects of patient safety; and

4. Evaluating the consistency of the implementation of CareConnect's decision-making system through inter-rater reliability.

E. Maintaining compliance with local, state and federal regulatory requirements and accreditation standards by:

1. Monitoring compliance with regulatory requirements for quality, improvement and risk management opportunities and respond as needed;

2. Ensuring that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies;

3. Monitoring performance and compliance;

4. Achieving required performance standards established by CareConnect for each measure based on the rate calculated by CareConnect. Developing an improvement

action plan for each measure not meeting the required performance standards to bring performance up to at least the minimum level established by CareConnect; and

5. Evaluating the consistency of the implementation of CareConnect's decision-making system through inter-rater reliability.

Medical Management Scope

Under the direction of the Chief Medical Officer ("CMO"), the Quality Improvement ("QI") and Medical Management ("MM") Departments coordinate and facilitate ongoing monitoring and improvement of CareConnect activities. Using an integrated approach throughout the company and the provider network, quality management monitoring and evaluation processes, improvement action plans are coordinated and implemented as part of the business plan whenever opportunities for improvement are identified.

Quality Management Summary

In order to fulfill the goals and objectives of the QIP, CareConnect has integrated quality improvement activities into all CareConnect functional areas. These include, but are not limited to, the following functional areas and departments:

- Medical Management, including UM, Care Management (Care Coordination)
- Operations, including member and provider relations
- Network Management
- Compliance
- Customer Service Center
- Appeals and Grievance Services
- Claims
- Preventive Health Services
- Delegation Oversight

Health promotion and health management activities are integral parts of the QIP. Specific attention is given to high volume, high risk areas of care and services for the populations served by CareConnect.

Monitoring and improvement actions undertaken based on the QIP are described in detail in Quality Improvement Program Section of this program description and in the work plan.

Utilization and Care Management Summary

The MM Plan describes and guides implementation of CareConnect's utilization management program, which integrates utilization functions—prior authorization, case management, disease specific management services, coordination of care, appeals and grievances, behavioral health, medical claims review, and processes for monitoring, evaluating, and improving these areas — under the direction of the CMO.

The MM Program Description and UM Evaluation are reviewed and approved annually by the Medical Management Committee (MMC), and accepted by the Quality Improvement Committee (QIC). The QIC coordinates with MM and Care Management (CM) activities. The MM Program Description documents the methodology used to assess the degree of conformance to standards, practices, and activities designed to continuously improve quality service and care, with involvement of multiple organizational components and committees. The MM Program is

designed to assess complex delivery systems and customer experience while optimizing health outcomes and managing costs. Incorporating the continuous quality improvement concept (CQI), the MM Program is comprehensive and integrated throughout the company and practitioner and provider network.

Monitoring and improvement actions undertaken based on the MM Program are described in detail in the MM Work Plan.

CareConnect is guided in its CM Program development by a desire to optimize the health and well-being of members with complex health issues or at high risk for adverse medical outcomes. To accomplish this, CareConnect, in close collaboration with the North Shore-LIJ Health System, is working to further develop a comprehensive CM Program that is person-centered and facilitates collaboration between members and their health care team as well as to promote self-management, active decision-making, and participation in health care interventions and outcomes.

CareConnect's CM philosophy is:

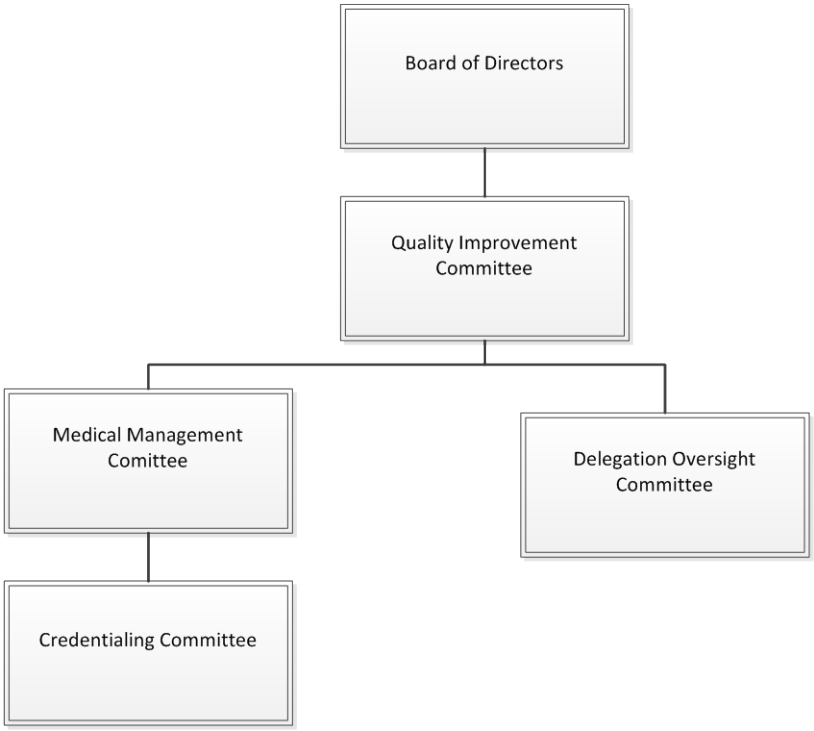
- Person-centric
- Offers comprehensive solutions
- Engages the health care team
- Measures, reports, and analyzes outcomes
- Improves quality
- Promotes cost efficiencies

Specifically, CareConnect's CM programs focus on Members with the following medical conditions based on the needs of the enrolled Members and contractual requirements:

- Asthma
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic Kidney Disease/End Stage Renal Disease (CKD/ESRD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- High Risk Pregnancy & NICU
- Hypertension
- Human Immunodeficiency Virus (HIV)

Program Accountability and Oversight

Quality Improvement Committee Structure



CareConnect Committee Descriptions

Board of Directors

The Board of Directors (BOD) is the governing body of CareConnect and has overall responsibility to ensure that timely and high quality services are provided to members. The BOD shall approve the QIP, and will meet on a quarterly basis to oversee the QIP responsibilities, or more frequently if problems have been identified. The BOD has delegated the responsibility to direct, oversee and monitor the QIP to the Quality Improvement Committee (QIC).

The BOD functions as they relate to the quality improvement program include:

- Annually reviews and approves the QIP Description, QI Work Plan, Annual QI Evaluation and other reports and information as required or requested.

- Provides feedback and recommendations to the QIC related to summary reports, documents and any issues of concern.

- Demonstrates a senior level commitment to quality and to CareConnect's QIP, including resource allocation.

The membership of the BOD is composed of CareConnect leadership and other designees as identified by the Chair. The BOD meets at least quarterly.

Quality Improvement Committee

The BOD has delegated responsibility for the oversight of the health plan's quality improvement activities to the QIC. The QIC is the decision-making body that is ultimately responsible for overseeing and assuring the quality, safety, appropriateness, and cost effectiveness of the clinical care and services provided to CareConnect members on a daily basis. The QIC's primary focus is the coordination and integration of all quality improvement and utilization management activities for CareConnect.

The QIC also objectively and systematically monitors and evaluates the appropriateness of clinical and non-clinical Member care and services. The QIC examines the components of its service and delivery system through the continuous process of monitoring and evaluation, identify opportunities for improvement and recommend changes to effect those improvements.

The responsibilities of the QIC are:

- Provide program direction and continuous oversight of quality improvement activities as related to the unique needs of the Members and providers in the areas of clinical care, service, patient safety, administrative processes, and compliance.

- Identify actions to improve quality and prioritize them based on the analysis and significance of the QI activity
- Formally evaluate, at least annually, the imMMCt and effectiveness of specific Performance Improvement Projects (PIPs) and recommend changes as necessary.
- Regularly review, prioritize and align the Annual QI Work Plan with strategic objectives of the organization.
- Oversee and accept the annual MM Program Description, MM Work Plan and MM Annual Evaluation for the MM Program of the health plan.
- Review and approve benchmarks, performance goals and standards for quality activities.
- Analyze and evaluate the QIP annually and assess the overall effectiveness of the program. Recommend policy decisions based on this evaluation.
- Annually, submit the QIP Description, QI Work Plan and QI Evaluation of the QIP to the BOD for review and approval.
- Report annually or more frequently as needed to the BOD, on the following health plan quality activities monitored by the QIC:
    - Annual HEDIS®, CAHPS®, and QARR results as well as other clinical metrics and action plans to improve results.
    - Medical management metrics and activities
    - Member complaints, appeals and grievances and results of member satisfaction surveys as well as any action plans to address identified opportunities and improve performance.
    - Network access and availability and results of performance review against standards.
    - Delegation oversight activities
- Review summary reports on mortality, serious adverse events, quality of care, and quality of service to identify trends and recommend corrective actions as needed.
- Monitor, evaluate and implement improvement plans for access and availability of network providers.
- Monitor and evaluate the cultural and linguistic needs of CareConnect's membership and identify opportunities to improve.
- Review reports and recommendations from CareConnect committees, act upon recommendations as appropriate and provide feedback, follow-up and direction to the committees.
- Recommend, monitor and assure barrier analysis and follow up of quality activities.
- Incorporate findings from the quality improvement activities into strategic program and resource planning. Adjust programs to address identified needs.
- Ensure practitioner participation in clinical aspects of the QIP, through the MM Committee(, including advising on clinical and practitioner issues
- Ensure compliance with regulatory requirements and accrediting organizations.
- Review peer review decisions concerning credentialing and clinical quality of care.
- Recommend appropriate resources in support of prioritized activities.

The QIC membership includes:

- Plan President (Chair)

- Chief Medical Officer (CMO)
- QI Director
- Medical Director
- Chief Operations Officer
- Network Director
- Behavioral Health Director
- Pharmacy Director
- Compliance Officer
- Legal Representative
- External providers who represent a range of healthcare services used by participants in CareConnect's population (e.g., physicians, psychologists, pharmacists, hospital CMOs, and providers) as designated by Chair
- Other representation as identified by the Chair

The QIC is chaired by the President who may designate the CareConnect CMO as Chair. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. The QIC meets at least quarterly and reports to the Board of Directors on a quarterly basis. The QIC chair can convene an ad hoc quality sub-committee to address quality activities on an as needed basis.

Medical Management Committee (MMC)

The Medical Management Committee (MMC) is responsible for overseeing the development, implementation and evaluation of the MM Program for all entities within the program's scope as guided by the medical policies of CareConnect and outlined in the MM Program Description. The MMC monitors all clinical quality improvement and utilization management activities within CareConnect. In addition, the MMC is responsible for overseeing the coordination of behavioral and medical health services, providing clinical oversight for the development and maintenance of CPGs, the Preferred Drug List (PDL) and Clinical Pharmacotherapy policies to promote the use of appropriate drug therapy based upon clinical evidence.

The responsibilities of the MMC are to:

- Evaluate, review and approve the UM Program Description, UM Work Plan and UM Program Evaluation at least annually.
- Oversee implementation of the UM Program and work plans.
- Review and approve appropriate MM and CM Policies and Procedures at least annually to assure they reflect current standards of medical practices.
- Review and approve performance metrics from all clinical areas, including behavioral health services. Monitor progress on clinical performance improvement programs.
- Evaluate the consistency of the UM decision making process through inter-rater reliability reports. Recommend improvement actions as indicated.
- Analyze, design, and implement interventions as related to continuity and coordination of medical and behavioral care

- Monitor and evaluate, at least annually, the efficiency and effectiveness of processes through analysis and review of under and over utilization and satisfaction with the UM processes, and recommend corrective actions as indicated.
- Reviews quarterly reports and performance metrics from all areas serving members and providers, including:
    - Customer service – member/provider
    - Network management
    - Grievance/appeals
    - Utilization Management
    - CM & Disease (Condition Management) and other health services functions
    - Behavioral Health
    - Pharmacy
- Evaluate, review, and approve the Preferred Drug List (PDL) and Clinical Pharmacotherapy policies at least annually.
- Conduct assessments of the evidence supporting new and emerging technologies as well as new indications for existing technologies and develop, review, and approve evidence-based position statements on selected medical technologies.
- Develop, review and approve CPGs for company-wide implementation.
- Ensure that clinical decisions about the safety and efficacy of medical care are consistent across all products and lines of business.
- Develop, implement, and evaluate the UM Program training and process improvement activities.
- Maintain approved records of all committee meetings.
- Provide feedback and recommendations to the UM Process.
  Promote compliance with regulatory and accreditation requirements, including oversight of corrective actions, as applicable.
- Review member and practitioner experience results and ongoing improvement activities
- Monitor trends related to member and provider call center activities as well as complaints, grievance and appeals
- Monitor the quality, access and availability of network providers
- Review, approve and monitor service-related Performance Improvement Projects (PIPs) and timeframe)
- Review CareConnect's service-related operational policies and procedures
- Accept the Credentialing plan annually, and ensure compliance with the contractual, regulatory, and accreditation requirements
- Oversee delegation of credentialing functions to external entities and monitoring of improvement action plans (IAP)
- Provide a summary report to the QIC at least 4 times per year.

The MMC membership includes:

- Chief Medical Officer
- Chief Operating Officer
- Division Director Health Services and QI

- Quality Representative
- Behavioral Health Director
- Pharmacy Director
- Legal Representative
- Chief Compliance Officer
- Provider Network Representative
- Customer Service Representative
- Member Services Representative
- Claims Representative
- A&G Representative
- Ad hoc CareConnect staff by invitation of Chair to lend subject matter expertise

The MMC meets at least 4 times per year and is chaired by the Chief Medical Officer (CMO). A minimum of 51% of committee membership constitutes a quorum. The MMC reports at least 4 times per year to the QIC. Cross reporting to the MMC is made as appropriate for peer review and other matters.

Delegation Oversight Committee (DOC)

The Delegation Oversight Committee (DOC) is an interdisciplinary committee that provides oversight of healthcare contracts and selected non-healthcare contracts. The DOC has specific focus on the qualifications and performance of delegates, the performance of internal contracting procedures, and compliance with legal and regulatory requirements in the contracting process.

Responsibilities of the DOC include:

- Ensuring that appropriate and necessary policies are developed, implemented and reviewed on an annual basis, including a re-delegation policy

- Conduct regular meetings as a forum for the following activities:

    - Review and evaluation of delegate/vendor reports to measure performance and identify opportunities for improvement

    - Use of data to provide guidance on how delegates and vendors can improve their performance

    - Discussion and assistance in finding resolution to new, ongoing, and outstanding delegate/vendor issues

    - Review and evaluation of delegate/vendor annual audit findings

    - Monitoring of Improvement Action Plans (IAP) that are initiated by the delegate/vendor or imposed by CareConnect.

The DOC is chaired by the Chief Operating Officer. The DOC includes, but is not limited to:

- Chief Operating Officer
- Chief Financial Officer
- Chief Medical Officer
- Division Director of QI & Health Services
- Legal Representation
- Ad hoc CareConnect staff by invitation of Chair to lend subject matter expertise

The DOC meets at least quarterly. The DOC reports quarterly to the Quality Improvement Committee (QIC). Quarterly reports will include information highlighting all DOC activities for QIC review and acceptance.

A minimum of 51% of committee membership constitutes a quorum. All members are voting members.

Credentialing Sub-committee

The Credentialing Sub-committee's primary focus is to perform oversight of all delegated entities performing credentialing and re-credentialing functions on behalf of CareConnect. The Credentialing Sub-committee reports directly to the MM Committee.

Responsibilities of the Credentialing Sub-committee include:

- Review all proposed delegations and make recommendations on the appropriate action.
- Review, evaluate, and approve credentialing plan and all related policies and procedures on an annual basis.
- Receive and evaluate credentialing reports on a regular basis.
- Review and make final recommendations of approval or denial of delegation pre-assessments
- Conduct annual on-site audits
- Determine acceptance or denial of delegates to a given network

The Credentialing Sub-committee's membership includes:

- Chief Medical Officer
- Medical Director
- Quality Improvement Director
- Behavioral Health Director
- Pharmacy Director
- Legal/Compliance Representative

- Network primary care and subspecialty physicians who represent the type of care and services provided for CareConnect members.
- Other CareConnect representatives, as appropriate, from time to time as determined by the Chair

The Credentialing Sub-committee meets at minimum on a quarterly basis and more often as needed. The Credentialing Sub-committee reports up to the MMC which acts as a senior level body that monitors the integrity of the delegated credentialing processes of CareConnect.

The Credentialing Sub-committee's activities and meeting minutes are presented to the MMC. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. Members may not designate surrogate attendees. Minutes are created contemporaneously and are forwarded to the MMC at least on a quarterly basis.

Committee Quorum

A quorum, as outlined by the individual Committee charters, is required for all meetings. If not stated, a majority of members present constitutes a quorum.

Committee Minutes

Minutes are recorded at all quality committee meetings using a standardized format including topic, discussion, recommendations, and follow-up. The meeting secretary will be assigned by the Chair. Follow-up items will become topics for the next committee meeting. All minutes are maintained in a confidential manner. The appropriate Chairperson reviews the minutes for accuracy and completeness. The Chairperson signs and dates the minutes.

Robert's Rules of Order

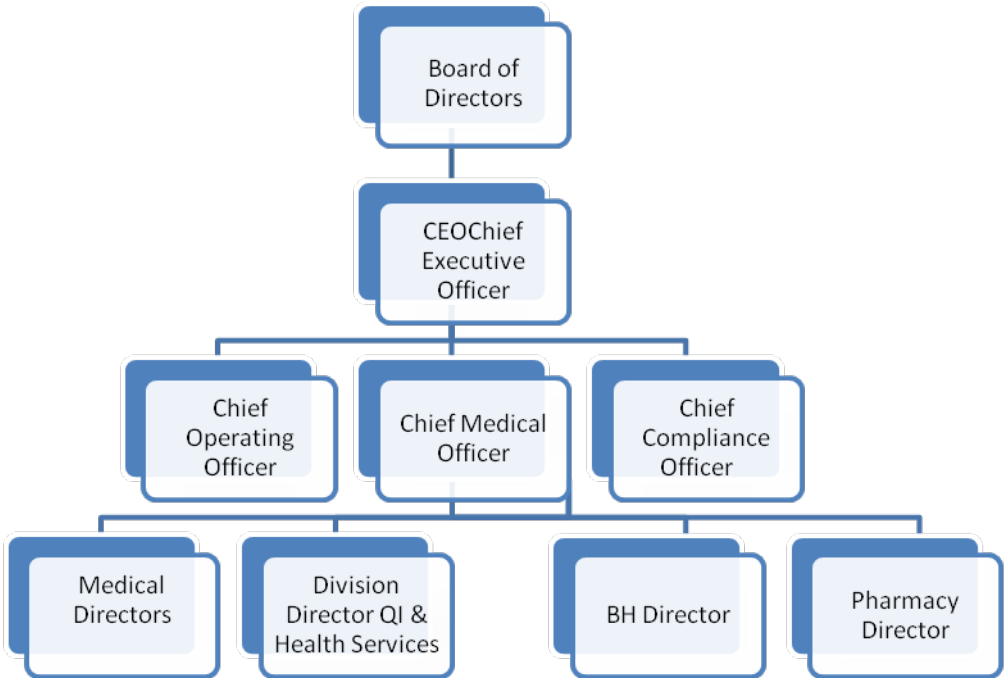
All Committees are conducted according to Robert's Rules of Order as modified by CareConnect.

Quality Improvement Program

Organizational Structure

The Board of Directors has ultimate responsibility for the QIP and related processes and activities. The Board of Directors has delegated to the QIC responsibility for ensuring the quality improvement processes outlined in this plan are implemented and monitored.

Below is an organizational chart depicting key staff of the health plan related to the QIP, followed by brief descriptions of select senior level and QI positions.



CEO

The Chief Executive Officer (CEO) is responsible for oversight of the implementation of the QIP. The CEO or designee chairs the QIC. The CEO is responsible for monitoring the quality of care and service CareConnect provides, and ensures the appropriate level of resources is available for the QIP. The CEO also makes certain that fiscal and administrative management decisions do not compromise the quality of care and service CareConnect provides to members.

Chief Medical Officer

The Chief Medical Officer (CMO) is a New York licensed physician who is responsible for implementation of the QIP. The CMO reports to the CEO and provides the medical direction for CareConnect staff. The CMO chairs the QIC. The CMO participates in the credentialing and re-credentialing process for CareConnect and coordinates review with the MMC. The CMO oversees and implements activities to measure health services efficacy. The CMO, in

collaboration with legal and network management, is responsible for the immediate decision and resolution of all situations involving the potential of imminent harm.

Behavioral Health Director

The Behavioral Health Director is responsible for the oversight of the Behavioral Health (BH) program and participates in various QI committee activities.

Division Director of QI & Health Services

The Division Director of QI & Health Services is responsible for oversight of the implementation of the QIP, including monitoring the quality of care and service complaints and, provides the evaluation of quality improvement initiatives involving member and provider outreach. The Division Director of QI & Health Services is also responsible for oversight of activities designed to increase performance on clinical quality measures, preparation of the annual QIP documents, oversight of submissions of quality regulatory reports, oversight responsibility for implementation of quality improvement studies and patient safety initiatives, oversight of Appeals and Grievances, oversight of delegated vendors and manages CareConnect QI infrastructure.

The Division Director of QI & Health Services is a point of contact for regulatory inquiries and works with the Compliance Officer to assure compliance with regulatory and accreditation standards. The Division Director of QI & Health Services consults with Quality Management staff who are subject matter experts in program design and statistics and with other business units as needed. Other business units that support quality improvement and reporting include Information Technology, Compliance, and Finance. The Division Director of QI & Health Services reports to the CMO to ensure that fiscal and administrative management decisions do not compromise the quality of care and service CareConnect provides to members.

Quality Improvement Program Activities

Integration is a key component of successful quality improvement. Departments involved in quality improvement activities are integrated with one another through coordinated referral systems for quality/risk/utilization issues, case management, member/practitioner complaints, and grievances, an integrated computer information system that is accessible to all areas, and cooperative problem-solving practices. As the central area for receiving potential quality/risk management issues and coordination of quality improvement activity, the QI Department acts as a critical interface between members, members' representatives, practitioners, providers, state and federal regulators, as well as other various departments. Information received by QI is reviewed and investigated and coordinated as necessary with Case Management, Prior Authorization, Behavioral Health, and other departments (such as Network Management, Member Service, Appeals and Claims Disputes, Claims, or Finance).

The QIP uses a variety of mechanisms to continuously measure, evaluate and improve the services provided to health plan members. All are founded on Continuous Quality Improvement (CQI) principles which focus on implementing the PDSA (plan, do, study and act) cycle as a

means to meet or exceed the minimum performance standards established by CareConnect and regulators. The following activities are included in reviews that reflect important aspects of care and service.

Clinical and Preventive Care Guidelines

Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating providers. CareConnect adopts pediatric, adolescent, adult and maternal preventive health and clinical practice guidelines that are reviewed at least annually and approved by the MMC. The MMC evaluates guidelines from the most current and reasonable medical evidence available, including but not limited to, the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and specialty organizations. CareConnect measures population-based performance against preventive health and clinical guidelines annually, primarily through HEDIS®, CAHPS®, and QARR measurement. CareConnect adopts MMC approved guidelines through the QIC.

Preventive health and clinical practice guidelines are available on-line to both members and providers. To encourage the use of appropriate preventive care, CareConnect promotes member focused educational and outreach programs. These programs identify at-risk members and involve members and/or member representatives and their health care providers in the decision-making process.

Complaints/Grievances

Member complaints/grievances are expressions of dissatisfaction with any aspect of care or service provided by the health plan and/or subcontracted provider, excluding appeals and other actions such as service denials, claims and billing issues. Allegations of a violation of member's rights are included in complaint/grievance investigations. Member complaints/grievances are tracked and trended through the QI program to:

- Monitor effective and timely resolution of member concerns.
- Identify opportunities for improvement in the quality of care and service provided to members.

Complaints/grievances are classified using the following categories:

- Quality of Care
- Quality of Service
- Access
- Attitude and Service
- Billing and Financial Issues
- Quality of Practitioner Office Site

Complaints/grievances can be made on behalf of the member by their representative, as well as identified by any department, member, provider or regulatory agency. Member grievances are also identified through escalation by the Customer Service Department. The QI Department reviews member complaints/grievances, identifies potential quality of care and/or abuse issues

and facilitates the investigation and resolution process. Data for quality of care/service issues are collected, reviewed and trended to identify opportunities for improvement. Analysis of quality of care and service issues is presented to the MMC respectively, for review of aggregate trends and identification of actions for improvement.

- Designed to bring the providers into compliance with the practice guidelines.

Member Experience

Member experience is assessed through annual member experience surveys such as CAHPS®, as well as member complaint data. Member survey results are used to:

- Measure CareConnect performance.
- Establish benchmarks and monitor performance.
- Assess overall levels of satisfaction to determine if CareConnect is meeting member expectations.
- Assess service performance.

Complaint/grievance data are trended to identify potential opportunities for improvement. Action plans to address opportunities for improvement based on member experience results are reviewed and approved by the MMC.

Monitoring of Performance Indicators

Ongoing monitoring of performance indicators is designed to reveal trends and improvement opportunities in targeted populations. National standard indicators, (i.e. HEDIS®, QARR, and CAHPS®) are used to continuously measure plan performance. Results are used to identify current gaps in care or service and are integrated in quality improvement projects for the health plan.

Provider Accessibility and Availability Monitoring

Provider accessibility, and availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographic location of providers, number of providers, appointment availability, provision for emergency care, and after hours service are measured. The cultural, ethnic, racial, linguistic needs of its members are assessed on an ongoing basis and formally evaluated at least annually.

Monitoring activities include provider surveys, on-site visits, evaluation of member experience, evaluation of complaints, geo-access surveys and when applicable. Specific deficiencies are addressed with an improvement action plan, and follow-up activity is conducted to reassess compliance. Provider accessibility and availability activities are reported to and overseen by the MMC.

Provider Experience

Provider experience surveys are designed to:

- Assess which services are important to health plan providers.
- Determine provider satisfaction with CareConnect processes, including the medical management process.
- Assess satisfaction with continuity and coordination of care.

Provider experience surveys are conducted annually. The survey results are summarized and reviewed by the MMC to identify areas for improvement and develop action plans.

Performance Improvement Projects (PIPs)

Performance Improvement Projects (also known as Quality Improvement Projects) may be designed for the entire plan population or a targeted population or subgroup. PIPs are studies designed to include measurement of performance, interventions, improving performance and systematic and periodic follow-up on the effect of the interventions.

Performance Improvement indicators are objective, clearly defined, based on current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement. Results of evaluations and recommendations are reviewed and approved by the QIC. Current PIPs are defined in detail as part of CareConnect's annual QI Work Plan.

Patient Safety and Risk Management

CareConnect supports the prevention and elimination of healthcare errors by our commitment to the practice of Evidence-Based Medicine. This is accomplished through a variety of mechanisms, including but not limited to measurement tools and reporting metrics focusing on patient safety, evidence-based claims and prescription reports to identify adverse events, quality of care referrals and databases to identify, track, and address patient safety concerns. Annually, patient safety goals are developed and integrated into the overall QI Work Plan.

CareConnect's patient safety program is also supported through several initiated activities. CareConnect supports the Leapfrog Group's four pillars: transparency, standardized measures and practices, incentives and rewards, opportunity rate and external collaboration.

CareConnect is committed to providing quality care and service while preserving the financial integrity to continue our vision. Risk management is a coordinated, interdisciplinary process designed to identify, evaluate, and resolve actual and potential liability exposures. The risk management program includes coordination between CareConnect staff and corporate Legal counsel.

Cultural Competence and Awareness

It is important that CareConnect staff is aware of, and sensitive to, the cultural and demographic diversity of the CareConnect membership and of colleagues and stakeholders. Providing culturally competent care can potentially enhance the delivery of services and increase the likelihood of successful engagement with the member, and family/ caregivers. Being culturally competent and aware can include, but is not limited to:

- Becoming knowledgeable about the communication styles and linguistic needs of specific cultural and ethnic groups in order to enhance communication with enrollees and families,
- Seeking to recognize personal prejudices, biases, and assumptions concerning particular cultural and ethnic groups and working to correct these and to avoid allowing these characteristics to improve the delivery of services.
- Obtaining accurate information about patterns of utilization and typical attitudes about healthcare services and seeking to tailor service delivery to take into account such information.
- Seeking to obtain and understand data about incidence and prevalence of certain disease states or conditions within the various cultural and ethnic populations served by the plan.
- Seeking supervision and consultation to enhance service delivery when issues related to cultural and ethnic diversity of enrollees and families are identified.

CareConnect provides training for all employees on cultural competence and awareness, and employees are encouraged to seek opportunities for ongoing continuing education to enhance their ability to deliver services in the most culturally competent manner.

Preventive Care Program

The Preventive Care Program is an outreach program serving CareConnect enrollees. CareConnect provides preventive health and screening services for its members within its program benefits. Because of the demographics of the enrolled population, targeting these groups for preventive services has the potential to yield improvements for a large number of members.
CareConnect chooses preventive service indicators that reflect important aspects of care for our members -- indicators that are relevant to the enrolled population, are reflective of high volume services, encompass preventive and chronic care, and span a variety of delivery settings. Categories of indicators may include the following:

- Preventive (e.g. lead screening, immunizations, cervical cancer screening, breast cancer screening, and well- child visits).
- Chronic care (e.g. diabetes, cholesterol management, treatment of asthma).
- Access/ availability of care.

Preventive services are both population and condition based. Using multiple data sources, including but not limited to HEDIS® and QARR® and claims data, members are identified for outreach. Claims/encounter data are monitored on an ongoing basis to identify members in need

of services and to provide feedback to providers on individual performance as well as CareConnect performance.

Outreach is provided in both written and verbal form. On a routine basis, mailings are sent to members to provide education related to preventive care and/or screenings due. Verbal outreach can be provided through both automated telephone calls and direct-member outreach. In addition, on an annual basis, written information is mailed to members to encourage the utilization of physical exams and recommended screenings.

Educational information related to preventive care is also made available to members on CareConnect website. Communication with internal departments including case management, member services and provider services is ongoing to promote the Preventive Care program and to work collaboratively on individual cases when indicated.

Educational and member-specific information is submitted to providers on a routine basis to provide up-to-date screening guidelines and notification of screenings due among the assigned member panel. On-site visits to providers may also be conducted for focused education and/or medical record review.

CareConnect staff develops partnerships with Community and State agencies for health promotion on a community-wide scale. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members. Using state and/or national guidelines, as well as HEDIS® and QARR data, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

Utilization Management

The Utilization Management Program Description and Evaluation are reviewed by the MMC and approved by the QIC. Clinical criteria and technology assessments developed by CareConnect are reviewed and discussed by the MMC and with recommendation, approved by the QIC. Chronic conditions related to the populations demographic, health status and utilization of CareConnect members and epidemiologies are identified and programs are designed to assist members in managing these conditions. Additionally, any clinical issues identified during Health Services activities that relate to CareConnect's population are assessed and evaluated. Review activities include evaluation of continuity and coordination of care and patient safety.

Behavioral Health

CareConnect provides mental health and substance abuse services to members. CareConnect's Behavioral Health Director is involved in the implementation of the behavioral health aspects of the QI Program including quality improvement, utilization management, member rights and responsibilities. These activities include, but are not limited to, access and availability, practice

guideline development, continuity and coordination of care between medical and behavioral health care, over and underutilization, complaints, grievances/appeals, and triage/referral.

CareConnect's behavioral health program is built by utilizing a strategic yet robust network that will ensure access to integrated care and appropriate levels of care, based on the intensity of our member's need. This multi-disciplinary network of psychiatrists, psychologists, and social workers as well as our partnerships with community-based organizations helps our CareConnect clinical team ensure an individualized, member-centric care plan.

CareConnect's behavioral health program utilizes data in order to properly train providers as well as help engage members on prevention, promotion and improvement of health. Behavioral health services will continue to establish baseline utilization and health of our members and implement programs with targeted outcomes in order to improve health as well as member satisfaction.

Examples of strategic initiatives that are utilized to improve health outcomes:

- Assist with the coordination of ambulatory follow-up rates after an inpatient mental health admission
- Encourage the initiation and engagement in alcohol and substance abuse treatment once a member has been flagged with an identified issue
- Improve adherence in outpatient behavioral health treatment for major depression

Provider Profiling

Annual PCP utilization and quality profiles are designed by the quality improvement department. Profiles summarize utilization history on five utilization and nine quality indicators for PCPs with sufficient data to generate statistically significant profiles. Individual provider scores are compared to network peer scores.

Utilization indicators may include:

- Encounters
- Specialist visits
- Emergency room visits
- Hospital days
- Hospital discharges

Quality indicators may include, but are not limited to:

- Well child visits
- Childhood immunizations
- Adult BMI assessment
- Colorectal cancer screening
- Cervical cancer screening
- Breast cancer screening

- Comprehensive diabetes treatment
- Antidepressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment
- Follow-up after hospitalization for mental illness
- Medication reconciliation after discharge from inpatient facility

To identify potential over-utilization or under-utilization, profile data is further analyzed to identify scores greater than one standard deviation from the mean. Providers in the lowest quartile are targeted for quality improvement initiatives.

Preventing Hospital Re-Admissions

Preventing re-admissions is a strategic priority for CareConnect. To achieve this goal, CareConnect focuses on two areas: preventing re-hospitalizations and managing advanced illnesses.

CareConnect works collaboratively with the NSLIJ system to reduce re-hospitalizations by using industry standard tools and evidenced based medicine that assist members with receiving coordinated, appropriate follow-up care following a hospitalization. These efforts are aimed at empowering and educating members on how to access the appropriate resources and services following a hospitalization.

Some examples would be:

- Providing the member/family with educational material regarding their current condition/diagnosis
- Medication reconciliation
- Post follow-up calls to ensure the member's understanding of the discharge summary
- Assistance with scheduling follow-up appointments with primary care and specialty providers

Managing advanced illness, CareConnect works directly with NSLIJ physicians to improve the care of members with serious illness by aligning treatments with member preferences. The goal is to ensure that member preferences are known, documented and followed to decrease hospital admissions and readmissions, reduce non-emergent ER visits, and working with physicians to coordinate care for member's in their home setting so as to reduce overall suffering.

Annual Oversight

Communication

CareConnect has various mechanisms through which QI Program activities are communicated and through which CareConnect's progress in meeting its goals is reported. These mechanisms include but are not limited to:

- Board of Director Reports
- Committee reporting; specific, summary and feedback
- Member, provider newsletters and internet portals
- Member and Provider Handbooks
- Regulatory body reports and surveys
- Staff meetings, employee communication materials and intranet portals

CareConnect informs practitioners and providers about the QI Program and its progress toward meeting goals, improvement activities, and results of surveys and studies at least annually through the Provider Manual, Provider Newsletters, provider training, on-site training, mailings, and one-on-one discussions with Medical Directors. Feedback to practitioners and providers about individual performance (such as medical record reviews, complaints, profile information, or peer review decisions) is given by face-to-face discussions as well and/or direct mailings to the practitioner or provider.

Members are informed of the QI Program and progress towards meeting goals, improvement activities and results of surveys and studies at least annually through the CareConnect Website and Member Newsletters. Information is communicated to staff members during new employee orientation, at departmental staff meetings, and designated committee meetings.

Delegation Oversight

When operational activities are delegated to another organization, CareConnect evaluates the organization's caMMCity to perform the proposed delegated activities prior to entering into a delegation agreement consistent with CareConnect guidelines.

At the time of delegation, CareConnect executes a mutually agreed upon document which clearly defines the performance expectations for the delegated entity.

At a minimum, the document:

- Defines the delegate's specific duties and responsibilities.
- Describes the delegate's activities.
- Describes the requirements for the delegate's reporting to CareConnect.
- Defines the process by which CareConnect will evaluate the delegate's performance.
- Specifies the remedies available to CareConnect, including revocation of the delegation, in the event the delegate does not fulfill its obligations.

Ongoing oversight will be conducted to ensure that the delegated entities are in compliance with CareConnect's delegation standards and that services meet professionally recognized standards of practice. CareConnect will retain ultimate responsibility for reviewing the overall quality of care and services delivered to CareConnect members.

CareConnect will demonstrate accountability for delegated functions through summary documentation, descriptions of the delegates' activities, and the standards and requirements with which the delegated organization must comply.

Pre-Delegation Evaluation

Prior to delegating a function to an external entity, CareConnect will require the external entity to demonstrate their ability to perform the functions being considered for delegation. If the assessment results in a mutually agreed upon delegation agreement, CareConnect will obtain regulatory approval (if required) prior to implementation.

Annual Delegation Evaluation

After an entity has been delegated for a specific function, the entity will be evaluated on an ongoing basis, at least annually, to determine continued compliance with stated standards and the ability to continue in delegated status. Annual on-site audits may be conducted, but at a minimum, an annual documentation review will be conducted.

Document(s) to be reviewed may include, but are not limited to:

- The formal, written contract or description of delegated activities.
- The delegated organization's Program Description and Work Plan.
- The delegated organization's Annual Evaluation.
- The delegated organization's pertinent policies and procedures.
- Appropriate activity reports, files, or committee minutes regarding the delegated activity for the past 12-24 months.

Delegation Standards

All entities who have delegated responsibility for specific functions will adhere to CareConnect delegation standards as defined in the delegation agreement. To ensure that delegated entities are meeting the standards, CareConnect conducts the following oversight:

1. A monthly Service Level Activity report will compare the actual results of services performed for the month by the delegated entity against the Service Level standards that were established in the administrative agreement. The Service Level Activity report will also aggregate year-to-date results through the month being reported. The combination of monthly and year-to-date aggregate summary results will ensure that Service Level Activity is being met for both the current period and on an aggregate year-to-date basis.

2. A quarterly Service Level Activity report will compare the actual results of services performed for the 3-month period by the delegated entity against the Service Level standards that were established in the administrative agreement. The quarterly Service Level Activity report will also aggregate year-to-date results through the quarter being reported. The combination of quarterly and year-to-date aggregate summary results will ensure that Service Level Activity is being met for both the current 3-month quarter and on an aggregate year-to-date basis through the quarter being reported.

3. An annual Service Level Activity report will compare the actual results of services performed for the 12-month period by the delegated entity against the Service Level standards that were established in the administrative agreement.

4. All deficiencies will be reported ("Deficiency Notice") to CareConnect by the delegated entity within 24 hours of discovery of the deficiency. The Deficiency Notice shall be submitted in writing and faxed, e-mailed or mailed (via certified mail) to the health plan.

5. The delegated entity will submit to CareConnect a "Corrective Action Plan" ("CAP") within 48 hours of the Deficiency Notice. The CAP will include:

    - The root cause of the deficiency,
    - Plan of action correcting the deficiency
    - The on-going monitoring of the corrective action for a minimum of 90 days following the correction of the deficiency.
    - All deficiency corrections or resolutions will be enacted and resolved no more than 30 days from the approval of the CAP by CareConnect.

6. Quarterly and Annual delegated Service Level Results reported by the delegated entity to CareConnect will be reported by CareConnect to its Delegated Oversight Committee. The Quarterly and Annual delegated Service Level Results will be reported to the Delegated Oversight Committee at its next Committee meeting following the Quarterly or Annual Service Level Results meeting.

7. All Deficiency Notices received by CareConnect from its delegated entities will be immediately forwarded to the Delegation Oversight Committee along with the approved CAP and be duly noted in the "Minutes" of the special meeting of the Delegation Oversight Committee. All CAP resolution and monitoring will be reported to the Delegation Oversight Committee at its next Committee meeting following the CAP resolution. The following steps and process will be followed to ensure timely and accurate information is reported to the Delegation Oversight Committee who in turn will report to the Quality Improvement Committee of the Board of Directors of CareConnect:

    a. A "Notice of Deficiency" will be sent to the Members of the Delegation Oversight Committee within 72 hours of the receipt of the deficiency from the Delegated Entity or if the deficiency was discovered by CareConnect representatives during the course of an audit or routine meeting with the delegated entity.

    b. A special meeting of the Delegation Oversight Committee will be called by the Chairman of the Committee if it is determined by both the Chairman of the

Delegation Oversight Committee and Compliance Officer of CareConnect a meeting is warranted to review the severity and magnitude of the deficiency in question. The Delegation Oversight Committee will be informed of the deficiency and the CAP developed to resolve it.

c. The Quality Improvement Committee will be informed by the Delegation Oversight Committee of all delegated deficiencies at the next upcoming Quality Improvement Committee meeting unless it is determined by the Chairman of the Quality Improvement Committee that a special meeting communication is necessary as well as a special Quality Improvement Committee meeting.

d. The CAP will be implemented by the delegated entity and monitored by the appropriate Plan personnel to ensure the deficiency has been resolved. The Delegation Oversight Committee will be informed of the resolution once resolution of the deficiency has been attained.

e. The Board of Directors of CareConnect will be informed by the Quality Improvement Committee of the deficiency and the resolution or if root cause issues still persist.

8. CareConnect will ensure that monitoring of delegates is carried out by CareConnect staff that is qualified to assess the delegates' activities.

9. When CAPS fail to demonstrate effectiveness within an allocated timeframe, CareConnect retains authority to revoke the delegation agreement at any time.

Annual Evaluation

An annual evaluation of the QIP is conducted to assess the overall effectiveness of the CareConnect's quality improvement processes. The evaluation reviews all aspects of the Program work plan, focusing on whether the Program has demonstrated improvements in the quality of care and service provided to members. The annual evaluation includes:

- An assessment of whether goals and objectives for each activity were met.
- A review of human and technological resources.
- A summary of all quality improvement activities performed during the year.
- Reports for each Performance (Quality) Improvement Project.
- The imMMCt and effectiveness of the QI process had on improving the care and service provided to members.
- Trends and related improvement activities.
- Potential and actual barriers to achieving goals.
- Recommendations for QIP and QI Work Plan revisions, rationale and timelines.

The annual evaluation is reviewed and approved by the QIC and the BOD. The results of the annual evaluation are used to develop and prioritize the next year's annual QI work plan. Annual plan evaluation reports are submitted to state or federal agencies as required.

Annual Work Plans

The annual QI Work Plan focuses on QIP goals, objectives and planned projects for the upcoming year. The QI Work Plan includes specific tasks, responsible owners of activities, and anticipated time frames for completion. It serves as the road map to reflect a coordinated strategy to implement the QIP including planning, decision-making, interventions, assessment of results, and achievement of the desired improvements. The BOD and the QIC approve the QI Evaluation as well as the annual QI Work Plan based on the QIP Description. The QI Work Plan is a living document with periodic updates expected as a result of interim project findings and reports. Updates to the QI Work Plan are reviewed and approved by the QIC, and submitted to state or federal agencies as required and/or when substantial changes are made.

The annual QI Work Plan specifically addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

Policies and Procedures

CareConnect policies are reviewed annually and are available to all CareConnect employees through a shared online source.

Data Sources

Data to support the QIP is obtained through many sources including but not limited to:

- CareConnect business partners
- Population and demographic reports
- Claims data
- National evidence–based guidelines
- National inpatient and outpatient criteria
- Care management data
- Utilization, service and outcome reports
- Member and provider reported satisfaction data
- Medical records review and abstraction
- Surveys and questionnaires

- National benchmarks
- Internal databases and tracking systems

Confidentiality

CareConnect maintains confidentiality policies, and no voluntary disclosure of peer review information is made except to persons authorized to receive such information to conduct QI activities. Information is strictly confidential and is not considered discoverable under state and federal peer review laws.

CareConnect adheres to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the American Recovery and Reinvestment Act of 2009 (ARRA) Regulations. No voluntary disclosure of identifiable member information or Personal Health Information (PHI) is made without obtaining prior consent from the member except as required by law. Member information is used only as necessary to meet the administrative and legal obligations of CareConnect.

The data used in the QIP are maintained in a confidential manner using codes and summary information. Only those persons who require information to perform corrective action(s) are given access to identifiers. Committee records are available only to authorized personnel in accordance with local, state, federal, and other regulatory agencies. Each external committee participant must agree to comply with these confidentiality policies and sign a Committee Member Confidentiality Statement.

Appendices

Glossary

The following abbreviations are used in this document:

CAHPS	Consumer Assessment of Healthcare Providers and Systems
CFO	Chief Financial Officer
CMO	Chief Medical Officer
COO	Chief Operating Officer
CMS	Centers for Medicare and Medicaid Services
CQI	Continuous Quality Improvement
DOC	Delegation Oversight Committee
IRR	Inter-Rater Reliability
MM	Medical Management
MMC	Medical Management Committee
MMC	Provider Advisory Committee
PDSA	Plan, Do, Study, Act quality improvement cycle
PIP	Performance Improvement Project
QIP	Quality Improvement Program
QI	Quality Improvement
QIC	Quality Improvement Committee
UM	Utilization Management

Attachment C

User Inputs for Plan Parameters

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$35.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	93.75%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.12%
Metal Tier:	Platinum

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?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,500.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1				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
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.69%
Metal Tier:	Silver

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.99%
Metal Tier:	Silver

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?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.83%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.66%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.43%
Metal Tier:	Platinum

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.99%
Metal Tier:	Bronze

North Shore LIJ CareConnect | Insuring better health

Attachment D

	Subscribers	Members	Average Contract Size	Rate Factor
Single	5,835	5,835	1.000	1.000
Individual & Spouse	2,632	5,264	2.000	2.000
Individual & Child (ren)	406	1,408	3.468	1.700
Family	1,127	5,941	5.272	2.850
Child only	1,866	1,866	1.000	0.412
Total	11,866	20,313	1.712	1.329
	Conversion Factor:			1.288

North Shore LIJ CareConnect | Insuring better health

North Shore-LIJ CareConnect Insurance Company, Inc.

Individual On-Exchange Plans

Prior Approval Adjustment Filing

2015 Premium Rates

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GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

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

State: New York

HIOS Issuer ID: 82483

Market: Individual

Effective Date: January 1, 2015

COMPANY CONTACT INFORMATION

Primary Contact Name: [redacted]

Primary Contact Telephone Number: [redacted]

Primary Contact E-mail Address: [redacted]

PURPOSE

The purpose of this actuarial memorandum is to provide certain information related to the submission of North Shore-LIJ CareConnect Insurance Company, Inc.'s (NS-LIJ CC's) rate filing, including support for the values entered into the Part 1 Unified Rate Review Template and New York State Department of Financial Services' Exhibit 18 "Index Rate/Plan Design Adjustment Worksheet", which supports compliance with the market rating rules and reasonableness of applicable rate changes.

ACTUARIAL QUALIFICATIONS

I, [redacted] am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

PROPOSED RATE INCREASE(S)

The proposed rates for individual plans to be offered for sale on New York State's Health Benefit Exchange are presented in Attachment A. We are requesting an overall rate decrease of 1.3%:

Rate Component	Area 8 (Long Island)	Area 4 (New York City)
Trend	2.0%	2.0%
Capitation Contract Correction	(2.9%)	(2.9%)
Change in Net Reinsurance Recoveries	3.8%	3.8%
Provider Contract Change	2.0%	(4.0%)
Improved Medical Management	(5.0%)	(5.0%)
Total	**0.0%**	**(6.3%)**

	Area 8	Area 4	Total
Rate Request	0.0%	(6.3%)	(1.3%)
Membership Weight	80%	20%	100%

All the plans shown in Attachment A are plans that were also offered for sale in the New York Health Benefits Exchange effective January 1, 2014. We used the following methodology to develop these rates.

Underlying Claims Experience: As NS-LIJ CC does not have any 2013 claims experience on which to base its premium rating, we carried forward the development from our 2014 rate filing.

Trend: We expect a 2% utilization trend for 2015 and expect that 2015 contracted rates will remain at 2014 levels.

Capitated Contracts: The 2014 rates were built assuming our capitated contracts applied to all members, when in fact, they only apply to children <19 years old. This correction results in a 2.9% reduction to our rates.

Net Reinsurance Recoveries: The change in the 2015 reinsurance parameters relative to the parameters used in our 2014 pricing results in a 3.8% increase to our rates.

Provider Contract Change: 2015 provider reimbursement rates are different from those assumed in our 2014 pricing.

Medical Management: We are expecting savings from the following:

- Reduced inpatient readmissions,
- Reduced Emergency room visits, and
- Better generic and specialty pharmacy management

The premium rates reflect the taxes and fees for 2015 noted below in the Taxes and Fees Section.

The rate development is based on generally accepted actuarial principles for community-rated blocks of business.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. We are a newly licensed insurer in New York State with no claims experience in 2013, therefore, the premium rates presented are 100% manually rated.

BENEFIT CATEGORIES

As we have no 2013 claim experience and the categorization from our previous filing appears sound, we carried forward the same relative relationship of the benefit categories used in our previous filing.

CREDIBILITY MANUAL RATE DEVELOPMENT

As we are a newly licensed health insurer in New York with no 2013 claims experience and considering the actuarial soundness of the development of the manual rates from the 2014 filing, we are making no changes to the development from our 2014 filing, other than those noted on page 5.

Source and Appropriateness of Experience Data Used: We used the same underlying data used in last year's rate filing, which is data from a national consulting firm, as the basis for NS-LIJ's manual rate development. The costs for our individual book of business, therefore, continue to assume utilization 10% higher than for our small group book of business.

Conversion Factor: A conversion factor is required to convert the premium from a PMPM basis to a single premium basis. As we have no experience from 2013, we are making no changes to the conversion factor developed in our 2014 filing. We continue to use a factor of 1.288. Refer to Attachment D for the development of this factor.

Standard Rating Regions: We are filing rates for both Long Island Area (Region 8) and New York City Area (Region 4). Based on the contract differences noted above, our area factors are:

Area	Factor
Area 4	0.937
Area 8	1.000

Inclusion of Capitation Payments: The following services will be paid on a capitated basis and were added to our premiums, by metal level tier, as indicated in our agreements with vendors.

- Pediatric dental
- Pediatric vision

CREDIBILITY OF EXPERIENCE

As we have no 2013 experience on which to base our premium rating, our premium rates are 100% manual rated.

PAID TO ALLOWED RATIO

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

RISK ADJUSTMENT AND REINSURANCE

PROJECTED RISK ADJUSTMENT PMPM

Consistent with our 2014 filing, we did not make any specific adjustment to reflect payments into, or from, the individual risk pool.

PROJECTED ACA REINSURANCE RECOVERIES NET OF REINSURANCE PREMIUM

The premium rates for each plan are reduced by the value of the expected recoveries for that plan.

To evaluate the change in the reinsurance parameters for 2015 relative to those of 2014 at the plan level, we used a cumulative probability distribution from a national consulting firm.

To estimate the market-wide impact of the transitional reinsurance program we multiplied the plan specific value by the projected member months for each plan. We assume that we will receive 100% of the value of these recoveries.

We estimate the net market-wide PMPM impact of the transitional reinsurance program to be:

Assessment	$3.67
Recoveries	($14.10)
Net Impact	($10.43)

NON-BENEFIT EXPENSES AND PROFIT & RISK

ADMINISTRATIVE EXPENSE LOAD

As a new plan, our initial fixed administrative costs will need to be amortized over several years in order to be competitive. Our proposed rates reflect an average loss ratio of 82.9%, i.e. a 17.1% load for administration, taxes and fees.

PROFIT (CONTRIBUTION TO SURPLUS) & RISK MARGIN

The proposed rates do not reflect an allowance for profit margin. We anticipate making a loss in our second year.

TAXES AND FEES

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

Contributions to the Federal Transitional Reinsurance Program	$3.67 PMPM
Patient Centered Outcomes Research Fee	$2.00 PMPY
Risk Adjustment User Fee	$0.96 PMPY
Health Insurance Provider Fee	0.0%*
New York State Exchange User Fee	0.0%*
New York State Premium Tax	1.3%*

* Percent of premium

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

PROJECTED LOSS RATIO

Under section 4308(c)(3)(A) of New York Insurance Law, the expected minimum loss ratio for an individual contract form cannot be less than 82%. The target pricing loss ratios for NS-LIJ CC's 2015 individual products are all at least 82% and on average is 82.9%. One minus the target loss ratio reflects the percent of administrative load. The table below shows the loss ratio by plan.

Metal Level	Loss Ratios
Catastrophic	82.0%
Bronze	82.0%
Silver	83.0%
Gold	83.0%
Platinum	83.0%

INDEX RATE

As we have no 2013 experience, we have no experience period index rate.

The projection period index rate is the projected allowed claims PMPM for the Essential Health Benefits (EHB), as shown in Section III of Worksheet 1 of the URRT. The index rate was calculated by taking a weighted average of the EHB allowed claims for each of the individual plans that we intend to offer for sale on the Health Benefit Exchange and off-Exchange. The plan index rates were weighted based on projected member months by plan.

We offer the following state mandated benefits and riders but no other non-EHB benefits.

- Elective abortion
- Dependent through age 29 rider

MARKET ADJUSTED INDEX RATE

The market adjusted index rate is the index rate plus the net reinsurance amount described above.

CALIBRATION

The Plan Adjusted Rates need to be multiplied by the geographic calibration factor before applying the area factors noted above. The table below derives our geographic calibration factor.

Area	Distribution	Factor
Area 4	.20	0.937
Area 8	.80	1.000
Calibration Factor:		0.987

AV METAL VALUES

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

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

AV PRICING VALUES

The URRT requires the calculation of an AV Pricing Value for each plan based on a comparison to a fixed reference plan. Our fixed reference plan is a 100% coverage plan with dependents through age 25.

The AV pricing values are developed using industry standard data from a national consulting firm.

MEMBERSHIP PROJECTIONS

We used several avenues to gather intelligence to develop the membership projections:

- Analysis of the existing market to identify areas of opportunity
- Survey data provided by the Department of Financial Services
- Actual sales to date

Using the above, we are projecting the following Silver CSR membership:

Silver CSR Level	Membership
200 -250% FPL	272
150-200% FPL	744
100-150% FPL	219

TERMINATED PRODUCTS

Not applicable.

WARNING ALERTS

UNIFIED RATE REVIEW TEMPLATE

Not Applicable.

ACTUARIAL CERTIFICATION

I, [redacted] am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification.

I certify that to the best of my knowledge:

- The submission is in compliance with all applicable laws and regulations of the State of New York
- The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

  ASOP No. 5, Incurred Health and Disability Claims

  ASOP No. 8, Regulatory Filings for Health Plan Entities

  ASOP No. 12, Risk Classification

  ASOP No. 23, Data Quality

  ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

  ASOP No. 41, Actuarial Communications

- The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York
- The benefits are reasonable in relation to the premium charged
- The rates are not unfairly discriminatory
- The projected index rate is:

  In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1))

  Developed in compliance with the applicable Actuarial Standards of Practice

  Reasonable in relation to the benefits provided and the population anticipated to be covered

  Neither excess nor deficient

- The index rate was generated at each plan level with only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)

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

- The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all non-standard plans. The State of New York provided the AV Metal Values for the standard plans.

The Part 1 Unified Rate Review Template and Exhibit 18 do not demonstrate the process used by NS-LIJ to develop the rates presented in this actuarial memorandum. Rather they represent information required by Federal and State regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the index rate is developed in accordance with Federal and State regulation and used consistently and only adjusted by the allowable modifiers.

Signed:

[redacted]

Name: [redacted]

Title: [redacted]

Date: June 10, 2014

Attachment A

North Shore-LIJ CareConnect Insurance Company, Inc.

2015 Individual Exchange Plans Rating Manual

2015 Premium Rates

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual

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North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual On-Exchange Plans Rating Manual
Premium Rates Effective January 1, 2015
New York City Area (Region 4)

Product Description	Form Number	Premium Per Contract				
		Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only
Base Plans						
Standard Platinum						
Base Plan	NSLIJIE/NSLIJP	$523.00	$1,046.00	$889.00	$1,491.00	
Child Only Plan	NSLIJCOE/NSLIJP					$215.00
Standard Gold						
Base Plan	NSLIJIE/NSLIJG	$455.00	$910.00	$774.00	$1,297.00	
Child Only Plan	NSLIJCOE/NSLIJG					$187.00
Standard Silver						
Base Plan	NSLIJIE/NSLIJS	$402.00	$804.00	$683.00	$1,146.00	
Child Only Plan	NSLIJCOE/NSLIJS					$166.00
Standard Bronze						
Base Plan	NSLIJIE/NSLIJB	$319.00	$638.00	$542.00	$909.00	
Child Only Plan	NSLIJCOE/NSLIJB					$131.00
Catastrophic Coverage						
Base Plan	NSLIJIE/NSLIJC	$175.00	$350.00	$298.00	$499.00	
Silver-CSR						
200-250% FPL	NSLIJIE/NSLIJS200-250	$402.00	$804.00	$683.00	$1,146.00	
150-200% FPL	NSLIJIE/NSLIJS150-200	$402.00	$804.00	$683.00	$1,146.00	
100-150% FPL	NSLIJIE/NSLIJS100-150	$402.00	$804.00	$683.00	$1,146.00	
200-250% FPL Child Only	NSLIJCOE/NSLIJS200-250					$166.00
150-200% FPL Child Only	NSLIJCOE/NSLIJS150-200					$166.00
100-150% FPL Child Only	NSLIJCOE/NSLIJS100-150					$166.00
Indian CSR						
Base Plan	NSLIJIE/NSLIJI	$402.00	$804.00	$683.00	$1,146.00	
Child Only Plan	NSLIJCOE/NSLIJI					$166.00
Riders						
Dependent Age 29 - (Platinum)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$8.00	
Dependent Age 29 - (Gold)	NSLIJIE/NSLIJR29	$4.00	$8.00	$6.00	$11.00	
Dependent Age 29 - (Silver)	NSLIJIE/NSLIJR29	$3.00	$6.00	$6.00	$8.00	
Dependent Age 29 - (Bronze)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$9.00	

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual On-Exchange Plans Rating Manual
Premium Rates Effective January 1, 2015
Long Island Area (Region 8)

Product Description	Form Number	Premium Per Contract				
		Single	Single + Spouse	Single + Child(ren)	Single + Spouse + Child(ren)	Child Only
Base Plans						
Standard Platinum						
Base Plan	NSLIJIE/NSLIJP	$558.00	$1,116.00	$949.00	$1,590.00	
Child Only Plan	NSLIJCOE/NSLIJP					$230.00
Standard Gold						
Base Plan	NSLIJIE/NSLIJG	$486.00	$972.00	$826.00	$1,385.00	
Child Only Plan	NSLIJCOE/NSLIJG					$200.00
Standard Silver						
Base Plan	NSLIJIE/NSLIJS	$429.00	$858.00	$729.00	$1,223.00	
Child Only Plan	NSLIJCOE/NSLIJS					$177.00
Standard Bronze						
Base Plan	NSLIJIE/NSLIJB	$341.00	$682.00	$580.00	$972.00	
Child Only Plan	NSLIJCOE/NSLIJB					$140.00
Catastrophic Coverage						
Base Plan	NSLIJIE/NSLIJC	$187.00	$374.00	$318.00	$533.00	
Silver-CSR						
200-250% FPL	NSLIJIE/NSLIJS200-250	$429.00	$858.00	$729.00	$1,223.00	
150-200% FPL	NSLIJIE/NSLIJS150-200	$429.00	$858.00	$729.00	$1,223.00	
100-150% FPL	NSLIJIE/NSLIJS100-150	$429.00	$858.00	$729.00	$1,223.00	
200-250% FPL Child Only	NSLIJCOE/NSLIJS200-250					$177.00
150-200% FPL Child Only	NSLIJCOE/NSLIJS150-200					$177.00
100-150% FPL Child Only	NSLIJCOE/NSLIJS100-150					$177.00
Indian CSR						
Base Plan	NSLIJIE/NSLIJI	$429.00	$858.00	$729.00	$1,223.00	
Child Only Plan	NSLIJCOE/NSLIJI					$177.00
Riders						
Dependent Age 29 - (Platinum)	NSLIJIE/NSLIJR29	$4.00	$8.00	$6.00	$12.00	
Dependent Age 29 - (Gold)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$9.00	
Dependent Age 29 - (Silver)	NSLIJIE/NSLIJR29	$3.00	$6.00	$5.00	$8.00	
Dependent Age 29 - (Bronze)	NSLIJIE/NSLIJR29	$2.00	$4.00	$3.00	$6.00	

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Composition of Rating Regions

Region 4 (New York City Area)

Queens
Richmond
New York
Bronx
Kings
Westchester

Region 8 (Long Island Area)

Nassau
Suffolk

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual On-Exchange Plans Rating Manual
Benefit Design Description Grid

Form Number	NSLIJIE / NSLIJP	NSLIJIE / NSLIJG	NSLIJIE / NSLIJS	NSLIJIE / NSLIJS200-250	NSLIJIE / NSLIJS150-200	NSLIJIE / NSLIJS100-150	NSLIJIE / NSLIJB	NSLIJIE / NSLIJC	NSLIJIE / NSLIJI
				Silver - CSR Versions					Indian CSR Zero cost sharing variation
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Catastrophic	Less than or equal to 300% FPL
DEDUCTIBLE (single)	$0	$600	$2,000	$1,200	$250	$0	$3,000	$6,600	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,000	$5,500	$5,200	$2,000	$1,000	$6,350	$6,600	$0
COST SHARING - MEDICAL SERVICES									
Inpatient Facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	50% cost sharing	0% cost sharing	0% cost sharing
	The following applies to the Platinum, Gold, Silver and Silver-CSR Plans: For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery copay which is the same as the surgeon copay if this copay has not already been collected as part of another maternity related claim. There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc. For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn. # The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.								
Outpatient Facility-Surgery, including freestanding surgicenters	$100	$100	$100	$100	$75	$25	50% cost sharing	0% cost sharing	0% cost sharing
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$100	$100	$75	$25	50% cost sharing	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".								
PCP	$15	$25	$30	$30	$15	$10	50% cost sharing	0% cost sharing	0% cost sharing
Specialist	$35	$40	$50	$50	$35	$20	50% cost sharing	0% cost sharing	0% cost sharing
PT/OT/ST - rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	50% cost sharing	0% cost sharing	0% cost sharing
ER	$100	$150	$150	$150	$75	$50	50% cost sharing	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	50% cost sharing	0% cost sharing	0% cost sharing
Urgent Care	$55	$60	$70	$70	$50	$30	50% cost sharing	0% cost sharing	0% cost sharing
DME/Medical supplies	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Eyewear	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing

Form Number	NSLIJIE / NSLIJP	NSLIJIE / NSLIJG	NSLIJIE / NSLIJS	NSLIJIE / NSLIJS200-250	NSLIJIE / NSLIJS150-200	NSLIJIE / NSLIJS100-150	NSLIJIE / NSLIJB	NSLIJIE / NSLIJC	NSLIJIE / NSLIJI
				Silver - CSR Versions					Indian CSR Zero cost sharing variation
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Catastrophic	Less than or equal to 300% FPL
INPATIENT HOSPITAL SERVICES									
Observation stay	ER copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Hospital services - non-maternity	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and well newborn combined)	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Detoxification	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility						50% cost sharing	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility						50% cost sharing	0% cost sharing	0% cost sharing
EMERGENCY MEDICAL SERVICES									
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay) directly from the emergency room						50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Emergency Room visit	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Facility charge - Freestanding urgent care center	Urgent Care copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Free standing urgent care center visit	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case						50% cost sharing	0% cost sharing	0% cost sharing
OUTPATIENT HOSPITAL/FACILITY SERVICES									
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Pre-admission/pre-operative testing	$0 copay						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay						50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
PREVENTIVE & PRIMARY CARE SERVICES									
Allergy testing	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services in this benefit service category.								
Bone density testing									
Cervical cytology									
Colonoscopy screening									
Gynecological exams	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Immunizations									
Mammography									
Prenatal maternity care									
Prostate cancer screening									
Routine exams									
Women's preventive health services									

Form Number	NSLIJIE / NSLIJP	NSLIJIE / NSLIJG	NSLIJIE / NSLIJS	NSLIJIE / NSLIJS200-250	NSLIJIE / NSLIJS150-200	NSLIJIE / NSLIJS100-150	NSLIJIE / NSLIJB	NSLIJIE / NSLIJC	NSLIJIE / NSLIJI
				Silver - CSR Versions					Indian CSR Zero cost sharing variation
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Catastrophic	Less than or equal to 300% FPL
PHYSICIAN/PROFESSIONAL SERVICES									
Inpatient hospital surgery - surgeon	Surgeon copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Second medical opinion for cancer	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)						50% cost sharing	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
ADDITIONAL BENEFITS/SERVICES									
ABA treatment for Autism Specturm Disorder	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per device						50% cost sharing	0% cost sharing	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30 days supply						50% cost sharing	0% cost sharing	0% cost sharing
Diabetic education and self-management	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.								
PEDIATRIC DENTAL SERVICES									
Dental office visit	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
PEDIATRIC VISION SERVICES									
Eye exam visit	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames						50% cost sharing	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
PRESCRIPTION DRUGS									
Generic or Tier 1	$10	$10	$10	$10	$9	$6	$10	0% cost sharing	0% cost sharing
Formulary Brand or Tier 2	$30	$35	$35	$35	$20	$15	$35	0% cost sharing	0% cost sharing
Non-Formulary Brand or Tier 3	$60	$70	$70	$70	$40	$30	$70	0% cost sharing	0% cost sharing
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply									

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Description of Revised Rating Classes, Factors, and Discounts

Not applicable.

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Examples of Rate Calculations

Not applicable.

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Commission Schedule

Broker	2.0% of premium
General Agents	1.0% of premium

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Underwriting Guidelines

Not applicable.

North Shore-LIJ CareConnect Insurance Company, Inc.
2015 Individual Exchange Plans Rating Manual
Expected Loss Ratio

Product Description	Form Number	Expected Loss Ratio
Platinum	NSLIJGE/NSLIJP	83%
Gold	NSLIJGE/NSLIJG	83%
Silver	NSLIJGE/NSLIJS	83%
Bronze	NSLIJGE/NSLIJB	82%
Catastrophic	NSLIJGE/NSLIJB	82%

Attachment B

Quality Improvement Program Description 2015

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North Shore-LIJ CareConnect Overview

Background:

North Shore - LIJCareConnect Insurance Company, Inc. ("CareConnect") is a health insurer that covers members in the state of New York. CareConnect has been licensed by the New York State Department of Financial Services to write accident and health business since January 1, 2014.

Vision Statements

CareConnect's focus is to improve the health and quality of life of Members we serve by designing, implementing and managing a health insurance program that ensures access to and consistent delivery of the highest quality health care services and support.

We are committed to giving our Members access to an established integrated, multi-disciplinary healthcare network

In connection with quality our vision is:

- To empower our Members to live healthy lives, self-manage their chronic diseases, and work in partnership within a comprehensive, structured health system where there is no fear, stigma, or barrier to adequate and appropriate services to maintain optimal quality of life.

- To be the premier healthcare insurance organization in the eyes of our Members, providers, and customers.

- To be the plan of choice for members seeking a health insurance company that is attentive and sensitive to their needs.

- To be an effective partner with providers in serving their patients.

Strategic Overview

CareConnect strives to continuously improve the care and service provided by CareConnect and by our health care delivery system. CareConnect's Quality Improvement Program (QIP) establishes the standards that encompass all quality improvement activities.
Three pillars that support our success in this endeavor are:

1. Clinical quality and excellence
2. Access and affordability
3. Customer service and operational excellence

These pillars are achieved by:

A. Promoting and incorporating quality into CareConnect's organizational structure and processes by:

   1. Facilitating a partnership between Members, providers, and State agencies for the continuous improvement of quality health care delivery;

   2. Clearly defining roles, responsibilities and accountability for the quality program;

   3. Continuously improving communication and education in support of these efforts; and

   4. Considering and facilitating achievement of public health goals in the areas of health promotion and early detection and treatment.

B. Providing effective monitoring and evaluation of patient care and services to ensure that care provided by the CareConnect delivery system meets the requirements of standard medical practice, meets the linguistic and cultural needs of the membership, is administered in the most appropriate setting and is perceived positively by CareConnect Members and health care professionals by:

   1. Evaluating and disseminating clinical and preventive practice guidelines;

   2. Monitoring provider performance against established evidence-based medicine;

   3. Developing guidelines for quality improvement activities (e.g. access and availability, peer review, etc.);

   4. Surveying CareConnect Members' and providers' experience with the quality of care and services provided;

   5. Conducting and analyzing data such as Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Health Providers & Systems (CAHPS®), and Quality Assurance Reporting Requirements (QARR); and developing programs to improve satisfaction and preventive services as identified. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). QARR refers to New York State-specific measures.

   6. Collecting and analyzing data for population specific Quality Improvement (QI) projects;

   7. Developing, defining and maintaining data systems to support quality improvement activities and encourage data-driven decision-making;

   8. Providing culturally proficient care and services in the most appropriate setting; and

9. Providing disease management programs that improve the quality of life for chronically ill members.

C. Ensuring prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up by:

1. Identifying, tracking and monitoring important aspects of care and service, quality indicators, critical incidents, abuse, and concerns about health care services provided to members;

2. Implementing and conducting a comprehensive QIP;

3. Recognizing that opportunities for improvement are unlimited;

4. Providing ongoing feedback to CareConnect Members and providers regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities; and

5. Supporting re-measurement of effectiveness and continued development and implementation of improvement interventions.

D. Coordinating of quality improvement, risk management and patient safety activities by.

1. Aggregating and using data to develop quality improvement activities;

2. Providing a regular means by which risk management and patient safety are included in the development of quality improvement initiatives;

3. Identifying, developing and monitoring key aspects of patient safety; and

4. Evaluating the consistency of the implementation of CareConnect's decision-making system through inter-rater reliability.

E. Maintaining compliance with local, state and federal regulatory requirements and accreditation standards by:

1. Monitoring compliance with regulatory requirements for quality, improvement and risk management opportunities and respond as needed;

2. Ensuring that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies;

3. Monitoring performance and compliance;

4. Achieving required performance standards established by CareConnect for each measure based on the rate calculated by CareConnect. Developing an improvement

action plan for each measure not meeting the required performance standards to bring performance up to at least the minimum level established by CareConnect; and

5. Evaluating the consistency of the implementation of CareConnect's decision-making system through inter-rater reliability.

Medical Management Scope

Under the direction of the Chief Medical Officer ("CMO"), the Quality Improvement ("QI") and Medical Management ("MM") Departments coordinate and facilitate ongoing monitoring and improvement of CareConnect activities. Using an integrated approach throughout the company and the provider network, quality management monitoring and evaluation processes, improvement action plans are coordinated and implemented as part of the business plan whenever opportunities for improvement are identified.

Quality Management Summary

In order to fulfill the goals and objectives of the QIP, CareConnect has integrated quality improvement activities into all CareConnect functional areas. These include, but are not limited to, the following functional areas and departments:

- Medical Management, including UM, Care Management (Care Coordination)
- Operations, including member and provider relations
- Network Management
- Compliance
- Customer Service Center
- Appeals and Grievance Services
- Claims
- Preventive Health Services
- Delegation Oversight

Health promotion and health management activities are integral parts of the QIP. Specific attention is given to high volume, high risk areas of care and services for the populations served by CareConnect.

Monitoring and improvement actions undertaken based on the QIP are described in detail in Quality Improvement Program Section of this program description and in the work plan.

Utilization and Care Management Summary

The MM Plan describes and guides implementation of CareConnect's utilization management program, which integrates utilization functions—prior authorization, case management, disease specific management services, coordination of care, appeals and grievances, behavioral health, medical claims review, and processes for monitoring, evaluating, and improving these areas — under the direction of the CMO.

The MM Program Description and UM Evaluation are reviewed and approved annually by the Medical Management Committee (MMC), and accepted by the Quality Improvement Committee (QIC). The QIC coordinates with MM and Care Management (CM) activities. The MM Program Description documents the methodology used to assess the degree of conformance to standards, practices, and activities designed to continuously improve quality service and care, with involvement of multiple organizational components and committees. The MM Program is

designed to assess complex delivery systems and customer experience while optimizing health outcomes and managing costs. Incorporating the continuous quality improvement concept (CQI), the MM Program is comprehensive and integrated throughout the company and practitioner and provider network.

Monitoring and improvement actions undertaken based on the MM Program are described in detail in the MM Work Plan.

CareConnect is guided in its CM Program development by a desire to optimize the health and well-being of members with complex health issues or at high risk for adverse medical outcomes. To accomplish this, CareConnect, in close collaboration with the North Shore-LIJ Health System, is working to further develop a comprehensive CM Program that is person-centered and facilitates collaboration between members and their health care team as well as to promote self-management, active decision-making, and participation in health care interventions and outcomes.

CareConnect's CM philosophy is:

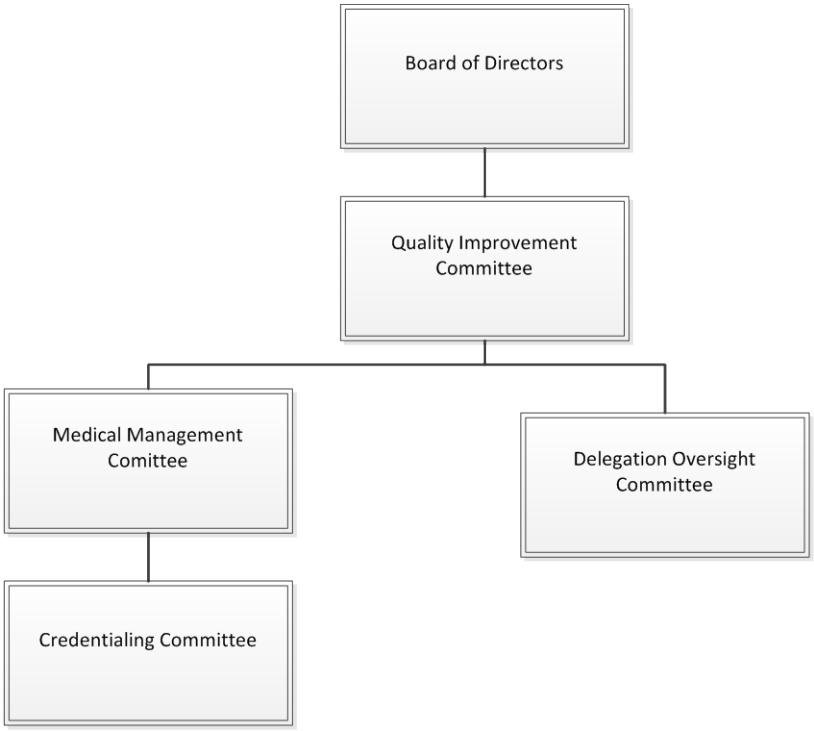
- Person-centric
- Offers comprehensive solutions
- Engages the health care team
- Measures, reports, and analyzes outcomes
- Improves quality
- Promotes cost efficiencies

Specifically, CareConnect's CM programs focus on Members with the following medical conditions based on the needs of the enrolled Members and contractual requirements:

- Asthma
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic Kidney Disease/End Stage Renal Disease (CKD/ESRD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- High Risk Pregnancy & NICU
- Hypertension
- Human Immunodeficiency Virus (HIV)

Program Accountability and Oversight

Quality Improvement Committee Structure



CareConnect Committee Descriptions

Board of Directors

The Board of Directors (BOD) is the governing body of CareConnect and has overall responsibility to ensure that timely and high quality services are provided to members. The BOD shall approve the QIP, and will meet on a quarterly basis to oversee the QIP responsibilities, or more frequently if problems have been identified. The BOD has delegated the responsibility to direct, oversee and monitor the QIP to the Quality Improvement Committee (QIC).

The BOD functions as they relate to the quality improvement program include:

- Annually reviews and approves the QIP Description, QI Work Plan, Annual QI Evaluation and other reports and information as required or requested.

- Provides feedback and recommendations to the QIC related to summary reports, documents and any issues of concern.

- Demonstrates a senior level commitment to quality and to CareConnect's QIP, including resource allocation.

The membership of the BOD is composed of CareConnect leadership and other designees as identified by the Chair. The BOD meets at least quarterly.

Quality Improvement Committee

The BOD has delegated responsibility for the oversight of the health plan's quality improvement activities to the QIC. The QIC is the decision-making body that is ultimately responsible for overseeing and assuring the quality, safety, appropriateness, and cost effectiveness of the clinical care and services provided to CareConnect members on a daily basis. The QIC's primary focus is the coordination and integration of all quality improvement and utilization management activities for CareConnect.

The QIC also objectively and systematically monitors and evaluates the appropriateness of clinical and non-clinical Member care and services. The QIC examines the components of its service and delivery system through the continuous process of monitoring and evaluation, identify opportunities for improvement and recommend changes to effect those improvements.

The responsibilities of the QIC are:

- Provide program direction and continuous oversight of quality improvement activities as related to the unique needs of the Members and providers in the areas of clinical care, service, patient safety, administrative processes, and compliance.

- Identify actions to improve quality and prioritize them based on the analysis and significance of the QI activity
- Formally evaluate, at least annually, the imMMCt and effectiveness of specific Performance Improvement Projects (PIPs) and recommend changes as necessary.
- Regularly review, prioritize and align the Annual QI Work Plan with strategic objectives of the organization.
- Oversee and accept the annual MM Program Description, MM Work Plan and MM Annual Evaluation for the MM Program of the health plan.
- Review and approve benchmarks, performance goals and standards for quality activities.
- Analyze and evaluate the QIP annually and assess the overall effectiveness of the program. Recommend policy decisions based on this evaluation.
- Annually, submit the QIP Description, QI Work Plan and QI Evaluation of the QIP to the BOD for review and approval.
- Report annually or more frequently as needed to the BOD, on the following health plan quality activities monitored by the QIC:
    - Annual HEDIS®, CAHPS®, and QARR results as well as other clinical metrics and action plans to improve results.
    - Medical management metrics and activities
    - Member complaints, appeals and grievances and results of member satisfaction surveys as well as any action plans to address identified opportunities and improve performance.
    - Network access and availability and results of performance review against standards.
    - Delegation oversight activities
- Review summary reports on mortality, serious adverse events, quality of care, and quality of service to identify trends and recommend corrective actions as needed.
- Monitor, evaluate and implement improvement plans for access and availability of network providers.
- Monitor and evaluate the cultural and linguistic needs of CareConnect's membership and identify opportunities to improve.
- Review reports and recommendations from CareConnect committees, act upon recommendations as appropriate and provide feedback, follow-up and direction to the committees.
- Recommend, monitor and assure barrier analysis and follow up of quality activities.
- Incorporate findings from the quality improvement activities into strategic program and resource planning. Adjust programs to address identified needs.
- Ensure practitioner participation in clinical aspects of the QIP, through the MM Committee(, including advising on clinical and practitioner issues
- Ensure compliance with regulatory requirements and accrediting organizations.
- Review peer review decisions concerning credentialing and clinical quality of care.
- Recommend appropriate resources in support of prioritized activities.

The QIC membership includes:

- Plan President (Chair)

- Chief Medical Officer (CMO)
- QI Director
- Medical Director
- Chief Operations Officer
- Network Director
- Behavioral Health Director
- Pharmacy Director
- Compliance Officer
- Legal Representative
- External providers who represent a range of healthcare services used by participants in CareConnect's population (e.g., physicians, psychologists, pharmacists, hospital CMOs, and providers) as designated by Chair
- Other representation as identified by the Chair

The QIC is chaired by the President who may designate the CareConnect CMO as Chair. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. The QIC meets at least quarterly and reports to the Board of Directors on a quarterly basis. The QIC chair can convene an ad hoc quality sub-committee to address quality activities on an as needed basis.

Medical Management Committee (MMC)

The Medical Management Committee (MMC) is responsible for overseeing the development, implementation and evaluation of the MM Program for all entities within the program's scope as guided by the medical policies of CareConnect and outlined in the MM Program Description. The MMC monitors all clinical quality improvement and utilization management activities within CareConnect. In addition, the MMC is responsible for overseeing the coordination of behavioral and medical health services, providing clinical oversight for the development and maintenance of CPGs, the Preferred Drug List (PDL) and Clinical Pharmacotherapy policies to promote the use of appropriate drug therapy based upon clinical evidence.

The responsibilities of the MMC are to:

- Evaluate, review and approve the UM Program Description, UM Work Plan and UM Program Evaluation at least annually.
- Oversee implementation of the UM Program and work plans.
- Review and approve appropriate MM and CM Policies and Procedures at least annually to assure they reflect current standards of medical practices.
- Review and approve performance metrics from all clinical areas, including behavioral health services. Monitor progress on clinical performance improvement programs.
- Evaluate the consistency of the UM decision making process through inter-rater reliability reports. Recommend improvement actions as indicated.
- Analyze, design, and implement interventions as related to continuity and coordination of medical and behavioral care

- Monitor and evaluate, at least annually, the efficiency and effectiveness of processes through analysis and review of under and over utilization and satisfaction with the UM processes, and recommend corrective actions as indicated.
- Reviews quarterly reports and performance metrics from all areas serving members and providers, including:
    - Customer service – member/provider
    - Network management
    - Grievance/appeals
    - Utilization Management
    - CM & Disease (Condition Management) and other health services functions
    - Behavioral Health
    - Pharmacy
- Evaluate, review, and approve the Preferred Drug List (PDL) and Clinical Pharmacotherapy policies at least annually.
- Conduct assessments of the evidence supporting new and emerging technologies as well as new indications for existing technologies and develop, review, and approve evidence-based position statements on selected medical technologies.
- Develop, review and approve CPGs for company-wide implementation.
- Ensure that clinical decisions about the safety and efficacy of medical care are consistent across all products and lines of business.
- Develop, implement, and evaluate the UM Program training and process improvement activities.
- Maintain approved records of all committee meetings.
- Provide feedback and recommendations to the UM Process.
  Promote compliance with regulatory and accreditation requirements, including oversight of corrective actions, as applicable.
- Review member and practitioner experience results and ongoing improvement activities
- Monitor trends related to member and provider call center activities as well as complaints, grievance and appeals
- Monitor the quality, access and availability of network providers
- Review, approve and monitor service-related Performance Improvement Projects (PIPs) and timeframe)
- Review CareConnect's service-related operational policies and procedures
- Accept the Credentialing plan annually, and ensure compliance with the contractual, regulatory, and accreditation requirements
- Oversee delegation of credentialing functions to external entities and monitoring of improvement action plans (IAP)
- Provide a summary report to the QIC at least 4 times per year.

The MMC membership includes:

- Chief Medical Officer
- Chief Operating Officer
- Division Director Health Services and QI

- Quality Representative
- Behavioral Health Director
- Pharmacy Director
- Legal Representative
- Chief Compliance Officer
- Provider Network Representative
- Customer Service Representative
- Member Services Representative
- Claims Representative
- A&G Representative
- Ad hoc CareConnect staff by invitation of Chair to lend subject matter expertise

The MMC meets at least 4 times per year and is chaired by the Chief Medical Officer (CMO). A minimum of 51% of committee membership constitutes a quorum. The MMC reports at least 4 times per year to the QIC. Cross reporting to the MMC is made as appropriate for peer review and other matters.

Delegation Oversight Committee (DOC)

The Delegation Oversight Committee (DOC) is an interdisciplinary committee that provides oversight of healthcare contracts and selected non-healthcare contracts. The DOC has specific focus on the qualifications and performance of delegates, the performance of internal contracting procedures, and compliance with legal and regulatory requirements in the contracting process.

Responsibilities of the DOC include:

- Ensuring that appropriate and necessary policies are developed, implemented and reviewed on an annual basis, including a re-delegation policy

- Conduct regular meetings as a forum for the following activities:

    - Review and evaluation of delegate/vendor reports to measure performance and identify opportunities for improvement

    - Use of data to provide guidance on how delegates and vendors can improve their performance

    - Discussion and assistance in finding resolution to new, ongoing, and outstanding delegate/vendor issues

    - Review and evaluation of delegate/vendor annual audit findings

    - Monitoring of Improvement Action Plans (IAP) that are initiated by the delegate/vendor or imposed by CareConnect.

The DOC is chaired by the Chief Operating Officer. The DOC includes, but is not limited to:

- Chief Operating Officer
- Chief Financial Officer
- Chief Medical Officer
- Division Director of QI & Health Services
- Legal Representation
- Ad hoc CareConnect staff by invitation of Chair to lend subject matter expertise

The DOC meets at least quarterly. The DOC reports quarterly to the Quality Improvement Committee (QIC). Quarterly reports will include information highlighting all DOC activities for QIC review and acceptance.

A minimum of 51% of committee membership constitutes a quorum. All members are voting members.

Credentialing Sub-committee

The Credentialing Sub-committee's primary focus is to perform oversight of all delegated entities performing credentialing and re-credentialing functions on behalf of CareConnect. The Credentialing Sub-committee reports directly to the MM Committee.

Responsibilities of the Credentialing Sub-committee include:

- Review all proposed delegations and make recommendations on the appropriate action.
- Review, evaluate, and approve credentialing plan and all related policies and procedures on an annual basis.
- Receive and evaluate credentialing reports on a regular basis.
- Review and make final recommendations of approval or denial of delegation pre-assessments
- Conduct annual on-site audits
- Determine acceptance or denial of delegates to a given network

The Credentialing Sub-committee's membership includes:

- Chief Medical Officer
- Medical Director
- Quality Improvement Director
- Behavioral Health Director
- Pharmacy Director
- Legal/Compliance Representative

- Network primary care and subspecialty physicians who represent the type of care and services provided for CareConnect members.
- Other CareConnect representatives, as appropriate, from time to time as determined by the Chair

The Credentialing Sub-committee meets at minimum on a quarterly basis and more often as needed. The Credentialing Sub-committee reports up to the MMC which acts as a senior level body that monitors the integrity of the delegated credentialing processes of CareConnect.

The Credentialing Sub-committee's activities and meeting minutes are presented to the MMC. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. Members may not designate surrogate attendees. Minutes are created contemporaneously and are forwarded to the MMC at least on a quarterly basis.

Committee Quorum

A quorum, as outlined by the individual Committee charters, is required for all meetings. If not stated, a majority of members present constitutes a quorum.

Committee Minutes

Minutes are recorded at all quality committee meetings using a standardized format including topic, discussion, recommendations, and follow-up. The meeting secretary will be assigned by the Chair. Follow-up items will become topics for the next committee meeting. All minutes are maintained in a confidential manner. The appropriate Chairperson reviews the minutes for accuracy and completeness. The Chairperson signs and dates the minutes.

Robert's Rules of Order

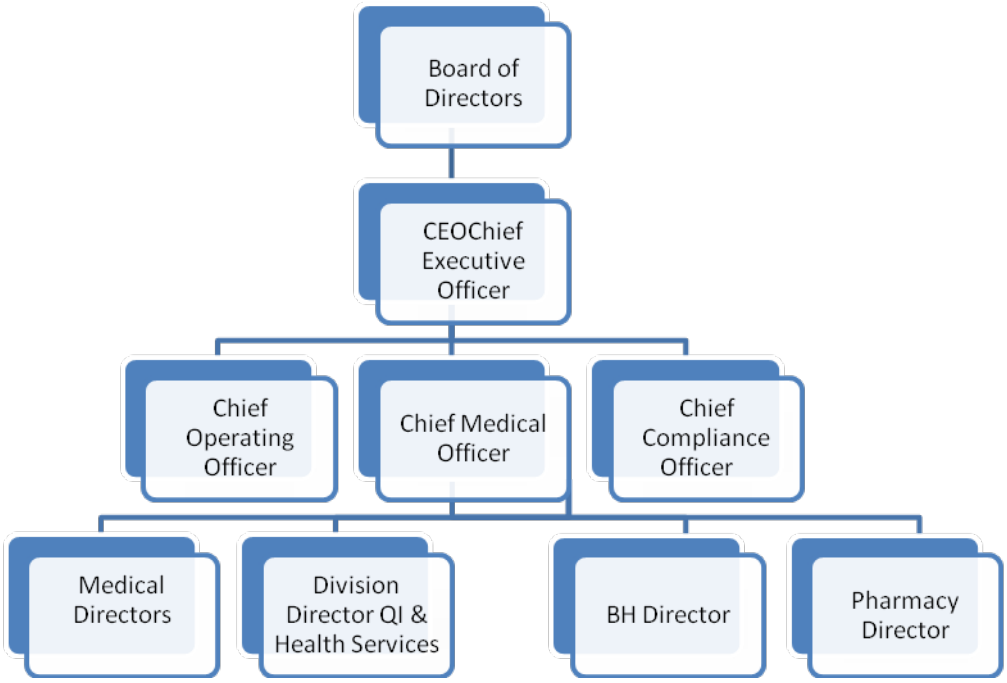
All Committees are conducted according to Robert's Rules of Order as modified by CareConnect.

Quality Improvement Program

Organizational Structure

The Board of Directors has ultimate responsibility for the QIP and related processes and activities. The Board of Directors has delegated to the QIC responsibility for ensuring the quality improvement processes outlined in this plan are implemented and monitored.

Below is an organizational chart depicting key staff of the health plan related to the QIP, followed by brief descriptions of select senior level and QI positions.



CEO

The Chief Executive Officer (CEO) is responsible for oversight of the implementation of the QIP. The CEO or designee chairs the QIC. The CEO is responsible for monitoring the quality of care and service CareConnect provides, and ensures the appropriate level of resources is available for the QIP. The CEO also makes certain that fiscal and administrative management decisions do not compromise the quality of care and service CareConnect provides to members.

Chief Medical Officer

The Chief Medical Officer (CMO) is a New York licensed physician who is responsible for implementation of the QIP. The CMO reports to the CEO and provides the medical direction for CareConnect staff. The CMO chairs the QIC. The CMO participates in the credentialing and re-credentialing process for CareConnect and coordinates review with the MMC. The CMO oversees and implements activities to measure health services efficacy. The CMO, in

collaboration with legal and network management, is responsible for the immediate decision and resolution of all situations involving the potential of imminent harm.

Behavioral Health Director

The Behavioral Health Director is responsible for the oversight of the Behavioral Health (BH) program and participates in various QI committee activities.

Division Director of QI & Health Services

The Division Director of QI & Health Services is responsible for oversight of the implementation of the QIP, including monitoring the quality of care and service complaints and, provides the evaluation of quality improvement initiatives involving member and provider outreach. The Division Director of QI & Health Services is also responsible for oversight of activities designed to increase performance on clinical quality measures, preparation of the annual QIP documents, oversight of submissions of quality regulatory reports, oversight responsibility for implementation of quality improvement studies and patient safety initiatives, oversight of Appeals and Grievances, oversight of delegated vendors and manages CareConnect QI infrastructure.

The Division Director of QI & Health Services is a point of contact for regulatory inquiries and works with the Compliance Officer to assure compliance with regulatory and accreditation standards. The Division Director of QI & Health Services consults with Quality Management staff who are subject matter experts in program design and statistics and with other business units as needed. Other business units that support quality improvement and reporting include Information Technology, Compliance, and Finance. The Division Director of QI & Health Services reports to the CMO to ensure that fiscal and administrative management decisions do not compromise the quality of care and service CareConnect provides to members.

Quality Improvement Program Activities

Integration is a key component of successful quality improvement. Departments involved in quality improvement activities are integrated with one another through coordinated referral systems for quality/risk/utilization issues, case management, member/practitioner complaints, and grievances, an integrated computer information system that is accessible to all areas, and cooperative problem-solving practices. As the central area for receiving potential quality/risk management issues and coordination of quality improvement activity, the QI Department acts as a critical interface between members, members' representatives, practitioners, providers, state and federal regulators, as well as other various departments. Information received by QI is reviewed and investigated and coordinated as necessary with Case Management, Prior Authorization, Behavioral Health, and other departments (such as Network Management, Member Service, Appeals and Claims Disputes, Claims, or Finance).

The QIP uses a variety of mechanisms to continuously measure, evaluate and improve the services provided to health plan members. All are founded on Continuous Quality Improvement (CQI) principles which focus on implementing the PDSA (plan, do, study and act) cycle as a

means to meet or exceed the minimum performance standards established by CareConnect and regulators. The following activities are included in reviews that reflect important aspects of care and service.

Clinical and Preventive Care Guidelines

Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating providers. CareConnect adopts pediatric, adolescent, adult and maternal preventive health and clinical practice guidelines that are reviewed at least annually and approved by the MMC. The MMC evaluates guidelines from the most current and reasonable medical evidence available, including but not limited to, the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and specialty organizations. CareConnect measures population-based performance against preventive health and clinical guidelines annually, primarily through HEDIS®, CAHPS®, and QARR measurement. CareConnect adopts MMC approved guidelines through the QIC.

Preventive health and clinical practice guidelines are available on-line to both members and providers. To encourage the use of appropriate preventive care, CareConnect promotes member focused educational and outreach programs. These programs identify at-risk members and involve members and/or member representatives and their health care providers in the decision-making process.

Complaints/Grievances

Member complaints/grievances are expressions of dissatisfaction with any aspect of care or service provided by the health plan and/or subcontracted provider, excluding appeals and other actions such as service denials, claims and billing issues. Allegations of a violation of member's rights are included in complaint/grievance investigations. Member complaints/grievances are tracked and trended through the QI program to:

- Monitor effective and timely resolution of member concerns.
- Identify opportunities for improvement in the quality of care and service provided to members.

Complaints/grievances are classified using the following categories:

- Quality of Care
- Quality of Service
- Access
- Attitude and Service
- Billing and Financial Issues
- Quality of Practitioner Office Site

Complaints/grievances can be made on behalf of the member by their representative, as well as identified by any department, member, provider or regulatory agency. Member grievances are also identified through escalation by the Customer Service Department. The QI Department reviews member complaints/grievances, identifies potential quality of care and/or abuse issues

and facilitates the investigation and resolution process. Data for quality of care/service issues are collected, reviewed and trended to identify opportunities for improvement. Analysis of quality of care and service issues is presented to the MMC respectively, for review of aggregate trends and identification of actions for improvement.

- Designed to bring the providers into compliance with the practice guidelines.

Member Experience

Member experience is assessed through annual member experience surveys such as CAHPS®, as well as member complaint data. Member survey results are used to:

- Measure CareConnect performance.
- Establish benchmarks and monitor performance.
- Assess overall levels of satisfaction to determine if CareConnect is meeting member expectations.
- Assess service performance.

Complaint/grievance data are trended to identify potential opportunities for improvement. Action plans to address opportunities for improvement based on member experience results are reviewed and approved by the MMC.

Monitoring of Performance Indicators

Ongoing monitoring of performance indicators is designed to reveal trends and improvement opportunities in targeted populations. National standard indicators, (i.e. HEDIS®, QARR, and CAHPS®) are used to continuously measure plan performance. Results are used to identify current gaps in care or service and are integrated in quality improvement projects for the health plan.

Provider Accessibility and Availability Monitoring

Provider accessibility, and availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographic location of providers, number of providers, appointment availability, provision for emergency care, and after hours service are measured. The cultural, ethnic, racial, linguistic needs of its members are assessed on an ongoing basis and formally evaluated at least annually.

Monitoring activities include provider surveys, on-site visits, evaluation of member experience, evaluation of complaints, geo-access surveys and when applicable. Specific deficiencies are addressed with an improvement action plan, and follow-up activity is conducted to reassess compliance. Provider accessibility and availability activities are reported to and overseen by the MMC.

Provider Experience

Provider experience surveys are designed to:

- Assess which services are important to health plan providers.
- Determine provider satisfaction with CareConnect processes, including the medical management process.
- Assess satisfaction with continuity and coordination of care.

Provider experience surveys are conducted annually. The survey results are summarized and reviewed by the MMC to identify areas for improvement and develop action plans.

Performance Improvement Projects (PIPs)

Performance Improvement Projects (also known as Quality Improvement Projects) may be designed for the entire plan population or a targeted population or subgroup. PIPs are studies designed to include measurement of performance, interventions, improving performance and systematic and periodic follow-up on the effect of the interventions.

Performance Improvement indicators are objective, clearly defined, based on current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement. Results of evaluations and recommendations are reviewed and approved by the QIC. Current PIPs are defined in detail as part of CareConnect's annual QI Work Plan.

Patient Safety and Risk Management

CareConnect supports the prevention and elimination of healthcare errors by our commitment to the practice of Evidence-Based Medicine. This is accomplished through a variety of mechanisms, including but not limited to measurement tools and reporting metrics focusing on patient safety, evidence-based claims and prescription reports to identify adverse events, quality of care referrals and databases to identify, track, and address patient safety concerns. Annually, patient safety goals are developed and integrated into the overall QI Work Plan.

CareConnect's patient safety program is also supported through several initiated activities. CareConnect supports the Leapfrog Group's four pillars: transparency, standardized measures and practices, incentives and rewards, opportunity rate and external collaboration.

CareConnect is committed to providing quality care and service while preserving the financial integrity to continue our vision. Risk management is a coordinated, interdisciplinary process designed to identify, evaluate, and resolve actual and potential liability exposures. The risk management program includes coordination between CareConnect staff and corporate Legal counsel.

Cultural Competence and Awareness

It is important that CareConnect staff is aware of, and sensitive to, the cultural and demographic diversity of the CareConnect membership and of colleagues and stakeholders. Providing culturally competent care can potentially enhance the delivery of services and increase the likelihood of successful engagement with the member, and family/ caregivers. Being culturally competent and aware can include, but is not limited to:

- Becoming knowledgeable about the communication styles and linguistic needs of specific cultural and ethnic groups in order to enhance communication with enrollees and families,
- Seeking to recognize personal prejudices, biases, and assumptions concerning particular cultural and ethnic groups and working to correct these and to avoid allowing these characteristics to improve the delivery of services.
- Obtaining accurate information about patterns of utilization and typical attitudes about healthcare services and seeking to tailor service delivery to take into account such information.
- Seeking to obtain and understand data about incidence and prevalence of certain disease states or conditions within the various cultural and ethnic populations served by the plan.
- Seeking supervision and consultation to enhance service delivery when issues related to cultural and ethnic diversity of enrollees and families are identified.

CareConnect provides training for all employees on cultural competence and awareness, and employees are encouraged to seek opportunities for ongoing continuing education to enhance their ability to deliver services in the most culturally competent manner.

Preventive Care Program

The Preventive Care Program is an outreach program serving CareConnect enrollees. CareConnect provides preventive health and screening services for its members within its program benefits. Because of the demographics of the enrolled population, targeting these groups for preventive services has the potential to yield improvements for a large number of members.
CareConnect chooses preventive service indicators that reflect important aspects of care for our members -- indicators that are relevant to the enrolled population, are reflective of high volume services, encompass preventive and chronic care, and span a variety of delivery settings. Categories of indicators may include the following:

- Preventive (e.g. lead screening, immunizations, cervical cancer screening, breast cancer screening, and well- child visits).
- Chronic care (e.g. diabetes, cholesterol management, treatment of asthma).
- Access/ availability of care.

Preventive services are both population and condition based. Using multiple data sources, including but not limited to HEDIS® and QARR® and claims data, members are identified for outreach. Claims/encounter data are monitored on an ongoing basis to identify members in need

of services and to provide feedback to providers on individual performance as well as CareConnect performance.

Outreach is provided in both written and verbal form. On a routine basis, mailings are sent to members to provide education related to preventive care and/or screenings due. Verbal outreach can be provided through both automated telephone calls and direct-member outreach. In addition, on an annual basis, written information is mailed to members to encourage the utilization of physical exams and recommended screenings.

Educational information related to preventive care is also made available to members on CareConnect website. Communication with internal departments including case management, member services and provider services is ongoing to promote the Preventive Care program and to work collaboratively on individual cases when indicated.

Educational and member-specific information is submitted to providers on a routine basis to provide up-to-date screening guidelines and notification of screenings due among the assigned member panel. On-site visits to providers may also be conducted for focused education and/or medical record review.

CareConnect staff develops partnerships with Community and State agencies for health promotion on a community-wide scale. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members. Using state and/or national guidelines, as well as HEDIS® and QARR data, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

Utilization Management

The Utilization Management Program Description and Evaluation are reviewed by the MMC and approved by the QIC. Clinical criteria and technology assessments developed by CareConnect are reviewed and discussed by the MMC and with recommendation, approved by the QIC. Chronic conditions related to the populations demographic, health status and utilization of CareConnect members and epidemiologies are identified and programs are designed to assist members in managing these conditions. Additionally, any clinical issues identified during Health Services activities that relate to CareConnect's population are assessed and evaluated. Review activities include evaluation of continuity and coordination of care and patient safety.

Behavioral Health

CareConnect provides mental health and substance abuse services to members. CareConnect's Behavioral Health Director is involved in the implementation of the behavioral health aspects of the QI Program including quality improvement, utilization management, member rights and responsibilities. These activities include, but are not limited to, access and availability, practice

guideline development, continuity and coordination of care between medical and behavioral health care, over and underutilization, complaints, grievances/appeals, and triage/referral.

CareConnect's behavioral health program is built by utilizing a strategic yet robust network that will ensure access to integrated care and appropriate levels of care, based on the intensity of our member's need. This multi-disciplinary network of psychiatrists, psychologists, and social workers as well as our partnerships with community-based organizations helps our CareConnect clinical team ensure an individualized, member-centric care plan.

CareConnect's behavioral health program utilizes data in order to properly train providers as well as help engage members on prevention, promotion and improvement of health. Behavioral health services will continue to establish baseline utilization and health of our members and implement programs with targeted outcomes in order to improve health as well as member satisfaction.

Examples of strategic initiatives that are utilized to improve health outcomes:

- Assist with the coordination of ambulatory follow-up rates after an inpatient mental health admission
- Encourage the initiation and engagement in alcohol and substance abuse treatment once a member has been flagged with an identified issue
- Improve adherence in outpatient behavioral health treatment for major depression

Provider Profiling

Annual PCP utilization and quality profiles are designed by the quality improvement department. Profiles summarize utilization history on five utilization and nine quality indicators for PCPs with sufficient data to generate statistically significant profiles. Individual provider scores are compared to network peer scores.

Utilization indicators may include:

- Encounters
- Specialist visits
- Emergency room visits
- Hospital days
- Hospital discharges

Quality indicators may include, but are not limited to:

- Well child visits
- Childhood immunizations
- Adult BMI assessment
- Colorectal cancer screening
- Cervical cancer screening
- Breast cancer screening

- Comprehensive diabetes treatment
- Antidepressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment
- Follow-up after hospitalization for mental illness
- Medication reconciliation after discharge from inpatient facility

To identify potential over-utilization or under-utilization, profile data is further analyzed to identify scores greater than one standard deviation from the mean. Providers in the lowest quartile are targeted for quality improvement initiatives.

Preventing Hospital Re-Admissions

Preventing re-admissions is a strategic priority for CareConnect. To achieve this goal, CareConnect focuses on two areas: preventing re-hospitalizations and managing advanced illnesses.

CareConnect works collaboratively with the NSLIJ system to reduce re-hospitalizations by using industry standard tools and evidenced based medicine that assist members with receiving coordinated, appropriate follow-up care following a hospitalization. These efforts are aimed at empowering and educating members on how to access the appropriate resources and services following a hospitalization.

Some examples would be:

- Providing the member/family with educational material regarding their current condition/diagnosis
- Medication reconciliation
- Post follow-up calls to ensure the member's understanding of the discharge summary
- Assistance with scheduling follow-up appointments with primary care and specialty providers

Managing advanced illness, CareConnect works directly with NSLIJ physicians to improve the care of members with serious illness by aligning treatments with member preferences. The goal is to ensure that member preferences are known, documented and followed to decrease hospital admissions and readmissions, reduce non-emergent ER visits, and working with physicians to coordinate care for member's in their home setting so as to reduce overall suffering.

Annual Oversight

Communication

CareConnect has various mechanisms through which QI Program activities are communicated and through which CareConnect's progress in meeting its goals is reported. These mechanisms include but are not limited to:

- Board of Director Reports
- Committee reporting; specific, summary and feedback
- Member, provider newsletters and internet portals
- Member and Provider Handbooks
- Regulatory body reports and surveys
- Staff meetings, employee communication materials and intranet portals

CareConnect informs practitioners and providers about the QI Program and its progress toward meeting goals, improvement activities, and results of surveys and studies at least annually through the Provider Manual, Provider Newsletters, provider training, on-site training, mailings, and one-on-one discussions with Medical Directors. Feedback to practitioners and providers about individual performance (such as medical record reviews, complaints, profile information, or peer review decisions) is given by face-to-face discussions as well and/or direct mailings to the practitioner or provider.

Members are informed of the QI Program and progress towards meeting goals, improvement activities and results of surveys and studies at least annually through the CareConnect Website and Member Newsletters. Information is communicated to staff members during new employee orientation, at departmental staff meetings, and designated committee meetings.

Delegation Oversight

When operational activities are delegated to another organization, CareConnect evaluates the organization's caMMCity to perform the proposed delegated activities prior to entering into a delegation agreement consistent with CareConnect guidelines.

At the time of delegation, CareConnect executes a mutually agreed upon document which clearly defines the performance expectations for the delegated entity.

At a minimum, the document:

- Defines the delegate's specific duties and responsibilities.
- Describes the delegate's activities.
- Describes the requirements for the delegate's reporting to CareConnect.
- Defines the process by which CareConnect will evaluate the delegate's performance.
- Specifies the remedies available to CareConnect, including revocation of the delegation, in the event the delegate does not fulfill its obligations.

Ongoing oversight will be conducted to ensure that the delegated entities are in compliance with CareConnect's delegation standards and that services meet professionally recognized standards of practice. CareConnect will retain ultimate responsibility for reviewing the overall quality of care and services delivered to CareConnect members.

CareConnect will demonstrate accountability for delegated functions through summary documentation, descriptions of the delegates' activities, and the standards and requirements with which the delegated organization must comply.

Pre-Delegation Evaluation

Prior to delegating a function to an external entity, CareConnect will require the external entity to demonstrate their ability to perform the functions being considered for delegation. If the assessment results in a mutually agreed upon delegation agreement, CareConnect will obtain regulatory approval (if required) prior to implementation.

Annual Delegation Evaluation

After an entity has been delegated for a specific function, the entity will be evaluated on an ongoing basis, at least annually, to determine continued compliance with stated standards and the ability to continue in delegated status. Annual on-site audits may be conducted, but at a minimum, an annual documentation review will be conducted.

Document(s) to be reviewed may include, but are not limited to:

- The formal, written contract or description of delegated activities.
- The delegated organization's Program Description and Work Plan.
- The delegated organization's Annual Evaluation.
- The delegated organization's pertinent policies and procedures.
- Appropriate activity reports, files, or committee minutes regarding the delegated activity for the past 12-24 months.

Delegation Standards

All entities who have delegated responsibility for specific functions will adhere to CareConnect delegation standards as defined in the delegation agreement. To ensure that delegated entities are meeting the standards, CareConnect conducts the following oversight:

1. A monthly Service Level Activity report will compare the actual results of services performed for the month by the delegated entity against the Service Level standards that were established in the administrative agreement. The Service Level Activity report will also aggregate year-to-date results through the month being reported. The combination of monthly and year-to-date aggregate summary results will ensure that Service Level Activity is being met for both the current period and on an aggregate year-to-date basis.

2. A quarterly Service Level Activity report will compare the actual results of services performed for the 3-month period by the delegated entity against the Service Level standards that were established in the administrative agreement. The quarterly Service Level Activity report will also aggregate year-to-date results through the quarter being reported. The combination of quarterly and year-to-date aggregate summary results will ensure that Service Level Activity is being met for both the current 3-month quarter and on an aggregate year-to-date basis through the quarter being reported.

3. An annual Service Level Activity report will compare the actual results of services performed for the 12-month period by the delegated entity against the Service Level standards that were established in the administrative agreement.

4. All deficiencies will be reported ("Deficiency Notice") to CareConnect by the delegated entity within 24 hours of discovery of the deficiency. The Deficiency Notice shall be submitted in writing and faxed, e-mailed or mailed (via certified mail) to the health plan.

5. The delegated entity will submit to CareConnect a "Corrective Action Plan" ("CAP") within 48 hours of the Deficiency Notice. The CAP will include:

    - The root cause of the deficiency,
    - Plan of action correcting the deficiency
    - The on-going monitoring of the corrective action for a minimum of 90 days following the correction of the deficiency.
    - All deficiency corrections or resolutions will be enacted and resolved no more than 30 days from the approval of the CAP by CareConnect.

6. Quarterly and Annual delegated Service Level Results reported by the delegated entity to CareConnect will be reported by CareConnect to its Delegated Oversight Committee. The Quarterly and Annual delegated Service Level Results will be reported to the Delegated Oversight Committee at its next Committee meeting following the Quarterly or Annual Service Level Results meeting.

7. All Deficiency Notices received by CareConnect from its delegated entities will be immediately forwarded to the Delegation Oversight Committee along with the approved CAP and be duly noted in the "Minutes" of the special meeting of the Delegation Oversight Committee. All CAP resolution and monitoring will be reported to the Delegation Oversight Committee at its next Committee meeting following the CAP resolution. The following steps and process will be followed to ensure timely and accurate information is reported to the Delegation Oversight Committee who in turn will report to the Quality Improvement Committee of the Board of Directors of CareConnect:

    a. A "Notice of Deficiency" will be sent to the Members of the Delegation Oversight Committee within 72 hours of the receipt of the deficiency from the Delegated Entity or if the deficiency was discovered by CareConnect representatives during the course of an audit or routine meeting with the delegated entity.

    b. A special meeting of the Delegation Oversight Committee will be called by the Chairman of the Committee if it is determined by both the Chairman of the

Delegation Oversight Committee and Compliance Officer of CareConnect a meeting is warranted to review the severity and magnitude of the deficiency in question. The Delegation Oversight Committee will be informed of the deficiency and the CAP developed to resolve it.

c. The Quality Improvement Committee will be informed by the Delegation Oversight Committee of all delegated deficiencies at the next upcoming Quality Improvement Committee meeting unless it is determined by the Chairman of the Quality Improvement Committee that a special meeting communication is necessary as well as a special Quality Improvement Committee meeting.

d. The CAP will be implemented by the delegated entity and monitored by the appropriate Plan personnel to ensure the deficiency has been resolved. The Delegation Oversight Committee will be informed of the resolution once resolution of the deficiency has been attained.

e. The Board of Directors of CareConnect will be informed by the Quality Improvement Committee of the deficiency and the resolution or if root cause issues still persist.

8. CareConnect will ensure that monitoring of delegates is carried out by CareConnect staff that is qualified to assess the delegates' activities.

9. When CAPS fail to demonstrate effectiveness within an allocated timeframe, CareConnect retains authority to revoke the delegation agreement at any time.

Annual Evaluation

An annual evaluation of the QIP is conducted to assess the overall effectiveness of the CareConnect's quality improvement processes. The evaluation reviews all aspects of the Program work plan, focusing on whether the Program has demonstrated improvements in the quality of care and service provided to members. The annual evaluation includes:

- An assessment of whether goals and objectives for each activity were met.
- A review of human and technological resources.
- A summary of all quality improvement activities performed during the year.
- Reports for each Performance (Quality) Improvement Project.
- The imMMCt and effectiveness of the QI process had on improving the care and service provided to members.
- Trends and related improvement activities.
- Potential and actual barriers to achieving goals.
- Recommendations for QIP and QI Work Plan revisions, rationale and timelines.

The annual evaluation is reviewed and approved by the QIC and the BOD. The results of the annual evaluation are used to develop and prioritize the next year's annual QI work plan. Annual plan evaluation reports are submitted to state or federal agencies as required.

Annual Work Plans

The annual QI Work Plan focuses on QIP goals, objectives and planned projects for the upcoming year. The QI Work Plan includes specific tasks, responsible owners of activities, and anticipated time frames for completion. It serves as the road map to reflect a coordinated strategy to implement the QIP including planning, decision-making, interventions, assessment of results, and achievement of the desired improvements. The BOD and the QIC approve the QI Evaluation as well as the annual QI Work Plan based on the QIP Description. The QI Work Plan is a living document with periodic updates expected as a result of interim project findings and reports. Updates to the QI Work Plan are reviewed and approved by the QIC, and submitted to state or federal agencies as required and/or when substantial changes are made.

The annual QI Work Plan specifically addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

Policies and Procedures

CareConnect policies are reviewed annually and are available to all CareConnect employees through a shared online source.

Data Sources

Data to support the QIP is obtained through many sources including but not limited to:

- CareConnect business partners
- Population and demographic reports
- Claims data
- National evidence–based guidelines
- National inpatient and outpatient criteria
- Care management data
- Utilization, service and outcome reports
- Member and provider reported satisfaction data
- Medical records review and abstraction
- Surveys and questionnaires

- National benchmarks
- Internal databases and tracking systems

Confidentiality

CareConnect maintains confidentiality policies, and no voluntary disclosure of peer review information is made except to persons authorized to receive such information to conduct QI activities. Information is strictly confidential and is not considered discoverable under state and federal peer review laws.

CareConnect adheres to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the American Recovery and Reinvestment Act of 2009 (ARRA) Regulations. No voluntary disclosure of identifiable member information or Personal Health Information (PHI) is made without obtaining prior consent from the member except as required by law. Member information is used only as necessary to meet the administrative and legal obligations of CareConnect.

The data used in the QIP are maintained in a confidential manner using codes and summary information. Only those persons who require information to perform corrective action(s) are given access to identifiers. Committee records are available only to authorized personnel in accordance with local, state, federal, and other regulatory agencies. Each external committee participant must agree to comply with these confidentiality policies and sign a Committee Member Confidentiality Statement.

Appendices

Glossary

The following abbreviations are used in this document:

CAHPS	Consumer Assessment of Healthcare Providers and Systems
CFO	Chief Financial Officer
CMO	Chief Medical Officer
COO	Chief Operating Officer
CMS	Centers for Medicare and Medicaid Services
CQI	Continuous Quality Improvement
DOC	Delegation Oversight Committee
IRR	Inter-Rater Reliability
MM	Medical Management
MMC	Medical Management Committee
MMC	Provider Advisory Committee
PDSA	Plan, Do, Study, Act quality improvement cycle
PIP	Performance Improvement Project
QIP	Quality Improvement Program
QI	Quality Improvement
QIC	Quality Improvement Committee
UM	Utilization Management

Attachment C

User Inputs for Plan Parameters

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$35.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	93.75%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.12%
Metal Tier:	Platinum

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?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,500.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1				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
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.69%
Metal Tier:	Silver

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.99%
Metal Tier:	Silver

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?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.83%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.66%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.43%
Metal Tier:	Platinum

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.99%
Metal Tier:	Bronze

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Attachment D

	Subscribers	Members	Average Contract Size	Rate Factor
Single	5,835	5,835	1.000	1.000
Individual & Spouse	2,632	5,264	2.000	2.000
Individual & Child (ren)	406	1,408	3.468	1.700
Family	1,127	5,941	5.272	2.850
Child only	1,866	1,866	1.000	0.412
Total	11,866	20,313	1.712	1.329
	Conversion Factor:			1.288

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.99%
Metal Tier:	Bronze

User Inputs for Plan Parameters

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$35.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	93.75%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.12%
Metal Tier:	Platinum

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?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,500.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1				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
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.69%
Metal Tier:	Silver

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.99%
Metal Tier:	Silver

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?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.83%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.66%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.43%
Metal Tier:	Platinum

EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE FILING

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Tracking #: NSCC-129574144
Market Segment: Individuals On Exchange

A. Insurer Information:

North Shore-LIJ CareConnect insurance Company, Inc.	A&H - 42	For Profit	15309
Company submitting the rate filing request	Company Type	Org. Type	Company NAIC Code

2200 Northern Boulevard, Suite 104 East Hills, New York 11548
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):

Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information:

1/1/2015 - 12/31/15	1/1/2015	
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): Individual

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (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 16.	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).	No
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 number	No

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 North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Trac NSCC-129574144
Market Segment: Individuals On 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 the 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	$572.20	$490.83	$422.62	$332.48	$180.53
2015 Premium Rates	$554.80	$483.00	$426.60	$338.80	$184.60

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	-1.30%

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	N/A	N/A	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	N/A	N/A	N/A

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	N/A	2.00%
Expense Ratios	N/A	0.826	0.829
Pre Tax Profit Ratios	N/A	0.0%	0.0%

* If product was not offered in a particular year, indicate "N/A" in the applicable box.

EXHIBIT 14 - PART A: SUMMARY OF REQUESTED PERCENTAGE CHANGES TO EXISTING RATES

-- for Individual Medical Plans

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Tracking #: NSCC-129574144
Market Segment: Individuals On Exchange

1) Use this Exhibit for Individual Medical Plans. Individual market ACA compliant plans must use non-rolling rates where rates change each January 1.
2) The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
3) Market segment refers to Individual 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 metal level, rating region, and product name.
5) The product 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 DFS). A separate row is to be used for each combination of metal level, rating region and product name.
6) If the percentage changes (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.).
7) The "requested rate change" includes the impact of any riders (such as: age 29, domestic partner, family planning, pediatric dental, etc.).
8) Lowest should be the smallest percentage change that could affect any contract holder due to the submitted rate filing with that metal level, and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
9) Highest should be the largest percentage change that could affect any contract holder due to the submitted rate filing with that metal level, and rating region, including any applicable riders. This includes plan designs included in this rate filing which have no actual members.
10) The weighted average percentage should be developed based on annualized premium volume or membership for that metal level, and rating region, including any applicable riders.
11) This exhibit must be submitted as an Excel file and as a PDF file.

Individual Medical Plan Products

Market Segment	Effective Date of New Rate	Metal Level (or Catastrophic)	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Individual	01/01/15	Platinum	4 - New York City Area	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep25	-7.70%	-7.70%	-7.70%
Individual	01/01/15	Platinum	8 - Long Island Area	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep25	-1.80%	-1.80%	-1.80%
Individual	01/01/15	Platinum	4 - New York City Area	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep29	-7.60%	-7.60%	-7.60%
Individual	01/01/15	Platinum	8 - Long Island Area	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Platinum, ST, INN, Pediatric Dental & Vision, Dep29	-1.70%	-1.70%	-1.70%
Individual	01/01/15	Gold	4 - New York City Area	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep25	-6.20%	-6.20%	-6.20%
Individual	01/01/15	Gold	8 - Long Island Area	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep25	-0.21%	-0.21%	-0.21%
Individual	01/01/15	Gold	4 - New York City Area	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep29	-6.19%	-6.19%	-6.19%
Individual	01/01/15	Gold	8 - Long Island Area	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Gold, ST, INN, Pediatric Dental & Vision, Dep29	-0.20%	-0.20%	-0.20%
Individual	01/01/15	Silver	4 - New York City Area	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep25	-3.82%	-3.82%	-3.82%
Individual	01/01/15	Silver	8 - Long Island Area	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep25	2.31%	2.31%	2.31%
Individual	01/01/15	Silver	4 - New York City Area	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep29	-3.83%	-3.83%	-3.83%
Individual	01/01/15	Silver	8 - Long Island Area	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Silver, ST, INN, Pediatric Dental & Vision, Dep29	2.31%	2.31%	2.31%
Individual	01/01/15	Bronze	4 - New York City Area	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep25	-2.90%	-2.90%	-2.90%
Individual	01/01/15	Bronze	8 - Long Island Area	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep25	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep25	3.30%	3.30%	3.30%
Individual	01/01/15	Bronze	4 - New York City Area	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep29	-2.91%	-2.91%	-2.91%
Individual	01/01/15	Bronze	8 - Long Island Area	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep29	NS-LIJ CC EPO, Bronze, ST, INN, Pediatric Dental & Vision, Dep29	3.29%	3.29%	3.29%

EXHIBIT 14A

Individual Medical Plan Products

Market Segment	Effective Date of New Rate	Metal Level (or Catastrophic)	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Individual	01/01/15	Catastrophic	4 - New York City Area	NS-LIJ CC EPO, Catastrophic, ST, INN, Pediatric Dental & Vision	NS-LIJ CC EPO, Catastrophic, ST, INN, Pediatric Dental & Vision	-2.62%	-2.62%	-2.62%
Individual	01/01/15	Catastrophic	8 - Long Island Area	NS-LIJ CC EPO, Catastrophic, ST, INN, Pediatric Dental & Vision	NS-LIJ CC EPO, Catastrophic, ST, INN, Pediatric Dental & Vision	3.60%	3.60%	3.60%
Individual	01/01/15							
Individual	01/01/15							

EXHIBIT 15 - PART A: DISTRIBUTION OF CONTRACTS BY REQUESTED PERCENT ADJUSTMENTS FOR INDIVIDUAL PRODUCTS

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Tracking #: NSCC-129574144
Market Segment: Individuals On 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 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.
3) The Weighted Average Percentage change should be developed based on the distribution of annualized premiums for that Market Segment/Metal Level/Rating Region and for the market segment in total.
4) Market segment refers to Individual market segment.
5) 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.
6) Under each market segment, the table should provide the distribution by metal level (platinum, gold, silver, bronze, catastrophic).
7) Provide the distribution of contracts or members affected by proposed rate change for all contracts by metal level/rating region.
8) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
9) Enter the sum of the counts in the various columns, and the market segment weighted avg change %.
10) This exhibit must be submitted as an Excel file and a PDF file.

Distribution by Requested Rate Adjustment

Market Segment	Effective Date	Metal Level (or Catastrophic)	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										
					5/31/2014			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%	50.0% or higher
Individual	1/1/2015	Platinum	4 - New York City Area	-7.7%	8.6%	623		623										
Individual	1/1/2015	Platinum	8 - Long Island Area	-1.8%	35.7%	2494		2,494										
Individual	1/1/2015	Gold	4 - New York City Area	-6.2%	4.4%	375		375										
Individual	1/1/2015	Gold	8 - Long Island Area	-0.2%	18.7%	1500		1,500										
Individual	1/1/2015	Silver	4 - New York City Area	-3.8%	4.3%	414		414										
Individual	1/1/2015	Silver	8 - Long Island Area	2.3%	18.2%	1657				1,657								
Individual	1/1/2015	Bronze	4 - New York City Area	-2.9%	1.8%	220		220										
Individual	1/1/2015	Bronze	8 - Long Island Area	3.3%	7.7%	879				879								
Individual	1/1/2015	Catastrophic	4 - New York City Area	-2.6%	0.1%	29		29										
Individual	1/1/2015	Catastrophic	8 - Long Island Area	3.6%	0.5%	117				117								
Market Segment Total:					100.0%	8,308	0.0%	5,655	0.0%	2,653	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		

EXHIBIT 16: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.

NAIC Code: 15309

SERFF Number: NSCC-129574144

Market Segment: Individuals On Exchange

Instructions:

1) This Exhibit summarizes all benefit/rate changes filed after the initial rate filing in calendar year 2013 that impacts the rate tables in this current filing.
2) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with DFS).
3) Enter filing status (approved or pending) using the drop down list. For pending files leave the approval date blank.
4) Extend the worksheet to add more rows as needed. Only use the first tab for data entry.
5) This form must be submitted as an Excel file and as a PDF file.

List of rate filings that have been approved since the §3231(d) or §4308(b) initial rate filing in calendar year 2013, or are currently pending with DFS.

Filing Status	SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Number: NSCC-129574144
Market Segment : Individuals On Exchange

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

Line #	General													
1	Product*	North Shore-LIJ Platinum EPO Child-Only Coverage with Dental	North Shore-LIJ Platinum EPO with Dependent Age 26 & Dental	North Shore-LIJ Platinum EPO with Dependent Age 29 & Dental	North Shore-LIJ Gold EPO Child-Only Coverage with Dental	North Shore-LIJ Gold EPO with Dependent Age 26 & Dental	North Shore-LIJ Gold EPO with Dependent Age 29 & Dental	North Shore-LIJ Silver EPO Child-Only Coverage with Dental	North Shore-LIJ Silver EPO with Dependent Age 26 & Dental	North Shore-LIJ Silver EPO with Dependent Age 29 & Dental	North Shore-LIJ Bronze EPO Child-Only Coverage with Dental	North Shore-LIJ Bronze EPO with Dependent Age 26 & Dental	North Shore-LIJ Bronze EPO with Dependent Age 29 & Dental	North Shore-LIJ Bronze EPO Catastrophic Coverage with Dependent Age 26 & Dental
2	Product ID*	82483NY018	82483NY025	82483NY026	82483NY017	82483NY023	82483NY024	82483NY016	82483NY021	82483NY022	82483NY015	82483NY019	82483NY020	82483NY010
3	Metal Level (or catastrophic)*	Platinum	Platinum	Platinum	Gold	Gold	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze	Catastrophic
4	AV Metal Value (HHS Calculator)*	0.88	0.88	0.88	0.79	0.79	0.79	0.71	0.71	0.71	0.62	0.62	0.62	0.00
5	AV Pricing Value (total, risk pool experience based)*	0.917	0.917	0.917	0.799	0.799	0.799	0.705	0.705	0.705	0.554	0.554	0.554	0.511
6	Plan Type*	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
7	Plan Name*	Standard Platinum Child-Only Coverage	Standard Platinum with Dependent Age	Standard Platinum with Dependent Age	Standard Gold Child-Only Coverage	Standard Gold with Dependent Age 26	Standard Gold with Dependent Age 29	Standard Silver Child-Only Coverage	Standard Silver with Dependent Age 26	Standard Silver with Dependent Age 29	Standard Bronze Child-Only Coverage	Standard Bronze with Dependent Age 26	Standard Bronze with Dependent Age 29	Standard Catastrophic
8	HIOS Plan ID*	82483NY0180001	82483NY0250001	82483NY0260001	82483NY0170001	82483NY0230001	82483NY0240001	82483NY0160001	82483NY0210001	82483NY0220001	82483NY0150001	82483NY0190001	82483NY0200001	82483NY0100001
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* 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	0.000												
10B	Member-Months for Latest Experience Period	0.000												
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	0.00												
11	Average Pricing Actuarial Value reflected in experience period	0.000												
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**	**413.47**

Market Wide Adjustments to the AV Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	1.000												
14	Market wide adjustment for changes in provider network **	1.000												
15	Market wide adjustment for fee schedule changes **	1.000												
16	Market wide adjustment for utilization management changes **	0.950												
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000												
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics **	1.000												
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**												
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)	0.958												
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)	1.020												
25	Other 1 (specify)	1.000												
26	Other 2 (specify)	1.000												
27	Other 3 (specify)	1.000												
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**	**0.928**

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

29	Pricing actuarial value (without induced demand factor) #	0.917	0.917	0.917	0.850	0.850	0.850	0.787	0.787	0.787	0.637	0.637	0.637	0.587	0.51069
30	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	0.940	0.940	0.940	0.896	0.896	0.896	0.870	0.870	0.870	0.870	
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.007	1.000	1.000	1.007	1.000	1.000	1.007	1.000	1.000	1.007	1.000	
36	Administrative costs (excluding Exchange user fees and profits)	1.205	1.205	1.205	1.205	1.205	1.205	1.205	1.205	1.205	1.220	1.220	1.220	1.220	
37	Profit/Contribution to surplus margins	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.595	
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Number: NSCC-129574144
Market Segment : Individuals On Exchange

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

Line #	General													
1	Product*	North Shore-LIJ Platinum EPO Child-Only Coverage with Dental	North Shore-LIJ Platinum EPO with Dependent Age 26 & Dental	North Shore-LIJ Platinum EPO with Dependent Age 29 & Dental	North Shore-LIJ Gold EPO Child-Only Coverage with Dental	North Shore-LIJ Gold EPO with Dependent Age 26 & Dental	North Shore-LIJ Gold EPO with Dependent Age 29 & Dental	North Shore-LIJ Silver EPO Child-Only Coverage with Dental	North Shore-LIJ Silver EPO with Dependent Age 26 & Dental	North Shore-LIJ Silver EPO with Dependent Age 29 & Dental	North Shore-LIJ Bronze EPO Child-Only Coverage with Dental	North Shore-LIJ Bronze EPO with Dependent Age 26 & Dental	North Shore-LIJ Bronze EPO with Dependent Age 29 & Dental	North Shore-LIJ Bronze EPO Catastrophic Coverage with Dependent Age 26 & Dental
2	Product ID*	82483NY018	82483NY025	82483NY026	82483NY017	82483NY023	82483NY024	82483NY016	82483NY021	82483NY022	82483NY015	82483NY019	82483NY020	82483NY010
3	Metal Level (or catastrophic)*	Platinum	Platinum	Platinum	Gold	Gold	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze	Catastrophic
4	AV Metal Value (HHS Calculator)*	0.88	0.88	0.88	0.79	0.79	0.79	0.71	0.71	0.71	0.62	0.62	0.62	0.00
5	AV Pricing Value (total, risk pool experience based)*	0.917	0.917	0.917	0.799	0.799	0.799	0.705	0.705	0.705	0.554	0.554	0.554	0.511
41	Other 1 - Addition of capitation rates for Pediatric Dental and Vision - differs by metallic tier	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.003	1.003	1.003	1.000
42	Other 2 - Abortion	1.002	1.002	1.002	1.003	1.003	1.003	1.003	1.003	1.003	1.004	1.004	1.004	1.007
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.114**	**1.114**	**1.122**	**0.971**	**0.971**	**0.978**	**0.857**	**0.857**	**0.863**	**0.681**	**0.681**	**0.685**	**0.373**

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

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**427.55**	**427.55**	**430.71**	**372.51**	**372.51**	**375.22**	**328.87**	**328.87**	**331.20**	**261.23**	**261.23**	**263.05**	**143.26**

EXHIBIT 19 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Number: NSCC-129574144
Market Segment: Individuals On Exchange

1) Complete a separate ROW for Metal Level/Product
- Information should be for all the benefits included in that plan design including any riders (medical, drugs, etc).
- Enter in column 1 the Metal Tier level. Use the drop down menu.
- Enter in column 2 the plan designation as to On/Off Plan and Std/Non Standard Plan. Use the drop down menu.
- Enter in column 3 the Estimated Membership as of a recent date mm/dd/yyy; enter the date in column heading.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

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

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

4) Enter the corresponding information requested for the immediately prior rate and form filing. This refers to the various expense components in the requested rates submitted for the immediately prior rate and form filing and the average claim trend assumed. If there is no immediately prior rate and form filing, enter the data from the initial rate and form filing.

5) **ACA Fees** are to be entered in columns 6.5 and 16.5.

6) This exhibit must be submitted as an Excel file and as a PDF file.

				For the rate period included in this rate adjustment filing												For the rate period included in this rate adjustment filing					
1. Metal Level [drop down menu]	2. On/Off Exchange Designation **and** Standard/Non Std [drop down menu]	3. Estimated Membership as of 07/01/2015		4.1 Period assumed beginning date (mm/dd/yy)	4.2 Period assumed ending date (mm/dd/yy)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 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/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	
Platinum	On Std	1890	XX	01/01/15	12/31/15	2.00%	6.50%	1.70%	1.10%	1.30%	0.90%	16.90%	28.40%	0.00%	0.00%	7.10%	0.00%	39.60%	-0.66%	27.74%	XX
Gold	On Std	1350	XX	01/01/15	12/31/15	2.00%	7.50%	2.00%	1.10%	1.30%	1.00%	19.40%	32.30%	0.00%	0.00%	7.10%	0.00%	39.60%	-0.76%	31.54%	XX
Silver	On Std	1620	XX	01/01/15	12/31/15	2.00%	8.50%	2.30%	1.10%	1.30%	1.20%	22.00%	36.40%	0.00%	0.00%	7.10%	0.00%	39.60%	-0.86%	35.54%	XX
Bronze	On Std	945	XX	01/01/15	12/31/15	2.00%	10.70%	2.90%	1.10%	1.30%	1.50%	27.70%	45.20%	0.00%	0.00%	7.10%	0.00%	39.60%	-1.08%	44.12%	XX
Catastrophic	On Std	473	XX	01/01/15	12/31/15	2.00%	15.50%	5.20%	1.10%	1.30%	2.70%	50.50%	76.30%	0.00%	0.00%	7.10%	0.00%	39.60%	-1.96%	74.34%	XX

EXHIBIT 19: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES

				For the rate period included in the prior rate and form filing																
1. Metal Level [drop down menu]	2. On/Off Exchange Designation **and** Standard/Non Std [drop down menu]	3. Estimated Membership as of 07/01/2015		14.1 Period assumed - beginning date (mm/dd/yy)	14.2 Period assumed - ending date (mm/dd/yy)	15. Average annual claim trend assumed	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	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
Platinum	On Std	1890	XX	01/01/14	12/13/14	N/A	6.41%	1.72%	2.16%	1.30%	1.25%	46.26%	59.10%	0.00%	0.00%	7.10%	0.00%	39.60%	-0.65%	58.45%
Gold	On Std	1350	XX	01/01/14	12/13/14	N/A	7.47%	2.00%	2.27%	1.30%	1.45%	53.93%	68.42%	0.00%	0.00%	7.10%	0.00%	39.60%	-0.75%	67.67%
Silver	On Std	1620	XX	01/01/14	12/13/14	N/A	8.67%	2.32%	2.40%	1.30%	1.69%	62.63%	79.01%	0.00%	0.00%	7.10%	0.00%	39.60%	-0.88%	78.13%
Bronze	On Std	945	XX	01/01/14	12/13/14	N/A	11.03%	2.95%	2.64%	1.30%	2.15%	79.61%	99.68%	0.00%	0.00%	7.10%	0.00%	39.60%	-1.11%	98.57%
Catastrophic	On Std	473	XX	01/01/14	12/13/14	N/A	15.72%	5.40%	3.58%	1.30%	3.92%	145.58%	175.50%	0.00%	0.00%	7.10%	0.00%	39.60%	-2.04%	173.46%

EXHIBIT 20: HIOS ID MAPPING TO PRODUCT NAMES

Company Name: **North Shore-LIJ CareConnect insurance Company, Inc.**
NAIC Code: **15309**
SERFF Number: **NSCC-129574144**
Market Segment: **Individuals On Exchange**

1) This exhibit is to help DFS reconcile the 14 digit HIOS IDs used to the different plan designs and to reconcile the rate manual to the binder rate template.
2) The HIOS IDs should be without the variants after the hyphen.
3) Column 3: Enter Metal Level. Use drop down menu.
4) Column 4: Enter On/Off Plan Designation. Use drop down menu.
5) Column 5: Enter Standard/Non Standard Plan Designation. Use drop down menu.
6) Column 6: Enter coverage of children to 26th birthday (26) or to 30th birthday. Use drop down menu.
7) Column 7: Enter Yes/No for coverage of Domestic Partner. Use drop down menu.
8) Column 8: Enter Yes/No for coverage of Family Planning. Use drop down menu.
9) Column 9: Enter Yes/No for coverage of Embedded Pediatric Dental. Use drop down menu.
10) Column 10: Enter Yes/No for coverage of Out of Network Benefits [PPO or POS]. Use drop down menu.
11) Column 11: Indicate if the plan design includes benefits in addition to the EHB benefits (yes) or (no). Use drop down menu.
12) This exhibit must be submitted as an Excel and as PDF file.

1 HIOS ID	2 Rate Manual Plan Name	3 Metal Level	4 Exchange Plan? (on, off, both)	5 Standard Plan Design? (yes, no)	6 Limiting Child Age? (26 or 30)	7 Domestic Partner Coverage Included? (yes, no)	8 Family Planning Coverage? (included, excluded)	9 Pediatric Dental Coverage Included? (yes, no)	10. Out of Network Benefits? (yes, no)	11 Include Benefits in Addition to EHB? (yes, no)
82483NY0180001	North Shore-LIJ CareConne	Platinum	BOTH	YES		NO	EXCLUDED	YES	NO	YES
82483NY0250001	North Shore-LIJ CareConne	Platinum	BOTH	YES	26	NO	EXCLUDED	YES	NO	YES
82483NY0260001	North Shore-LIJ CareConne	Platinum	BOTH	YES	29	NO	EXCLUDED	YES	NO	YES
82483NY0170001	North Shore-LIJ CareConne	Gold	BOTH	YES		NO	EXCLUDED	YES	NO	YES
82483NY0230001	North Shore-LIJ CareConne	Gold	BOTH	YES	26	NO	EXCLUDED	YES	NO	YES
82483NY0240001	North Shore-LIJ CareConne	Gold	BOTH	YES	29	NO	EXCLUDED	YES	NO	YES
82483NY0160001	North Shore-LIJ CareConne	Silver	BOTH	YES		NO	EXCLUDED	YES	NO	YES
82483NY0210001	North Shore-LIJ CareConne	Silver	BOTH	YES	26	NO	EXCLUDED	YES	NO	YES
82483NY0220001	North Shore-LIJ CareConne	Silver	BOTH	YES	29	NO	EXCLUDED	YES	NO	YES
82483NY0150001	North Shore-LIJ CareConne	Bronze	BOTH	YES		NO	EXCLUDED	YES	NO	YES
82483NY0190001	North Shore-LIJ CareConne	Bronze	BOTH	YES	26	NO	EXCLUDED	YES	NO	YES
82483NY0200001	North Shore-LIJ CareConne	Bronze	BOTH	YES	29	NO	EXCLUDED	YES	NO	YES
82483NY0100001	North Shore-LIJ CareConne	Catastrophic	BOTH	YES		NO	EXCLUDED	YES	NO	YES

EXHIBIT 23: SUMMARY OF REQUESTED 2015 PREMIUM RATES

Company Name: North Shore-LIJ CareConnect insurance Company, Inc.
NAIC Code: 15309
SERFF Number: NSCC-129574144
Market Segment: Individuals On Exchange

1) Purpose of this Exhibit is to summarize all Premium Rates for all Metal Levels and for all Regions.
2) Premium rates are Calendar Year 2015 premium rates for Individual Only on Individual Plans and First Quarter 2015 premium rates for Employee Only on Small Group Plans.
3) Premium rates are only for plans with the following benefit provisions:
   (a) Through Age 29; **and**
   (b) With Domestic Partner; **and**
   (c) With Family Planning.
4) This exhibit must be submitted as an Excel and as a PDF file.

SUMMARY OF REQUESTED 2015 PREMIUM RATES

1. HIOS ID PLAN (14 Digits)	2. Metal Level or Catastrophic	3. Exchange [Ind/Sml Grp]	4. On/Off Exchange	5. Plan Type [Std or Non Std]	6. Pediatric Dental [Yes/No]	Region 1 Albany	Region 2 Buffalo	Region 3 Mid-Hudson	Region 4 New York	Region 5 Rochester	Region 6 Syracuse	Region 7 Utica	Region 8 Long Island
82483NY0260	Platinum	IND	On	Standard	Yes	N/A	N/A	N/A	526	N/A	N/A	N/A	562
82483NY0240	Gold	IND	On	Standard	Yes	N/A	N/A	N/A	459	N/A	N/A	N/A	489
82483NY0220	Silver	IND	On	Standard	Yes	N/A	N/A	N/A	405	N/A	N/A	N/A	432
82483NY0200	Bronze	IND	On	Standard	Yes	N/A	N/A	N/A	322	N/A	N/A	N/A	343
82483NY0100	Catastrophic	IND	On	Standard	Yes	N/A	N/A	N/A	175	N/A	N/A	N/A	187

Insert Logo

[Date]

[Contact Name]
[Address]
[City State Zip]

Re: Notice of Proposed Premium Rate Change
Product Name and Health Insurance Oversight System (HIOS) identification number

Dear [Name]:

North Shore-LIJ CareConnect Insurance Company, 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 Change

If approved, the percentage change to your premium is ___%.

If you enrolled through the NY State of Health, the state's health plan marketplace, and you qualified for financial assistance, called an Advanced Premium Tax Credit, your current premium is less than the amount shown above and your 2015 premium will be less than shown above if you qualify for the APTC again next year. NY State of Health will calculate your eligibility for financial assistance each year.

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

We are requesting a change of ___% from our 2014 Individual rates. The main reasons for this request include the projected changes in medical utilization, the anticipated impact of our medical management programs, and the implementation of geographic rating factors.

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 North Shore-LIJ CareConnect Insurance Company, Inc. for additional information at:

North Shore-LIJ CareConnect Insurance Company, Inc.
2200 Northern Blvd.
East Hills, NY 11548
(855) 706-7545
www.nslijcareconnect.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
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer
2. The name of your plan
3. Whether you have individual or 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.

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:

North Shore-LIJ CareConnect website: www.nslijcareconnect.com

DFS website: https://myportal.dfs.ny.gov/web/prior-approval/north-shore-lij-ins-co

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.

Thank you for being a loyal CareConnect member. We look forward to continuing our service to you.

Sincerely,

Unified Rate Review v2.0.2

Company Legal Name:	**North Shore-LIJ CareConnect I**	State:	**NY**
HIOS Issuer ID:	**82483**	Market:	**Individual**
Effective Date of Rate Change(s):	**1/1/2015**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2014 to 12/31/2014

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$33	$1.00	100.00%
Incurred Claims in Experience Period	$33	1.00	100.00%
Allowed Claims:	$33	1.00	100.00%
Index Rate of Experience Period		$33.00	
Experience Period Member Months	33		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2015 to 12/31/2015 Mid-point to Mid-point, Experience to Projection: 12 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Days	1.00	$2,000.00	$0.17	1.000	1.000	1.000	1.000	1.00	$2,000.00	$0.17	336.45	$2,595.41	$72.77
Outpatient Hospital	Visits	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	2165.94	$327.18	59.05
Professional	Other	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	19066.75	$75.17	119.43
Other Medical	Other	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	464.18	$873.86	33.80
Capitation	Benefit Period	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	12000.00	$1.87	1.87
Prescription Drug	Prescriptions	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	10323.75	$123.01	105.82
Total				$1.00							$1.00			$392.75

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$392.75	$63,623,208
Paid to Allowed Average Factor in Projection Period			0.790	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$310.27	$50,262,334
Projected Risk Adjustments PMPM			0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$310.27	$50,262,334
Projected ACA reinsurance recoveries, net of rein prem, PMPM			10.43	1,689,597
Projected Incurred Claims			$299.84	$48,572,737
Administrative Expense Load		14.71%	53.20	8,618,878
Profit & Risk Load		0.00%	0.00	0
Taxes & Fees		2.39%	8.64	1,400,348
Single Risk Pool Gross Premium Avg. Rate, PMPM			$361.69	$58,591,962
Index Rate for Projection Period			$413.47	
% increase over Experience Period			36069.22%	
% Increase, annualized:			36069.22%	
Projected Member Months				161,994

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name: **North Shore-LIJ CareConnect Insurance Company, Inc.** State: **NY**
HIOS Issuer ID: **82483** Market: **Individual**
Effective Date of Rate Change(s): **1/1/2015**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	rth Shore-LIJ Platinum	um EPO Child-Only	um EPO with Depen	um EPO with Depen	d EPO Child-Only Gold	d EPO with Depend	d EPO with Depend	er EPO Child-Only Cer	er EPO with Depend	er EPO with Depend	ze EPO Child-Only Cze	ze EPO with Depen	ze EPO with Depen	astrophic Coverage	um EPO with Depen	um EPO with Depen	d EPO with Depend	d EPO with Depend	er EPO with Depend	er EPO with Depend	ze EPO with Depen	ze EPO with Depen
Product ID:		82483NY018	82483NY025	82483NY026	82483NY017	82483NY023	82483NY024	82483NY016	82483NY021	82483NY022	82483NY015	82483NY019	82483NY020	82483NY010	82483NY025	82483NY026	82483NY023	82483NY024	82483NY021	82483NY022	82483NY019	82483NY020
Metal:		Platinum	Platinum	Platinum	Gold	Gold	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze	Catastrophic	Platinum	Platinum	Gold	Gold	Silver	Silver	Bronze	Bronze
AV Metal Value		0.881	0.881	0.881	0.791	0.791	0.791	0.707	0.707	0.707	0.620	0.620	0.620	0.000	0.881	0.881	0.791	0.791	0.707	0.707	0.620	0.620
AV Pricing Value		0.917	0.917	0.917	0.799	0.799	0.799	0.705	0.705	0.705	0.554	0.554	0.554	0.511	0.917	0.917	0.799	0.799	0.705	0.705	0.554	0.554
Plan Type:		EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	rth Shore-LIJ Platinum	um EPO Child-Only	um EPO with Depen	um EPO with Depen	d EPO Child-Only Gold	d EPO with Depend	d EPO with Depend	er EPO Child-Only Cer	er EPO with Depend	er EPO with Depend	ze EPO Child-Only Cze	ze EPO with Depen	ze EPO with Depen	astrophic Coverage	um EPO with Depen	um EPO with Depen	d EPO with Depend	d EPO with Depend	er EPO with Depend	er EPO with Depend	ze EPO with Depen	ze EPO with Depen
Plan ID (Standard Component ID):		82483NY0180001	82483NY0250001	82483NY0260001	82483NY0170001	82483NY0230001	82483NY0240001	82483NY0160001	82483NY0210001	82483NY0220001	82483NY0150001	82483NY0190001	82483NY0200001	82483NY0100001	82483NY0250001	82483NY0260001	82483NY0230001	82483NY0240001	82483NY0210001	82483NY0220001	82483NY0190001	82483NY0200001
Exchange Plan?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Historical Rate Increase - Calendar Year - 1		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Historical Rate Increase - Calendar Year 0		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Effective Date of Proposed Rates		1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)		-3.10%	-3.10%	-3.00%	-1.50%	-1.50%	-1.50%	0.90%	0.90%	0.90%	1.90%	1.90%	1.90%	2.20%	-3.10%	-3.00%	-1.50%	-1.50%	0.90%	0.90%	1.90%	1.90%
Cum'tive Rate Change % (over 12 mos prior)		-3.10%	-3.10%	-3.00%	-1.50%	-1.50%	-1.50%	0.90%	0.90%	0.90%	1.90%	1.90%	1.90%	2.20%	-3.10%	-3.00%	-1.50%	-1.50%	0.90%	0.90%	1.90%	1.90%
Proj'd Per Rate Change % (over Exper. Period)		42654.88%	42654.88%	42970.61%	37150.80%	37150.80%	37421.72%	32786.80%	32786.80%	33019.53%	26022.89%	26022.89%	26205.13%	14226.39%	42654.88%	42970.61%	37150.80%	37421.72%	32786.80%	33019.53%	26022.89%	26205.13%
Product Threshold Rate Increase %		-3.10%	-3.10%	-3.00%	-1.51%	-1.51%	-1.51%	0.89%	0.89%	0.89%	1.89%	1.89%	1.89%	2.19%	-3.10%	-3.00%	-1.51%	-1.51%	0.89%	0.89%	1.89%	1.89%

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

Plan ID (Standard Component ID):	Total	82483NY0180001	82483NY0250001	82483NY0260001	82483NY0170001	82483NY0230001	82483NY0240001	82483NY0160001	82483NY0210001	82483NY0220001	82483NY0150001	82483NY0190001	82483NY0200001	82483NY0100001	82483NY0250001	82483NY0260001	82483NY0230001	82483NY0240001	82483NY0210001	82483NY0220001	82483NY0190001	82483NY0200001
Inpatient	$0.24							$0.57	$0.57	$0.57	$0.91	$0.91	$0.91	$0.57					$0.57	$0.57	$0.91	$0.91
Outpatient	$0.20							$0.46	$0.46	$0.46	$0.74	$0.74	$0.74	$0.47					$0.46	$0.46	$0.74	$0.74
Professional	$0.40							$0.94	$0.94	$0.94	$1.50	$1.50	$1.50	$0.94					$0.94	$0.94	$1.50	$1.50
Prescription Drug	$0.35							$0.83	$0.83	$0.83	$1.32	$1.32	$1.32	$0.84					$0.83	$0.83	$1.32	$1.32
Other	$0.11							$0.26	$0.26	$0.26	$0.42	$0.42	$0.42	$0.27					$0.26	$0.26	$0.42	$0.42
Capitation	$0.01							$0.01	$0.01	$0.01	$0.02	$0.02	$0.02	$0.01					$0.01	$0.01	$0.02	$0.02
Administration	$0.00							$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00					$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00							$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00					$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00							$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00					$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$1.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.08	$3.08	$3.08	$4.92	$4.92	$4.92	$3.10	$0.00	$0.00	$0.00	$0.00	$3.08	$3.08	$4.92	$4.92
Member Cost Share Increase	$0.00																					

Average Current Rate PMPM	$357.05	$427.55	$427.55	$430.71	$372.51	$372.51	$375.22	$328.87	$328.87	$331.20	$261.23	$261.23	$263.05	$143.26	$427.55	$430.71	$372.51	$375.22	$328.87	$331.20	$261.23	$263.05
Projected Member Months	161,994	9,396	9,396	9,396	6,480	6,480	6,480	7,128	7,128	7,128	3,564	3,564	3,564	8,910	9,396	9,396	6,480	6,480	7,128	7,128	3,564	3,564

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	82483NY0180001	82483NY0250001	82483NY0260001	82483NY0170001	82483NY0230001	82483NY0240001	82483NY0160001	82483NY0210001	82483NY0220001	82483NY0150001	82483NY0190001	82483NY0200001	82483NY0100001	82483NY0250001	82483NY0260001	82483NY0230001	82483NY0240001	82483NY0210001	82483NY0220001	82483NY0190001	82483NY0200001
Average Rate PMPM	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Member Months	33	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Total Premium (TP)	$33	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1
EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$33	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1
EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Incurred claims, payable with issuer funds	$33	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1	$1
Net Amt of Rein	$33.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Net Amt of Risk Adj	$33.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Incurred Claims PMPM	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Allowed Claims PMPM	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
EHB portion of Allowed Claims, PMPM	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	82483NY0180001	82483NY0250001	82483NY0260001	82483NY0170001	82483NY0230001	82483NY0240001	82483NY0160001	82483NY0210001	82483NY0220001	82483NY0150001	82483NY0190001	82483NY0200001	82483NY0100001	82483NY0250001	82483NY0260001	82483NY0230001	82483NY0240001	82483NY0210001	82483NY0220001	82483NY0190001	82483NY0200001
Plan Adjusted Index Rate	$357.05	$427.55	$427.55	$430.71	$372.51	$372.51	$375.22	$328.87	$328.87	$331.20	$261.23	$261.23	$263.05	$143.26	$427.55	$430.71	$372.51	$375.22	$328.87	$331.20	$261.23	$263.05
Member Months	161,994	9,396	9,396	9,396	6,480	6,480	6,480	7,128	7,128	7,128	3,564	3,564	3,564	8,910	9,396	9,396	6,480	6,480	7,128	7,128	3,564	3,564
Total Premium (TP)	$57,839,512	$4,017,249	$4,017,249	$4,046,914	$2,413,852	$2,413,852	$2,431,408	$2,344,171	$2,344,171	$2,360,760	$931,020	$931,020	$937,515	$1,276,481	$4,017,249	$4,046,914	$2,413,852	$2,431,408	$2,344,171	$2,360,760	$931,020	$937,515
EHB Percent of TP, [see instructions]	99.43%	99.77%	99.77%	99.04%	99.73%	99.73%	99.01%	99.70%	99.70%	99.00%	99.62%	99.62%	98.93%	99.30%	99.77%	99.04%	99.73%	99.01%	99.70%	99.00%	99.62%	98.93%
state mandated benefits portion of TP that are other than EHB	0.57%	0.23%	0.23%	0.96%	0.27%	0.27%	0.99%	0.30%	0.30%	1.00%	0.38%	0.38%	1.07%	0.70%	0.23%	0.96%	0.27%	0.99%	0.30%	1.00%	0.38%	1.07%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$64,103,420	$3,708,977	$3,708,977	$3,736,603	$2,556,814	$2,556,814	$2,574,865	$2,814,206	$2,814,206	$2,833,098	$1,405,036	$1,405,036	$1,414,194	$3,511,839	$3,708,977	$3,736,603	$2,556,814	$2,574,865	$2,814,206	$2,833,098	$1,405,036	$1,414,194
EHB Percent of TAC, [see instructions]	99.42%	99.77%	99.77%	99.04%	99.73%	99.73%	99.01%	99.70%	99.70%	99.00%	99.62%	99.62%	98.93%	99.30%	99.77%	99.04%	99.73%	99.01%	99.70%	99.00%	99.62%	98.93%
state mandated benefits portion of TAC that are other than EHB	0.58%	0.23%	0.23%	0.96%	0.27%	0.27%	0.99%	0.30%	0.30%	1.00%	0.38%	0.38%	1.07%	0.70%	0.23%	0.96%	0.27%	0.99%	0.30%	1.00%	0.38%	1.07%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	$15,709,348	$461,981	$461,981	$465,398	$605,659	$605,659	$610,026	$918,844	$918,844	$925,402	$661,550	$661,550	$666,152	$810,699	$461,981	$465,398	$605,659	$610,026	$918,844	$925,402	$661,550	$666,152
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Total Incurred claims, payable with issuer funds	$48,394,073	$3,246,996	$3,246,996	$3,271,205	$1,951,155	$1,951,155	$1,964,839	$1,895,362	$1,895,362	$1,907,696	$743,485	$743,485	$748,043	$2,701,140	$3,246,996	$3,271,205	$1,951,155	$1,964,839	$1,895,362	$1,907,696	$743,485	$748,043
Net Amt of Rein	$1,690,239	$122,766	$122,766	$123,933	$70,438	$70,438	$71,086	$66,647	$66,647	$67,360	$29,759	$29,759	$30,045	$9,266	$122,766	$123,933	$70,438	$71,086	$66,647	$67,360	$29,759	$30,045
Net Amt of Risk Adj	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0