

State: New York **Filing Company:** UnitedHealthcare Insurance Company of New York
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: 2015 UHIC SG OFFX Plans
Project Name/Number: 2015 UHIC SG OFFX Plans/

Filing at a Glance

Company: UnitedHealthcare Insurance Company of New York
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TOI: H15G Group Health - Hospital/Surgical/Medical Expense
Sub-TOI: H15G.003 Small Group Only
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General Information

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 2015 UHIC SG Off Exchange Plans

Company and Contact

Filing Contact Information

[Redacted]
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 Trumbull, CT 06611

Filing Company Information

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 (952) 992-5142 ext. [Phone]

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.): Yes - UHIC SG Off Exch Form Filing, 6/13/14, SERFF Tr Num: UHLC-129590048
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial

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3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York?
Yes/No (If Yes, enter which one.): 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 prefilling notification, out-of-state, or a report filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate Only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation.): 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.): Yes - State Tr Num: 2014060102, SERFF Tr Num: UHLC-129574839

State:

New York

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UnitedHealthcare Insurance Company of New York

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Form Schedule

Lead Form Number: UHICNY_SG_COC_2015

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Certificate of Coverage	UHICNY_SG_COC_2015	CER	Initial		45.100	Draft_UHICNY_SG_2015_COC_clean.pdf
2		Family Planning Rider	UHICNY_SG_RDR_FAM_2015	CERA	Initial		45.700	Draft_UHICNY_SG_2015_RDR_Fam_clean.pdf
3		Domestic Partner Rider	UHICNY_SG_RDR_DP_2015	CERA	Initial		45.300	Draft_UHICNY_SG_2015_RDR_DomPtr_clean.pdf
4		Dependent Age Rider	UHICNY_SG_RDR_AGE29_2015	CERA	Initial		45.600	Draft_UHICNY_SG_2015_RDR_Age29_clean.pdf
5		Out-of-Network Rider	UHICNY_SG_RDR_ONET_2015	CERA	Initial		45.300	Draft_UHICNY_SG_2015_RDR_ONET_clean.pdf
6		Schedule of Benefits	UHICNY_SG_SBN_GOLD_VR-W_2015	CERA	Initial		46.300	Draft_UHICNY_SG_2015_SBN_Gold_VR-W_clean.pdf
7		Schedule of Benefits	UHICNY_SG_SBN_GOLD_VR-2_2015	CERA	Initial		46.300	Draft_UHICNY_SG_2015_SBN_Gold_VR-2_clean.pdf
8		Schedule of Benefits	UHICNY_SG_SBN_PLATNM_VR-Z_2015	CERA	Initial		46.100	Draft_UHICNY_SG_2015_SBN_Platinum_VR-Z_clean.pdf
9		Schedule of Benefits	UHICNY_SG_SBN_SILVER_VR-X_2015	CERA	Initial		46.300	Draft_UHICNY_SG_2015_SBN_Silver_VR-X_clean.pdf
10		Schedule of Benefits	UHICNY_SG_SBN_SILVER_VR-4_2015	CERA	Initial		46.300	Draft_UHICNY_SG_2015_SBN_Silver_VR-4_clean.pdf

SERFF Tracking #:

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State Tracking #:

2014060234

Company Tracking #:**State:**

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Form Type Legend:

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

This is Your
[⁷PREFERRED PROVIDER ORGANIZATION]
[⁸EXCLUSIVE PROVIDER ORGANIZATION]
CERTIFICATE OF COVERAGE

Issued by
UnitedHealthcare Insurance Company of New York

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Group Policy between UnitedHealthcare Insurance Company of New York (hereinafter referred to as “We”, “Us”, or “Our”) and the Group listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

[⁷This Certificate offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our [⁶Choice; Choice Plus; Navigate Plus; Tiered; Charter; Core] network. You should always consider receiving health care services first through the in-network benefits portion of this Certificate. [¹²In-network care covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive in-network benefits, You must contact Your Primary Care Physician before You obtain the services except for services to treat an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate.]
2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge. Some Covered services, such as Preventive Care for adults are only Covered when received from Participating Providers and are not Covered as

out-of-network benefits. See the Schedule of Benefits section of this Certificate for more information.]

[⁹This Certificate offers You the option to receive Covered Services on three benefit levels:

1. **In-Network Preferred Benefits.** In-network preferred benefits are the highest level of coverage available. In-network preferred benefits apply when Your care is provided by Preferred Providers in Our Tiered network. You should always consider receiving health services first through Our Preferred Providers in Our Tiered network.
2. **In-Network Benefits.** In-network benefits are the intermediate level of coverage available. In-network benefits apply when Your care is provided by Participating Providers that are not Preferred Providers and are in Our Choice Plus network. You should always consider receiving health care services first through Preferred Providers and then from Participating Providers that are not Preferred Providers.
3. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. See the Schedule of Benefits in Section XV - Schedule of Benefits of this Certificate for more information.]

[⁸**In-Network Benefits.** This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our [⁶Choice; Choice Plus; Navigate Plus; Tiered; Charter; Core] network. [¹²Care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Physician before You obtain the services except for services to treat an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate.] Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.]

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

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

[1Officer Signature, name and title]

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Riders End of Certificate

Section I - Definitions

Defined terms will appear capitalized throughout this Certificate.

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

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. [⁷If your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.]

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

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

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

Certificate: This Certificate issued by UnitedHealthcare Insurance Company of New York, including the Schedule of Benefits and any attached riders.

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

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

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

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

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

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

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

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

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public

Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

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

Group: The employer or party that has entered into an agreement with Us as a policyholder.

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

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

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

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

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

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);

- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitatory care.

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

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

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

[⁷In-Network Coinsurance: Your share of the Costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider [⁹or to a Preferred Provider]. The amount can vary by the type of Covered Service.]

[⁷In-Network Copayment: A fixed amount You pay directly to a Participating Provider [⁹or to a Preferred Provider] for a Covered Service when You receive the Covered Service. The amount can vary by the type of Covered Service.]

[⁷In-Network Deductible: The amount you owe before We begin to pay for Covered Services received from Participating Providers [⁹or to a Preferred Provider]. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.]

[⁷In-Network Out-of-Pocket Limit: The most you pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers [⁹or to a Preferred Provider]. This limit never includes Your Premium or services We do not Cover.]

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

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

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

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. [⁷You will pay more to see a Non-Participating Provider.] [⁸The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.]

[⁷Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to

pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.]

[⁷**Out-of-Network Copayment:** A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.]

[⁷**Out-of-Network Deductible:** The amount you owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Copayments are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.]

[⁷**Out-of-Network Out-of-Pocket Limit:** The most you pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.]

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at [¹XXX] or upon Your request to Us. The list will be revised from time to time by Us. [⁹You will pay higher Cost-Sharing to see a Participating Provider as compared to a Preferred Provider, but less than if You received Covered Services from a Non-Participating Provider.]

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

Plan Year: [²⁵The 12-month period beginning on the effective date of the Policy or any anniversary date thereafter, during which the Policy is in effect.] [²⁶A calendar year ending on December 31 of each year.]

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

[⁹**Preferred Provider:** A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.]

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

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law.

[¹²**Referral:** An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate a Referral will not be made to a Non-Participating Provider.]

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

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements^[12], Referral requirements] and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: [²⁸Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Niagara, Orleans, Erie, Genesee, Wyoming, Chautauqua, Cattaraugus, Allegany, Delaware, Monroe, Wayne, Livingston, Ontario, Yates, Seneca, Broome, Onodaga, Tioga, Cortland, Cayuga, Tompkins, Schuyler, Chemung, Steuben, Jefferson, Oswego, Lewis, Madison, Oneida, Otsego, Chenago, Herkimer, Clinton, Essex, Franklin, Hamilton, St. Lawrence, Suffolk, Nassau.] [²⁹Suffolk, Nassau, Queens.]

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility

under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

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

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse ^[22]and a domestic partner].

Subscriber: The person to whom this Certificate is issued.

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

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

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: UnitedHealthcare Insurance Company of New York and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

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

You, Your: The Member.

Section II - How Your Coverage Works

- A. **Your Coverage under this Certificate.** Your employer (referred to as the “Group”) has purchased a Group health insurance Policy from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.
- B. **Covered Services.** You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:
- Medically Necessary;
 - Provided by a Participating Provider [⁷for in-network Coverage];
 - Listed as a Covered Service;
 - Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
 - Received while Your Certificate is in force.

[³⁰When you are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.]

- C. **Participating Providers.** To find out if a Provider is a Participating Provider:
- Check Your Provider directory, available at Your request;
 - Call the number on your ID card; or
 - Visit Our website at [¹XXX].

[⁹D. **Preferred Providers.** Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.]

[E.]. **The Role of Primary Care Physicians.** This Certificate [¹²has] [¹³does not have] a gatekeeper, usually known as a Primary Care Physician ("PCP"). You [¹³do not] need a written Referral from a PCP before receiving Specialist care. [¹²You may select any participating PCP who is available from the list of PCPs in the [⁸EPO] [⁷PPO] [⁶Choice; Choice Plus; Navigate Plus; Tiered; Charter; Core] Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general

practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.]

1. [¹² **Services Not Requiring a Referral from Your PCP.** Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- ◆ Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- ◆ Emergency Services;
- ◆ Pre-Hospital emergency Medical Services and emergency ambulance transportation;

However, the Participating Provider must discuss the services and treatment plan with Your PCP; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Certificate for the services that require a Referral.]

You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits section of this Certificate for the services that require Preauthorization.

2. [¹² **Access to Providers and Changing Providers.** Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are an Oxford Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When you go to the Provider's office, bring Your ID card with You.

You may change your PCP by selecting a new Provider from our Roster and either contacting Us at the Customer Service number on your ID card or by accessing our website. This can be done at any time and the change will be effective immediately.

[¹²You may change your Specialist by asking your PCP to refer you to another Network Specialist of your choice. This can be done at any time. The change will be effective upon your PCP issuing a new referral.]

[F]. **Services Subject to Preauthorization.** Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is responsible

for requesting Preauthorization for in-network services [7 and You are responsible for requesting Preauthorization for the out-of-network services listed in the Schedule of Benefits section of this Certificate].

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

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

We may base Our decision on a review of:

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

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;

- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See the Utilization Review and External Appeals sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

[I]. Protection from Surprise Bills.

A surprise bill is a bill You receive for Covered Services provided on or after April 1, 2015 in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
 - ♦ A participating Physician is unavailable at the time the health care services are performed;
 - ♦ A non-participating Physician performs services without Your knowledge; or
 - ♦ Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us.

You will be held harmless for any non-participating Physician charges for the surprise bill that exceed Your [⁷In-Network] Copayment, Deductible or Coinsurance if You assign benefits to the non-participating Physician in writing. In such cases, the non-participating Physician may only bill You for Your [⁷In-Network] Copayment, Deductible or Coinsurance.

[J]. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s) , and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

[K]. Important Telephone Numbers and Addresses.

- **CLAIMS**

[¹XXX-XXX-XXXX]

*Submit claim forms to this address.

- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**

[¹XXX-XXX-XXXX]

- **MEDICAL EMERGENCIES AND URGENT CARE**

[¹XXX-XXX-XXXX]

[¹Monday - Friday 8:00 a.m. - 5:00 p.m.]

[¹Evenings, Weekends and Holidays]

- **CUSTOMER SERVICE**

[¹XXX-XXX-XXXX]

* Customer Service Representatives are available [¹Monday – Friday 8:00 a.m. – 5:00 p.m.]

- **PREAUTHORIZATION**

[¹XXX-XXX-XXXX]

- **OUR WEBSITE**

[¹XXX]

Section III - Access to Care and Transitional Care

A. [¹²Referral] [¹³ Authorization] to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve [¹²a Referral] [¹³an authorization] to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the [¹²Referral] [¹³authorization] to a specific Non-Participating Provider. Approvals of [¹²Referrals] [¹³authorizations] to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the [¹²Referral] [¹³authorization], all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event [¹²a Referral] [¹³an authorization] is not approved, any services rendered by a Non-Participating Provider will not be Covered.

[¹²B. When a Specialist Can Be Your Primary Care Physician.

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

[¹²C. Standing Referral to a Participating Specialist.

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

the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.]

[¹²D. **Specialty Care Center.**

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

[E.] **When Your Provider Leaves the Network.**

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

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

[F.] **New Members In a Course of Treatment**

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

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

Section IV - Cost-Sharing Expenses and Allowed Amount

[A.] [²Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year. [⁹There are different Deductibles for services provided by Preferred Providers and Participating Providers. The Deductibles for Preferred Providers and Participating Providers apply to Covered in-network Services.] [⁹In-network Cost-Sharing amounts to which a Deductible applies accumulate toward both the Deductibles for Preferred Providers and for Participating Providers.]

[³Deductible. Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Schedule of Benefits section of this Certificate for Covered in-network Services under this Certificate during each Plan Year before We provide coverage for any person covered under this Certificate. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.]

[⁷You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**]

[³¹The Deductible runs from January 1 to December 31 of each calendar year.]

[¹⁴**Prescription Drug Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Prescription Drugs during each Plan Year before We provide coverage. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**]

[³²There is no Deductible for Covered Services under this Certificate during each Plan Year.]

[B.] **Copayments.** Except where stated otherwise, [²¹after You have satisfied the Deductible as described above,] You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

[C.] **Coinsurance.** Except where stated otherwise, [²¹after You have satisfied the Deductible described above,] You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your [⁷In-Network or Out-of-Network] benefit as shown in the Schedule of Benefits section of this Certificate. [⁷You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.]

[D.] [⁷In-Network] **Out-of-Pocket Limit.** When You have met Your [⁷In-Network] Out-of-Pocket Limit in payment of [⁷In-Network] Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered [⁷In-Network] Services for the remainder of that Plan Year. If You have other than individual coverage, the individual [⁷In-Network] Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual [⁷In-Network] Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family [⁷In-Network] Out-of-Pocket Limit in payment of [⁷In-Network] Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. [⁹There are different Out-of-Pocket limits for services provided by Preferred Providers and Participating Providers. The Out-of-Pocket limits for Preferred Providers and Participating Providers apply to Covered in-network Services.] [⁹In-network Cost-Sharing amounts to which an Out-of-Pocket limit applies accumulate toward both the Out-of-Pocket Limits for Preferred Providers and for Participating Providers.] [⁷Cost-sharing for out-of-network services, except for Emergency Services [⁸and out-of-network dialysis] does not apply toward your In-Network Out-of-Pocket Limit.]

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

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

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for an Emergency Condition.

Section V - Who Is Covered

- A. Who is Covered Under this Certificate.** You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. Your employer must have an office location in Our Service Area. You must live, work, or reside in a state in which we are authorized to deliver a Certificate. This list presently includes New York, New Jersey, Connecticut and other states outside of the New York tri-state area. If you would like to confirm if your state is on the list, you may do so by calling the Customer Service number on your ID card. Members of Your family may also be covered depending on the type of coverage You selected.
- B. Types of Coverage.** We offer the following types of coverage:
1. Individual. If You selected individual coverage, then You are covered.
 2. Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered.
 3. Parent and Child/Children. If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
 4. Family. If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.
- C. Children Covered Under This Certificate.** If You selected parent and child/children or family coverage, “Children” covered under this Certificate include Your natural Children, legally adopted Children, step Children, foster children and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the end of the year in which the Child turns [426] years of age. Coverage also includes Children for whom You are a [20 permanent] legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Grandchildren are not Covered.
- Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child’s attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

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

D. When Coverage Begins. Coverage under this Certificate will begin as follows:

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

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

1. Termination of employment;

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

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

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

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

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

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

Section VI – Preventive Care

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

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

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

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the

Covered preventive Services is available on Our website at [¹XXX], or will be mailed to You upon request.

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

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

- C. Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.
- D. Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at [¹XXX], or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.
- E. Mammograms.** We Cover mammograms for the screening of breast cancer as follows:
- One baseline screening mammogram for women age 35 through 39; and
 - One baseline screening mammogram annually for women age 40 and over.

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

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

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

F. Family Planning & Reproductive Health Services. ^[5]We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

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

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

^[33]Family planning and reproductive health services, such as contraceptive drugs and devices and sterilization procedures, are not Covered under the Certificate. You may purchase coverage for these services directly from Us.]

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

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

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

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

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate

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

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Section VII – Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation. We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

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

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

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

We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide

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

- From a non-participating Hospital to a participating Hospital;

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

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:
 - ◆ The point of pick-up is inaccessible by land vehicle; or
 - ◆ Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Section VIII - Emergency Services and Urgent Care

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

A. Emergency Services. We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

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

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

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

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

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

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

- 1.. Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department.** If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

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

[⁷We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital. Any inpatient Hospital services received from a non-participating Hospital after Your medical condition no longer prevents Your transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing, unless We authorize continued treatment at the non-participating Hospital.]

[⁸We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital, unless We authorize continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital will not be Covered.]

- 3. Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare.

The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Copayment, Deductible or Coinsurance . [²⁴You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.]

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

- 1. In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.
- 2. Out-of-Network.** We do not Cover Urgent Care from non-participating Urgent Care Centers or Physicians.

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

Section IX - Outpatient and Professional Services

(for other than Mental Health and Substance Use)

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

- A.** [¹⁵Acupuncture. We Cover acupuncture services.]
- [B.] Advanced Imaging Services.** We Cover PET scans, MRI, nuclear medicine, and CAT scans.
- [C.] Allergy Testing and Treatment.** We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.
- [D.] Ambulatory Surgery Center.** We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.
- [E.] Chemotherapy.** We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.
- [F.] Chiropractic Services.** We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.
- [G.] Clinical Trials.** We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:
- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
 - Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of

managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

[H.] Dialysis. We Cover dialysis treatments of an Acute or chronic kidney ailment.

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

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.]

[I.] Habilitation Services. We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per year for physical therapy, speech therapy and occupational therapy combined.

[J.] Home Health Care. We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional n;
- Part-time or intermittent services of a home health aide;
- Physical, occupational, or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

^[19]Home Health Care is limited to [60] visits per calendar year.] Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is considered one visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

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

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services.

Basic infertility services include:

- ♦ Initial evaluation;
- ♦ Semen analysis;
- ♦ Laboratory evaluation;
- ♦ Evaluation of ovulatory function;
- ♦ Postcoital test;
- ♦ Endometrial biopsy;
- ♦ Pelvic ultra sound;
- ♦ Hysterosalpingogram;
- ♦ Sono-hystogram;
- ♦ Testis biopsy;
- ♦ Blood tests; and

- ♦ Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. Comprehensive Infertility Services. If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

Comprehensive infertility services include:

- ♦ Ovulation induction and monitoring;
- ♦ Pelvic ultra sound;
- ♦ Artificial insemination;
- ♦ Hysteroscopy;
- ♦ Laparoscopy; and
- ♦ Laparotomy.

3. Exclusions and Limitations. We do not Cover:

- ♦ In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- ♦ Costs for an ovum donor or donor sperm;
- ♦ Sperm storage costs;
- ♦ Cryopreservation and storage of embryos;
- ♦ Ovulation predictor kits;
- ♦ Reversal of tubal ligations;
- ♦ Reversal of vasectomies;
- ♦ Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- ♦ Sex change procedures;
- ♦ Cloning; or
- ♦ Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

[L.] Infusion Therapy. We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the

muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

[M.] Interruption of Pregnancy. We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest or fetal malformation. ⁵We Cover elective abortions.]

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

[O.] Maternity and Newborn Care. We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

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

[P.] Medications for Use in the Office. We Cover medications and injectables (excluding self-injectables used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

[Q.] Office Visits. We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

[R.] Outpatient Hospital Services. We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

[S.] Preadmission Testing. We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven days of the tests; and
- The patient is physically present at the Hospital for the tests.

[T.] Rehabilitation Services. We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per year for physical therapy, speech therapy and occupational therapy combined.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

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

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

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

[U.] Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-participating Provider on an in-network basis when Your attending Physician provides a written Referral to a Non-Participating Specialist.
2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.
3. **Required Second Surgical Opinion.** We may require a second opinion before We Preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
 - ♦ The second opinion must be given by a board certified Specialist who personally examines You.

- ♦ If the first and second opinions do not agree, You may obtain a third opinion.
- ♦ The second and third surgical opinion consultants may not perform the surgery on You.

4. Second Opinions in Other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

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

Sometimes two or more surgical procedures can be performed during the same operation.

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

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

[W.] Oral Surgery. We Cover the following limited dental and oral surgical procedures:

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

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

[Y.] Other Reconstructive and Corrective Surgery. We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

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

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

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

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

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

Section X - Additional Benefits, Equipment and Devices

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

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

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

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

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

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

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.
5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.
7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for Persons With

Developmental Disabilities shall not affect Coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

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

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

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

- 1. Equipment and Supplies.** We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:
 - ◆ Acetone reagent strips
 - ◆ Acetone reagent tablets
 - ◆ Alcohol or peroxide by the pint
 - ◆ Alcohol wipes
 - ◆ All insulin preparations
 - ◆ Automatic blood lance kit
 - ◆ Blood glucose kit
 - ◆ Blood glucose strips (test or reagent)
 - ◆ Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
 - ◆ Cartridges for the visually impaired
 - ◆ Diabetes data management systems

- ◆ Disposable insulin and pen cartridges
- ◆ Drawing-up devices for the visually impaired
- ◆ Equipment for use of the pump
- ◆ Glucagon for injection to increase blood glucose concentration
- ◆ Glucose acetone reagent strips
- ◆ Glucose reagent strips
- ◆ Glucose reagent tape
- ◆ Injection aides
- ◆ Injector (Busher) Automatic
- ◆ Insulin
- ◆ Insulin cartridge delivery
- ◆ Insulin infusion devices
- ◆ Insulin pump
- ◆ Lancets
- ◆ Oral agents such as glucose tablets and gels
- ◆ Oral anti-diabetic agents used to reduce blood sugar levels
- ◆ Syringe with needle; sterile 1 cc box
- ◆ Urine testing products for glucose and ketones
- ◆ Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through Participating pharmacies. If you require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling the number on Your ID card. Our Medical Director will make all medical exception determinations.

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

- ♦ By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
 - ♦ Upon the referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
 - ♦ Education will also be provided in Your home when Medically Necessary.
- 3. Limitations.** The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

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

- 1. Durable Medical Equipment.** Durable Medical Equipment is equipment which is:
- ♦ Designed and intended for repeated use;
 - ♦ Primarily and customarily used to serve a medical purpose;
 - ♦ Generally not useful to a person in the absence of disease or injury; and
 - ♦ Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We do not Cover over-the-counter durable medical equipment. We will determine whether to rent or purchase such equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) , as it does not meet the definition of durable medical equipment.

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

D. Hearing Aids. We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from

slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

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

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

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

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

- E. Hospice.** Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

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

- F. Medical Supplies.** We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the “Diabetic Equipment, Supplies, and Self-Management” Education section above for a description of diabetic supply Coverage.

- [G. ²³Orthotics:** We Cover orthotics (e.g., shoe inserts) that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We Cover replacements: due to a change in Your condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced;

or when there has been an irreparable change in the condition of the device due to normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.]

[H]. Prosthetics.

- 1. External Prosthetic Devices.** We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Pediatric Vision Care section of this Certificate.

We do not Cover orthotics (e.g., shoe inserts)..

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

Coverage is for standard equipment only.

- ◆ **External Prosthetic Devices for Adults.** For adults, We Cover the cost of one prosthetic device, once every three years. We do not Cover the cost of repair or replacement.
- ◆ **External Prosthetic Devices for Children.** For children, We Cover the cost of one prosthetic device, per limb, per lifetime. We Cover the cost of replacement for children, but only if the previous device has been outgrown. We do not Cover the cost of repairs.

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

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

Section XI - Inpatient Services

(for other than Mental Health and Substance Use)

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

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

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

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

B. Observation Services. We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician

decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

- C. Inpatient Medical Services.** We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.
- D. Inpatient Stay for Maternity Care.** We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.
- E. Inpatient Stay for Mastectomy Care.** We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.
- F. Autologous Blood Banking Services.** We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.
- G. Rehabilitation Services.** We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for up to 60 days per calendar Year.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy it is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

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

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

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

H. Skilled Nursing Facility. We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. [¹⁷We Cover up to [200] days, per calendar Year, for non-custodial care.]

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

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

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

J. Centers of Excellence. Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover the following Services only when performed at Centers of Excellence:

- Bariatric surgery;
- Transplants.

K. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.

2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

Section XII - Mental Health Care and Substance Use Services

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

A. Mental Health Care Services.

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

- ♦ A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- ♦ A state or local government run psychiatric inpatient Facility;
- ♦ A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- ♦ A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed

psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

3. Limitations/Terms of Coverage. We do not Cover:

- ◆ Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- ◆ Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- ◆ Services solely because they are ordered by a court.

B. Substance Use Services.

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

We also Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. Outpatient Services. We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency, including methadone treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

We also Cover up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependency. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Section XIII - Prescription Drug Coverage

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

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

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

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn’s disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.

- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- [\[⁵Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.\]](#)

You may request a copy of Our drug Formulary. Our drug Formulary is also available on Our website at [\[¹XXX\]](#). You may inquire if a specific drug is Covered under this Certificate by contacting Us at the number on Your ID card.

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

C. Benefit and Payment Information.

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

You have a three tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on Tier 1 and

highest for Prescription Drugs on Tier 3. Your out-of-pocket expense for Prescription Drugs on Tier 2 will generally be more than for Tier 1 but less than Tier 3.

An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance. The cost difference does not apply toward Your [7 In-Network] Out-of-Pocket Limit.

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

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

- ♦ The applicable Cost-Sharing; or
- ♦ The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

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

In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card or visit our website at [1XXX] to request approval.

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

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

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

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

- ◆ [²⁷Age related macular edema;
- ◆ Anemia, neutropenia, thrombocytopenia;
- ◆ Contraceptives;
- ◆ Crohn's disease;
- ◆ Cystic fibrosis;
- ◆ Cytomegalovirus;
- ◆ Endocrine disorders/neurologic disorders such as infantile spasms;
- ◆ Enzyme deficiencies/liposomal storage disorders;
- ◆ Gaucher's disease;
- ◆ Growth hormone;
- ◆ Hemophilia;
- ◆ Hepatitis B, hepatitis C;
- ◆ Hereditary angioedema;
- ◆ HIV/AIDS;
- ◆ Immune deficiency;
- ◆ Immune modulator;
- ◆ Infertility;
- ◆ Iron overload;
- ◆ Iron toxicity;
- ◆ Multiple sclerosis;
- ◆ Oral oncology;
- ◆ Osteoarthritis;
- ◆ Osteoporosis;
- ◆ Parkinson's disease;
- ◆ Pulmonary arterial hypertension;
- ◆ Respiratory condition;
- ◆ Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis);

- ♦ [Transplant;](#)
 - ♦ [RSV prevention.\]](#)
5. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order supplier. You are responsible for paying the lower of:
- ♦ The applicable Cost-Sharing; or
 - ♦ The Prescription Drug Cost for that Prescription Drug.

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

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

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

For maintenance Prescription Drugs, You may obtain Your first two (2) Prescription Orders at a retail Participating Pharmacy. After Your first two (2) Prescription Orders, you must obtain maintenance Prescription Drugs from Our mail order pharmacy or You must opt out of obtaining Your maintenance Prescription Drugs from Our mail order pharmacy. You may opt out by visiting Our website at [¹XXX] or by calling the number on your ID card. You must opt out on an annual basis for each different prescription drug.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at [¹XXX] or by calling the number on Your ID card. The maintenance drug list is updated periodically. Visit Our website or call the number on your ID card to find out if a particular drug is on the maintenance list.

6. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You

may access the most up to date tier status on Our website at [1XXX] or by calling the number on Your ID card.

7. **When a Brand-Name Drug Becomes Available as a Generic.** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of this Certificate.
8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You may request a Formulary exception for a clinically-appropriate Prescription Drug. Visit Our website at [1XXX] or call the number on your ID card to find out more about this process.
9. **Supply Limits.** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at [1XXX] or by the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeals sections of this Certificate.
10. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits section of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under the Outpatient and Professional Services section of this Certificate.
11. **Half Tablet Program.** Certain Prescription Drugs may be designated as eligible for Our voluntary half tablet program. This program provides the opportunity to reduce Your Prescription Drug out-of-pocket expenses by up to 50% by using higher strength tablets and splitting them in half. If You are taking an eligible Prescription Drug, and You would like to participate in this

program, please call Your Physician to see if the half tablet program is appropriate for Your condition. If Your Physician agrees, he or she must write a new prescription for Your medication to enable Your participation.

You can determine whether a Prescription Drug is eligible for the voluntary half tablet program by accessing Our website at [1XXX] or by calling the number on Your ID card.

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

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

For a list of Prescription Drugs that need Preauthorization, please visit Our website at [1XXX] or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one type of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list.

E. Limitations/Terms of Coverage.

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

pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug, **they are not essentially the same as a Prescription Drug from a manufacturer** and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require Your Provider to obtain Preauthorization.
4. Various specific and/or generalized “use management” protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
5. Injectable drugs (other than self-administered injectable drugs) are not Covered under this section but are Covered under other sections of this Certificate. Your benefit for diabetic insulin, oral hypoglycemics, and diabetic Prescription Drugs will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Additional Benefits, Equipment and Devices section of this Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Certificate.
7. We do not Cover drugs that do not by law require a prescription, except [¹⁸for smoking cessation drugs or] as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.
8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to

the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.
11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

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

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

1. **Brand-Name Drug:** A Prescription Drug that 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the

manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.
3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at [1XXX] or by calling the number on Your ID card.
4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as “generic” by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.
5. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members.
6. **Participating Pharmacy:** A pharmacy that has:
 - ◆ Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
 - ◆ Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
 - ◆ Been designated by Us as a Participating Pharmacy.

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

7. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.
8. **Prescription Drug Cost:** The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

9. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.
10. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the New York Education Law.

Section XIV - Wellness Benefits

A. **Wellness Program.** We offer a wellness program that seeks to increase consumer awareness and engage you in wellness activities. Participation is available to Subscribers and Enrolled Dependent Spouses and is completely voluntary.

1. **Biometric Health Screenings.** This program includes a biometric health screening which you can perform using a home screening kit. To order your home screening kit, you can call [1XXX] or log onto [1XXX]. The home screening kit will be mailed to your home or office and will contain all the instructions you need to complete the screening.

The following screenings will be performed: [³⁴blood pressure, cholesterol, body mass index and nicotine].

2. **Telephone-Based Health Coaching Program.** You may also choose to participate in a Telephone-Based Wellness Coaching Program. You may enroll in the program at any time by calling [1XXX] and following the telephonic prompt instructions.

The Telephone-Based Health Coaching Programs typically run for three to six months and cover the following topics:

- ◆ [³⁴Diabetes
- ◆ Exercise
- ◆ Heart health
- ◆ Nutrition
- ◆ Smoking cessation
- ◆ Stress
- ◆ Weight loss]

Section XV - Pediatric Vision Care

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

- A. Pediatric Vision Care.** We Cover emergency, preventive and routine vision care for Members up to age 19.
- B. Vision Examinations.** We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any twelve (12) month period unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:
- Case history;
 - External examination of the eye or internal examination of the eye;
 - Ophthalmoscopic exam;
 - Determination of refractive status;
 - Binocular distance;
 - Tonometry tests for glaucoma;
 - Gross visual fields and color vision testing; and
 - Summary findings and recommendation for corrective lenses.
- C. Prescribed Lenses and Frames.** We Cover standard prescription lenses or contact lenses for Members up to age 19, one (1) time in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames for Members up to age 19, adequate to hold lenses one (1) time in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

We do not Cover prescribed lenses and frames for Members over the age of 18.

Section XVI - Pediatric Dental Care

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

We Cover the following dental care services for Members up to age 19:

- A. Emergency Dental Care.** We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.
- B. Preventive Dental Care.** We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
 - Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
 - Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
 - Sealants on unrestored permanent molar teeth; and
 - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- C. Routine Dental Care.** We Cover routine dental care provided in the office of a dentist, including:
 - Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
 - X-rays, full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
 - Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
 - In-office conscious sedation;
 - Amalgam, composite restorations and stainless steel crowns; and
 - Other restorative materials appropriate for children.
- D. Endodontics.** We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.
- E. Periodontics.** We Cover periodontic services, including periodontic services in anticipation of, or leading to orthodontics Covered under this Certificate.
- F. Prosthodontics.** We Cover prosthodontic services as follows:
 - Removable complete or partial dentures, including six (6) months follow-up care; and

- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

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

Procedures include but are not limited to:

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

Section – XVII Exclusions

No coverage is available under this Certificate for the following:

- A. Aviation.** We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- B. Convalescent and Custodial Care.** We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.
- C. Cosmetic Services.** We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.
- D. Coverage Outside of the United States, Canada or Mexico.** We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.
- E. Dental Services.** We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.
- F. Experimental or Investigational Treatment.** We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational

treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

- G. Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).
- H. Foot Care.** We do not Cover routine foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.
- I. Government Facility.** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.
- J. Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device, or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.
- K. Medicare or Other Governmental Program.** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).
- L. Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- M. No-Fault Automobile Insurance.** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.
- N. Services not Listed.** We do not Cover services that are not listed in this Certificate as being Covered.
- O. Services Provided by a Family Member.** We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.
- P. Services Separately Billed by Hospital Employees.** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

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

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

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

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

Section XVIII - Claim Determinations

- A. Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.
- B. Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at [1XXX]. Completed claim forms should be sent to the address in the How Your Coverage Works of this Certificate or on Your ID card. Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, You may also submit a claim to Us electronically by visiting our website at [1XXX].
- C. Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 day period, You must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.
- D. Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.
- E. Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials [12and Referrals]. If You disagree with Our claim determination You may submit a Grievance pursuant to the Grievance section of this Certificate.

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

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received.

If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination [¹²or Referral]), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

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

2. **Urgent Pre-service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three (3) calendar days of the decision.

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

Section XIX – Grievance Procedures

- A. Grievances.** Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.
- B. Filing a Grievance.** You can contact Us at the number on Your ID card or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

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

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

Expedited/Urgent Grievances:

By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances:

(A claim for a service or a treatment that has already been provided.)

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

All Other Grievances:

(That are not in relation to a claim or request for service.)

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

- D. Grievance Appeals.** If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on

Your ID card or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

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

<u>Expedited/Urgent Grievances:</u>	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.
<u>Pre-Service Grievances:</u> (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
<u>Post-Service Grievances:</u> (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
<u>All Other Grievances:</u> (That are not in relation to a claim or request for service.)	30 calendar days of receipt of Your Appeal.

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

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010

Or call toll free: 1-888-614-5400 Or e-mail cha@cssny.org
www.communityhealthadvocates.org

Section XX - Utilization Review

- A. Utilization Review.** We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at [¹XXX].

B. Preauthorization Reviews.

1. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

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

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and

Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour time period.

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

C. Concurrent Reviews.

1. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within one (1) business day of the end of the 45-day time period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour time period.

D. Retrospective Reviews.

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

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

E. Retrospective Review of Preauthorized Services. We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

F. Reconsideration. If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

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

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically

manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

- 1. Out of Network Service Denial.** Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service You request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating Your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:

 - ♦ A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
 - ♦ Two (2) documents from the available medical and scientific evidence that the Out-of-Network service: 1) Is likely to be more clinically beneficial to You than the alternate In-Network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.
- 2. Out-of-Network Referral Denial.** Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

 - ♦ That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

- ♦ Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. First Level Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

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

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

- I. **Second level Appeal.** If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

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

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

- J. Appeal Assistance.** If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates

105 East 22nd Street

New York, NY 10010

Or call toll free: 1-888-614-5400, or email cha@cssny.org

www.communityhealthadvocates.org

Section XXI - External Appeal

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

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

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - ♦ We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - ♦ You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - ♦ We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

- B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.**

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

- C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.** If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**

2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

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

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

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

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, if We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

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

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

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

- E. Your Right to Appeal an Out-of-Network Referral Denial.** Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, if We have denied coverage of a request for an authorization to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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

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

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

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

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal

Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

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

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

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

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

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

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

SECTION XXII – Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments. [³⁵We do not coordinate benefit payments for pediatric vision benefits.]

A. Definitions.

1. **“Allowable expense”** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. **“Plan”** is other group health coverage with which We will coordinate benefits. The term “plan” includes:
 - ♦ Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
 - ♦ Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
 - ♦ Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
3. **“Primary plan”** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. **“Secondary plan”** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment. The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - ♦ The plan of the parent who has custody will be primary;
 - ♦ If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
 - ♦ If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination. When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our

obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

- D. Right to Receive and Release Necessary Information.** We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.
- E. Our Right to Recover Overpayment.** If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.
- F. Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans.** We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:
1. If this Certificate is primary, as defined in this section, We will pay benefits first.
 2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer;
 3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

Section XXIII – Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The [10date on; end of month in] which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the year in which the Child turns [426] years of age.
6. For all other Dependents, the [10date on; end of month in] which the Dependent ceases to be eligible.
7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If the Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to [11 one year; Your enrollment under the Certificate].
9. The date that the Group Policy is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.
10. If We elect to terminate or cease offering all hospital, surgical and medical expense coverage in the small group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
13. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
14. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

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

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination for Your right to conversion to an individual Policy.

Section XXIV –Extension of Benefits

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

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

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

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

B. Termination of Extension of Benefits. Extended benefits will end on the earliest of the following:

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

C. Limits on Extended Benefits. We will not pay extended benefits:

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

Section XXV - Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health

plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

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

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

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

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

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

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

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

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty. If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

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

C. Availability of Age 29 Dependent Coverage Extension - Young Adult Option.

The Subscriber's Child may be eligible to purchase his or her own individual coverage under the Group's Policy through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase coverage even if he or she is not financially Dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

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

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

Section XXVI - Conversion Right to a New Contract after Termination

- A. Circumstances Giving Rise to Right to Conversion.** You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.
- 1. Termination of the Group Policy.** If the Group Policy between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as direct payment members.
 - 2. If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.
 - 3. On the Death of the Subscriber.** If coverage terminates under Section XI – Termination of Coverage of this Certificate because of the death of the Subscriber, the Subscriber’s Dependents are entitled to purchase a new Contract as direct payment members.
 - 4. Termination of Your Marriage.** If a Spouse’s coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
 - 5. Termination of Coverage of a Child.** If a Child’s coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
 - 6. Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.
 - 7. Termination of Your Young Adult Coverage.** If a Child’s young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.
- B. When to Apply for the New Contract.** If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract. We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four Contracts offered by Us. The coverage may not be the same as Your current coverage. If We determine that You do not reside in New York State, We may issue You or Your family members coverage on a form that We use for conversion in that state.

Section XXVII - General Provisions

- 1. Agreements Between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.
- 2. Assignment.** You cannot assign any benefits under this Certificate to any person, corporation, or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Physician for a surprise bill for Covered Services provided on and after April 1, 2015. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment by You other than monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.
- 3. Changes in this Certificate.** We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.
- 4. Choice of Law.** This Certificate shall be governed by the laws of the State of New York.
- 5. Clerical Error.** Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.
- 6. Conformity with Law.** Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.
- 7. Continuation of Benefit Limitations.** Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.
- 8. Enrollment ERISA.** The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the “plan administrator” as defined by the Employee Retirement Income Security Act of 1974, (“ERISA”). The “plan administrator” is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

The Group will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Policy with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

9. **Entire Agreement.** This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.
10. **Fraud and Abusive Billing.** We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.
11. **Furnishing Information and Audit.** The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group;s New York office.
12. **Identification Cards.** Identification ("ID") cards are issued by Us for identification purposes only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits Your Premiums must be paid in full at the time the services are sought to be received.
13. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.
14. **Independent Contractors.** Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while

receiving care from any Participating Provider or in any Participating Provider's Facility.

15. **Input in Developing Our Policies.** Subscribers may participate in the development of Our policies by contacting Us at the Customer Service number on your ID card.
16. **Material Accessibility.** We will give the Group, and the Group will give You, ID cards, Certificates, riders, and other necessary materials.
17. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.
 - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
 - The information that We provide the State regarding Our consumer complaints.
 - A copy of Our procedures for maintaining confidentiality of Member information.
 - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
 - A written description of Our quality assurance program.
 - A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
 - Provider affiliations with participating Hospitals.
 - A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
 - Written application procedures and minimum qualification requirements for Providers.
18. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: [1XXX].
19. **Premium Refund.** We will give any refund of Premiums, if due, to the Group.
20. **Recovery of Overpayments.** On occasion, a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is

proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. **Renewal Date.** The renewal date for this Certificate is the anniversary of the effective date of the Group Policy of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us or as permitted by this Certificate or by the Group upon 30 days' prior written notice to Us.
22. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.
21. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.
22. **Severability.** The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.
23. **Significant Change in Circumstances.** If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.
24. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party

(including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

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

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

25. **Third Party Beneficiaries.** No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate or to bring an action or pursuit for the breach of any terms of this Certificate.
26. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 3 years from the date the claim was required to be filed.
27. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please contact Us by calling the number on Your ID card to access these services.
28. **Venue for Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

29. **Waiver.** The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
30. **Who May Change this Certificate.** This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.
31. **Who Receives Payment under this Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.
32. **Workers' Compensation Not Affected.** The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.
38. **Your Medical Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
 - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
 - Permit copying of Your medical records by Us.

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

39. **Your Rights.** You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

Section XXVIII - Other Covered Services

- **Hemophilia Factor Benefits**

The following benefits for hemophilia factor are available only when provided by the specific participating Providers listed below:

1. Prescription Drug Coverage for Factor provided by a Participating Hemophilia Treatment Center

We Cover Hemophilia Factor that you self-administer or is administered by a non-skilled caregiver when it would otherwise be covered under your Prescription Drug benefits and it is dispensed by a Participating Hemophilia Treatment Center as part of your written treatment plan. This benefit will be provided in lieu of receiving Factor dispensed by a Designated Pharmacy under your Prescription Drug Coverage benefit. A "Hemophilia Treatment Center" (HTC) means a unique federally funded entity that specializes in comprehensive care for pediatric and adult individuals with inherited bleeding and clotting disorders. An HTC must be a licensed Facility that is also designated as a comprehensive hemophilia diagnostic treatment center receiving a grant under Section 501(a) (2) of the Social Security Act and participates in the 340B Drug Pricing Program.

Hemophilia Factor dispensed by an HTC will be Covered under your Chemotherapy benefit. You will be responsible to pay the applicable Chemotherapy cost-share shown in the Schedule of Benefits.

2. Non-Emergent Home Health Care - Assisted Administration of Factor

In addition to the Home Health Care Benefits available under Your Certificate, we will Cover non-emergent administration of Hemophilia Factor in Your home when provided by a Participating Home Health Agency certified or licensed by the appropriate state agency. This additional Home Health Care benefit covers both the Factor and the administration services when assisted administration is medically necessary. Coverage will be provided in lieu of receiving medically necessary Covered assisted-administration service from your Physician or another health practitioner in an office or out-patient setting.

Any visits for assisted administration of Hemophilia Factor in Your home count towards Your Home Health Care visit limit. The cost-share and definition of a visit in the Home Health Care Benefits shall apply to these additional services. See your Schedule of Benefits and Home Health Care benefit for more information. Please note this benefit only provides Coverage for assisted administration of Factor. It does not Cover Factor that you self-administer or that is administered by a non-skilled caregiver.

3. Preauthorization

The benefits covered by this Section require Preauthorization. Your Provider must call Us or Our vendor at the number indicated on Your ID card.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

4. Exclusions and limitations

Except as expressly modified by this Section, all of the exclusions and limitations of the Certificate apply to the benefits covered by this Section.

5. Controlling Policy

All of the terms, conditions, limitations, and exclusions of Your Certificate shall also apply to this Section except where specifically changed by this Section.

STATEMENT OF VARIABILITY

¹ The appropriate contact information (officer signature, website, phone number, mailing address, hours of operation, etc.) will be included.

² If a deductible applies, this language will be used with plans that are not HSA-eligible. If there is no deductible for the plan, this language will be removed.

³ If a deductible applies, this language will be used with plans that are HSA-eligible. If there is no deductible for the plan, this language will be removed.

⁴ The dependent age may be either 26 or 29.

⁵ Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law .

⁶ The appropriate network name will be included.

⁷ This language will be included in the Certificate when the Out-of-Network rider is issued. It will be removed when the Out-of-Network rider is not issued.

⁸ This language will be included in the Certificate when the Out-of-Network rider is not issued. It will be removed when the Out-of-Network rider is issued.

⁹ This language will be included when the plan includes a tiered network.

¹⁰ Depending upon the group's selection, coverage will terminate on either the end of the month or the date on which eligibility is lost.

¹¹ The appropriate language describing the retroactivity of the rescission provision will be included.

¹² If a referral from a PCP is required for in-network services this language will be included. If a referral from a PCP is not required for in-network services this language will be removed.

¹³ If a referral from a PCP is not required for in-network services this language will be included. If a referral from a PCP is required for in-network services this language will be removed.

¹⁴ If a separate prescription drug deductible is required this language will be included. If the prescription drug deductible is combined with the medical deductible this language will be removed.

¹⁵ If acupuncture services are covered this language will be included. If acupuncture services are excluded this language will be removed.

¹⁷ If a limit applies to SNF services, it will be at least 200 days. The limit may be increased and such increased limit will be reflected here. If SNF is unlimited, this language will be removed.

¹⁸ If smoking cessation is covered under the plan, this language will be included. If smoking cessation is not covered under the plan, this language will be removed.

¹⁹If a limit applies to home health care services, it will be at least 40 visits. The limit may be increased and such increased limit will be reflected here. If home health care is unlimited, this language will be removed.

²⁰ If permanent guardianship is required for eligibility this language will be included.

²¹If the plan includes a deductible this language will be included. If the plan does not include a deductible, this language will be removed.

²² If domestic partner coverage is purchased this language will be included. This language will be removed if domestic partner coverage is not purchased.

²³ If orthotics are covered this language will be included. If orthotics are excluded this language will be removed

²⁴ This language will be included when the plan is an EPO plan. Beginning with plans issued or renewed on and after 4/1/15 this language will also be included in all PPO plans.

²⁵ If the Plan Year is defined based on anniversary date this language will be included.

²⁶ If the Plan Year is defined based on a calendar year this language will be included.

²⁷ The list of drug classes that are part of the designated pharmacy program will be included.

²⁸ This list of counties will be included for the EPO and PPO products.

²⁹ This list of counties will be included for the tiered products.

³⁰ If coverage is limited to our service area this language will be included.

³¹ If the deductible runs on a calendar year this language will be included.

³² If the plan does not have a deductible this language will be used.

³³ Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.

³⁴ The list of included screenings and/or topics will be included.

³⁵ Include this language if benefits are not coordinated for pediatric vision.

Coverage for Contraceptive Drugs and Devices, Family Planning Services and Interruption of Pregnancy

- A. **General.** This rider amends the benefits of Your Certificate and provides Coverage for the following:
- We Cover contraceptive drugs or devices approved by the FDA or generic Prescription Drug equivalents approved as substitutes by the FDA. The contraceptive drug or device must be prescribed for You by a Provider that is legally authorized to prescribe pursuant to applicable law. Certain contraceptive drugs and devices may require an office visit, such as drugs or devices that require injection or insertion. We also Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider and counseling on the use of contraceptives and related topics, and sterilization procedures for women. Such contraceptive drugs or devices, office visit, family planning services and sterilization procedures are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.
 - We Cover vasectomies subject to Copayments, Deductibles or Coinsurance.
 - We Cover elective abortions for one procedure per Member, per Plan Year.
 - We do not Cover services related to the reversal of elective sterilizations.
- B. **Controlling Certificate.** All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Domestic Partner Rider

A. Domestic Partner Coverage. This rider amends Your Certificate to provide coverage for domestic partners. This rider covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under the Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 - a. The affidavit must be notarized and must contain the following:
 - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
 - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
 - The partners have been living together on a continuous basis prior to the date of the application;
 - Neither individual has been registered as a member of another domestic partnership within the last six months; and
 - b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
 - c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
 - A joint bank account;
 - A joint credit card or charge card;
 - Joint obligation on a loan;
 - Status as an authorized signatory on the partner's bank account, credit card or charge card;
 - Joint ownership of holdings or investments;
 - Joint ownership of residence;
 - Joint ownership of real estate other than residence;
 - Listing of both partners as tenants on the lease of the shared residence;

- ▶ Shared rental payments of residence (need not be shared 50/50)
- ▶ Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- ▶ A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- ▶ Shared household budget for purposes of receiving government benefits;
- ▶ Status of one as representative payee for the other's government benefits;
- ▶ Joint ownership of major items of personal property (e.g., appliances, furniture);
- ▶ Joint ownership of a motor vehicle;
- ▶ Joint responsibility for child care (e.g., school documents, guardianship);
- ▶ Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- ▶ Execution of wills naming each other as executor and/or beneficiary;
- ▶ Designation as beneficiary under the other's life insurance policy;
- ▶ Designation as beneficiary under the other's retirement benefits account;
- ▶ Mutual grant of durable power of attorney;
- ▶ Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- ▶ Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- ▶ Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

B. Controlling Certificate. All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Rider to Extend Coverage for Young Adults through Age 29

This rider which has been selected by the Group extends the eligibility of Children for coverage under Your Certificate and any applicable rider(s) thereto.

A. Young Adults Covered Through Age 29. If You selected parent and child /children or family coverage, Your young adult Child will be eligible for coverage until the ¹[day] [end of the [month] [year] in which] the child turns 30 years of age when the young adult:

1. Is unmarried;
2. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; and
3. Lives, works or resides in New York State or Our Service Area.

The young adult need not live with or be financially dependent upon You or be a student in order to be covered under this rider.

The young adult's children are not eligible for coverage under this rider.

Coverage under this rider terminates the ¹[day] [end of the [month] [year] in which] the Child turns 30 years of age.

B. Controlling Certificate. All of the terms, conditions, limitations and exclusions of Your Certificate to which this rider is attached also apply to this rider, except where specifically changed by this rider.

Statement of Variability

¹ The appropriate termination timeframe will be included (day, end of the month or end of the year).

Out-of-Network Benefits Rider

This rider amends Your Certificate to provide benefits for Covered Services that are received from Non-Participating Providers and have not been approved by Us to be covered on an in-network basis. These benefits are referred to as “out-of-network benefits” and are subject to greater Copayment, Deductible and Coinsurance amounts than the benefits available if You obtain the same services from Participating Providers.

- A. **Out-Of-Network Benefits.** Benefits under this rider are only available for Medically Necessary services provided by Non-Participating Providers [outside Our Service Area] which would have been Covered under Your Certificate if they had been provided by a Participating Provider. All services must be furnished by Providers appropriately licensed to provide the particular service being rendered. See the Schedule of Benefits section of this Certificate for a list of the services covered out-of-network. Some services are only Covered when You go to a Participating Provider.
- B. **Day and Limit Visitations.** In any case where benefits of the Certificate are limited to a certain number of days or visits, such limits shall apply in the aggregate to services provided pursuant to the Certificate and this rider. Any days or visits covered pursuant to this rider will reduce the number of days or visits available under the Certificate and vice versa.
- C. **Out-of-Network Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered out-of-network Services. See the Schedule of Benefits section of this Certificate for the services that require Preauthorization.
- D. **Preauthorization Procedure.** If You seek coverage for services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

- E. **Failure to Seek Preauthorization.** If You fail to seek Our Preauthorization for benefits subject to this section, We will pay an amount \$500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.
- F. **Out-of-Network Deductible.** This Certificate has a separate Out-of-Network Deductible in the Schedule of Benefits section of this Certificate that You must pay for Covered out-of-network Services during each Plan Year before We provide coverage for out-of-network services. If You have other than Individual coverage, the individual Out-of-Network Deductible applies to each person covered under this Certificate. However, after Out-of-Network Deductible payments for persons covered under this Certificate collectively total the family Out-of-Network Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Out-of-Network Deductible will be required for any person covered under this Certificate for that Plan Year. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Out-of-Network Deductible.** [¹The Out-of-Network Deductible runs from January 1 to December 31 of each calendar year.]
- G. **Out-of-Network Out-of-Pocket Limit.** This Certificate has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If you have other than individual coverage, the individual Out-of-Network Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual Out-of-Network Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for that person. If other than Individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. **Any charges of a Non-**

Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.

Cost-Sharing for in-network services does not apply toward your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in this rider does not apply toward Your Out-of-Network Out-of-Pocket Limit. [²The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.]

H. Your Additional Payments for Out-of-Network Benefits

When You receive Covered services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment.

- I. **Allowed Amount.** "Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this rider, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount for Non-Participating Providers as follows:

1. **Facilities.** For Facilities, the Allowed Amount will be 110% of the Medicare amount.

If there is no amount as described above, the Allowed Amount will be 50% of the Facility's charge.

2. **For All Other Providers.** For all other Providers, the Allowed Amount will be 110% of the Medicare amount.

If there is no amount as described above, We use a gap methodology established by a *OptumInsight* and/or a third party vendor that uses a relative

value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). [We and OptumInsight are related companies through common ownership by UnitedHealth Group.](#) Refer to our website for information regarding the vendor that provides the applicable gap fill relative value scale information.

3. **Physician-Administered Pharmaceuticals.** For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

If there is no amount as described above, the Allowed Amount will be 50% of the Provider's charge.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge.

Contact Us at the number on Your ID card or visit our website for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers. Medicare based rates referenced in and applied under this Section shall be updated no less than annually.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for an Emergency Condition.

- J. **Filing a Claim For Out of Network Benefits.** A claim must be filed with Us by You or the out-of-network Provider. Claims forms can be obtained from Us by calling the number on your ID card or by visiting our website.
- K. **Exclusions.** Except as expressly modified by this rider, all of the exclusions of the Certificate apply to the benefits covered by this rider.
- L. **Controlling Certificate.** All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Statement of Variability

¹ If the deductible runs on a calendar year this language will be included.

² If the out-of-pocket limit runs on a calendar year this language will be included.

SECTION XXVII - Choice Schedule of Benefits

Gold Plan

[¹Group Name]

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible Individual Family	\$850 \$1,700
Prescription Drug Deductible Individual Family	\$100 \$300
Out-of-Pocket Limit Individual Family	\$4,000 \$8,000
[⁵ Your Deductible and Out-of-Pocket Limit will accumulate on a calendar year.]	

Office Visits	Participating Provider Member Responsibility for Cost- Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$15 Copayment not subject to Deductible	See benefit for description

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
Medications Administered in Office	10% Coinsurance after Deductible	
Specialist Office Visits (or Home Visits) Medications Administered in Office <i>[¹Preauthorization; Referral Required]</i>	\$25 Copayment not subject to Deductible 10% Coinsurance after Deductible	See benefit for description
Preventive Care		
Well Child Visits and Immunizations*	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	
Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
Mammography Screenings*	Covered in full	
<i>[²Sterilization Procedures for Women*]</i>	<i>Covered in full]</i>	
<i>[²Vasectomy]</i>	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)]	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
Bone Density Testing*	Covered in full	
Screening for Prostate Cancer	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. <i>[^Referral Required]</i>	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$200 Copayment not subject to Deductible	See benefit for description
Urgent Care Center	\$75 Copayment not subject to	See benefit for description

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	Deductible	

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Advanced Imaging Services</p> <p>Performed in a Freestanding Radiology Facility or Office Setting</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	See benefit for description
<p>Allergy Testing & Treatment</p> <p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>\$15 Copayment not subject to Deductible</p> <p>\$25 Copayment not subject to Deductible</p>	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Ambulatory Surgical Center Facility Fee <i>[^Preauthorization; Referral Required]</i>	\$200 Copayment not subject to Deductible	See benefit for description
Anesthesia Services (all settings) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	\$15 Copayment not subject to Deductible \$15 Copayment not subject to Deductible Included As Part of Inpatient Hospital Service Cost-Sharing	See benefit for description
Chemotherapy Performed in a PCP Office Performed in a Specialist Office	10% Coinsurance after Deductible 10% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	
Chiropractic Services <i>[^Preauthorization; Referral Required]</i>	\$15 Copayment not subject to Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See benefit for description
Dialysis Performed in a PCP Office Performed in a Freestanding Center or	10% Coinsurance after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Specialist Office Setting Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible	10 visits per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[^Preauthorization; Referral Required]</i>	\$15 Copayment not subject to Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance not subject to Deductible	60 visits per Plan Year
Infertility Services <i>[^Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy Performed in a PCP Office	10% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p>Home Infusion Therapy</p> <p><i>[↑Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	
<p>Inpatient Medical Visits</p> <p><i>[↑Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Laboratory Procedures</p> <p>Performed in a PCP Office</p> <p>Performed in a Freestanding Laboratory Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[↑Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>See benefit for description</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Maternity & Newborn Care</p> <p>Prenatal Care</p> <p>Inpatient Hospital Services and Birthing Center</p> <p>Physician and Midwife Services for Delivery</p> <p>Breast Pump</p> <p>Postnatal Care</p> <p><i>[^Preauthorization Required [for Inpatient Services; Breast Pump]</i></p>	<p>Covered in Full</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>Covered in Full</p> <p>\$25 Copayment not subject to Deductible</p>	<p>See benefit for description</p> <p>1 Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>\$200 Copayment not subject to Deductible</p>	<p>See benefit for description</p>
<p>Preadmission Testing</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)</p>	<p>See benefit for description</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Diagnostic Radiology Services Performed in a PCP Office</p> <p>Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i></p>	<p>\$15 Copayment not subject to Deductible</p>	<p>60 visits per Plan Year for PT/OT/ST combined. Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Second Opinions on the Diagnosis of Cancer, Surgery & Other <i>[^Preauthorization; Referral Required]</i>	\$25 Copayment not subject to Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$15 Copayment not subject to Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$15 Copayment not subject to Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[^Preauthorization; Referral Required [for Insulin Pump]]</i>	\$15 Copayment not subject to Deductible \$15 Copayment not subject to Deductible	See benefit for description
Durable Medical Equipment & Braces <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	One per ear per time Covered

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
Hospice Care Inpatient Outpatient <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible	5 visits for family bereavement counseling
Medical Supplies <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	See benefit for description
[³Orthotics] <i>[^Preauthorization; Referral Required]</i>	<i>[10% Coinsurance after Deductible]</i>	<i>[See benefit for description]</i>
Prosthetic Devices External Internal <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible	Single purchase of a type of prosthetic once every 3 years Unlimited See benefit for description

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	See benefit for description
Observation Stay <i>[^Preauthorization; Referral Required]</i>	\$200 Copayment not subject to Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	10% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$15 Copayment not subject to Deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	10% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services <i>[^Preauthorization; Referral Required]</i>	\$15 Copayment not subject to Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	\$15 Copayment not subject to Prescription Drug Deductible \$35 Copayment after Prescription Drug Deductible \$75 Copayment after Prescription Drug Deductible	See benefit for description
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	\$37.50 Copayment not subject to Prescription Drug Deductible \$87.50 Copayment after Prescription Drug Deductible \$187.50 Copayment after Prescription Drug Deductible	See benefit for description

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[^Orthodontics Require Preauthorization;]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One dental exam and cleaning per 6-month period
Pediatric Vision Care Exams Lenses & Frames	\$30 Copayment not subject to Deductible 50% Coinsurance not subject to Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12-month period

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Contact Lenses <i>[⁴Contact Lenses Require Preauthorization; Referral]</i>	50% Coinsurance not subject to Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

Statement of Variability

¹ The appropriate group name will be included.

² Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.

³ If the plan provides coverage for orthotics this language will be included. If orthotics are excluded from coverage this language will be removed.

⁴ Requirements for preauthorization and/or referrals for each service will be included as applicable.

⁵ If the deductible and out-of-pocket limit accumulate on a calendar year this language will be included.

SECTION XXVII - Tiered Schedule of Benefits

Gold Plan

[¹Group Name]

Cost Sharing	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible		
Individual	\$1,300	\$1,300
Family	\$2,600	\$2,600
Out-of-Pocket Limit		
Individual	\$3,000	\$3,000
Family	\$6,000	\$6,000
[⁵ Your Deductible and Out-of-Pocket Limit will accumulate on a calendar year.]		

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$10 Copayment after Deductible	\$30 Copayment after Deductible	See benefit for description
Medications Administered in Office	5% Coinsurance after Deductible	20% Coinsurance after Deductible	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Specialist Office Visits (or Home Visits) Medications Administered in Office <i>[¹Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible 5% Coinsurance after Deductible	\$40 Copayment after Deductible 20% Coinsurance after Deductible	See benefit for description
Preventive Care			
Well Child Visits and Immunizations*	Covered in full	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Covered in full	
Adult Immunizations*	Covered in full	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	
Mammography Screenings*	Covered in full	Covered in full	
<i>[²Sterilization Procedures for Women*]</i>	<i>[²Covered in full]</i>	<i>[²Covered in full]</i>	
<i>[²Vasectomy]</i>	<i>[² Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory</i>	<i>[²Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services;</i>	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
	Procedures & Diagnostic Testing)]	Laboratory Procedures & Diagnostic Testing)]	
Bone Density Testing*	Covered in full	Covered in full	
Screening for Prostate Cancer	Covered in full	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. <i>[^Referral Required]</i>	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

Emergency Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See benefit for description

Emergency Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Non-Emergency Ambulance Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$200 Copayment after Deductible	\$200 Copayment after Deductible	See benefit for description
Urgent Care Center <i>[^Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	\$75 Copayment after Deductible	\$75 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible 5% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Allergy Testing & Treatment			See benefit for

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>\$10 Copayment after Deductible</p> <p>\$20 Copayment after Deductible</p>	<p>\$30 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	description
<p>Ambulatory Surgical Center Facility Fee</p> <p><i>[^Preauthorization; Referral Required]</i></p>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
<p>Anesthesia Services (all settings)</p> <p><i>[^Preauthorization; Referral Required]</i></p>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
<p>Autologous Blood Banking</p> <p><i>[^Preauthorization; Referral Required]</i></p>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
<p>Cardiac & Pulmonary Rehabilitation</p> <p>Performed in a Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p>Included As Part of</p>	<p>\$10 Copayment after Deductible</p> <p>\$10 Copayment after Deductible</p> <p>Included As Part of</p>	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>Included As Part of</p>	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Inpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	Inpatient Hospital Service Cost-Sharing	Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible 5% Coinsurance after Deductible 5% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Chiropractic Services <i>[^Preauthorization; Referral Required]</i>	\$10 Copayment after Deductible	\$30 Copayment after Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office	5% Coinsurance after Deductible 5% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	
Dialysis Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible 5% Coinsurance after Deductible 5% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[^Preauthorization; Referral Required]</i>	\$10 Copayment after Deductible	\$30 Copayment after Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care	5% Coinsurance after	20% Coinsurance after	60 visits per Plan

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>	Deductible	Deductible	Year
Infertility Services <i>[^Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy			See benefit for description
Performed in a PCP Office	5% Coinsurance after Deductible	20% Coinsurance after Deductible	
Performed in Specialist Office	5% Coinsurance after Deductible	20% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	20% Coinsurance after Deductible	
Home Infusion Therapy	5% Coinsurance after Deductible	20% Coinsurance after Deductible	

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>			
Inpatient Medical Visits <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Laboratory Procedures Performed in a PCP Office	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Performed in a Freestanding Laboratory Facility or Specialist Office	5% Coinsurance after Deductible	20% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	20% Coinsurance after Deductible	
<i>[^Preauthorization; Referral Required]</i>			
Maternity & Newborn Care Prenatal Care	Covered in Full	Covered in Full	See benefit for description
Inpatient Hospital Services and Birthing Center	5% Coinsurance after Deductible	20% Coinsurance after Deductible	1 Home Care visit is Covered

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Physician and Midwife Services for Delivery Breast Pump Postnatal Care <i>↑ Preauthorization Required [for Inpatient Services; Breast Pump]</i>	5% Coinsurance after Deductible Covered in Full \$20 Copayment after Deductible	20% Coinsurance after Deductible Covered in Full \$40 Copayment after Deductible	at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge <i>↑ Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Preadmission Testing <i>↑ Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office	5% Coinsurance after Deductible 5% Coinsurance after	20% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[^] Preauthorization; Referral Required]</i></p>	<p>Deductible</p> <p>5% Coinsurance after Deductible</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	
<p>Therapeutic Radiology Services</p> <p>Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[^] Preauthorization; Referral Required]</i></p>	<p>5% Coinsurance after Deductible</p> <p>5% Coinsurance after Deductible</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	See benefit for description
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><i>[^] Preauthorization; Referral Required]</i></p>	\$10 Copayment after Deductible	\$30 Copayment after Deductible	60 visits per Plan Year for PT/OT/ST combined. Speech and Physical Therapy are only Covered following a

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
			Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other <i>[[^]Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible	\$40 Copayment after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery	5% Coinsurance after Deductible 5% Coinsurance after Deductible 5% Coinsurance after Deductible 5% Coinsurance after	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>	Deductible		

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$10 Copayment after Deductible	\$10 Copayment after Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$10 Copayment after Deductible	\$10 Copayment after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[^Preauthorization; Referral Required [for</i>	\$10 Copayment after Deductible \$10 Copayment after Deductible	\$30 Copayment after Deductible \$30 Copayment after Deductible	See benefit for description

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Insulin Pump]]</i>			
Durable Medical Equipment & Braces <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible 5% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	5 visits for family bereavement counseling
Medical Supplies <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
³ [Orthotics] <i>[Preauthorization; Referral Required]</i>	[5% Coinsurance after Deductible]	[20% Coinsurance after Deductible]	[See benefit for description]
Prosthetic Devices External Internal <i>[Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible 5% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	Single purchase of a type of prosthetic once every 3 years Unlimited See benefit for description

Inpatient Services & Facilities	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life)	5% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

Inpatient Services & Facilities	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Care) <i>[^Preauthorization; Referral Required]</i>			
Observation Stay <i>[^Preauthorization; Referral Required]</i>	\$200 Copayment after Deductible	\$200 Copayment after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance after Deductible	20% Coinsurance after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[[^]Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>			
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) <i>[[^]Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$10 Copayment after Deductible	\$10 Copayment after Deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[[^]Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services <i>[[^]Preauthorization; Referral Required]</i>	\$10 Copayment after Deductible	\$10 Copayment after Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply Tier 1	\$10 Copayment after Deductible	\$10 Copayment after Deductible	See benefit for description
Tier 2	\$35 Copayment after Deductible	\$35 Copayment after Deductible	
Tier 3	\$60 Copayment after Deductible	\$60 Copayment after Deductible	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$25 Copayment after Deductible	\$25 Copayment after Deductible	See benefit for description
Tier 2	\$87.50 Copayment after Deductible	\$87.50 Copayment after Deductible	
Tier 3	\$150 Copayment after Deductible	\$150 Copayment after Deductible	

Pediatric Dental & Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[[^]Orthodontics Require Preauthorization;]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One dental exam and cleaning per 6-month period
Pediatric Vision Care Exams Lenses & Frames Contact Lenses	Covered in Full not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	Covered in Full not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12- month period

Pediatric Dental & Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[¹Contact Lenses Require Preauthorization; Referral]</i>			

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

Statement of Variability

¹ The appropriate group name will be included.

² Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.

³ If the plan provides coverage for orthotics this language will be included. If orthotics are excluded from coverage this language will be removed.

⁴ Requirements for preauthorization and/or referrals for each service will be included as applicable.

⁵ If the deductible and out-of-pocket limit accumulate on a calendar year this language will be included.

SECTION XXVII - Tiered Schedule of Benefits

Platinum Plan

[¹Group Name]

Cost Sharing	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible Individual Family	None None	\$250 \$500
Prescription Drug Deductible Individual Family	\$100 \$300	\$100 \$300
Pediatric Dental Care Deductible Individual Family	\$100 \$200	\$100 \$200
Out-of-Pocket Limit Individual Family	\$1,000 \$2,000	\$2,000 \$4,000
[⁵ Your Deductible and Out-of-Pocket Limit will accumulate on a calendar year.]		

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$20 Copayment	\$40 Copayment not subject to Deductible	See benefit for description
Medications Administered in Office	5% Coinsurance	20% Coinsurance after Deductible	
Specialist Office Visits (or Home Visits)	\$40 Copayment	\$80 Copayment not subject to Deductible	See benefit for description
Medications Administered in Office <i>[¹Preauthorization; Referral Required]</i>	5% Coinsurance	20% Coinsurance after Deductible	
Preventive Care			
Well Child Visits and Immunizations*	Covered in full	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Covered in full	
Adult Immunizations*	Covered in full	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	
Mammography Screenings*	Covered in full	Covered in full	
<i>[²Sterilization Procedures for Women*</i>	<i>[²Covered in full]</i>	<i>[²Covered in full]</i>	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
[² Vasectomy	[² Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)]	[² Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)]	
Bone Density Testing*	Covered in full	Covered in full	
Screening for Prostate Cancer	Covered in full	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. [⁴ Referral Required]	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

Emergency Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	5% Coinsurance	5% Coinsurance	See benefit for description
Non-Emergency Ambulance Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance	5% Coinsurance	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$150 Copayment	\$150 Copayment	See benefit for description
Urgent Care Center <i>[^Preauthorization Required for Out-of- Network Urgent Care; Referral Required]</i>	\$50 Copayment	\$50 Copayment	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology Facility or Office Setting	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Performed as Outpatient Hospital Services	5% Coinsurance	20% Coinsurance after Deductible	

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
[↑ Preauthorization; Referral Required]			
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office [↑ Preauthorization; Referral Required]	\$20 Copayment \$40 Copayment	\$40 Copayment not subject to Deductible \$80 Copayment not subject to Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee [↑ Preauthorization; Referral Required]	\$100 Copayment	\$300 Copayment not subject to Deductible	See benefit for description
Anesthesia Services (all settings) [↑ Preauthorization; Referral Required]	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking [↑ Preauthorization; Referral Required]	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office Performed as Outpatient Hospital Services	\$20 Copayment \$20 Copayment	\$40 Copayment not subject to Deductible \$40 Copayment not subject to Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Inpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance 5% Coinsurance 5% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Chiropractic Services <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment	\$40 Copayment not subject to Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office	5% Coinsurance 5% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	5% Coinsurance	<p>Deductible</p> <p>20% Coinsurance after Deductible</p>	
<p>Dialysis</p> <p>Performed in a PCP Office</p> <p>Performed in a Freestanding Center or Specialist Office Setting</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>5% Coinsurance</p> <p>5% Coinsurance</p> <p>5% Coinsurance</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>See benefit for description</p> <p>Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan Year</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><i>[Preauthorization; Referral Required]</i></p>	\$20 Copayment	\$40 Copayment after Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care	5% Coinsurance	20% Coinsurance not	60 visits per Plan

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[[^]Preauthorization; Referral Required]</i>		subject to Deductible	Year
Infertility Services <i>[[^]Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy	5% Coinsurance 5% Coinsurance 5% Coinsurance 5% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
[↑ Preauthorization; Referral Required]			
Inpatient Medical Visits [↑ Preauthorization; Referral Required]	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Laboratory Procedures Performed in a PCP Office	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Performed in a Freestanding Laboratory Facility or Specialist Office	5% Coinsurance	20% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance	20% Coinsurance after Deductible	
[↑ Preauthorization; Referral Required]			
Maternity & Newborn Care Prenatal Care	Covered in Full	Covered in Full	See benefit for description
Inpatient Hospital Services and Birthing Center	\$100 Copayment per day to a maximum of \$500 per admission	\$500 Copayment per day to a maximum of \$2,500 per admission after deductible	1 Home Care visit is Covered at no Cost-

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Physician and Midwife Services for Delivery Breast Pump Postnatal Care <i>[^Preauthorization Required [for Inpatient Services; Breast Pump]</i>	5% Coinsurance Covered in Full \$40 Copayment	20% Coinsurance after Deductible Covered in Full \$80 Copayment not subject to Deductible	Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge <i>[^Preauthorization; Referral Required]</i>	\$100 Copayment	\$300 Copayment not subject to Deductible	See benefit for description
Preadmission Testing <i>[^Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology	5% Coinsurance 5% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Facility or Specialist Office Performed as Outpatient Hospital Services <i>[↑Preauthorization; Referral Required]</i>	5% Coinsurance	Deductible 20% Coinsurance after Deductible	
Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <i>[↑Preauthorization; Referral Required]</i>	5% Coinsurance 5% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[↑Preauthorization; Referral Required]</i>	\$20 Copayment	\$40 Copayment not subject to Deductible	60 visits per Plan Year for PT/OT/ST combined. Speech and Physical Therapy are only Covered following a Hospital stay or surgery.

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Second Opinions on the Diagnosis of Cancer, Surgery & Other <i>[^Preauthorization; Referral Required]</i>	\$40 Copayment	\$80 Copayment not subject to Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance 5% Coinsurance 5% Coinsurance 5% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment	\$20 Copayment	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment	\$20 Copayment	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[^Preauthorization; Referral Required [for Insulin Pump]]</i>	\$20 Copayment \$20 Copayment	\$40 Copayment not subject to Deductible \$40 Copayment not subject to Deductible	See benefit for description
Durable Medical Equipment & Braces <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[^Preauthorization; Referral Required]</i>	5% Coinsurance	20% Coinsurance after Deductible	Single purchase once Every 3 years

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Cochlear Implants <i>[¹Preauthorization; Referral Required]</i>	5% Coinsurance	20% Coinsurance after Deductible	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[¹Preauthorization; Referral Required]</i>	\$100 Copayment per day to a maximum of \$500 per admission 5% Coinsurance	\$500 Copayment per day to a maximum of \$2,500 per admission after Deductible 20% Coinsurance after Deductible	5 visits for family bereavement counseling
Medical Supplies <i>[¹Preauthorization; Referral Required]</i>	5% Coinsurance	20% Coinsurance after Deductible	See benefit for description
[³Orthotics] <i>[¹Preauthorization; Referral Required]</i>	<i>[5% Coinsurance]</i>	<i>[20% Coinsurance after Deductible]</i>	<i>[See benefit for description]</i>
Prosthetic Devices			

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
External	5% Coinsurance	20% Coinsurance after Deductible	Single purchase of a type of prosthetic once every 3 years
Internal	5% Coinsurance	20% Coinsurance after Deductible	Unlimited
<i>[^Preauthorization; Referral Required]</i>			
			See benefit for description

Inpatient Services & Facilities	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$100 Copayment per day to a maximum of \$500 per admission	\$500 Copayment per day to a maximum of \$2,500 per admission after Deductible	See benefit for description
<i>[^Preauthorization; Referral Required]</i>			
Observation Stay	\$150 Copayment	\$150 Copayment	See benefit for description
<i>[^Preauthorization; Referral Required]</i>			

Inpatient Services & Facilities	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[^Preauthorization; Referral Required]</i>	\$100 Copayment per day to a maximum of \$500 per admission	\$500 Copayment per day to a maximum of \$2,500 per admission after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[^Preauthorization; Referral Required]</i>	\$100 Copayment per day to a maximum of \$500 per admission	\$500 Copayment per day to a maximum of \$2,500 per admission after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$100 Copayment per day to a maximum of \$500 per admission	\$500 Copayment per day to a maximum of \$2,500 per admission after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$20 Copayment	\$20 Copayment	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$100 Copayment per day to a maximum of \$500 per admission	\$500 Copayment per day to a maximum of \$2,500 per admission after Deductible	See benefit for description
Outpatient Substance Use Services <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment	\$20 Copayment	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply Tier 1	\$10 Copayment not subject to Prescription Drug Deductible	\$10 Copayment not subject to Prescription Drug Deductible	See benefit for description
Tier 2	\$35 Copayment after Prescription Drug Deductible	\$35 Copayment after Prescription Drug Deductible	
Tier 3	\$60 Copayment after Prescription Drug Deductible	\$60 Copayment after Prescription Drug Deductible	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$25 Copayment not subject to Prescription Drug Deductible	\$25 Copayment not subject to Prescription Drug Deductible	See benefit for description
Tier 2	\$87.50 Copayment after Prescription Drug Deductible	\$87.50 Copayment after Prescription Drug Deductible	
Tier 3	\$150 Copayment after Prescription Drug Deductible	\$150 Copayment after Prescription Drug Deductible	

Prescription Drugs	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits

Pediatric Dental & Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			
Preventive Dental Care	20% Coinsurance after Pediatric Dental Care Deductible	20% Coinsurance after Pediatric Dental Care Deductible	One dental exam and cleaning per 6-month period
Routine Dental Care	20% Coinsurance after Pediatric Dental Care Deductible	20% Coinsurance after Pediatric Dental Care Deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after Pediatric Dental Care Deductible	50% Coinsurance after Pediatric Dental Care Deductible	
Orthodontics	50% Coinsurance after Pediatric Dental Care	50% Coinsurance after Pediatric Dental Care	

Pediatric Dental & Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[¹Orthodontics Require Preauthorization;]</i>	Deductible	Deductible	
Pediatric Vision Care Exams Lenses & Frames Contact Lenses <i>[¹Contact Lenses Require Preauthorization; Referral]</i>	\$20 Copayment 50% Coinsurance 50% Coinsurance	\$20 Copayment not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12- month period

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

Statement of Variability

¹ The appropriate group name will be included.

² Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.

³ If the plan provides coverage for orthotics this language will be included. If orthotics are excluded from coverage this language will be removed.

⁴ Requirements for preauthorization and/or referrals for each service will be included as applicable.

⁵ If the deductible and out-of-pocket limit accumulate on a calendar year this language will be included.

SECTION XXVII - Choice Plus Schedule of Benefits

Silver Plan

[¹Group Name]

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Deductible		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Out-of-Pocket Limit		
Individual	\$5,500	\$10,000
Family	\$11,000	\$20,000
		<p>The Allowed Amount is 110% of Medicare. See the Out-of-Network Rider for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.</p>

[⁵Your Deductible and Out-of-Pocket Limit will accumulate on a calendar year.]

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$30 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description
Medications Administered in Office	\$30 Copayment after Deductible	50% Coinsurance after Deductible	
Specialist Office Visits (or Home Visits)	\$60 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description
Medications Administered in Office <i>[[^]Preauthorization; Referral Required]</i>	\$60 Copayment after Deductible	50% Coinsurance after Deductible	
Preventive Care			
Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider Services are Not Covered and You	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
		Pay the Full Cost	
Adult Immunizations*	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
Mammography Screenings*	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
[² Sterilization Procedures for Women*	Covered in full]	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
[² Vasectomy	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
	Testing)]		
Bone Density Testing*	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
Screening for Prostate Cancer	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	
<p>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.</p> <p><i>[^Referral Required]</i></p>	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider Services are Not Covered and You Pay the Full Cost	

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services <i>[Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Urgent Care Center <i>[Preauthorization Required for Out-of- Network Urgent Care; Referral Required]</i>	\$75 Copayment not subject to Deductible	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology Facility or Office Setting	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	50% Coinsurance after Deductible	

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>			
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office <i>[^Preauthorization; Referral Required]</i>	\$30 Copayment not subject to Deductible \$60 Copayment not subject to Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee <i>[^Preauthorization; Referral Required]</i>	\$200 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office	\$30 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed as Outpatient Hospital Services</p> <p>Performed as Inpatient Hospital Services <i>[↑Preauthorization; Referral Required]</i></p>	<p>\$30 Copayment after Deductible</p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	
<p>Chemotherapy</p> <p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p> <p>Performed as Outpatient Hospital Services <i>[↑Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	See benefit for description
<p>Chiropractic Services <i>[↑Preauthorization; Referral Required]</i></p>	<p>\$30 Copayment after Deductible</p>	<p>50% Coinsurance after Deductible</p>	See benefit for description
<p>Diagnostic Testing</p>			See benefit for

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	<p>description</p>
<p>Dialysis</p> <p>Performed in a PCP Office</p> <p>Performed in a Freestanding Center or Specialist Office Setting</p> <p>Performed as Outpatient Hospital Services</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>			
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[^Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	50% Coinsurance after Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	25% Coinsurance after Deductible	60 visits per Plan Year
Infertility Services <i>[^Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	50% Coinsurance after Deductible	See benefit for description
Infusion Therapy Performed in a PCP Office	10% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p>Home Infusion Therapy</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	
<p>Inpatient Medical Visits</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>10% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Laboratory Procedures</p> <p>Performed in a PCP Office</p> <p>Performed in a Freestanding Laboratory Facility or Specialist Office</p> <p>Performed as Outpatient Hospital</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after</p>	<p>See benefit for description</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Services <i>[^Preauthorization; Referral Required]</i>		Deductible	
Maternity & Newborn Care			See benefit for description
Prenatal Care	Covered in Full	50% Coinsurance after Deductible	
Inpatient Hospital Services and Birthing Center	10% Coinsurance after Deductible	50% Coinsurance after Deductible	1 Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Physician and Midwife Services for Delivery	10% Coinsurance after Deductible	50% Coinsurance after Deductible	
Breast Pump	Covered in Full	50% Coinsurance after Deductible	
Postnatal Care <i>[^Preauthorization Required [for Inpatient Services; Breast Pump]</i>	\$60 Copayment after Deductible	50% Coinsurance after Deductible	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge <i>[^Preauthorization; Referral Required]</i>	\$200 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Preadmission Testing <i>[^Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	50% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><i>[Preauthorization; Referral Required]</i></p>	\$30 Copayment after Deductible	50% Coinsurance after Deductible	60 visits per Plan Year for PT/OT/ST combined. Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
<p>Second Opinions on the Diagnosis of Cancer, Surgery & Other</p> <p><i>[Preauthorization; Referral Required]</i></p>	\$60 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)</p>			See benefit for description All Transplants must be

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital Surgery	10% Coinsurance after Deductible	50% Coinsurance after Deductible	performed at Designated Facilities
Outpatient Hospital Surgery	10% Coinsurance after Deductible	50% Coinsurance after Deductible	
Surgery Performed at an Ambulatory Surgical Center	10% Coinsurance after Deductible	50% Coinsurance after Deductible	
Office Surgery	10% Coinsurance after Deductible	50% Coinsurance after Deductible	
<i>[^Preauthorization; Referral Required]</i>			

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$30 Copayment after Deductible	50% Coinsurance after Deductible	680 Hours per Plan Year

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>			
Assistive Communication Devices for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self- Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[^Preauthorization; Referral Required [for Insulin Pump]]</i>	\$30 Copayment after Deductible \$30 Copayment after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Durable Medical Equipment & Braces <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	One per ear per time Covered

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Hospice Care Inpatient Outpatient <i>[¹Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible 10% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	5 visits for family bereavement counseling
Medical Supplies <i>[¹Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
³ [Orthotics] <i>[¹Preauthorization; Referral Required]</i>	<i>[10% Coinsurance after Deductible]</i>	<i>[50% Coinsurance after Deductible]</i>	<i>[See benefit for description]</i>
Prosthetic Devices External	10% Coinsurance after Deductible	50% Coinsurance after Deductible	Single purchase of a type of prosthetic once every 3 years

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Internal <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited See benefit for description

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Observation Stay <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac	10% Coinsurance after	50% Coinsurance after	200 days per

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
& Pulmonary Rehabilitation) <i>[^Preauthorization; Referral Required]</i>	Deductible	Deductible	Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[^Preauthorization; Referral Required]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive	\$30 Copayment after Deductible	50% Coinsurance after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Program Services) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>			
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[^Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	10% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services <i>[^Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	50% Coinsurance after Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply Tier 1	\$15 Copayment after Deductible	\$15 Copayment after Deductible	See benefit for description
Tier 2	\$35 Copayment after Deductible	\$35 Copayment after Deductible	
Tier 3	\$75 Copayment after Deductible	\$75 Copayment after Deductible	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$37.50 Copayment after Deductible	\$37.50 Copayment after Deductible	See benefit for description
Tier 2	\$87.50 Copayment after Deductible	\$87.50 Copayment after Deductible	
Tier 3	\$187.50 Copayment after Deductible	\$187.50 Copayment after Deductible	

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[[^]Orthodontics Require Preauthorization;]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One dental exam and cleaning per 6-month period
Pediatric Vision Care Exams Lenses & Frames	Covered in Full not subject to Deductible 50% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12- month period

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Contact Lenses <i>[⁴Contact Lenses Require Preauthorization; Referral]</i>	50% Coinsurance after Deductible	50% Coinsurance after Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

Statement of Variability

¹ The appropriate group name will be included.

² Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.

³ If the plan provides coverage for orthotics this language will be included. If orthotics are excluded from coverage this language will be removed.

⁴ Requirements for preauthorization and/or referrals for each service will be included as applicable.

⁵ If the deductible and out-of-pocket limit accumulate on a calendar year this language will be included.

SECTION XXVII - Tiered Schedule of Benefits

Silver Plan

[¹Group Name]

Cost Sharing	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible		
Individual	\$2,000	\$2,000
Family	\$4,000	\$4,000
Out-of-Pocket Limit		
Individual	\$6,000	\$6,000
Family	\$12,000	\$12,000
[⁵ Your Deductible and Out-of-Pocket Limit will accumulate on a calendar year.]		

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$20 Copayment after Deductible	\$40 Copayment after Deductible	See benefit for description
Medications Administered in Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Specialist Office Visits (or Home Visits) Medications Administered in Office <i>[¹Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible 20% Coinsurance after Deductible	\$80 Copayment after Deductible 50% Coinsurance after Deductible	See benefit for description
Preventive Care			
Well Child Visits and Immunizations*	Covered in full	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Covered in full	
Adult Immunizations*	Covered in full	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	
Mammography Screenings*	Covered in full	Covered in full	
<i>[²Sterilization Procedures for Women*]</i>	<i>[²Covered in full]</i>	<i>[²Covered in full]</i>	
<i>[²Vasectomy]</i>	<i>[²Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory</i>	<i>[²Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services;</i>	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
	Procedures & Diagnostic Testing)]	Laboratory Procedures & Diagnostic Testing)]	
Bone Density Testing*	Covered in full	Covered in full	
Screening for Prostate Cancer	Covered in full	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. <i>[^Referral Required]</i>	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

Emergency Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

Emergency Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Non-Emergency Ambulance Services <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$300 Copayment after Deductible	\$300 Copayment after Deductible	See benefit for description
Urgent Care Center <i>[^Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	\$100 Copayment after Deductible	\$100 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Allergy Testing & Treatment			See benefit for

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>\$20 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>\$40 Copayment after Deductible</p> <p>\$80 Copayment after Deductible</p>	description
<p>Ambulatory Surgical Center Facility Fee</p> <p><i>[^Preauthorization; Referral Required]</i></p>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
<p>Anesthesia Services (all settings)</p> <p><i>[^Preauthorization; Referral Required]</i></p>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
<p>Autologous Blood Banking</p> <p><i>[^Preauthorization; Referral Required]</i></p>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
<p>Cardiac & Pulmonary Rehabilitation</p> <p>Performed in a Specialist Office</p> <p>Performed as Outpatient Hospital Services</p>	<p>\$20 Copayment after Deductible</p> <p>\$20 Copayment after Deductible</p> <p>Included As Part of</p>	<p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>Included As Part of</p>	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Inpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	Inpatient Hospital Service Cost-Sharing	Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Chiropractic Services <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible	\$40 Copayment after Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office	20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Dialysis Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible	\$40 Copayment after Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care	20% Coinsurance after	25% Coinsurance after	60 visits per Plan

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>	Deductible	Deductible	Year
Infertility Services <i>[^Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy			See benefit for description
Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Performed in Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Home Infusion Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible	

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>			
Inpatient Medical Visits <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Laboratory Procedures Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Performed in a Freestanding Laboratory Facility or Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
<i>[^Preauthorization; Referral Required]</i>			
Maternity & Newborn Care Prenatal Care	Covered in Full	Covered in Full	See benefit for description
Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible	50% Coinsurance after Deductible	1 Home Care visit is Covered

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Physician and Midwife Services for Delivery Breast Pump Postnatal Care <i>↑ Preauthorization Required [for Inpatient Services; Breast Pump]</i>	20% Coinsurance after Deductible Covered in Full \$40 Copayment after Deductible	50% Coinsurance after Deductible Covered in Full \$80 Copayment after Deductible	at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge <i>↑ Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Preadmission Testing <i>↑ Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	
<p>Therapeutic Radiology Services</p> <p>Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><i>[^Preauthorization; Referral Required]</i></p>	<p>\$20 Copayment after Deductible</p>	<p>\$40 Copayment after Deductible</p>	<p>60 visits per Plan Year for PT/OT/ST combined. Speech and Physical Therapy are only Covered following a</p>

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
			Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other <i>[[^]Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible	\$80 Copayment after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[^Preauthorization; Referral Required]</i>	Deductible		

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible	\$20 Copayment after Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[^Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible	\$20 Copayment after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[^Preauthorization; Referral Required]</i> for	\$20 Copayment after Deductible \$20 Copayment after Deductible	\$40 Copayment after Deductible \$40 Copayment after Deductible	See benefit for description

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Insulin Pump]]</i>			
Durable Medical Equipment & Braces <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	5 visits for family bereavement counseling
Medical Supplies <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

Additional Services, Equipment & Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
[³Orthotics] <i>[¹Preauthorization; Referral Required]</i>	<i>[20% Coinsurance after Deductible]</i>	<i>[50% Coinsurance after Deductible]</i>	<i>[See benefit for description]</i>
Prosthetic Devices External Internal <i>[¹Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	Single purchase of a type of prosthetic once every 3 years Unlimited See benefit for description

Inpatient Services & Facilities	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

Inpatient Services & Facilities	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Care) <i>[^Preauthorization; Referral Required]</i>			
Observation Stay <i>[^Preauthorization; Referral Required]</i>	\$300 Copayment after Deductible	\$300 Copayment after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[^Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[[^]Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>			
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) <i>[[^]Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$20 Copayment after Deductible	\$20 Copayment after Deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[[^]Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services <i>[[^]Preauthorization; Referral Required]</i>	\$20 Copayment after Deductible	\$20 Copayment after Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply Tier 1	\$10 Copayment after Deductible	\$10 Copayment after Deductible	See benefit for description
Tier 2	\$35 Copayment after Deductible	\$35 Copayment after Deductible	
Tier 3	\$60 Copayment after Deductible	\$60 Copayment after Deductible	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$25 Copayment after Deductible	\$25 Copayment after Deductible	See benefit for description
Tier 2	\$87.50 Copayment after Deductible	\$87.50 Copayment after Deductible	
Tier 3	\$150 Copayment after Deductible	\$150 Copayment after Deductible	

Pediatric Dental & Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[Orthodontics Require Preauthorization;]</i>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One dental exam and cleaning per 6-month period
Pediatric Vision Care Exams Lenses & Frames Contact Lenses	Covered in Full not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	Covered in Full not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12- month period

Pediatric Dental & Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[¹Contact Lenses Require Preauthorization; Referral]</i>			

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

Statement of Variability

¹ The appropriate group name will be included.

² Remove for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.

³ If the plan provides coverage for orthotics this language will be included. If orthotics are excluded from coverage this language will be removed.

⁴ Requirements for preauthorization and/or referrals for each service will be included as applicable.

⁵ If the deductible and out-of-pocket limit accumulate on a calendar year this language will be included.

SERFF Tracking #:

UHLC-129581429

State Tracking #:

2014060234

Company Tracking #:**State:**

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only

Product Name:

2015 UHIC SG OFFX Plans

Project Name/Number:

2015 UHIC SG OFFX Plans/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		UHIC SG Off Exch Rate Manual		New		2015 SG UHIC Off-Exch Rate Manual.pdf,
2		Underwriting Guidelines		New		United New York Small Group (1-50) Underwriting Requirements.final.pdf,

UnitedHealthcare Insurance Company of New York

New York Small Group

Off-Exchange

Form # UHICNY_SG_COC_2014

Rate Manual

Rates Effective January 1, 2015

UnitedHealthcare Insurance Company of New York
New York Small Group
Off-Exchange
Form # UHICNY_SG_COC_2014

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UnitedHealthcare Insurance Company of New York
New York Small Group
Off-Exchange
Form # UHICNY_SG_COC_2014
Area Factors - Service Area for Upstate Plans
Area Factor is "n/a" for counties outside the service area.

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

UnitedHealthcare Insurance Company of New York

New York Small Group

Off-Exchange

Form # UHICNY_SG_COC_2014

Area Factors - Service Area for NSLIJ Advantage Plans

Area Factor is "n/a" for counties outside the service area.

County	DFS Rating Region	Area Factor	County	DFS Rating Region	Area Factor	County	DFS Rating Region	Area Factor
Albany	1	n/a	Delaware	3	n/a	Broome	6	n/a
Columbia	1	n/a	Dutchess	3	n/a	Cayuga	6	n/a
Fulton	1	n/a	Orange	3	n/a	Chemung	6	n/a
Greene	1	n/a	Putnam	3	n/a	Cortland	6	n/a
Montgomery	1	n/a	Sullivan	3	n/a	Onondaga	6	n/a
Rensselaer	1	n/a	Ulster	3	n/a	Schuyler	6	n/a
Saratoga	1	n/a	Bronx	4	n/a	Steuben	6	n/a
Schenectady	1	n/a	Kings	4	n/a	Tioga	6	n/a
Schoharie	1	n/a	New York	4	n/a	Tompkins	6	n/a
Warren	1	n/a	Queens	4	1.188	Chenango	7	n/a
Washington	1	n/a	Richmond	4	n/a	Clinton	7	n/a
Allegany	2	n/a	Rockland	4	n/a	Essex	7	n/a
Cattaraugus	2	n/a	Westchester	4	n/a	Franklin	7	n/a
Chautauqua	2	n/a	Livingston	5	n/a	Hamilton	7	n/a
Erie	2	n/a	Monroe	5	n/a	Herkimer	7	n/a
Genesee	2	n/a	Ontario	5	n/a	Jefferson	7	n/a
Niagara	2	n/a	Seneca	5	n/a	Lewis	7	n/a
Orleans	2	n/a	Wayne	5	n/a	Madison	7	n/a
Wyoming	2	n/a	Yates	5	n/a	Oneida	7	n/a
						Oswego	7	n/a
						Otsego	7	n/a
						St. Lawrence	7	n/a
						Nassau	8	1.188
						Suffolk	8	1.188

UnitedHealthcare Insurance Company of New York
New York Small Group
Off-Exchange
Form # UHICNY_SG_COC_2014
Base Medical and Prescription Drug Rates - Upstate Plans

DFS Rating Region	Effective Quarter	Metal	Plan	Single Rate	Parent / Child(ren) Rate	Couple Rate	Family Rate
1	2015 Q1	Silver	UnitedHealthcare Choice Plus VR-X	\$ 696.60	\$ 1,184.22	\$ 1,393.20	\$ 1,985.31
1	2015 Q1	Gold	UnitedHealthcare Choice VR-W	\$ 804.96	\$ 1,368.43	\$ 1,609.92	\$ 2,294.14
2	2015 Q1	Silver	UnitedHealthcare Choice Plus VR-X	\$ 571.18	\$ 971.01	\$ 1,142.36	\$ 1,627.86
2	2015 Q1	Gold	UnitedHealthcare Choice VR-W	\$ 660.03	\$ 1,122.05	\$ 1,320.06	\$ 1,881.09
3	2015 Q1	Silver	UnitedHealthcare Choice Plus VR-X	\$ 745.42	\$ 1,267.21	\$ 1,490.84	\$ 2,124.45
3	2015 Q1	Gold	UnitedHealthcare Choice VR-W	\$ 861.37	\$ 1,464.33	\$ 1,722.74	\$ 2,454.90
5	2015 Q1	Silver	UnitedHealthcare Choice Plus VR-X	\$ 638.56	\$ 1,085.55	\$ 1,277.12	\$ 1,819.90
5	2015 Q1	Gold	UnitedHealthcare Choice VR-W	\$ 737.89	\$ 1,254.41	\$ 1,475.78	\$ 2,102.99
6	2015 Q1	Silver	UnitedHealthcare Choice Plus VR-X	\$ 617.57	\$ 1,049.87	\$ 1,235.14	\$ 1,760.07
6	2015 Q1	Gold	UnitedHealthcare Choice VR-W	\$ 713.64	\$ 1,213.19	\$ 1,427.28	\$ 2,033.87
7	2015 Q1	Silver	UnitedHealthcare Choice Plus VR-X	\$ 591.49	\$ 1,005.53	\$ 1,182.98	\$ 1,685.75
7	2015 Q1	Gold	UnitedHealthcare Choice VR-W	\$ 683.51	\$ 1,161.97	\$ 1,367.02	\$ 1,948.00
1	2015 Q2	Silver	UnitedHealthcare Choice Plus VR-X	\$ 714.93	\$ 1,215.38	\$ 1,429.86	\$ 2,037.55
1	2015 Q2	Gold	UnitedHealthcare Choice VR-W	\$ 826.14	\$ 1,404.44	\$ 1,652.28	\$ 2,354.50
2	2015 Q2	Silver	UnitedHealthcare Choice Plus VR-X	\$ 586.21	\$ 996.56	\$ 1,172.42	\$ 1,670.70
2	2015 Q2	Gold	UnitedHealthcare Choice VR-W	\$ 677.40	\$ 1,151.58	\$ 1,354.80	\$ 1,930.59
3	2015 Q2	Silver	UnitedHealthcare Choice Plus VR-X	\$ 765.04	\$ 1,300.57	\$ 1,530.08	\$ 2,180.36
3	2015 Q2	Gold	UnitedHealthcare Choice VR-W	\$ 884.04	\$ 1,502.87	\$ 1,768.08	\$ 2,519.51
5	2015 Q2	Silver	UnitedHealthcare Choice Plus VR-X	\$ 655.36	\$ 1,114.11	\$ 1,310.72	\$ 1,867.78
5	2015 Q2	Gold	UnitedHealthcare Choice VR-W	\$ 757.31	\$ 1,287.43	\$ 1,514.62	\$ 2,158.33
6	2015 Q2	Silver	UnitedHealthcare Choice Plus VR-X	\$ 633.82	\$ 1,077.49	\$ 1,267.64	\$ 1,806.39
6	2015 Q2	Gold	UnitedHealthcare Choice VR-W	\$ 732.42	\$ 1,245.11	\$ 1,464.84	\$ 2,087.40
7	2015 Q2	Silver	UnitedHealthcare Choice Plus VR-X	\$ 607.06	\$ 1,032.00	\$ 1,214.12	\$ 1,730.12
7	2015 Q2	Gold	UnitedHealthcare Choice VR-W	\$ 701.50	\$ 1,192.55	\$ 1,403.00	\$ 1,999.28
1	2015 Q3	Silver	UnitedHealthcare Choice Plus VR-X	\$ 733.74	\$ 1,247.36	\$ 1,467.48	\$ 2,091.16
1	2015 Q3	Gold	UnitedHealthcare Choice VR-W	\$ 847.88	\$ 1,441.40	\$ 1,695.76	\$ 2,416.46
2	2015 Q3	Silver	UnitedHealthcare Choice Plus VR-X	\$ 601.64	\$ 1,022.79	\$ 1,203.28	\$ 1,714.67
2	2015 Q3	Gold	UnitedHealthcare Choice VR-W	\$ 695.23	\$ 1,181.89	\$ 1,390.46	\$ 1,981.41
3	2015 Q3	Silver	UnitedHealthcare Choice Plus VR-X	\$ 785.17	\$ 1,334.79	\$ 1,570.34	\$ 2,237.73
3	2015 Q3	Gold	UnitedHealthcare Choice VR-W	\$ 907.30	\$ 1,542.41	\$ 1,814.60	\$ 2,585.81
5	2015 Q3	Silver	UnitedHealthcare Choice Plus VR-X	\$ 672.61	\$ 1,143.44	\$ 1,345.22	\$ 1,916.94
5	2015 Q3	Gold	UnitedHealthcare Choice VR-W	\$ 777.24	\$ 1,321.31	\$ 1,554.48	\$ 2,215.13
6	2015 Q3	Silver	UnitedHealthcare Choice Plus VR-X	\$ 650.50	\$ 1,105.85	\$ 1,301.00	\$ 1,853.93
6	2015 Q3	Gold	UnitedHealthcare Choice VR-W	\$ 751.69	\$ 1,277.87	\$ 1,503.38	\$ 2,142.32
7	2015 Q3	Silver	UnitedHealthcare Choice Plus VR-X	\$ 623.04	\$ 1,059.17	\$ 1,246.08	\$ 1,775.66
7	2015 Q3	Gold	UnitedHealthcare Choice VR-W	\$ 719.96	\$ 1,223.93	\$ 1,439.92	\$ 2,051.89
1	2015 Q4	Silver	UnitedHealthcare Choice Plus VR-X	\$ 753.05	\$ 1,280.19	\$ 1,506.10	\$ 2,146.19
1	2015 Q4	Gold	UnitedHealthcare Choice VR-W	\$ 870.19	\$ 1,479.32	\$ 1,740.38	\$ 2,480.04
2	2015 Q4	Silver	UnitedHealthcare Choice Plus VR-X	\$ 617.47	\$ 1,049.70	\$ 1,234.94	\$ 1,759.79
2	2015 Q4	Gold	UnitedHealthcare Choice VR-W	\$ 713.53	\$ 1,213.00	\$ 1,427.06	\$ 2,033.56
3	2015 Q4	Silver	UnitedHealthcare Choice Plus VR-X	\$ 805.83	\$ 1,369.91	\$ 1,611.66	\$ 2,296.62
3	2015 Q4	Gold	UnitedHealthcare Choice VR-W	\$ 931.18	\$ 1,583.01	\$ 1,862.36	\$ 2,653.86
5	2015 Q4	Silver	UnitedHealthcare Choice Plus VR-X	\$ 690.31	\$ 1,173.53	\$ 1,380.62	\$ 1,967.38
5	2015 Q4	Gold	UnitedHealthcare Choice VR-W	\$ 797.69	\$ 1,356.07	\$ 1,595.38	\$ 2,273.42
6	2015 Q4	Silver	UnitedHealthcare Choice Plus VR-X	\$ 667.62	\$ 1,134.95	\$ 1,335.24	\$ 1,902.72
6	2015 Q4	Gold	UnitedHealthcare Choice VR-W	\$ 771.47	\$ 1,311.50	\$ 1,542.94	\$ 2,198.69
7	2015 Q4	Silver	UnitedHealthcare Choice Plus VR-X	\$ 639.44	\$ 1,087.05	\$ 1,278.88	\$ 1,822.40
7	2015 Q4	Gold	UnitedHealthcare Choice VR-W	\$ 738.91	\$ 1,256.15	\$ 1,477.82	\$ 2,105.89

UnitedHealthcare Insurance Company of New York
 New York Small Group
 Off-Exchange
 Form # UHICNY_SG_COC_2014
 Base Medical and Prescription Drug Rates - NSLIJ Advantage Plans

DFS Rating Region	Effective Quarter	Metal	Plan	Single Rate	Parent / Child(ren) Rate	Couple Rate	Family Rate
4	2015 Q1	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 583.97	\$ 992.75	\$ 1,167.94	\$ 1,664.31
4	2015 Q1	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 693.71	\$ 1,179.31	\$ 1,387.42	\$ 1,977.07
4	2015 Q1	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 870.66	\$ 1,480.12	\$ 1,741.32	\$ 2,481.38
8	2015 Q1	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 583.97	\$ 992.75	\$ 1,167.94	\$ 1,664.31
8	2015 Q1	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 693.71	\$ 1,179.31	\$ 1,387.42	\$ 1,977.07
8	2015 Q1	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 870.66	\$ 1,480.12	\$ 1,741.32	\$ 2,481.38
4	2015 Q2	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 599.34	\$ 1,018.88	\$ 1,198.68	\$ 1,708.12
4	2015 Q2	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 711.97	\$ 1,210.35	\$ 1,423.94	\$ 2,029.11
4	2015 Q2	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 893.57	\$ 1,519.07	\$ 1,787.14	\$ 2,546.67
8	2015 Q2	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 599.34	\$ 1,018.88	\$ 1,198.68	\$ 1,708.12
8	2015 Q2	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 711.97	\$ 1,210.35	\$ 1,423.94	\$ 2,029.11
8	2015 Q2	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 893.57	\$ 1,519.07	\$ 1,787.14	\$ 2,546.67
4	2015 Q3	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 615.11	\$ 1,045.69	\$ 1,230.22	\$ 1,753.06
4	2015 Q3	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 730.71	\$ 1,242.21	\$ 1,461.42	\$ 2,082.52
4	2015 Q3	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 917.09	\$ 1,559.05	\$ 1,834.18	\$ 2,613.71
8	2015 Q3	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 615.11	\$ 1,045.69	\$ 1,230.22	\$ 1,753.06
8	2015 Q3	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 730.71	\$ 1,242.21	\$ 1,461.42	\$ 2,082.52
8	2015 Q3	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 917.09	\$ 1,559.05	\$ 1,834.18	\$ 2,613.71
4	2015 Q4	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 631.30	\$ 1,073.21	\$ 1,262.60	\$ 1,799.21
4	2015 Q4	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 749.94	\$ 1,274.90	\$ 1,499.88	\$ 2,137.33
4	2015 Q4	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 941.22	\$ 1,600.07	\$ 1,882.44	\$ 2,682.48
8	2015 Q4	Silver	UnitedHealthcare North Shore-LIJ Advantage VR-4	\$ 631.30	\$ 1,073.21	\$ 1,262.60	\$ 1,799.21
8	2015 Q4	Gold	UnitedHealthcare North Shore-LIJ Advantage VR-2	\$ 749.94	\$ 1,274.90	\$ 1,499.88	\$ 2,137.33
8	2015 Q4	Platinum	UnitedHealthcare North Shore-LIJ Advantage VR-Z	\$ 941.22	\$ 1,600.07	\$ 1,882.44	\$ 2,682.48

UnitedHealthcare Insurance Company of New York
 New York Small Group
 Off-Exchange
 Form # UHICNY_SG_COC_2014
 Ancillary Coverage Rider Rates

Domestic Partner Zero cost for all quarters, tiers, and areas.

Dependent Age Cut-off 29 2.00% load to Med+Rx base rate, for all quarters, tiers, and areas.

Women's Contraceptive

DFS Rating Region	Effective Quarter	Single Rate	Parent / Child(ren) Rate	Couple Rate	Family Rate
1	2015 Q1	\$ (2.91)	\$ (4.95)	\$ (5.82)	\$ (8.29)
2	2015 Q1	\$ (2.39)	\$ (4.06)	\$ (4.78)	\$ (6.81)
3	2015 Q1	\$ (3.11)	\$ (5.29)	\$ (6.22)	\$ (8.86)
4	2015 Q1	\$ (3.01)	\$ (5.12)	\$ (6.02)	\$ (8.58)
5	2015 Q1	\$ (2.67)	\$ (4.54)	\$ (5.34)	\$ (7.61)
6	2015 Q1	\$ (2.58)	\$ (4.39)	\$ (5.16)	\$ (7.35)
7	2015 Q1	\$ (2.47)	\$ (4.20)	\$ (4.94)	\$ (7.04)
8	2015 Q1	\$ (3.01)	\$ (5.12)	\$ (6.02)	\$ (8.58)
1	2015 Q2	\$ (2.99)	\$ (5.08)	\$ (5.98)	\$ (8.52)
2	2015 Q2	\$ (2.45)	\$ (4.17)	\$ (4.90)	\$ (6.98)
3	2015 Q2	\$ (3.19)	\$ (5.42)	\$ (6.38)	\$ (9.09)
4	2015 Q2	\$ (3.09)	\$ (5.25)	\$ (6.18)	\$ (8.81)
5	2015 Q2	\$ (2.74)	\$ (4.66)	\$ (5.48)	\$ (7.81)
6	2015 Q2	\$ (2.65)	\$ (4.51)	\$ (5.30)	\$ (7.55)
7	2015 Q2	\$ (2.54)	\$ (4.32)	\$ (5.08)	\$ (7.24)
8	2015 Q2	\$ (3.09)	\$ (5.25)	\$ (6.18)	\$ (8.81)
1	2015 Q3	\$ (3.07)	\$ (5.22)	\$ (6.14)	\$ (8.75)
2	2015 Q3	\$ (2.51)	\$ (4.27)	\$ (5.02)	\$ (7.15)
3	2015 Q3	\$ (3.27)	\$ (5.56)	\$ (6.54)	\$ (9.32)
4	2015 Q3	\$ (3.17)	\$ (5.39)	\$ (6.34)	\$ (9.03)
5	2015 Q3	\$ (2.81)	\$ (4.78)	\$ (5.62)	\$ (8.01)
6	2015 Q3	\$ (2.72)	\$ (4.62)	\$ (5.44)	\$ (7.75)
7	2015 Q3	\$ (2.61)	\$ (4.44)	\$ (5.22)	\$ (7.44)
8	2015 Q3	\$ (3.17)	\$ (5.39)	\$ (6.34)	\$ (9.03)
1	2015 Q4	\$ (3.15)	\$ (5.36)	\$ (6.30)	\$ (8.98)
2	2015 Q4	\$ (2.58)	\$ (4.39)	\$ (5.16)	\$ (7.35)
3	2015 Q4	\$ (3.36)	\$ (5.71)	\$ (6.72)	\$ (9.58)
4	2015 Q4	\$ (3.25)	\$ (5.53)	\$ (6.50)	\$ (9.26)
5	2015 Q4	\$ (2.88)	\$ (4.90)	\$ (5.76)	\$ (8.21)
6	2015 Q4	\$ (2.79)	\$ (4.74)	\$ (5.58)	\$ (7.95)
7	2015 Q4	\$ (2.68)	\$ (4.56)	\$ (5.36)	\$ (7.64)
8	2015 Q4	\$ (3.25)	\$ (5.53)	\$ (6.50)	\$ (9.26)

UnitedHealthcare Insurance Company of New York
 New York Small Group
 Off-Exchange
 Form # UHICNY_SG_COC_2014
 Medical and Rx Drug Benefits

INN = In-Network, OON = Out-of-network, Ded = Deductible, Coin = Coinsurance, MOOP = Maximum Out-of-pocket inc. Deductible,
 STD = Subject to Deductible, IP = Inpatient, OP = Outpatient, D&C = Subject to Ded and Coin.
 The key to the Prescription Drug plans is on a following page.

Plan Name	UnitedHealthcare Choice Plus VR-X	UnitedHealthcare Choice VR-W	UnitedHealthcare North Shore-LIJ Advantage VR-4 TIER 1	UnitedHealthcare North Shore-LIJ Advantage VR-4 TIER 2	UnitedHealthcare North Shore-LIJ Advantage VR-2 TIER 1	UnitedHealthcare North Shore-LIJ Advantage VR-2 TIER 2	UnitedHealthcare North Shore-LIJ Advantage VR-Z TIER 1	UnitedHealthcare North Shore-LIJ Advantage VR-Z TIER 2
Metal	Silver	Gold	Silver	Silver	Gold	Gold	Platinum	Platinum
Preventive	100%	100%	100%	100%	100%	100%	100%	100%
INN Ded	\$2,000	\$850	\$2,000	\$2,000	\$1,300	\$1,300	\$0	\$250
INN Coin	10%	10%	20%	50%	5%	20%	5%	20%
INN MOOP	\$5,500	\$4,000	\$6,000	\$6,000	\$3,000	\$3,000	\$1,000	\$2,000
OON Ded	\$4,000	n/a	n/a	n/a	n/a	n/a	n/a	n/a
OON Coin	50%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
OON MOOP	\$10,000	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Family Ded	2x Single	2x Single	2x Single	2x Single	2x Single	2x Single	2x Single	2x Single
Family MOOP	2x Single	2x Single	2x Single	2x Single	2x Single	2x Single	2x Single	2x Single
PCP Copay	\$30	\$15	\$20	\$40	\$10	\$30	\$20	\$40
PCP STD?	Y	N	Y	Y	Y	Y	N	N
Spec Copay	\$60	\$25	\$40	\$80	\$20	\$40	\$40	\$80
Spec STD?	Y	N	Y	Y	Y	Y	N	N
ER Copay	D&C	\$200	\$300	\$300	\$200	\$200	\$150	\$150
ER STD?	n/a	N	Y	Y	Y	Y	N	N
INN OP Surg Copay - ASC	\$200	\$200	D&C	D&C	D&C	D&C	\$100	\$300
INN OP Surg - ASC STD?	Y	Y	n/a	n/a	n/a	n/a	N	N
INN OP Surg Copay - Hospital	\$200	\$200	D&C	D&C	D&C	D&C	\$100	\$300
INN OP Surg - Hospital STD?	Y	Y	n/a	n/a	n/a	n/a	N	N
INN IP Copay	D&C	D&C	D&C	D&C	D&C	D&C	\$100	\$500
INN IP STD?	n/a	n/a	n/a	n/a	n/a	n/a	N	N
INN IP Copay Max	n/a	n/a	n/a	n/a	n/a	n/a	\$500	\$2,500
IP Copay per Admit / Day	n/a	n/a	n/a	n/a	n/a	n/a	Day	Day
PCP Gated?	N	N	N	N	N	N	N	N
Network	UHC	UHC	NSLIJ	NSLIJ	NSLIJ	NSLIJ	NSLIJ	NSLIJ
Prescription Drugs	Q	Z	M	M	M	M	W	W

UnitedHealthcare Insurance Company of New York
New York Small Group
Off-Exchange
Form # UHICNY_SG_COC_2014
Prescription Drug Benefit Key

Format is [Generic]/[Brand Formulary]/[Brand Non-Formulary].

Letter Code	Prescription Drug Plan
A	\$10/\$20/\$40
B	\$10/\$20/\$50
C	\$10/\$25/\$50
D	\$10/\$30/\$60
E	\$10/\$35/\$70
F	\$10/\$35/\$75
G	\$10/\$65/50% to \$800
H	\$15/50%/50%
I	\$7/\$20/\$40
J	Ded Med/RX then \$10/\$20/\$50
K	Ded Med/RX then \$10/\$25/\$50
L	Ded Med/RX then \$10/\$30/\$60
M	Ded Med/Rx then \$10/\$35/\$60
N	Ded Med/Rx then \$10/\$35/\$70
O	Ded Med/RX then \$10/\$35/\$75
P	Ded Med/Rx then \$10/30%, max \$150/45%, max \$400
Q	Ded Med/Rx then \$15/\$35/\$75
R	Ded Med/RX then \$15/50%/50%
S	Ded Med/Rx then \$20/\$40/\$80
T	Ded Med/Rx then 0%/0%/0%
U	Non-T1 Ded \$100 then \$10/\$25/\$50
V	Non-T1 Ded \$100 then \$10/\$30/\$60
W	Non-T1 Ded \$100 then \$10/\$35/\$60
X	Non-T1 Ded \$100 then \$10/50%/50%
Y	Non-T1 Ded \$100 then \$15/\$30/\$60
Z	Non-T1 Ded \$100 then \$15/\$35/\$75
AA	Non-T1 Ded \$100 then \$15/50%/50%
AB	Non-T1 Ded \$100 then \$7/\$20/\$40
AC	Non-T1 Ded \$150 then \$10/\$25/\$50
AD	Non-T1 Ded \$150 then \$15/50%/50%
AE	Non-T1 Ded \$250 then \$10/\$25/\$50
AF	Non-T1 Ded \$250 then \$10/\$30/\$60
AG	Non-T1 Ded \$250 then \$15/50%/50%
AH	Non-T1 Ded \$250 then \$5/20%, max \$150/35%, max \$400
AI	Non-T1 Ded \$250 then \$7/\$20/\$40
AJ	Non-T1 Ded \$50 then \$10/\$25/\$50
AK	Non-T1 Ded \$50 then \$15/\$35/\$75
AL	Non-T1 Ded \$50 then \$15/50%/50%
AM	Non-T1 Ded \$50 then \$7/\$20/\$40
AN	Non-T1 Ded \$500 then \$10/\$25/\$50
AO	Non-T1 Ded \$500 then \$10/\$30/\$60
AP	Non-T1 Ded \$500 then \$15/50%/50%
AQ	Non-T1 Ded Med/Rx then \$10/30%, max \$150/45%, max \$400
AR	Non-T1 Ded Med/Rx then \$10/50%, max \$150/50%, max \$400
AS	Non-T1 Ded Med/Rx then \$15/\$35/\$75

UnitedHealthcare Insurance Company of New York
New York Small Group
Off-Exchange
Form # UHICNY_SG_COC_2014
Pediatric Dental and Vision Benefits

Benefit Category	NY Commercial SG - UHIC
EHB - Prev & Diagnostic -Ped Dental (for children)	* 100% after Med Ded for traditional plans * HMO Plans are subject to Copay
Ped Dental Ded (Applies to - Basic Dental Svcs, Major Dental Svcs, Orthodontia, or any combination)	Basic, Major, Preventive & Diagnostic, Orthodontia
INN Ped Dental Single Ded	* \$100 if copay * Ded if D&C * No ded for HMO
INN Ped Dental Family Ded	* \$200 if copay * Ded if D&C * No ded for HMO
EHB - Basic Dental Svcs (e.g. Fillings/extractions) for Children	80% after Med or Den Ded
EHB - Major Dental Svcs (e.g. Crowns) for Children	50% after Med or Den Ded
EHB - Orthodontia (e.g. braces) for Children	50% after Med or Den Ded
Ped Vision Ded (\$/N/A/Inc in Med)	* N/A if copay/non-HSA plan * Ded if HSA
Ped Vision Ded (Applies to - Routine Vision Exam, Vision Materials, or both)	* No services fall under ded for non-HSA plans * Vision materials for HSA
EHB - Routine Vision Exam for Children	* Lesser of PCP copay or \$30 for non-HSA. Does not apply to ded but does apply to OOPM * 100% for HSA (treated like prev svc) and applies to OOPM
EHB - Prev Lens copay for Children	* 50% for copay * 50% after Ded for HSA
EHB - Prev Frames Tier 1 for Children	* 50% for copay * 50% after Ded for HSA
EHB - Prev Frames Tier 2 for Children	* 50% for copay * 50% after Ded for HSA
EHB - Prev Frames Tier 3 for Children	* 50% for copay * 50% after Ded for HSA
EHB - Prev Frames Tier 4 for Children	* 50% for copay * 50% after Ded for HSA
EHB - Prev Frames Tier 5 for Children	* 50% for copay * 50% after Ded for HSA
EHB - Prev Contacts for Children	* 50% for copay * 50% after Ded for HSA

UnitedHealthcare Insurance Company of New York
 New York Small Group
 Off-Exchange
 Form # UHICNY_SG_COC_2014
 Additional Notes

Estimated Commissions as a percent of premium: 3.0%

Expected Loss Ratio (Claims / Premium): 82.0%

To determine the premium rate for a plan design, first look up the rate for that plan design, demographic tier, area, and effective quarter. Then add the rate for any riders, for the demographic tier, area, and effective quarter. The total is the final rate.

Sample Calculation

2015 Q1 UnitedHealthcare Choice Plus VR-X Area 1
 Domestic Partner, Dependent Age Cut-off 29, and Women's Contraceptive riders

Tier:	Medical + Rx Rate	Domestic Partner Rider	Dependent Age Cut-off 29	Women's Contraceptive Rider	Total Rate
Single rate	\$ 696.60	\$ -	\$ 13.93	\$ (2.91)	\$ 707.62
Parent / Child(ren) rate	\$ 1,184.22	\$ -	\$ 23.68	\$ (4.95)	\$ 1,202.95
Couple rate	\$ 1,393.20	\$ -	\$ 27.86	\$ (5.82)	\$ 1,415.24
Family rate	\$ 1,985.31	\$ -	\$ 39.71	\$ (8.29)	\$ 2,016.73

UnitedHealthcare Insurance Company of New York Small Group (1-50) Underwriting Requirements (Off-Exchange) ⁱ

The following underwriting requirements apply to all applications or renewals of coverage on our UnitedHealthcare insurance products.

- A. Group Size Requirements:** To be eligible for small group coverage, a group must be located in a county where we offer Oxford products (see Section I.C for more information about the Service Area) and has at least one (1) but not more than fifty (50) eligible employees. (See Section I.B for the definition of eligible employees.) The following are not counted toward group size:
- any person who performs services for the company that are reported on an IRS 1099 form (such a person is not an employee and is not eligible for coverage); or
 - any former employee who is covered through retiree benefits, the Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation.
 - an individual business owner and his or her spouse (typically known as “sole proprietors”), when there are no other eligible employees. To qualify as a “group”, at least one other person must be employed and eligible for coverage. The employee does not have to accept the coverage offered, so long as the employee is eligible. (See special exception below for corporations.)
 - A business owner and his or her spouse are not considered a group of one (1) and will need to purchase individual coverage. For purposes of determining the existence of a group, spouses are not considered employees even if they are on the payroll.
 - Partnerships - There must be one employee eligible for coverage for a partnership to be considered a group health plan. (A plan with multiple owners and spouses without employees is not considered a group.)
 - Special rule for Corporations (LLCs, S and C Corporations) - An eligible employee is not required if the corporation has at least two owners who are not married.

If the employer does not offer group health coverage to all eligible employees, group size will be calculated based on the number of eligible employees in the Service Area or Expanded Service Area (if applicable). (See Section I.B-C and II.D.)

Groups that no longer meet the small group size requirements will be offered coverage in accordance with their appropriate market segment. If we learn this during an audit, the offering of the appropriate product may occur after we send information about small group replacement options. (See Section I.E-F for information about audits and documentation requirements.)

- B. Eligibility:** Only those eligible employees and eligible former employees who meet the below requirements can be enrolled in our small group products. The enrolled employees and former employees must live, work or reside in the Service Area or if applicable the Expanded Service Area (See Section I.C for more information).
- Eligible employees who may enroll: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work 20 or more hours per week and are eligible for health benefits under the employer’s group health plan. Business owners who work 20 hours per week and work for a business considered a group under Section I.A are eligible to enroll. (See Section I.A, Bullet 3 for more information.) Eligible employees do not include:
 - any person who performs services for the company that are reported on an IRS 1099 form (such a person is not an employee and is not eligible for coverage);
 - any former employee who is covered through retiree benefits, COBRA or state continuation;
 - any employee who does not live, work or reside in the United States;
 - co-employees of a Professional Employer Organization (PEO), Employee Leasing Company (ELC) or other such entity that is a co-employer with a client of client-site employees; or
 - an individual proprietor and his or her spouse (“sole proprietors”) when at least one other person is not employed. (See Section I. A, Bullet 3, above.)
 - Eligible Former Employees who may enroll: Former employees eligible for COBRA or state continuation can be enrolled in our small group products for the period allowed by law. If the employer offers retiree benefits, all eligible retired former employees, can be enrolled in our small group products.
 - Valid Employer Class(es): An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of

compensation, hours and occupational duties. Coverage may be limited to specific class(es) of employees if they are the only employees offered coverage on the New York product. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford products.

Example: Employer may elect to offer coverage only to employees who work at least 30 hours per week.

C. Service Area:

- Our UnitedHealthcare Service Area consists of the counties where we are licensed and authorized to sell products and have approved products and rates. For most products, our Service Area consists of Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Niagara, Orleans, Erie, Genesee, Wyoming, Chautauqua, Cattaraugus, Allegany, Delaware, Monroe, Wayne, Livingston, Ontario, Yates, Seneca, Broome, Onondaga, Tioga, Cortland, Cayuga, Tompkins, Schuyler, Chemung, Steuben, Jefferson, Oswego, Lewis, Madison, Oneida, Otsego, Chenango, Herkimer, Clinton, Essex, Franklin, Hamilton and St. Lawrence counties. For our UnitedHealthcare North Shore-LIJ Advantage product, our Service Area consists of Nassau, Suffolk and Queens counties. Employers must have an office location in one of these counties to be eligible to purchase our products.
- Out-of-area enrollment options may be available for eligible employees (defined in Eligibility section) who live, work or reside in locations outside of the UnitedHealthcare Service Area. Enrollment on our NY products is allowed only to the extent allowed in the eligible employees' state.

D. Multiple Plan Design Rules:

- Multiple plan design options can be offered as point of enrollment (POE) (e.g., High Plan vs. Low Plan) or by class distinction (e.g., Salaried vs. Hourly).
- If a renewing group makes a plan change, the multiple plan design rules (below) will apply.
- Groups may select two plan design options as long as there is enrollment in both plans.
- More than two plan design options will not be allowed.

E. Open Enrollment Period (New Business):

- From November 15 through December 15, the minimum participation requirements in Sections II.B and II.C will not apply to **new** groups applying for coverage. For example a group with a 1/1/14 **new business** date would be eligible to enroll from November 15 – December 15, 2013.

F. Minimum Participation – Calculation:

- A minimum of 60 percent of all eligible employees after valid waivers must be enrolled.
- Valid waivers: Spousal.
- To determine total enrollment for the purpose of calculating participation, we will count eligible employees enrolled in our products. Former employees enrolled through COBRA or state continuation are not counted.

G. Minimum Participation – Other Employer Sponsored Coverage:

- Other employer sponsored health insurance coverage may not be offered alongside our UnitedHealthcare products. Because our participation requirement is 60%, this would prevent both carriers from meeting New York state minimum participation requirements.
- Other employer sponsored HMO coverage may be offered alongside UnitedHealthcare products, but is not considered a valid waiver and may impact a group's ability to meet minimum participation requirements for UnitedHealthcare products.

E. Documentation Requirements: We require documents from new groups as part of a group's initial enrollment and for groups making changes on renewal. If documents are not provided within the required timeframe, the group will be denied enrollment. Most documentation can be submitted using IDEA, our online enrollment tool. We also may audit a new or renewing group before or after enrollment/renewal. If post enrollment/renewal, an audit shows the group did not meet the requirements at the time of enrollment and was not eligible for coverage, the group will be terminated.

Required documents:

- Group Application (new business) or Certification Form (renewing business)
- Eligible waivers (required for all new business, renewing groups on audit and groups renewing into a new market segment)
- The Quarterly Combined Withholding, Wage Reporting and Unemployment Insurance Return Form (NYS-45) or alternative tax documentation.

Additional documentation may be required upon audit.

ⁱ These guidelines may be updated from time to time and are subject to regulatory approval.

SERFF Tracking #:

UHLC-129581429

State Tracking #:

2014060234

Company Tracking #:

State:

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only

Product Name:

2015 UHIC SG OFFX Plans

Project Name/Number:

2015 UHIC SG OFFX Plans/

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum/Actuarial Certification
Comments:	Cover Letter Actuarial Memo Actuarial Cert
Attachment(s):	2015 UHIC Cover letter.pdf 2015 SG UHIC Off-Exch Act Memo.pdf 2015 UHIC SG Certification.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	2015 UHIC Off Exchange URRT Part III.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch AVs.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 13-Narrative Summary and Numerical Summary
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 13.pdf 2015 SG UHIC Off-Exch Ex 13.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 14B-Sm Grp Requested Percentage Changes
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 14B.pdf 2015 SG UHIC Off-Exch Ex 14B.xlsx
Item Status:	
Status Date:	

SERFF Tracking #:

UHLC-129581429

State Tracking #:

2014060234

Company Tracking #:

State:

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only

Product Name:

2015 UHIC SG OFFX Plans

Project Name/Number:

2015 UHIC SG OFFX Plans/

Satisfied - Item:	Exhibit 15B-Sm Grp Distribution by Rate Adj Percentages
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 15B.pdf 2015 SG UHIC Off-Exch Ex 15B.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 16-Summary of Policy Form & Product Changes
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 16.pdf 2015 SG UHIC Off-Exch Ex 16.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 17-Claims Experience for 2011-13 (Sm Grps)
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 17.pdf 2015 SG UHIC Off-Exch Ex 17.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 18-Index Rate Plan-Design Development
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 18.pdf 2015 SG UHIC Off-Exch Ex 18.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 19-Claim Trend, Admin Expenses & Profit
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 19.pdf 2015 SG UHIC Off-Exch Ex 19.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 20-HIOS ID Mapping
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 20.pdf 2015 SG UHIC Off-Exch Ex 20.xlsx

SERFF Tracking #:

UHLC-129581429

State Tracking #:

2014060234

Company Tracking #:

State:

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only

Product Name:

2015 UHIC SG OFFX Plans

Project Name/Number:

2015 UHIC SG OFFX Plans/

Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 23-Requested 2015 Premium Rates
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 23.pdf 2015 SG UHIC Off-Exch Ex 23.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Initial Notice of Proposed Rate Adjustment
Comments:	PDF versions of the Group and Subscriber Initial Notices.
Attachment(s):	Rate Review_Initial Notice UHIC SG_Off-Exchange Downstate Group.pdf Rate Review_Initial Notice UHIC SG_Off-Exchange Downstate Subscriber.pdf Rate Review_Initial Notice UHIC SG_Off-Exchange Upstate Group.pdf Rate Review_Initial Notice UHIC SG_Off-Exchange Upstate Subscriber.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Final Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	DRAFT 2015 NYSG Group Renewal Letter MANUAL.pdf DRAFT 2015 UHIC NY SG Final Notification Letter Subscriber.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Redacted Documents for Web Posting
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch Ex 21A - redacted.pdf 2015 SG UHIC Off-Exch Ex 21A - redacted.xlsx 2015 SG UHIC Off-Exch Ex 21B - redacted.pdf 2015 SG UHIC Off-Exch Ex 21B - redacted.xlsx 2015 UHIC Cover letter - redacted.pdf 2015 UHIC SG Certification - redacted.pdf 2015 UHIC Off Exchange URRT Part III_Redacted.pdf 2015 SG UHIC Off-Exch Ex 11 - redacted.pdf 2015 SG UHIC Off-Exch Ex 11 - redacted.xlsx 2015 SG UHIC Off-Exch Ex 22_Redacted.xlsx 2015 SG UHIC Off-Exch Ex 22_Redacted.pdf
Item Status:	
Status Date:	

SERFF Tracking #:

UHLC-129581429

State Tracking #:

2014060234

Company Tracking #:

State:

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only

Product Name:

2015 UHIC SG OFFX Plans

Project Name/Number:

2015 UHIC SG OFFX Plans/

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	2015 SG UHIC Off-Exch URRT.pdf 2015 SG UHIC Off-Exch URRT.xlsm
Item Status:	
Status Date:	

State:

New York

Filing Company:

UnitedHealthcare Insurance Company of New York

TOI/Sub-TOI:

H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only

Product Name:

2015 UHIC SG OFFX Plans

Project Name/Number:

2015 UHIC SG OFFX Plans/

Attachment 2015 SG UHIC Off-Exch Ex 13.xlsx is not a PDF document and cannot be reproduced here.

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Attachment 2015 SG UHIC Off-Exch URRT.xlsm is not a PDF document and cannot be reproduced here.



June 13, 2014

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

RE: UnitedHealthcare Insurance Company of New York
NY Small Group Off-Exchange
Effective January 2015 – December 2015

Dear [REDACTED]

This rate filing addresses the development of the New York small group Off-Exchange rates for plans written by UnitedHealthcare Insurance Company of New York. The rates are effective from January 2015 to December 2015.

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

Sincerely,

[REDACTED]
Director, Actuarial Pricing
UnitedHealthcare
48 Monroe Turnpike
Trumbull, CT 06611
[REDACTED]



UnitedHealthcare Insurance Company of New York, Inc.
New York Small Group Rates
HIOS ID: 54235
Effective January 2015 – December 2015

ACTUARIAL MEMORANDUM

I. Introduction

This rate filing addresses the rate development for the New York Small Group plans written by UnitedHealthcare Insurance Company of New York, Inc. (“UHIC”). Rates are effective from January 1, 2015 through December 31, 2015. This rate filing is being submitted under Section 3231(e)(1) of the New York State Insurance Law.

II. Determination of the Index Rate

A. Experience Period Claims

Please refer to Exhibit 18 for the development of the index rate. We used the Oxford Health Insurance, Inc. (“OHI”) small group experience to set the UHIC small group rates for two primary reasons: (1) the membership in UHIC small group plans is decreasing rapidly (3,176 average members in experience period) and (2) we anticipate that the majority of future UHIC enrollment will be in the North Shore LIJ (“NSLIJ”) plans that are only offered in Nassau and Suffolk counties and not reflected in the experience period data. We used OHI small group claims data with additional adjustments as described in this Actuarial Memorandum to calculate the UHIC rates. Specifically, we used OHI small group claims incurred between January 1, 2013 and December 31, 2013 paid through February 28, 2014 with an adjustment for claims incurred but not reported (“IBNR”). We excluded experience for sole proprietors consistent with the pricing/filing instructions issued by the New York State Department of Financial Services (“DFS”). The experience includes all other groups active in the period. There are no OHI Small Group grandfathered plans so no exclusion was required. Regulation 146 amounts were removed from the experience period claims. The resulting in-network only experience period claim PMPM excluding Regulation 146 is \$416.63.

B. Average AV Pricing Value

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

AVs, gatekeeper, and network factors based upon the membership distribution within the experience period for OHI. These are shown below.

In-Network Pricing Actuarial Value (AV) Excluding Gatekeeper & Network 0.805	
Average Gatekeeper and Network Benefit Adjustment	0.987

C. Average Induced Demand Adjustment

The induced demand adjustments used in the 2015 rate development are shown below.

Bronze 0.7779
 Silver 0.8012
 Gold 0.8401
 Platinum 0.8946

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

Bronze 1.00
 Silver 1.03
 Gold 1.08
 Platinum 1.15

We assigned the induced demand factors above to each in-force plan design based upon its HHS calculator metal level and calculated the average induced demand factor of 0.844 for the experience period.

D. Trend Assumptions

The projected annual OHI trend factor is 10.9%. This breaks down into the following components: 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging. Please note that this trend factor excludes any risk margin.

We have trended the experience period claim PMPM using the 10.9% annual trend factor and the 25 months between the midpoint of the experience period (July 1, 2013) and the midpoint of the average first quarter 2015 rating period (August 1, 2015). Please note that the midpoint of the rating period assumes an average effective date of February 1, 2015 for groups new or renewing in the first quarter of 2015.

The trended incurred in-network claim PMPM of \$517.32 was calculated by multiplying the experience period incurred in-network claim PMPM of \$416.63 by the trend factor of 1.242.

E. Projected Average PMPM Claims

We calculated the experience period in-network index rate PMPM adjusted for pricing AV, induced demand, and gating and network provisions of \$618.45. The trended AV-adjusted experience period in-network index rate PMPM is \$767.93.

F. Market-Wide Index Rate Adjustments

The development of the market wide adjustments is described below.

1. Federal Risk Adjustment: We have used the risk scores developed by Deloitte and DFS in the 2015 rate development with a 10 % adjustment (moving scores closer to 1.0). This additional adjustment is to account for potential issues with the underlying data since it was not audited. The adjustments are -0.3% for OHP and +0.6% for OHI. The resulting factors used to normalize the experience period claims in the rate development to the statewide average risk level are +2.2% for OHP and -5.1% for OHI.
2. Exchange User Fees: As instructed by DFS, we have not included an adjustment for exchange user fees in the 2015 premium rates. We understand this instruction is due to the fact that the 2014-2015 Executive Budget does not include any Exchange user fees.
3. Essential Health Benefits: While the OHI EPO plan was chosen as the benchmark plan, there are some required modifications to comply with the Essential Health Benefits (“EHB”) provision of PPACA. These changes and the estimated claim impacts are as follows.

Removal of \$1,500 DME Maximum	0.8%
Clinical Trials	0.03%
Habilitative Benefits	0.2%
Federal Mental Health Parity	0.6%
Total	1.6%

The claim cost estimates for these services were developed using national UnitedHealthcare data and the proprietary UnitedHealthcare pricing model.

The EHB line also includes an additional 0.5% adjustment to add pharmacy claims for the groups that did not have pharmacy coverage during the experience period. This adjustment was developed based upon the average pharmacy claim PMPM.

4. Provider Network & Fee Schedule Changes: We have increased the projected OHI claim PMPM by 4.0% to adjust from OHI to UHIC contracted rates. We also applied an additional 8.6% network decrement to the NSLIJ plans only to reflect the product specific contracting consistent with the original new product filing that was approved by DFS.
5. Utilization Management Changes: We do not expect any significant changes to our utilization management procedures.

6. Expected Covered Membership Risk: We are not projecting any material change in the risk profile of the overall small group market enrollment. We believe that the 4% expected statewide morbidity improvement that DFS reflected in its 2014 rate decisions is not materializing, nor do we expect it to occur in 2015. This is mainly because we do not believe that the small group market is contracting as much as it would have to in order to produce such a significant morbidity improvement. Based upon publicly available filing data, we have estimated that the statewide Small Group enrollment only decreased by 6.9% over the two year period from 2012 to 2014. Please note that this estimate is based upon 1st quarter effective membership. If we assume that half of this decrease is attributable to 2014, then the groups leaving the Small Group market would have to be at a morbidity level 114% above the statewide average level in order to produce a 4% overall decrease in morbidity. However, all measures available to us appear to indicate that the morbidity level of the Small Group market is remaining mostly unchanged in 2014, which is the expected result based upon the small decrease in the estimated market size. Furthermore, we do not believe there are any PPACA changes from 2014 to 2015 that would lead to a different result in 2015. Please also note that the 2015 rate development already assumes a 1% decrease in expected claims through the exclusion of Sole Proprietors.
7. Distribution of Membership by Rating Region: We expect that the majority of new UHIC small group enrollees will be in the NSLIJ plans offered downstate.
8. Credibility Adjustment: As previously mentioned, we have used OHI small group experience to develop the UHIC small group rates. There was an average of 432,303 members in OHI small group plans during the experience period. We consider this to be fully credible and therefore have made no adjustments.

III. Determination of the Premium Rates

A. Plan Level Adjustments

1. Pricing Actuarial Values: Consistent with the calculation of the average pricing AV values for the experience period, we also used the UnitedHealthcare proprietary pricing model to determine the AVs for each of the small group plans on the UHIC license.
2. Induced Demand Adjustments: The development of the induced demand factors is described in Section II(C). We used the same values to calculate the new plan rates as were used to calculate the average induced demand adjustment for the experience period. These values are as follows:

Bronze 0.7779
Silver 0.8012
Gold 0.8401
Platinum 0.8946

3. Provider Network Characteristics: We have increased the projected OHI claim PMPM by 4.0% to adjust from OHI to UHIC contracted rates. We also applied an additional 8.6% network decrement to the NSLIJ plans only to reflect the product specific contracting consistent with the original new product filing that was approved by DFS.
4. Delivery System Characteristics: Consistent with the values used to calculate the average experience period gatekeeper value, we have assumed 1.0 for non-gatekeeper and 0.96 for gatekeeper. These factors apply to the in-network medical portion of the rates only.
5. Utilization Management Practices: We do not expect any significant changes to our utilization management practices.
6. Benefits in Addition to EHB: We are not adding any benefits in addition to EHB that would require a rate adjustment.
7. Administrative Costs (Excluding Exchange User Fees and Profits): The projected 2015 expense percentage for UHIC small group is 13.1% excluding exchange user fees and profits. This includes fixed administration (3.8%), commissions (3.0%), state premium taxes and assessments (2.6%), the PPACA insurer fee (3.2%), and the PPACA reinsurance fee (0.5%).
8. Profit: The requested rates reflect an 85.2% target BCR before the application of the PPACA fees and assessments and 82.0% after the application of the PPACA fees and assessments. This reflects projected profit of 4.9% for UHIC small group based upon premium including the PPACA fees and assessments. The projected loss ratio using federally prescribed MLR methodology is 87.6%.
9. Addition of Out-of-Network Benefit Option: We developed the out-of-network adjustment factors by separately projecting the out-of-network portions of the experience period claims using the same assumptions used to project the in-network claims when setting the index rate with one additional adjustment. We then used the proprietary UnitedHealthcare pricing model to determine the average out-of-network pricing AV. We determined the new pricing factors by running the out-of-network benefit plan designs through the pricing model and adjusting the projected out-of-network PMPM by the ratio of the new plan pricing AV to the experience period average AV. Consistent with the OHI PPO rate development, we also applied a 20% adjustment to the out-of-network rates to address adverse selection.
10. SMC Rate Credit: On May 14, 2014, DFS instructed UnitedHealthcare Insurance Company of New York, Inc. ("UHIC") to include a \$3.2M dollar credit in the 2015 Small Group rates due to an SMC Pool overage. Since the business on this license has decreased significantly, this would have resulted in a 64% decrease in 2015 rates. Therefore, as discussed with DFS, we have applied the credit to 2015 Small Group rates for OHP, OHI, and UHIC. The resulting credit is 0.1% based upon projected plan year 2015 premium.

B. Census Factors

The requested premium rates reflect the state-mandated tier factors as shown in the table below. Due to the credibility issues with the existing UHIC small group block, we propose using the OHI small group conversion factor. We calculated the OHI PMPM-to-single conversion factor of 1.241 using the combined OHP and OHI distribution of members and subscribers for January 2014 as shown in the table below and then adjusted the factor by the ratio of the experience period cost level to the January 2014 cost level. Since there has been a change in contract distribution from 2013 to 2014, we believe this approach most accurately captures this change while still being consistent with the 2013 cost level.

Oxford Small Group Total				
Tier	Members	Subs	Relativity	Conversion Factor
Single	26,019	26,019	1.000	1.262
Parent/Child(ren)	10,005	3,490	1.700	
Couple	10,020	5,010	2.000	
Family	43,040	10,036	2.850	

As described above, we applied a factor of .983 to the 1.262 conversion factor to make the conversion factor consistent with the 2013 cost level. The resulting final conversion factor is 1.241.

C. Area Factors

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

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

D. Quarterly Trend Increases

We are requesting 2.6% quarterly increases for the 2nd, 3rd, and 4th quarters of 2015. We calculated this by taking our projected annual UHIC trend to the ¼ power.

IV. Supporting Details

A. HHS Actuarial Value Calculator Adjustments

HHS metal screenshots are included in the filing. For plans using the NY DFS Standard In-Network benefits, we used the screenshots provided by DFS, without modification. For other plans, we calculated federal metal AVs using the HHS AV calculator. We made some modifications to the inputs, which are described below. We only changed the inputs; the final metal AVs came directly from the calculator output. We used only permitted factors in determining the metal AVs. We assumed that the difference between EHBs covered by our plans and those included in the calculator's continuance tables was negligible.

1. We always used 99.999% coinsurance instead of 100% due to unreasonable calculator outputs we observed in testing.
2. We converted copays after deductible (including Rx) to equivalent coinsurance values based on average unit costs from the continuance tables in the calculator.
3. We specially handled the inpatient and outpatient facility copays. Our inpatient copays cover only the facility portion of the service cost, but the HHS AV calculator inpatient copay line corresponds to both facility and professional charges. Our outpatient facility copay does not cover all services included under outpatient facility in the HHS calculator. Therefore we used the 2-tier function of the HHS calculator to more accurately value these copays. On tier 1, the inpatient and / or outpatient copays are applied (converted to coinsurance if appropriate, as discussed above). On tier 2, inpatient and outpatient facility are covered at the plan's general coinsurance level. We used the following weights, which are derived from our company's pricing model, on tier 1:
 - a. 73% if there is an outpatient facility copay but no inpatient facility copay;
 - b. 80% if there is a copay on both; and,
 - c. 100% if there is a copay on neither.
4. Our Rx plans do not have separate copays for Specialty drugs. For the Specialty drug copay calculator input, we calculated the approximate average copay for specialty drugs as the weighted average of the copays in the other 3 tiers, based on the distribution of specialty drugs among those tiers in our data.
5. The AV calculator does not support an Outpatient Facility copay. For such plans, we converted the copay to coinsurance based on the average unit cost from the calculator's continuance tables. For plans with a 2-tier OP surgery copay (Free-standing and Hospital), in the calculator we used the average of the two with 50% weight on each, which was reasonable based on our data.
6. Some plans within this portfolio have different cost-sharing features for family coverage (i.e., when two or more people are covered by the plan) from the cost-sharing features for individual coverage. For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

B. Trend

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

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

The projected annual trend factor is 10.9%. This breaks down into the following components: 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging. Please note that this trend factor excludes any risk margin.

C. Administrative Costs

The projected 2014 expense percentage for UHIC small group is 13.1% excluding exchange user fees and profits but including PPACA fees and assessments. The projected 2014 expense percentages in the 2014 UHIC small group rate filing was 15.0%. The decrease in projected expenses is mainly due to the termination of the upstate Healthy New York program.

D. Profit Assumptions

The requested rates reflect an 85.2% target loss ratio before PPACA fees and assessments. The target loss ratio is 82.0% after PPACA fees and assessments consistent with guidance from DFS. The resulting projected profit percentage is 4.9% relative to premium including PPACA fees.



UnitedHealthcare Insurance Company of New York.

New York Small Group
Rates Effective January 1, 2015 – December 31, 2015

ACTUARIAL CERTIFICATION

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

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

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
 - ASOP No. 5, Incurred Health and Disability Claims
 - ASOP No. 8, Regulatory Filings for Health Plan Entities
 - ASOP No. 12, Risk Clarification
 - ASOP No. 23, Data Quality
 - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/ Casualty Coverages
 - ASOP No. 41, Actuarial Communications
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.

[REDACTED]

[REDACTED]

UnitedHealthcare

June 13, 2014

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

State of New York Rate Review

General Information

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

Company Identifying Information:

- **Company Legal Name:** UnitedHealthcare Insurance Company of New York, Inc.
- **State:** New York
- **HIOS Issuer ID:** 54235
- **Market:** Small Group
- **Effective Date:** 1/1/2015 – 12/31/2015

Company Contact Information:

- **Primary Contact Name:** [REDACTED]
- **Primary Contact Telephone Number:** [REDACTED]
- **Primary Contact Email Address:** [REDACTED]

Proposed Rate Increase

UnitedHealthcare Insurance Company of New York, Inc. ("UHIC") is filing rates for benefit plans written under existing policy forms and certificates of coverage that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). We have developed the new rates using historical claims experience for Oxford Health Insurance, Inc. ("OHI") small group due to credibility concerns with the UHIC small group block of business. The average requested annual rate increase for 1st quarter renewals is 16.4%. In addition to new rates effective 1/1/2015, we are also filing 2.6% quarterly trend increases for each of the last three quarters in 2015.

Reasons for Rate Increase

The rate filing we have made is seeking an increase mainly related to rising medical costs. Medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs. The 2nd, 3rd, and 4th quarter 2015 quarterly increases of 2.6% are based upon projected annual increases in utilization trend (5.5%), unit cost trend (4.1%), and benefit leveraging (1.0%).

Experience Period Premiums and Claims

- **Experience Period:** The experience period is 1/1/2013 to 12/31/2013 paid through 2/28/2014.

- **Premiums (net of MLR Rebate) in Experience Period:** Earned premiums for the experience period are shown in Part I. The earned premiums are the sum of the actual premium amounts in the experience period for all small group UHIC policies with the exception of sole proprietors which were removed per instructions received from the New York State Department of Financial Services (“DFS”). UHIC does not anticipate paying any MLR rebates for this company for the months included in the experience period.
- **Allowed and Incurred Claims Incurred During the Experience Period:** The incurred and allowed claims were extracted from internal data warehouses and financial reports and include fee-for-service medical claims, fee-for-service pharmacy claims, graduate medical expense, HCRA hospital surcharge, pharmacy rebates, and capitations. We added estimates of incurred but not reported (“IBNR”) claims to the incurred and allowed claims. In order to calculate the IBNR amounts, we used a completion factor method based on actual adjudicated claims as well as taking the current inventory into account. We also use seasonality estimates to help guide our picks where completion factors may not have been credible.

Benefit Categories

Claims were assigned to benefit categories by our claim department using standard industry definitions of services.

Projection Factors

- **Changes in the Morbidity of the Population Insured:** No changes in the average morbidity are assumed.
- **Changes in Benefits:** We have estimated that the cost increase of adding benefits to comply with the Essential Health Benefits (“EHB”) provision is 1.6%. This estimate was developed using the UnitedHealthcare proprietary pricing model. The EHB line also includes an additional 0.5% adjustment to add pharmacy claims for the groups that did not have pharmacy coverage during the experience period. This adjustment was developed based upon the average pharmacy claim PMPM.
- **Changes in Demographics:** No changes in demographics are assumed.
- **Other Adjustments:** The rate development includes a 0.1% credit for SMC Pool coverage as instructed by NY DFS.
- **Trend Factors:** UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. As a general matter, we review our own recent/emerging claims experience at the state level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

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

The projected annual trend factor is 10.9%. This breaks down into the following components: 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging. Please note that this trend factor excludes any risk margin.

Credibility

We used the Oxford Health Insurance, Inc. ("OHI") small group experience to set the UHIC small group rates for two primary reasons: (1) the membership in UHIC small group plans is decreasing rapidly (3,176 average members in experience period) and (2) we anticipate that the majority of future UHIC enrollment will be in the North Shore LIJ ("NSLIJ") plans that are only offered in Nassau and Suffolk counties and not reflected in the experience period data. We used OHI small group claims data with additional adjustments as described in this Actuarial Memorandum to calculate the UHIC rates. There was an average of 432,303 members in OHI small group plans during the experience period. We consider this to be fully credible and therefore have made no further adjustments.

Paid to Allowed Ratio

We have developed the average paid to allowed factor for the projection period based upon a combination of the distribution of the UHIC small group members by plan and the pricing actuarial values for those plans.

Risk Adjustment and Reinsurance

- **Projected Risk Adjustments:** DFS and Deloitte performed risk adjustment modeling based upon data received from New York health plans. We analyzed the results of this analysis and made a slight adjustment based upon this review. As a result, we project OHI will be a net receiver and have included a 5.1% reduction to the index rate to account for this.
- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** We have assumed a payment of \$3.32 PMPM for the reinsurance fee. We have assumed no reinsurance recoveries since it is not applicable to small group.

Non-Benefit Expenses and Risk Margin

The 6.8% administrative expense load includes general administration (3.8%) and broker commissions (3.0%). We have estimated the expenses included in the development of the proposed rates based upon actual historical expenses and financial projections.

Projected Profit & Risk Margin

The projected profit and risk margin is 4.9% before state and federal income taxes and 3.2% after.

Taxes and Fees

The 8.0% includes state premium tax and assessments (2.6%), PPACA Insurer fee (3.2%), and state and federal income taxes (2.2%). This excludes the \$3.32 PMPM reinsurance fee.

Projected Loss Ratio

The projected loss ratio using federally prescribed MLR methodology is 87.6%.

Index Rate

The index rate of the experience period is \$457.00 and reflects the total allowed claims PMPM from the experience period for EHB benefits only. The index rate for the projection period is \$670.40. We applied 6 months of trend, at our 2015 annual trend rate of 10.9%, to the projection period index rate. This accounts for Small Group quarterly trend, under the assumption that members are equally distributed among the quarters.

AV Metal Values

HHS metal screenshots are included in the filing. For plans using the NY DFS Standard In-Network benefits, we used the screenshots provided by DFS, without modification. For other plans, we calculated federal metal AVs using the HHS AV calculator. We made some modifications to the inputs, which are described below. We only changed the inputs; the final metal AVs came directly from the calculator output. We used only permitted factors in determining the metal AVs. We assumed that the difference between EHBs covered by our plans and those included in the calculator's continuance tables was negligible.

1. We always used 99.999% coinsurance instead of 100% due to unreasonable calculator outputs we observed in testing.
2. We converted copays after deductible (including Rx) to equivalent coinsurance values based on average unit costs from the continuance tables in the calculator.
3. We specially handled the inpatient and outpatient facility copays. Our inpatient copays cover only the facility portion of the service cost, but the HHS AV calculator inpatient copay line corresponds to both facility and professional charges. Our outpatient facility copay does not cover all services included under outpatient facility in the HHS calculator. Therefore we used the 2-tier function of the HHS calculator to more accurately value these

copays. On tier 1, the inpatient and / or outpatient copays are applied (converted to coinsurance if appropriate, as discussed above). On tier 2, inpatient and outpatient facility are covered at the plan's general coinsurance level. We used the following weights, which are derived from our company's pricing model, on tier 1:

- a. 73% if there is an outpatient facility copay but no inpatient facility copay;
 - b. 80% if there is a copay on both; and,
 - c. 100% if there is a copay on neither.
4. Our Rx plans do not have separate copays for Specialty drugs. For the Specialty drug copay calculator input, we calculated the approximate average copay for specialty drugs as the weighted average of the copays in the other 3 tiers, based on the distribution of specialty drugs among those tiers in our data.
 5. The AV calculator does not support an Outpatient Facility copay. For such plans, we converted the copay to coinsurance based on the average unit cost from the calculator's continuance tables. For plans with a 2-tier OP surgery copay (Free-standing and Hospital), in the calculator we used the average of the two with 50% weight on each, which was reasonable based on our data.
 6. Some plans within this portfolio have different cost-sharing features for family coverage (i.e., when two or more people are covered by the plan) from the cost-sharing features for individual coverage. For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

I certify that the values were developed in accordance with generally accepted actuarial principles and methodologies.

AV Pricing Values

The AV pricing values in Worksheet 2 reflect the product of plan relativities from the proprietary UnitedHealthcare pricing model, utilization adjustments, gatekeeper adjustments, and network adjustments. The relativities from the UnitedHealthcare model reflect the cost sharing differences between plans and do not include any adjustments for health status or utilization. The utilization adjustments were also determined by the proprietary UnitedHealthcare pricing model and only reflect utilization differences due to the levels of cost sharing. For the gatekeeper adjustment, we have assumed factors of 1.0 for non-gatekeeper and 0.96 for gatekeeper. For the network differences, we have assumed factors of 1.0 for Freedom and 0.976 for Liberty. These adjustments do not reflect any differences in anticipated risk status. Please note that the gatekeeper factors apply to in-network medical claims only.

Membership Projections

We are not projecting any significant changes in membership.

Terminated Products

No products are being terminated.

Plan Type

Not applicable.

Warning Alerts

Not applicable

Reliance

Not applicable.

Actuarial Certification

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

I certify that the projected index rate is:

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

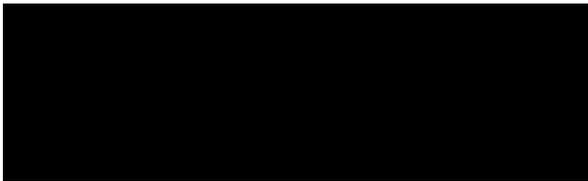
I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

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

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plans designs that did not fit into the AV Calculator, included in this Part III Actuarial Memorandum is a description of the methodology and numerical values used to develop the AV metal values, and a certification as required by 45 CFR Part 156, §156.135.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is described in detail in my state submitted actuarial memorandum. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

A large black rectangular redaction box covering the signature area.A black rectangular redaction box covering the name of the sender.

UnitedHealthcare
48 Monroe Turnpike
Trumbull, CT 06611

A black rectangular redaction box covering the contact information of the sender.

UnitedHealthcare North Shore-LIJ Advantage VR-Z

User Inputs for Plan Parameters

pf UHC P - Adv, x

- 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?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	75.00%
		2nd Tier Utilization:	25.00%

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$100.00	
Coinsurance (%; Insurer's Cost Share)	95.000%	99.999%	
OOP Maximum (\$)	\$1,000.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$250.00	\$100.00	
Coinsurance (%; Insurer's Cost Share)	80.000%	99.999%	
OOP Maximum (\$)	\$2,000.00		
OOP Maximum if Separate (\$)			

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$150.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$150.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$100.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$500.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$20.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$40.00
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$40.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$80.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$20.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$40.00
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$20.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$40.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$20.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$40.00
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	95.000%	\$100.00	<input type="checkbox"/>	<input type="checkbox"/>	80.000%	\$500.00
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	96.715%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	90.145%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	76.808%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	76.808%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.839%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.839%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input type="checkbox"/>
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	<input checked="" type="checkbox"/>
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

89.808%

Metal Tier:

Platinum

UnitedHealthcare North Shore-LIJ Advantage VR-2

User Inputs for Plan Parameters

pf UHC G - Adv, x

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

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? <input type="checkbox"/>	Blended Network/POS Plan? <input checked="" type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 75.00%
	2nd Tier Utilization: 25.00%

- Deductible (\$) _____
- Coinsurance (%; Insurer's Cost Share) _____
- OOP Maximum (\$) _____
- OOP Maximum if Separate (\$) _____

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$1,300.00
		95.000%
		\$3,000.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		\$1,300.00
		80.000%
		\$3,000.00

[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	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.373%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.373%	\$0.00
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	92.631%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.892%	\$0.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	87.980%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75.960%	\$0.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	91.828%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75.484%	\$0.00
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.841%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	72.522%	\$0.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.841%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	72.522%	\$0.00
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	\$0.00
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.347%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.347%	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	76.808%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	76.808%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.839%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.839%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

78.053%

Gold

UnitedHealthcare North Shore-LIJ Advantage VR-4

User Inputs for Plan Parameters

pf UHC S - Adv, x

- 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? <input type="checkbox"/>	Blended Network/POS Plan? <input checked="" type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 75.00%
	2nd Tier Utilization: 25.00%

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$2,000.00
Coinsurance (%; Insurer's Cost Share)			80.000%
OOP Maximum (\$)			\$6,000.00
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$2,000.00
Coinsurance (%; Insurer's Cost Share)			50.000%
OOP Maximum (\$)			\$6,000.00
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	85.560%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	85.560%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50.000%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	85.262%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70.523%	
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75.960%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	51.920%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	83.656%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	67.312%	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50.000%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	81.682%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	63.363%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	81.682%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	63.363%	
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.347%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.347%	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	76.808%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	76.808%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.839%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.839%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

68.092%

Silver

UnitedHealthcare Choice VR-W

User Inputs for Plan Parameters

pf UHC G - EPO, C

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

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? <input type="checkbox"/>	Blended Network/POS Plan? <input checked="" type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 73.00%
	2nd Tier Utilization: 27.00%

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$850.00	\$100.00	
Coinsurance (% Insurer's Cost Share)	90.000%	99.999%	
OOP Maximum (\$)	\$4,000.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$850.00	\$100.00	
Coinsurance (% Insurer's Cost Share)	90.000%	99.999%	
OOP Maximum (\$)	\$4,000.00		
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input type="checkbox"/>	<input type="checkbox"/>		\$200.00
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$0.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$90.00	<input type="checkbox"/>	<input type="checkbox"/>		\$90.00
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93.430%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.010%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.010%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.750%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.750%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

81.891%

Gold

UnitedHealthcare Choice Plus VR-X

User Inputs for Plan Parameters

pf UHC S - POS, C

- 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? <input type="checkbox"/>	Blended Network/POS Plan? <input checked="" type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 73.00%
	2nd Tier Utilization: 27.00%

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$2,000.00
Coinsurance (%; Insurer's Cost Share)			90.000%
OOP Maximum (\$)			\$5,500.00
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$2,000.00
Coinsurance (%; Insurer's Cost Share)			90.000%
OOP Maximum (\$)			\$5,500.00
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.892%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.892%	
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	63.940%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	63.940%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75.484%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75.484%	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	85.807%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	85.807%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	72.522%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	72.522%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	72.522%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	72.522%	
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100.000%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50.000%	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93.430%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90.000%	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	57.020%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	57.020%	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	77.432%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.010%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71.010%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.750%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98.750%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

68.746%

Silver

EXHIBIT 13: NUMERICAL SUMMARY

Company Name: UnitedHealthcare Insurance Company of New York
NAIC Code: 60093
SERFF Tracking #: UHLC-129581429
Market Segment: Small Groups Off Exchange

A. Average 2014 and 2015 Premium Rates:

Premium Rates are based on the following criteria:

- 1) The average monthly premium rates for 1st quarter rates for Employee Only.
- 2) The average arithmetic premium rates for all plans combined and for all regions combined.
- 3) Rates include Through Age 29, Domestic Partner and Family Planning Coverages.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	\$766.87	\$644.56	\$551.19	N/A	N/A
2015 Premium Rates	\$888.07	\$745.72	\$641.17	N/A	N/A

B. Weighted Average Annual Percentage Requested Adjustments*:

	2014 to 2015
Requested Rate Adjustment	16.0%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	25.5%	23.2%	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	93.2%	91.6%	85.5%

E. Claim Trend Rates and Average Ratios to Earned Premiums [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	12.3%	12.1%	10.9%
Expense Ratios	13.8%	15.0%	13.1%
Pre Tax Profit Ratios	3.0%	3.7%	4.9%

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

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

-- for Small Group Medical Plans

Company Name: UnitedHealthcare Insurance Company of New York
NAIC Code: 60093
SERFF Tracking #: UHLC-129581429
Market Segment: Small Groups Off Exchange

Small Group Medical Products

Market Segment	Effective Date of New Rate	Metal Level	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Small Group	1/1/2015	Platinum	99 - All Regions	EPO	EPO	15.81%	15.81%	15.81%
Small Group	1/1/2015	Gold	99 - All Regions	EPO	EPO	14.60%	16.04%	16.04%
Small Group	1/1/2015	Silver	99 - All Regions	EPO	EPO	14.61%	14.61%	14.61%
Small Group	1/1/2015	Silver	99 - All Regions	PPO	PPO	16.85%	16.85%	16.85%
Small Group	4/1/2015	Platinum	99 - All Regions	EPO	EPO	15.51%	15.51%	15.51%
Small Group	4/1/2015	Gold	99 - All Regions	EPO	EPO	14.30%	15.74%	15.74%
Small Group	4/1/2015	Silver	99 - All Regions	EPO	EPO	14.31%	14.31%	14.31%
Small Group	4/1/2015	Silver	99 - All Regions	PPO	PPO	16.55%	16.55%	16.55%
Small Group	7/1/2015	Platinum	99 - All Regions	EPO	EPO	15.21%	15.21%	15.21%
Small Group	7/1/2015	Gold	99 - All Regions	EPO	EPO	14.01%	15.44%	15.44%
Small Group	7/1/2015	Silver	99 - All Regions	EPO	EPO	14.02%	14.02%	14.02%
Small Group	7/1/2015	Silver	99 - All Regions	PPO	PPO	16.25%	16.25%	16.25%
Small Group	10/1/2015	Platinum	99 - All Regions	EPO	EPO	14.91%	14.91%	14.91%
Small Group	10/1/2015	Gold	99 - All Regions	EPO	EPO	13.72%	15.15%	15.15%
Small Group	10/1/2015	Silver	99 - All Regions	EPO	EPO	13.72%	13.72%	13.72%
Small Group	10/1/2015	Silver	99 - All Regions	PPO	PPO	15.95%	15.95%	15.95%

EXHIBIT 15 - PART B: DISTRIBUTION OF CONTRACTS BY REQUESTED PERCENT ADJUSTMENTS FOR SMALL GROUP PRODUCTS

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Tracking #: UHLC-129581429
 Market Segment: Small Groups Off Exchange

Distribution by Requested Rate Adjustment

Market Segment	Effective Date	Metal Level	Rating Region	Weighted Avg Change %	Annualized Premiums as of	Total # of Members as of	Total # of Contracts as of	Number of Members with Requested Percentage Rate Change at Renewal											
								3/31/2014	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
Small Group	1/1/2015	Platinum	99 - All Regions	15.8%	\$ 129,765	18	n/a	0	0	0	0	0	18	0	0	0	0	0	0
Small Group	1/1/2015	Gold	99 - All Regions	16.0%	\$ 1,831,155	250	n/a	0	0	0	0	0	250	0	0	0	0	0	0
Small Group	1/1/2015	Silver	99 - All Regions	16.9%	\$ 758,441	118	n/a	0	0	0	0	0	118	0	0	0	0	0	0
Small Group	1/1/2015	Bronze	99 - All Regions	0.0%	\$ -	-	n/a	0	0	0	0	0	0	0	0	0	0	0	0
Market Segment Total:				16.3%	\$ 2,719,361	386	n/a	0	0	0	0	0	386	0	0	0	0	0	0

EXHIBIT 16: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: UnitedHealthcare Insurance Company of New York
NAIC Code: 60093
SERFF Number: UHLC-129581429
Market Segment: Small Groups Off 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

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: UHCNY_SG_COC_2014
 Market Segment: Small Groups Off Exchange

- 1) Complete a separate ROW for each base medical policy form included in the rate adjustment filing.
 - Information requested applies to New York State business only and for all rating regions combined.
 - Include riders that may be available with that policy form in each policy form response. Discontinued policy forms and products are to be included in the Exhibit.
 - Insert additional rows as needed to include all base medical policy forms included in a particular market segment for Small Groups and Small Group HNY Business.
 - Add a row with the aggregate values for that entire market segment (including any Small Group Healthy NY and enter an appropriate identifier in column 1b (such as TOTAL).
- 2) In Column 4, market segment refers to Small Group, Small Group Sole Proprietors and Small Group Healthy NY Business.
- 3) Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, and Consumer Health Plans. Indicate appropriate designation for policy form, etc.
- 4) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- 5) Note that many cells include a drop down list. Use the drop down list for entries.
- 6) If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- 7) This exhibit must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form										Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)													
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identification	3. Effective date of rate change (mm/dd/yy)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change	14.1 Beginning Date of the experience period (mm/dd/yy)	14.2 Ending Date of the experience period (mm/dd/yy)	14.3 Member months for experience period	14.4 Earned premiums for experience period (\$)	14.5 Standardized earned premiums for experience period (\$)	14.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	14.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) (\$)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)			
SBN.CHC2.I	EPO	EPO	SG	01/01/2015	SG-All Others	EPO	Yes	Closed	207	1,389	XX	01/01/13	12/31/13	17,388	7,251,189	7,933,991	4,098,590	4,637,747	0	(170,901)	1,151,542	XX	
SBN.CHP1.I	POS	POS	SG	01/01/2015	SG-All Others	Non-HMO	Yes	Closed	168	1,595	XX	01/01/13	12/31/13	20,724	9,342,023	10,237,510	8,902,468	9,296,216	0	(203,689)	1,483,582	XX	
APP.I.08.NY	Healthy NY	Healthy NY	SG	01/01/2015	SG-HNY	EPO	Yes	Closed	179	218	XX	01/01/13	12/31/13	14,141	4,042,602	4,402,723	3,873,443	4,511,822	(1,197,884)	0	641,995	XX	
APP.I.08.NY	Healthy NY	Healthy NY	SG	01/01/2015	SG-Sole P	EPO	Yes	Closed	609	622	XX	01/01/13	12/31/13	10,031	3,509,329	3,822,114	4,736,804	4,614,299	(849,726)	0	557,307	XX	
Total																							
									1,163	3,824	XX	01/01/13	12/31/13	62,284	24,145,143	26,396,338	21,611,304	23,060,084	(2,047,610)	(374,590)	3,834,425	XX	
																							XX
																							XX
																							XX
																							XX
																							XX
																							XX
																							XX
																							XX
																							XX

EXHIBIT 17: HISTORICAL CLAIM DATA

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)												
15.1 Beginning date of the experience period (mm/dd/yy)	15.2 Ending Date of the experience period (mm/dd/yy)	15.3 Member months for experience period	15.4 Earned premiums for experience period (\$)	15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	15.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) (\$)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.1 Beginning date of the experience period (mm/dd/yy)	16.2 Ending Date of the experience period (mm/dd/yy)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) (\$)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)			
XX	01/01/12	12/31/12	25,365	9,134,430	11,240,024	6,989,344	7,318,158	0	(360,098)	1,334,087	XX	01/01/11	12/31/11	39,362	12,977,799	19,066,449	10,811,147	11,485,136	0	(476,067)	2,383,249	XX
XX	01/01/12	12/31/12	25,629	10,352,904	12,751,034	10,123,045	10,433,159	0	(363,845)	1,449,406	XX	01/01/11	12/31/11	34,479	12,107,815	16,975,008	11,997,780	12,219,099	0	(417,010)	2,023,007	XX
XX	01/01/12	12/31/12	15,658	4,701,091	6,163,843	4,768,794	5,179,192	(1,296,169)	0	720,737	XX	01/01/11	12/31/11	13,229.00	3,508,850	5,251,886	3,646,066	3,894,888	(884,623)	0	594,478	XX
XX	01/01/12	12/31/12	13,519	4,167,317	5,459,396	5,717,635	6,195,515	(1,119,103)	0	638,903	XX	01/01/11	12/31/11	13,633.00	3,622,337	5,425,172	4,931,638	5,105,889	(911,639)	0	613,705	XX
XX	01/01/12	12/31/12	80,171	28,355,742	35,614,297	27,598,817	29,126,023	(2,415,272)	(723,943)	4,143,133	XX	01/01/11	12/31/11	100,703	32,216,802	46,718,514	31,386,631	32,705,012	(1,796,262)	(893,077)	5,614,439	XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX

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

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: UHLC-129581429
 Market Segment : Small Groups Off Exchange

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

Line #	General	Separate column for each plan design (on or off Exchange)				
1	Product*	EPO	EPO	EPO	EPO	PPO
2	Product ID*	54297NY003	54297NY003	54297NY003	54297NY003	54297NY001
3	Metal Level (or catastrophic)*	Gold	Platinum	Silver	Gold	Silver
4	AV Metal Value (HHS Calculator)*	78.1%	89.8%	68.1%	81.9%	68.7%
5	AV Pricing Value (total, risk pool experience based)*	76.7%	90.5%	67.6%	84.2%	70.3%
6	Plan Type*	EPO	EPO	EPO	EPO	PPO
7	Plan Name*	UnitedHealthcare North Shore-LIJ Advantage VR-2	UnitedHealthcare North Shore-LIJ Advantage VR-Z	UnitedHealthcare North Shore-LIJ Advantage VR-4	UnitedHealthcare Choice VR-W	UnitedHealthcare Choice Plus VR-X
8	HIOS Plan ID*	54297NY0030004	54297NY0030003	54297NY0030005	54297NY0030001	54297NY0010002
9	Exchange Plan?*	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	\$ 2,161,348,155				
10B	Member-Months for Latest Experience Period	5,187,640				
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	416.63				
11	Average Pricing Actuarial Value reflected in experience period	0.674				
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	618.46	618.46	618.46	618.46	618.46

7	Plan Name*	UnitedHealthcare North Shore-LIJ Advantage VR-2	UnitedHealthcare North Shore-LIJ Advantage VR-Z	UnitedHealthcare North Shore-LIJ Advantage VR-4	UnitedHealthcare Choice VR-W	UnitedHealthcare Choice Plus VR-X
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**Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate**

13	Impact of adjusting experience period data to EHB benefit level	1.021				
14	Market wide adjustment for changes in provider network **	1.000				
15	Market wide adjustment for fee schedule changes **	1.000				
16	Market wide adjustment for utilization management changes **	1.000				
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000				
18	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)	0.949				
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000				
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000				
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.242				
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)	1.203	1.203	1.203	1.203	1.203

** Not Included in Claim Trend Adjustment

7	Plan Name*	UnitedHealthcare North Shore-LIJ Advantage VR-2	UnitedHealthcare North Shore-LIJ Advantage VR-Z	UnitedHealthcare North Shore-LIJ Advantage VR-4	UnitedHealthcare Choice VR-W	UnitedHealthcare Choice Plus VR-X
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Plan Level Adjustments

29	Pricing actuarial value (without induced demand factor) #	0.767	0.905	0.676	0.842	0.703
30	Pricing actuarial value (only the induced demand factor) #	0.840	0.895	0.801	0.840	0.801
31	Impact of provider network characteristics ##	0.951	0.951	0.951	1.040	1.040
32	Impact of delivery system characteristics ##	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
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.160	1.160	1.160	1.160	1.160
37	Profit/Contribution to surplus margins	1.051	1.051	1.051	1.051	1.051
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.086
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000
41	SHOP Selection, Reg 146 Payback	1.000	1.000	1.000	1.000	1.000
42	Pediatric Dental and Vision	1.007	1.006	1.008	1.006	1.007
43	Impact of Plan Level Adjustments (product L29 through L42)	0.751	0.943	0.633	0.902	0.780

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

Beyond what is reflected in Market Wide adjustments

44	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)	559.02	701.62	470.59	670.81	580.51
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EXHIBIT 19 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: JHLC-129581429
 Market Segment: Small Groups Off 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/yyyy; 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 05/31/2014	4.1 Period assumed beginning date (mm/dd/yy)	4.2 Period assumed ending date (mm/dd/yy)	5. Average annual claim trend assumed	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/contribu- tion 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	
Silver	Off Non Std	172	XX 01/01/15	12/31/15	10.95%	0.50%	0.00%	3.00%	1.63%	4.17%	3.80%	13.10%	3.16%	0.00%	0.00%	1.70%	35.00%	0.00%	17.96%	XX
Gold	Off Non Std	319	XX 01/01/15	12/31/15	10.95%	0.50%	0.00%	3.00%	1.63%	4.17%	3.80%	13.10%	3.16%	0.00%	0.00%	1.70%	35.00%	0.00%	17.96%	XX
Platinum	Off Non Std	20	XX 01/01/15	12/31/15	10.95%	0.50%	0.00%	3.00%	1.63%	4.17%	3.80%	13.10%	3.16%	0.00%	0.00%	1.70%	35.00%	0.00%	17.96%	XX

EXHIBIT 19: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES

			For the rate period included in the prior rate and form filing										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 05/31/2014		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
Silver	Off Non Std	172	XX	01/01/14	12/31/14	12.12%	0.80%	0.00%	5.17%	2.00%	3.30%	3.77%	15.05%	2.41%	0.01%	0.34%	1.30%	35.00%	0.00%	18.77%
Gold	Off Non Std	319	XX	01/01/14	12/31/14	12.12%	0.80%	0.00%	5.17%	2.00%	3.30%	3.77%	15.05%	2.41%	0.01%	0.34%	1.30%	35.00%	0.00%	18.77%
Platinum	Off Non Std	20	XX	01/01/14	12/31/14	12.12%	0.80%	0.00%	5.17%	2.00%	3.30%	3.77%	15.05%	2.41%	0.01%	0.34%	1.30%	35.00%	0.00%	18.77%

EXHIBIT 20: HIOS ID MAPPING TO PRODUCT NAMES

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: UHLC-129581429
 Market Segment: Small Groups Off 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)
54297NY0030001	UnitedHealthcare Choice VR-W	Gold	OFF	NO	26	NO	INCLUDED	YES	NO	NO
54297NY0030030	UnitedHealthcare Choice VR-W	Gold	OFF	NO	26	NO	EXCLUDED	YES	NO	NO
54297NY0030029	UnitedHealthcare Choice VR-W	Gold	OFF	NO	26	YES	INCLUDED	YES	NO	NO
54297NY0030011	UnitedHealthcare Choice VR-W	Gold	OFF	NO	26	YES	EXCLUDED	YES	NO	NO
54297NY0030031	UnitedHealthcare Choice VR-W	Gold	OFF	NO	29	NO	INCLUDED	YES	NO	NO
54297NY0030010	UnitedHealthcare Choice VR-W	Gold	OFF	NO	29	YES	INCLUDED	YES	NO	NO
54297NY0030012	UnitedHealthcare Choice VR-W	Gold	OFF	NO	29	NO	EXCLUDED	YES	NO	NO
54297NY0030009	UnitedHealthcare Choice VR-W	Gold	OFF	NO	29	YES	EXCLUDED	YES	NO	NO
54297NY0010002	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	26	NO	INCLUDED	YES	YES	NO
54297NY0010003	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	26	NO	EXCLUDED	YES	YES	NO
54297NY0010001	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	26	YES	INCLUDED	YES	YES	NO
54297NY0010015	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	26	YES	EXCLUDED	YES	YES	NO
54297NY0010004	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	29	NO	INCLUDED	YES	YES	NO
54297NY0010014	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	29	YES	INCLUDED	YES	YES	NO
54297NY0010016	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	29	NO	EXCLUDED	YES	YES	NO
54297NY0010013	UnitedHealthcare Choice Plus VR-X	Silver	OFF	NO	29	YES	EXCLUDED	YES	YES	NO
54297NY0030003	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	26	NO	INCLUDED	YES	NO	NO
54297NY0030033	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	26	NO	EXCLUDED	YES	NO	NO
54297NY0030032	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	26	YES	INCLUDED	YES	NO	NO
54297NY0030019	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	26	YES	EXCLUDED	YES	NO	NO
54297NY0030034	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	29	NO	INCLUDED	YES	NO	NO
54297NY0030018	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	29	YES	INCLUDED	YES	NO	NO
54297NY0030020	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	29	NO	EXCLUDED	YES	NO	NO
54297NY0030017	UnitedHealthcare North Shore-LIJ Advantage VR-Z	Platinum	OFF	NO	29	YES	EXCLUDED	YES	NO	NO
54297NY0030004	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	26	NO	INCLUDED	YES	NO	NO
54297NY0030036	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	26	NO	EXCLUDED	YES	NO	NO
54297NY0030035	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	26	YES	INCLUDED	YES	NO	NO
54297NY0030023	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	26	YES	EXCLUDED	YES	NO	NO
54297NY0030037	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	29	NO	INCLUDED	YES	NO	NO
54297NY0030022	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	29	YES	INCLUDED	YES	NO	NO
54297NY0030024	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	29	NO	EXCLUDED	YES	NO	NO
54297NY0030021	UnitedHealthcare North Shore-LIJ Advantage VR-2	Gold	OFF	NO	29	YES	EXCLUDED	YES	NO	NO
54297NY0030005	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	26	NO	INCLUDED	YES	NO	NO
54297NY0030039	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	26	NO	EXCLUDED	YES	NO	NO
54297NY0030038	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	26	YES	INCLUDED	YES	NO	NO
54297NY0030027	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	26	YES	EXCLUDED	YES	NO	NO
54297NY0030040	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	29	NO	INCLUDED	YES	NO	NO
54297NY0030026	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	29	YES	INCLUDED	YES	NO	NO
54297NY0030028	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	29	NO	EXCLUDED	YES	NO	NO
54297NY0030025	UnitedHealthcare North Shore-LIJ Advantage VR-4	Silver	OFF	NO	29	YES	EXCLUDED	YES	NO	NO

EXHIBIT 23: SUMMARY OF REQUESTED 2015 PREMIUM RATES

Company Name: UnitedHealthcare Insurance Company of New York
NAIC Code: 60093
SERFF Number: UHLC-129581429
Market Segment: Small Groups Off 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	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
						Albany	Buffalo	Mid-Hudson	New York	Rochester	Syracuse	Utica	Long Island
54297NY0010014	Silver	SG	OFF	Non Std	Yes	711	583	760	n/a	651	630	603	n/a
54297NY0030026	Silver	SG	OFF	Non Std	Yes	n/a	n/a	n/a	596	n/a	n/a	n/a	596
54297NY0030010	Gold	SG	OFF	Non Std	Yes	821	673	879	n/a	753	728	697	n/a
54297NY0030022	Gold	SG	OFF	Non Std	Yes	n/a	n/a	n/a	708	n/a	n/a	n/a	708
54297NY0030018	Platinum	SG	OFF	Non Std	Yes	n/a	n/a	n/a	888	n/a	n/a	n/a	888



<Date>

<BA Name>

<Group Name>, <Group #>

<Group Address 1>

<Group Address 2>

<City>, <State> <Zip>

Re: Notice of Proposed Premium Rate Change
<Plan Name>

Dear <BA Name>:

UnitedHealthcare Insurance Company of New York (UHIC) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your group premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Changes

The requested percentage change to your group's premium is shown in the attached exhibit. Please use the plan name listed above to reference the rate increase for your plan.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features that your group policyholder selects on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change

Rising medical expenses are the main reason for the requested increase. A number of factors contribute to these rising costs, including increases in the cost of medical services and increases in the amount of services used. We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment. This summary will be posted both on our website and DFS's website for at least 30 days from the date of our rate filing. Our rate application will be posted on DFS's website and additional information will be available on companyprofiles.healthcare.gov.

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 UHC for additional information at:

UnitedHealthcare
NY Prior Approval
P.O. Box 862
Monroe, CT 06468
888-842-4571
www.uhc.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 Plan Name, which is <Plan Name>

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:

UnitedHealthcare website: http://www.uhc.com/legal/required_state_notices/new_york.htm

DFS website: www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate

After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,



Howard C. Margolies
Vice President
Small Business, New York



UnitedHealthcare Insurance Company of New York (UHIC) - Small Group Off Exchange

Plan Name	Annual Requested Increase by Quarter			
	Dep Age 26		Dep Age 29	
	Q1	Q2	Q1	Q2
Platinum				
VRZ-IK	15.8%	15.5%	15.8%	15.5%
Gold				
VR2-IJ	14.6%	14.3%	14.6%	14.3%
Silver				
VR4-IJ	14.6%	14.3%	14.6%	14.3%

NY-14-401

NYSG UHIC Off-Exchange Downstate Group Grid



<Date>

<Subscriber First Name> <Subscriber Last Name>

<Group Name>, <Group #>

<Address 1>

<Address 2>

<City>, <State> <Zip>

Re: Notice of Proposed Premium Rate Change
<Plan Name>

Dear <Subscriber First Name> <Subscriber Last Name>:

UnitedHealthcare Insurance Company of New York (UHIC) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Changes

The requested percentage change to your premium is shown in the attached exhibit. Please use the plan name listed above to reference the rate increase for your plan.

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

Rising medical expenses are the main reason for the requested increase. A number of factors contribute to these rising costs, including increases in the cost of medical services and increases in the amount of services used. We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment. This summary will be posted both on our website and DFS's website for at least 30 days from the date of our rate filing. Our rate application will be posted on DFS's website and additional information will be available on companyprofiles.healthcare.gov.

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 UHC for additional information at:

UnitedHealthcare
NY Prior Approval
P.O. Box 862
Monroe, CT 06468
800-357-0978
www.myuhc.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 Plan Name, which is <Plan Name>

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:

UnitedHealthcare website: http://www.uhc.com/legal/required_state_notices/new_york.htm

DFS website: www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate

After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,



Howard C. Margolies
Vice President
Small Business, New York



UnitedHealthcare Insurance Company of New York (UHIC) - Small Group Off Exchange

Plan Name	Annual Requested Increase by Quarter			
	Dep Age 26		Dep Age 29	
	Q1	Q2	Q1	Q2
Platinum				
VRZ-IK	15.8%	15.5%	15.8%	15.5%
Gold				
VR2-IJ	14.6%	14.3%	14.6%	14.3%
Silver				
VR4-IJ	14.6%	14.3%	14.6%	14.3%

NY-14-403

NYSG UHIC Off-Exchange Downstate Subscriber Grid



<Date>

<BA Name>

<Group Name>, <Group #>

<Group Address 1>

<Group Address 2>

<City>, <State> <Zip>

Re: Notice of Proposed Premium Rate Change
<Plan Name>

Dear <BA Name>:

UnitedHealthcare Insurance Company of New York (UHIC) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your group premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Changes

The requested percentage change to your group's premium is shown in the attached exhibit. Please use the plan name listed above to reference the rate increase for your plan.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features that your group policyholder selects on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change

Rising medical expenses are the main reason for the requested increase. A number of factors contribute to these rising costs, including increases in the cost of medical services and increases in the amount of services used. We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment. This summary will be posted both on our website and DFS's website for at least 30 days from the date of our rate filing. Our rate application will be posted on DFS's website and additional information will be available on companyprofiles.healthcare.gov.

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 UHC for additional information at:

UnitedHealthcare
NY Prior Approval
P.O. Box 862
Monroe, CT 06468
888-842-4571
www.uhc.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 Plan Name, which is <Plan Name>

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:

UnitedHealthcare website: http://www.uhc.com/legal/required_state_notices/new_york.htm

DFS website: www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate

After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,



Howard C. Margolies
Vice President
Small Business, New York



UnitedHealthcare Insurance Company of New York (UHIC) - Small Group Off Exchange

Plan Name	Annual Requested Increase by Quarter			
	Dep Age 26		Dep Age 29	
	Q1	Q2	Q1	Q2
Gold				
VRW-8C	16.0%	15.7%	16.0%	15.7%
Silver				
VRX-DM	16.9%	16.5%	16.9%	16.5%

NY-14-409

NYSG UHIC Off-Exchange Upstate Group Grid



<Date>

<Subscriber First Name> <Subscriber Last Name>

<Group Name>, <Group #>

<Address 1>

<Address 2>

<City>, <State> <Zip>

Re: Notice of Proposed Premium Rate Change
<Plan Name>

Dear <Subscriber First Name> <Subscriber Last Name>:

UnitedHealthcare Insurance Company of New York (UHIC) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Changes

The requested percentage change to your premium is shown in the attached exhibit. Please use the plan name listed above to reference the rate increase for your plan.

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

Rising medical expenses are the main reason for the requested increase. A number of factors contribute to these rising costs, including increases in the cost of medical services and increases in the amount of services used. We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment. This summary will be posted both on our website and DFS's website for at least 30 days from the date of our rate filing. Our rate application will be posted on DFS's website and additional information will be available on companyprofiles.healthcare.gov.

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 UHC for additional information at:

UnitedHealthcare
NY Prior Approval
P.O. Box 862
Monroe, CT 06468
800-357-0978
www.myuhc.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 Plan Name, which is <Plan Name>

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change

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DFS website: www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate

After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,



Howard C. Margolies
Vice President
Small Business, New York



UnitedHealthcare Insurance Company of New York (UHIC) - Small Group Off Exchange

Plan Name	Annual Requested Increase by Quarter			
	Dep Age 26		Dep Age 29	
	Q1	Q2	Q1	Q2
Gold				
VRW-8C	16.0%	15.7%	16.0%	15.7%
Silver				
VRX-DM	16.9%	16.5%	16.9%	16.5%

NY-14-411

NYSG UHIC Off-Exchange Upstate Subscriber Grid



<Date>

<BA Name>
<Group Name>
<Address>
<City>, <State> <ZIP>

RE: Renewal Information for: <Group Name>, Group #: <Group # >; <CSP Code>

Dear <BA Name>,

Thank you for allowing UnitedHealthcare to serve your health benefit plan needs with an Oxford¹ plan. Your company's policy is scheduled to renew on **<effective date>**. Please review this renewal package to understand your options and learn about the tools available to help you determine which plan(s) best meet your business needs.

In addition, please review your **Summary of Benefits and Coverage (SBC)**,² which you can now access from the Employer portal of **oxfordhealth.com**, so that you fully understand your benefits and member cost shares.

You can choose to renew into your proposed Affordable Care Act (ACA) compliant plan or, if you prefer, you may also choose any of the other Oxford plans we offer in the New York small group market. **Please note that if no action is taken prior to renewal, you will be renewed automatically into the plan described in this renewal packet and billed accordingly.**

Our Oxford portfolio includes a variety of products with a wide range of affordable and flexible health plan solutions. We also offer dedicated service for members and employers, comprehensive online resources and health coach programs, plus a variety of disease management programs and services.

We know how important it is to find the right physician. That's why we offer a choice of robust local provider networks as well as access to our national provider network when traveling outside of the Oxford service area:

- Our **Freedom Network** offers your employees access to more than [104,000] physicians and other health care professionals at more than [173,000] locations in the tri-state region of New York, New Jersey and Connecticut – of which nearly [60,000] of those physicians have their practice in New York.³
- The **Liberty Network**, a subset of our Freedom Network, tends to be a more affordable option for many employers and provides access to over [70,000] physicians and other health care professionals at more than [121,000] office locations.³
- **[Oxford Metro Network]**
- The **UnitedHealthcare Choice Plus national network** is available with most plans and provides your employees seamless access to more than [739,000] physicians, 5,600 hospitals and 65,000 pharmacies across the United States.⁴

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We also understand how important it is for employers to have the ability to offer their employees a comprehensive benefit package. If you are interested in purchasing specialty benefits, look no further. UnitedHealthcare offers a full suite of dental, vision, life and disability products in addition to our medical products.

- **Pre-packaged specialty benefits** are available to New York small group employers with more than two employees through Oxford Benefit Management (OBM). This bundled solution combines dental and vision products with several health and wellness programs, including an Employee Assistance Program (EAP) with WorkLife services, health discounts and an optional life benefit. More details can be found at www.oxfordbenefitmanagement.com.⁵
- **Stand-alone specialty benefits** are also available to New York small group employers with more than two employees, which include basic life insurance, supplemental life insurance, dental insurance, vision insurance and long-term disability insurance. More details can be found at www.uhcspecialtybenefits.com.⁵

Plus, you don't have to wait for your renewal period to add specialty products to your benefit package. You can add these benefits at any time. If you have any questions regarding your renewal, prefer to speak to someone directly, or if you would like more information on a specialty benefits quote, please contact your broker or General Agent, or contact Client Services at **1-888-201-4216** or by email at groupservices@oxfordhealth.com.

We are also here to help you with our online systems and can provide copies of any materials you may not be able to access. We look forward to a continued and long-lasting relationship, serving you and your employees.

Sincerely,

Client Services

Enclosures

cc: <Broker>

¹ Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

² **Please Note:** As of Sept. 23, 2012, the Affordable Care Act (ACA) requires all health plan issuers (i.e., UnitedHealthcare and Oxford) and group health plans to provide new and renewing groups and members a Summary of Benefits and Coverage (SBC) for their health benefit plan. This notification provides information regarding when and how SBCs will be made available to you and when you need to provide it to your members. All assumed renewal plan SBCs are made available through Idea Management SystemSM (IDEA) and the Employer portal of oxfordhealth.com within 60 days of your renewal date. If, for any reason, the assumed renewal SBC is not successfully loaded to IDEA or the employer portal, a hard copy will be mailed within 30 days of your renewal date. The information related to when you must provide the SBCs to your members is found directly on IDEA and the employer portal. A paper copy is available upon request by calling Client Services.

³ [As of Dec. 31, 2012]; represents all participating providers except ancillary providers. Dental and complementary and alternative medicine providers are included (~6 percent of the total without chiropractors who are considered specialists). Providers who are multiple boarded are counted multiple times. Tri-state area includes Connecticut, New Jersey and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau and Suffolk).

⁴ As of [Q3 2013.] UnitedHealth Networks national network statistics. Not available with Liberty HMO.

⁵ Oxford Benefit Management (OBM) packages are not available in all states and state-specific requirements may cause limitations or variations to the plans. Packaged Savings is not available for this product. OBM Benefit options may vary by group size. Components are subject to change. UnitedHealthcare Life and Disability products are provided by Unimerica Life Insurance Company of New York. In New York, the Life Insurance product is provided on Form LASD-POL-LIFE NY (05/03) and the Disability product on Form LASD-POL-ADD/DIS NY (05/03). Unimerica Life Insurance Company of New York is located in New York. UnitedHealthcare Dental plans are provided by or through UnitedHealthcare Insurance Company of New York, NY. The New York Select Managed Care Plan is underwritten by UnitedHealthcare Insurance Company of New York located in Islandia, New York. Administrative services provided by Dental Benefit Providers, Inc. UnitedHealthcare Vision[®] plans are provided by UnitedHealthcare Insurance Company of New York, NY. UnitedHealthcare Vision[®] benefits and administrative services are provided by or through Spectera, Inc. UnitedHealthcare Insurance Company of New York is located in New York, NY.

Renewal Rates and Plan Information⁶

Below is a high level description of your plan changes as well as your renewal rates. Small group plan designs are now identified by four “metallic” benefit coverage levels: Bronze, Silver, Gold and Platinum. These designations indicate the relative value of the covered benefits, from Bronze (lowest) to Platinum (highest). Please review your SBC (available online) for more information about the benefits and member cost shares for this plan. You may also call Client Services to request a paper copy of your SBC.

PLAN INFORMATION

PLAN DESIGN	EXISTING	RENEWAL
Metallic Level	N/A	<Data>
Network	<Data>	<Data>
Office Visit Copayment	<Data>	<Data>
Package Description	<Data>	<Data>
Prescription	<Data>	<Data>
Out-of-Network Coinsurance	<Data>	<Data>
Out-of-Network Deductible	<Data>	<Data>
Out-of Network Reimbursement ⁷ Amount (where available)	<Data>	<Data>
Other Benefit Information (formerly Riders)	<Data>	<Data>

MONTHLY PREMIUMS

TIERS	EXISTING RATES		RENEWAL RATES	
	Employee #	Rate	Employee #	Rate
Single	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Couple	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Parent/Children	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Family	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Premium Total	<Total # of EEs>	<Total \$0.00>	<Total # of EEs>	<Total \$0.00>

COMPLETING YOUR RENEWAL

The SBC for your ACA compliant plan is now available to help you better understand your group coverage. You can access your SBC by logging on to the Employer portal of oxfordhealth.com. Then select “Request” from the top navigation bar on the home page. From there, select “Summary of Benefits and Coverage.” You will have the option to search for the appropriate SBC based on your Contract Specific Package (CSP). The SBC shows you the plan details for your proposed ACA compliant plan. You may also explore other available ACA compliant plan options. If your group has one employee, please work with your broker, general agent or contact Individual Product Sales at 1-800-969-7480 to help you in this process.⁸

Renewing into your ACA compliant plan

- We will **automatically renew your group into the above plan**. Unless your group is selected for an audit, you do not need to take any further action.

Renewing into an alternative ACA compliant plan

You also may choose any other ACA compliant small group plan we offer. To do so, you **must submit** the following documents to the Oxford Enrollment Department at 14 Central Park Drive, Hooksett, NH 03106.

- A completed *New York Small Group Annual Certification Form*, which is needed to ensure that your group is covered within the correct ACA definition. This form is included in this renewal package and available through oxfordhealth.com.

(over)

- Tax documentation: Examples of acceptable documents include a *Quarterly Combined Withholding, Wage Reporting and Unemployment Insurance Return Form (NYS-45)*, *Form 11-20S* and *K1 Schedule C*. If you filed a consolidated tax return as an affiliated group, please provide your most recent *IRS form 851*. See enclosed *Instruction Sheet* for details.
- A letter of request on company letterhead signed by an authorized contact detailing requested changes along with a signed rate sheet must be submitted. If you are moving into a different product underwritten by another licensed company (e.g., HMO to EPO), you may also be asked to submit the appropriate application.

OTHER CHANGES THAT MAY IMPACT YOUR RENEWAL

[Below are some additional modifications that we wanted to bring to your attention:]

ADDITIONAL INFORMATION

- **Audits**: We may conduct an audit of your group to confirm that the group meets eligibility and/or participation requirements. At that time, additional documentation may be required. Please visit oxfordhealth.com to review the *New York Small Group (1-50) Underwriting Requirements*, which gives more detail about our participation (does not apply to HMO products) and eligibility requirements for small group coverage. Our lock box administrator automatically cashes all premium checks upon receipt. If your group does not meet eligibility and participation requirements, your cashed check does not obligate us to renew your coverage. Further, if you submit payment that exceeds any outstanding balance, and your group is not renewed, we will refund the additional amount.
- **Age 29 Rider**: The law extends the availability of health insurance coverage to young adults through the age of 29. This expansion assists young adults who do not have access to employer-sponsored health insurance. This Rider is still an option for groups wishing to purchase this coverage. If the group does not purchase this Rider, the young adult option is available, which permits eligible young adults to continue their coverage through a parent's health insurance coverage once they reach age 26 without contribution from the employer. Young adults may also have this coverage if they meet other eligibility criteria.
- **Actuarial Value and Health Savings Accounts (HSAs)**: If you are currently offering or considering offering an HSA plan to your employees, you will need to understand how the contributions you make to your employees' HSAs can affect the actuarial value of your health plan. If you would like more information on HSA Contribution Requirements under the ACA, please visit the "Tools & Resources" section of the Employer portal of oxfordhealth.com.

⁶ Premium rates and/or product forms included herein have been filed and are subject to approval by regulators. We reserve the right to modify this quote if needed, once final approval is received. The rates quoted above or your total premium may change if benefits are required to be added to your plan during the plan year or if your census changes.

⁷ All small group plans that have out-of-network benefits use a Medicare-based reimbursement methodology for out-of-network claims. Please see your Certificate of Coverage for more information. Please note that when we will use a relative value scale based on difficulty, time, work, risk and resources of the service; the scale for certain services may be provided by our Affiliate OptumInsight. Our HMO and EPO products do not have out-of-network benefits, however, if we are required to reimburse for services from a non-participating provider reimbursement is based upon seventieth (70th) percentile FairHealth data. In certain instances, members may not be billed for the amounts above their cost-share.

⁸ New York has changed the small group size to "1-50" employees from "2-50" employees. A small group with one employee requires that the business employ an individual who is not the owner. When a business is owned only by an individual or an individual and his or her spouse, these individuals are not considered "employees" and the benefit plan is not considered a one employee group health plan.



<Date>

<Subscriber First Name> <Subscriber Last Name>

<Address 1>

<Address 2>

<City>, <State> <Zip>

Notice of Premium Rate Adjustment Decision
<Group Name>, <Group # >; <CSP Code>
THIS IS NOT A BILL

Dear <Subscriber First Name> <Subscriber Last Name> ,

In <Month YYYY>, we wrote to you to tell groups and their employees about a rate application we were filing with the New York State Department of Financial Services (DFS). Your group's UnitedHealthcare plan is scheduled to renew on <Effective Date>. The information below shows your group's current rates and approved renewal rates. These renewal rates reflect the total premiums your group must pay. Your individual contribution will be established by your employer.

Renewal rates are effective for twelve months beginning on <Effective Date>. The rates listed below could change if (1) your group makes benefit changes, (2) benefits are required to be added during the plan year and/or (3) your group becomes a large group before renewal (has 50 or more eligible employees).

MONTHLY PREMIUMS FOR <PLAN DESIGN NAME>

TIERS	CURRENT RATES	RENEWAL RATES
	Rate	Rate
Single	<Curr Single Rate>	<Renew Single Rate>
Couple	<Curr Couple Rate>	<Renew Couple Rate>
Parent/Children	<Curr P/CH Rate>	<Renew P/CH Rate>
Family	<Curr Fam Rate>	<Renew Fam Rate>

Please contact your employer for information about your contribution or for more information about the upcoming renewal.

Sincerely,

Howard C. Margolies
Vice President
Small Business, New York

EXHIBIT 21A: HOSPITAL UNIT COST DEVELOPMENT - INPATIENT SERVICES

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: UHLC-129581429
 Market Segment: Small Groups Off Exchange

- 1) This exhibit shows a history of fee schedule increases by hospital for **INPATIENT services**.
- 2) Enter in column 1 the provider number for the hospital, in column 2 the provider tax ID, and in column 3 the provider name.
- 3) Enter in column 4 the allowed charges by hospital over a recent 12 month period which will be used as the hospital weights.
- 4) Enter the Small Group Market allowed charges for calendar year 2013; Charges should be only be for hospital inpatient services.
- 5) Enter in column 5 the actual or estimated percentage fee increase for that hospital over the proposed rate period (2015 over 2014).
- 6) Enter in column 6 the actual or estimated percentage fee increase for that hospital for the year immediately preceding the rate period (2014 over 2013).
- 7) Enter in column 7 the actual or estimated percentage fee increase for that hospital for the second year immediately preceding the rate period (2013 over 2012).
- 8) At the end, add a total row and show the sum of the weights and the weighted average of columns 5, 6, and 7.
- 9) The provider list need not include all hospitals but must include data for the hospitals comprising 90% of the New York State total allowed charges for the Small Group Market in calendar year 2013 used to develop the weights.
- 10) A redacted version of this exhibit can be created for posting on the DFS website as part of posting the rate adjustment submission.
- 11) This exhibit must be submitted as an Excel and as a PDF file.

1. Provider Number	2. Provider Tax ID	3. Provider Name	4. 2013 Small Groups Allowed Charges	5. % Change for Rate Year	6. % Change for Prior Year	7. % Change for Second Prior Year
1031424	161469571	UNIV HOSP-SUNY HEALTH SCI CTR				
250327	150532254	ST JOSEPHS HOSPITAL HLTH CTR				
78125	160743209	STRONGHEALTH				
847471	160960470	CROUSE HEALTH HOSPITAL				
498543	161576637	FAXTON-ST LUKES HEALTHCARE				
588856	150532245	ST ELIZABETH MEDICAL CENTER				
393029	131624135	HOSPITAL FOR SPECIAL SURGERY				
286746	141338307	ALBANY MEDICAL CENTER HOSPITAL				
107845	133957095	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
151385	150532220	OSWEGO HOSPITAL				
569141	150533577	SAMARITAN MEDICAL CENTER - WATERTOWN				
232588	161137084	EASTERN NIAGARA HEALTH SYSTEMS				
		TOTAL				

EXHIBIT 21B: HOSPITAL UNIT COST DEVELOPMENT - OUTPATIENT SERVICES

Company Name: UnitedHealthcare Insurance Company of New York
NAIC Code: 60093
SERFF Number: UHLC-129581429
Market Segment: Small Groups Off Exchange

- 1) This exhibit shows a history of fee schedule increases by hospital for **OUTPATIENT services**.
- 2) Enter in column 1 the provider number for the hospital, in column 2 the provider tax ID, and in column 3 the provider name.
- 3) Enter in column 4 the allowed charges by hospital over a recent 12 month period which will be used as the hospital weights.
- 4) Enter in Small Group Market allowed charges for calendar year 2013; Charges should be only be for hospital outpatient services.
- 5) Enter in column 5 the actual or estimated percentage fee increase for that hospital over the proposed rate period (2015 over 2014).
- 6) Enter in column 6 the actual or estimated percentage fee increase for that hospital for the year immediately preceding the rate period (2014 over 2013).
- 7) Enter in column 7 the actual or estimated percentage fee increase for that hospital for the second year immediately preceding the rate period (2013 over 2012).
- 8) At the end, add a total row and show the sum of the weights and the weighted average of columns 5, 6, and 7.
- 9) The provider list need not include all hospitals but must include data for the hospitals comprising 90% of the New York State total allowed charges for the Small Group Market in calendar year 2013 used to develop the weights.
- 10) A redacted version of this exhibit can be created for posting on the DFS website as part of posting the rate adjustment submission.
- 11) This exhibit must be submitted as an Excel and as a PDF file.

1. Provider Number	2. Provider Tax ID	3. Provider Name	4. 2013 Small Groups Allowed Charges	5. % Change for Rate Year	6. % Change for Prior Year	7. % Change for Second Prior Year
1031424	161469571	UNIV HOSP-SUNY HEALTH SCI CTR				
250327	150532254	ST JOSEPHS HOSPITAL HLTH CTR				
847471	160960470	CROUSE HEALTH HOSPITAL				
170242	161492011	ONEIDA HEALTHCARE CENTER				
498543	161576637	FAXTON-ST LUKES HEALTHCARE				
151385	150532220	OSWEGO HOSPITAL				
50463	150532054	AUBURN COMMUNITY HOSPITAL				
569141	150533577	SAMARITAN MEDICAL CENTER - WATERTOWN				
133641	161471634	ROME MEMORIAL HOSPITAL				
588856	150532245	ST ELIZABETH MEDICAL CENTER				
393029	131624135	HOSPITAL FOR SPECIAL SURGERY				
78125	160743209	STRONGHEALTH				
2404659	131624082	MEMORIAL SLOAN KETTERING CANCER CTR				
595787	150548010	COMMUNITY MEMORIAL HOSPITAL-SYRACUSE				
588519	150532221	ASCENSION HEALTH				
307321	150622079	CARTHAGE AREA HOSPITAL				
531994	150532079	CORTLAND REGIONAL MEDICAL CENTER				
622163	161533232	GR LAKES HLTH SYS W NY				
186968	156000458	LEWIS COUNTY GENERAL HOSPITAL				
107845	133957095	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
		TOTAL				



June 13, 2014

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

RE: UnitedHealthcare Insurance Company of New York
NY Small Group Off-Exchange
Effective January 2015 – December 2015

Dear [REDACTED]

This rate filing addresses the development of the New York small group Off-Exchange rates for plans written by UnitedHealthcare Insurance Company of New York. The rates are effective from January 2015 to December 2015.

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

Sincerely,

[REDACTED]



UnitedHealthcare Insurance Company of New York.

New York Small Group
Rates Effective January 1, 2015 – December 31, 2015

ACTUARIAL CERTIFICATION

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

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

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
 - ASOP No. 5, Incurred Health and Disability Claims
 - ASOP No. 8, Regulatory Filings for Health Plan Entities
 - ASOP No. 12, Risk Clarification
 - ASOP No. 23, Data Quality
 - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/ Casualty Coverages
 - ASOP No. 41, Actuarial Communications
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.

[REDACTED]

June 13, 2014

UnitedHealthcare

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

State of New York Rate Review

General Information

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

Company Identifying Information:

- **Company Legal Name:** UnitedHealthcare Insurance Company of New York, Inc.
- **State:** New York
- **HIOS Issuer ID:** 54235
- **Market:** Small Group
- **Effective Date:** 1/1/2015 – 12/31/2015

Company Contact Information:

- **Primary Contact Name:** [REDACTED]
- **Primary Contact Telephone Number:** [REDACTED]
- **Primary Contact Email Address:** [REDACTED]

Proposed Rate Increase

UnitedHealthcare Insurance Company of New York, Inc. ("UHIC") is filing rates for benefit plans written under existing policy forms and certificates of coverage that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). We have developed the new rates using historical claims experience for Oxford Health Insurance, Inc. ("OHI") small group due to credibility concerns with the UHIC small group block of business. The average requested annual rate increase for 1st quarter renewals is 16.4%. In addition to new rates effective 1/1/2015, we are also filing 2.6% quarterly trend increases for each of the last three quarters in 2015.

Reasons for Rate Increase

The rate filing we have made is seeking an increase mainly related to rising medical costs. Medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs. The 2nd, 3rd, and 4th quarter 2015 quarterly increases of 2.6% are based upon projected annual increases in utilization trend (5.5%), unit cost trend (4.1%), and benefit leveraging (1.0%).

Experience Period Premiums and Claims

- **Experience Period:** The experience period is 1/1/2013 to 12/31/2013 paid through 2/28/2014.

- **Premiums (net of MLR Rebate) in Experience Period:** Earned premiums for the experience period are shown in Part I. The earned premiums are the sum of the actual premium amounts in the experience period for all small group UHIC policies with the exception of sole proprietors which were removed per instructions received from the New York State Department of Financial Services (“DFS”). UHIC does not anticipate paying any MLR rebates for this company for the months included in the experience period.
- **Allowed and Incurred Claims Incurred During the Experience Period:** The incurred and allowed claims were extracted from internal data warehouses and financial reports and include fee-for-service medical claims, fee-for-service pharmacy claims, graduate medical expense, HCRA hospital surcharge, pharmacy rebates, and capitations. We added estimates of incurred but not reported (“IBNR”) claims to the incurred and allowed claims. In order to calculate the IBNR amounts, we used a completion factor method based on actual adjudicated claims as well as taking the current inventory into account. We also use seasonality estimates to help guide our picks where completion factors may not have been credible.

Benefit Categories

Claims were assigned to benefit categories by our claim department using standard industry definitions of services.

Projection Factors

- **Changes in the Morbidity of the Population Insured:** No changes in the average morbidity are assumed.
- **Changes in Benefits:** We have estimated that the cost increase of adding benefits to comply with the Essential Health Benefits (“EHB”) provision is 1.6%. This estimate was developed using the UnitedHealthcare proprietary pricing model. The EHB line also includes an additional 0.5% adjustment to add pharmacy claims for the groups that did not have pharmacy coverage during the experience period. This adjustment was developed based upon the average pharmacy claim PMPM.
- **Changes in Demographics:** No changes in demographics are assumed.
- **Other Adjustments:** The rate development includes a 0.1% credit for SMC Pool coverage as instructed by NY DFS.
- **Trend Factors:** UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. As a general matter, we review our own recent/emerging claims experience at the state level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

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

The projected annual trend factor is 10.9%. This breaks down into the following components: 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging. Please note that this trend factor excludes any risk margin.

Credibility

We used the Oxford Health Insurance, Inc. ("OHI") small group experience to set the UHIC small group rates for two primary reasons: (1) the membership in UHIC small group plans is decreasing rapidly (3,176 average members in experience period) and (2) we anticipate that the majority of future UHIC enrollment will be in the North Shore LJJ ("NSLJJ") plans that are only offered in Nassau and Suffolk counties and not reflected in the experience period data. We used OHI small group claims data with additional adjustments as described in this Actuarial Memorandum to calculate the UHIC rates. There was an average of 432,303 members in OHI small group plans during the experience period. We consider this to be fully credible and therefore have made no further adjustments.

Paid to Allowed Ratio

We have developed the average paid to allowed factor for the projection period based upon a combination of the distribution of the UHIC small group members by plan and the pricing actuarial values for those plans.

Risk Adjustment and Reinsurance

- **Projected Risk Adjustments:** DFS and Deloitte performed risk adjustment modeling based upon data received from New York health plans. We analyzed the results of this analysis and made a slight adjustment based upon this review. As a result, we project OHI will be a net receiver and have included a 5.1% reduction to the index rate to account for this.
- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** We have assumed a payment of \$3.32 PMPM for the reinsurance fee. We have assumed no reinsurance recoveries since it is not applicable to small group.

Non-Benefit Expenses and Risk Margin

The 6.8% administrative expense load includes general administration (3.8%) and broker commissions (3.0%). We have estimated the expenses included in the development of the proposed rates based upon actual historical expenses and financial projections.

Projected Profit & Risk Margin

The projected profit and risk margin is 4.9% before state and federal income taxes and 3.2% after.

Taxes and Fees

The 8.0% includes state premium tax and assessments (2.6%), PPACA Insurer fee (3.2%), and state and federal income taxes (2.2%). This excludes the \$3.32 PMPM reinsurance fee.

Projected Loss Ratio

The projected loss ratio using federally prescribed MLR methodology is 87.6%.

Index Rate

The index rate of the experience period is \$457.00 and reflects the total allowed claims PMPM from the experience period for EHB benefits only. The index rate for the projection period is \$670.40. We applied 6 months of trend, at our 2015 annual trend rate of 10.9%, to the projection period index rate. This accounts for Small Group quarterly trend, under the assumption that members are equally distributed among the quarters.

AV Metal Values

HHS metal screenshots are included in the filing. For plans using the NY DFS Standard In-Network benefits, we used the screenshots provided by DFS, without modification. For other plans, we calculated federal metal AVs using the HHS AV calculator. We made some modifications to the inputs, which are described below. We only changed the inputs; the final metal AVs came directly from the calculator output. We used only permitted factors in determining the metal AVs. We assumed that the difference between EHBs covered by our plans and those included in the calculator's continuance tables was negligible.

1. We always used 99.999% coinsurance instead of 100% due to unreasonable calculator outputs we observed in testing.
2. We converted copays after deductible (including Rx) to equivalent coinsurance values based on average unit costs from the continuance tables in the calculator.
3. We specially handled the inpatient and outpatient facility copays. Our inpatient copays cover only the facility portion of the service cost, but the HHS AV calculator inpatient copay line corresponds to both facility and professional charges. Our outpatient facility copay does not cover all services included under outpatient facility in the HHS calculator. Therefore we used the 2-tier function of the HHS calculator to more accurately value these

copays. On tier 1, the inpatient and / or outpatient copays are applied (converted to coinsurance if appropriate, as discussed above). On tier 2, inpatient and outpatient facility are covered at the plan's general coinsurance level. We used the following weights, which are derived from our company's pricing model, on tier 1:

- a. 73% if there is an outpatient facility copay but no inpatient facility copay;
 - b. 80% if there is a copay on both; and,
 - c. 100% if there is a copay on neither.
4. Our Rx plans do not have separate copays for Specialty drugs. For the Specialty drug copay calculator input, we calculated the approximate average copay for specialty drugs as the weighted average of the copays in the other 3 tiers, based on the distribution of specialty drugs among those tiers in our data.
 5. The AV calculator does not support an Outpatient Facility copay. For such plans, we converted the copay to coinsurance based on the average unit cost from the calculator's continuance tables. For plans with a 2-tier OP surgery copay (Free-standing and Hospital), in the calculator we used the average of the two with 50% weight on each, which was reasonable based on our data.
 6. Some plans within this portfolio have different cost-sharing features for family coverage (i.e., when two or more people are covered by the plan) from the cost-sharing features for individual coverage. For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

I certify that the values were developed in accordance with generally accepted actuarial principles and methodologies.

AV Pricing Values

The AV pricing values in Worksheet 2 reflect the product of plan relativities from the proprietary UnitedHealthcare pricing model, utilization adjustments, gatekeeper adjustments, and network adjustments. The relativities from the UnitedHealthcare model reflect the cost sharing differences between plans and do not include any adjustments for health status or utilization. The utilization adjustments were also determined by the proprietary UnitedHealthcare pricing model and only reflect utilization differences due to the levels of cost sharing. For the gatekeeper adjustment, we have assumed factors of 1.0 for non-gatekeeper and 0.96 for gatekeeper. For the network differences, we have assumed factors of 1.0 for Freedom and 0.976 for Liberty. These adjustments do not reflect any differences in anticipated risk status. Please note that the gatekeeper factors apply to in-network medical claims only.

Membership Projections

We are not projecting any significant changes in membership.

Terminated Products

No products are being terminated.

Plan Type

Not applicable.

Warning Alerts

Not applicable

Reliance

Not applicable.

Actuarial Certification

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

I certify that the projected index rate is:

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

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

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

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plans designs that did not fit into the AV Calculator, included in this Part III Actuarial Memorandum is a description of the methodology and numerical values used to develop the AV metal values, and a certification as required by 45 CFR Part 156, §156.135.

Proprietary & Confidential

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is described in detail in my state submitted actuarial memorandum. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

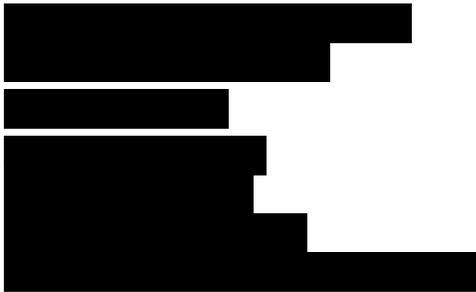
A large black rectangular redaction box covers the signature and name of the sender. The redaction is composed of several overlapping horizontal bars of varying lengths, completely obscuring any text that might have been present.

EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE APPLICATION

<p>Company Name: NAIC Code: SERFF Tracking #: Market Segment:</p>	<p>UnitedHealthcare Insurance Company of New York</p>																
	60093																
	UHLC-129581429																
	Small Groups Off Exchange																
A. Insurer Information:	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">UnitedHealthcare Insurance Company of New York</td> <td style="width: 15%;">A&H - 42</td> <td style="width: 15%;">For Profit</td> <td style="width: 20%;">60093</td> </tr> <tr> <td>Company submitting the rate adjustment request</td> <td>Company Type</td> <td>Org. Type</td> <td>Company NAIC Code</td> </tr> <tr> <td colspan="4" style="border-bottom: 1px solid black;">48 Monroe Turnpike, Trumbull, CT 06611</td> </tr> <tr> <td colspan="4" style="border-bottom: 1px solid black;">Company mailing address</td> </tr> </table>	UnitedHealthcare Insurance Company of New York	A&H - 42	For Profit	60093	Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code	48 Monroe Turnpike, Trumbull, CT 06611				Company mailing address			
UnitedHealthcare Insurance Company of New York	A&H - 42	For Profit	60093														
Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code														
48 Monroe Turnpike, Trumbull, CT 06611																	
Company mailing address																	
B. Contact Person:	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; background-color: black; color: black;">[REDACTED]</td> <td style="width: 25%; background-color: black; color: black;">[REDACTED]</td> <td style="width: 25%; background-color: black; color: black;">[REDACTED]</td> </tr> <tr> <td>Rate filing contact person name, title</td> <td>Contact phone number</td> <td>Contact Email address</td> </tr> </table>	[REDACTED]	[REDACTED]	[REDACTED]	Rate filing contact person name, title	Contact phone number	Contact Email address										
[REDACTED]	[REDACTED]	[REDACTED]															
Rate filing contact person name, title	Contact phone number	Contact Email address															
C. Actuarial Contact (If different from above):	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Actuary name, title</td> <td style="width: 25%;">Actuary phone number</td> <td style="width: 25%;">Actuary Email address</td> </tr> </table>	Actuary name, title	Actuary phone number	Actuary Email address													
Actuary name, title	Actuary phone number	Actuary Email address															
D. New Rate Information:	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">February 15, 2015 through November 14, 2016</td> <td style="width: 25%;">1/1/2015</td> <td style="width: 25%;">UHLC-129581429</td> </tr> <tr> <td>New rate applicability period</td> <td>New rate effective date</td> <td>SERFF Tracking Number</td> </tr> </table>	February 15, 2015 through November 14, 2016	1/1/2015	UHLC-129581429	New rate applicability period	New rate effective date	SERFF Tracking Number										
February 15, 2015 through November 14, 2016	1/1/2015	UHLC-129581429															
New rate applicability period	New rate effective date	SERFF Tracking Number															
E. Market segment included in filing (e.g., Small Group (including Healthy NY Small Group), Individual - only one market segment per rate adjustment filing):	Small Group																
F. Provide responses for the following questions:	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.	Yes, This filing contains revised Certificate of Coverage, Rider and Schedule of Benefit documents that will be used for plans effective on or after 1/1/15. The revised forms utilize the model language provided by NY DFS. That model language was updated for use in 2015 so all forms will be updated accordingly.																
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing? If yes, mention these filings on Exhibit 18.	No																
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (2).	Yes, notices have been sent to all groups and subscribers in PPACA compliant plans. They were mailed on June 13th, 2014.																
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes, all the required exhibits have been submitted with this rate application																
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	Yes, UHLC-129574839																

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 form and rate 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 application is submitted to the Department of Financial Services.

EXHIBIT 22: MEDICAL AND HOSPITAL UTILIZATION DATA FOR SMALL GROUPS

Company Name: UnitedHealthcare Insurance Company of New York
 NAIC Code: 60093
 SERFF Number: UHLC-129581429
 Market Segment: Small Groups Off Exchange

- 1) Information requested applies to New York State business only, for all rating regions combined for Small Groups and Small Group Healthy New York Plans. (Small Group Sole Proprietor plan to be excluded)
- 2) Include riders that may be available with policy forms. Discontinued policy forms and products are to be included in the Exhibit.
- 3) If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- 4) This exhibit must be submitted as an Excel file and as a PDF file.

Experience Period:	1/1/13 - 12/31/13						1/1/12 - 12/31/12					
	2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]	2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]
1. Medical and Hospital												
Inpatient Hospital												
Inpatient Mental Health												
Inpatient Alcohol and Sub. Abuse												
Newborn Birth Services												
Primary Care												
Physician Specialty Services												
Ambulatory Surgery												
Other Professional Services												
Special Therapies												
Out-of-Area Other												
Emergency Room												
Outpatient Mental Health												
Outpatient Drug & Alcohol Treatment												
Dental (excluding Orthodontia)												
Pharmacy												
Durable Medical Equipment												
Home Health Care												
Transportation - Emergent												
Diagnostic Testing, Lab & X-Ray												
Family Planning												
Vision Care (incl. eyeglasses)												
Pharmacy (Non Prescription Drugs)												
Speech & Hearing												
Other Medical												
Total Medical & Hospital												

1/1/11 - 12/31/11					
2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]
[REDACTED]					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	X	Y
1	Unified Rate Review v2.0.2																							
2																								
3	Company Legal Name:		UnitedHealthcare Insurance Co State:												NY									
4	HIOS Issuer ID:		54297												Market:		Small Group							
5	Effective Date of Rate Change(s):		1/1/2015																					
6																								
7																								
8	Market Level Calculations (Same for all Plans)																							
9																								
10																								
11	Section I: Experience period data																							
12	Experience Period:		1/1/2013		to		12/31/2013																	
13			<u>Experience Period</u>																					
14			<u>Aggregate Amount</u>		<u>PMPM</u>		<u>% of Prem</u>																	
15	Premiums (net of MLR Rebate) in Experience Period:		\$16,593,212		\$435.38		100.00%																	
16	Incurred Claims in Experience Period		\$13,933,962		365.61		83.97%																	
17	Allowed Claims:		\$17,417,453		457.01		104.97%																	
18	Index Rate of Experience Period				\$457.00																			
19	Experience Period Member Months		38,112																					
20	Section II: Allowed Claims, PMPM basis																							
21																								
22																								
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Information Not Releasable to the Public Unless Authorized by Law: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

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

UnitedHealthcare Insurance Company of New York
54297
1/1/2015

State: **NY**
 Market: **Small Group**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Product	PPO	EPO			
Product ID:	54297NY001	54297NY001	54297NY003			
Metal:	Catastrophic	Silver	Silver	Gold	Platinum	Gold
AV Metal Value	0.808	0.687	0.681	0.781	0.898	0.819
AV Pricing Value	0.808	0.703	0.683	0.774	0.905	0.842
Plan Type:	EPO	PPO	EPO	EPO	EPO	EPO
Plan Name	2013 Experience	UnitedHealthcare Choice Plus VR-X	UnitedHealthcare North Shore-LIJ Advantage VR-4	UnitedHealthcare North Shore-LIJ Advantage VR-2	UnitedHealthcare North Shore-LIJ Advantage VR-Z	UnitedHealthcare Choice VR-W
Plan ID (Standard Component ID):	54297NY0010000	54297NY0010002	54297NY0030005	54297NY0030004	54297NY0030003	54297NY0030001
Exchange Plan?	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2	-99.00%	0.00%	0.00%			
Historical Rate Increase - Calendar Year - 1	-99.00%	0.00%	0.00%			
Historical Rate Increase - Calendar Year 0	-99.00%	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
Rate Change % (over prior filing)	0.00%	16.85%	14.61%	14.60%	15.81%	16.04%
Cum'tive Rate Change % (over 12 mos prior)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Proj'd Per Rate Change % (over Exper. Period)	-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	#DIV/0!	0.00%	0.00%			

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

Plan ID (Standard Component ID):	Total	54297NY0010000	54297NY0010002	54297NY0030005	54297NY0030004	54297NY0030003	54297NY0030001
Inpatient	\$0.00	\$0.00	\$7.84	\$4.53	\$5.38	\$8.22	\$8.13
Outpatient	\$0.00	\$0.00	\$5.96	\$3.45	\$4.09	\$6.25	\$6.18
Professional	\$0.00	\$0.00	\$11.78	\$6.81	\$8.08	\$12.35	\$12.21
Prescription Drug	\$0.00	\$0.00	\$6.52	\$3.77	\$4.48	\$6.84	\$6.77
Other	\$0.00	\$0.00	\$4.55	\$2.63	\$3.12	\$4.77	\$4.72
Capitation	\$0.00	\$0.00	\$0.55	\$0.32	\$0.38	\$0.58	\$0.57
Administration	\$0.00	\$0.00	-\$12.49	-\$10.33	-\$12.27	-\$15.23	-\$14.54
Taxes & Fees	\$0.00	\$0.00	\$1.16	\$0.96	\$1.14	\$1.42	\$1.35
Risk & Profit Charge	\$0.00	\$0.00	\$13.43	\$11.10	\$13.19	\$16.38	\$15.63
Total Rate Increase	\$0.00	\$0.00	\$39.29	\$23.25	\$27.58	\$41.57	\$41.02
Member Cost Share Increase	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Average Current Rate PMPM	\$561.97	\$1.00	\$541.22	\$447.34	\$531.44	\$660.05	\$629.79
Projected Member Months	25,000	0	5,000	5,000	5,000	5,000	5,000

Product-Plan Data Collection

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

UnitedHealthcare Insurance Company of New York
54297
1/1/2015

State: **NY**
 Market: **Small Group**

Product/Plan Level Calculations

Section III: Experience Period Information

Plan ID (Standard Component ID):	Total	54297NY0010000	54297NY0010002	54297NY0030005	54297NY0030004	54297NY0030003	54297NY0030001
Average Rate PMPM	\$435.38	\$435.38					
Member Months	38,112	38,112					
Total Premium (TP)	\$16,593,212	\$16,593,212	\$0	\$0	\$0	\$0	\$0
EHB Percent of TP, [see instructions]	100.00%	100.00%					
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%					
Other benefits portion of TP	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	\$17,417,453	\$17,417,453					
EHB Percent of TAC, [see instructions]	100.00%	100.00%					
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%					
Other benefits portion of TAC	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	\$3,483,491	\$3,483,491					
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	\$0		\$0	\$0	\$0	\$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Incurred claims, payable with issuer funds	\$13,933,962	\$13,933,962	\$0	\$0	\$0	\$0	\$0
Net Amt of Rein	\$0.00						
Net Amt of Risk Adj	\$0.00						
Incurred Claims PMPM	\$365.61	\$365.61	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	\$457.01	\$457.01	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	\$457.01	\$457.01	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	54297NY0010000	54297NY0010002	54297NY0030005	54297NY0030004	54297NY0030003	54297NY0030001
Plan Adjusted Index Rate	\$620.16		\$603.52	\$489.25	\$581.19	\$729.44	\$697.41
Member Months	25,000	-	5,000	5,000	5,000	5,000	5,000
Total Premium (TP)	\$15,504,009	\$0	\$3,017,617	\$2,446,240	\$2,905,939	\$3,647,179	\$3,487,034
EHB Percent of TP, [see instructions]	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%
Other benefits portion of TP	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$16,247,463		\$3,523,784	\$2,939,665	\$3,078,315	\$3,306,244	\$3,399,455
EHB Percent of TAC, [see instructions]	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%
Other benefits portion of TAC	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	\$3,527,658		\$1,048,070	\$932,720	\$694,223	\$314,024	\$538,622
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0			\$0	\$0	\$0	\$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/0!		0.00%	0.00%	0.00%	0.00%

Product-Plan Data Collection

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

UnitedHealthcare Insurance Company of New York
54297
1/1/2015

State: **NY**
 Market: **Small Group**

Product/Plan Level Calculations

Total Incurred claims, payable with issuer funds	\$12,719,805	\$0	\$2,475,714	\$2,006,945	\$2,384,091	\$2,992,220	\$2,860,834
Net Amt of Rein	\$0						
Net Amt of Risk Adj	\$0						

Incurred Claims PMPM	\$508.79	#DIV/0!	\$495.14	\$401.39	\$476.82	\$598.44	\$572.17
Allowed Claims PMPM	\$649.90	#DIV/0!	\$704.76	\$587.93	\$615.66	\$661.25	\$679.89
EHB portion of Allowed Claims, PMPM	\$649.90	#DIV/0!	\$704.76	\$587.93	\$615.66	\$661.25	\$679.89