

State: New York **Filing Company:** Aetna Health Inc. (NY)
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003C Large Group Only
- HMO
Product Name: HMO and Riders
Project Name/Number: 3q13 thru 2q14 HMO Rate Filing /

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
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 an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation.): Yes: Prior Approval Rate Adjustment
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): N/A
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.): N/A
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.): N/A
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes: AETN-128814745, 2012120081

SERFF Tracking #:

AETN-128841943

State Tracking #:

2013010131

Company Tracking #:

State:

New York

Filing Company:

Aetna Health Inc. (NY)

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003C Large Group Only - HMO

Product Name:

HMO and Riders

Project Name/Number:

3q13 thru 2q14 HMO Rate Filing /

Rate Information

Rate data applies to filing.

Filing Method:

Rate Adjustment pursuant to Section 4308(c)

Rate Change Type:

Increase

Overall Percentage of Last Rate Revision:

0.000%

Effective Date of Last Rate Revision:

04/01/2013

Filing Method of Last Filing:

Rate Adjustment pursuant to Section 4308(c)

Company Rate Information

| Company Name: | Company Rate Change: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|------------------------|----------------------|-----------------------------|------------------------|--|--|-----------------------------------|---------------------------------|---------------------------------|
| Aetna Health Inc. (NY) | Increase | 5.900% | 5.900% | \$11,504,827 | 105 | \$181,731,288 | 5.900% | 5.900% |

| Product Type: | HMO | PPO | EPO | POS | HSA | HDHP | FFS | Other |
|-----------------|--------|-----|-----|-----|-----|------|-----|-------|
| Covered Lives: | 24,162 | | | | | | | |
| Policy Holders: | 105 | | | | | | | |

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Project Name/Number: 3q13 thru 2q14 HMO Rate Filing /

Rate Review Detail

COMPANY:

Company Name: Aetna Health Inc. (NY)
HHS Issuer Id: 50138
Product Names: HMO
Trend Factors: We are proposing a 5.9% rate level adjustment for 3q13 over the current approved 2q13 rate level. Note that because benefit changes are reflected in a prior approved filing, this filing is reflecting increases on a common benefit basis.

FORMS:

New Policy Forms:
Affected Forms:
Other Affected Forms: HMO/NY GA-2 11/01 (HMO), HMO/NY COC-2 04/02

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 311,808
Benefit Change: None
Percent Change Requested: Min: 5.9 Max: 5.9 Avg: 5.9

PRIOR RATE:

Total Earned Premium: 181,731,288.00
Total Incurred Claims: 145,420,112.00
Annual \$: Min: 502.00 Max: 679.00 Avg: 624.00

REQUESTED RATE:

Projected Earned Premium: 193,236,114.00
Projected Incurred Claims: 159,989,810.00
Annual \$: Min: 534.00 Max: 723.00 Avg: 665.00

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Product Name:

HMO and Riders

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3q13 thru 2q14 HMO Rate Filing /

Supporting Document Schedules

| | | Item Status: | Status Date: |
|---------------------------------------|--|--------------|--------------|
| Satisfied - Item: | Actuarial Memorandum/Actuarial Certification | | |
| Comments: | Actuarial Certification and Memorandum (including form approval letters) | | |
| Attachment(s): | | | |
| AHI LRG Actuarial Memorandum.pdf | | | |
| Attachment I.pdf | | | |
| Approval Ltr Autism.pdf | | | |
| Approval Ltr Med SOB.pdf | | | |
| Approval Ltr Prev Care.pdf | | | |
| Approval Ltr Transgender.pdf | | | |
| Approval Ltr Vision.pdf | | | |
| Large AHI Actuarial Certification.pdf | | | |

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

| | | Item Status: | Status Date: |
|-------------------|--------------------------|--------------|--------------|
| Satisfied - Item: | Consumer Disclosure Form | | |
| Comments: | | | |
| Attachment(s): | | | |
| HHS Part II.pdf | | | |

| | | Item Status: | Status Date: |
|-------------------|--|--------------|--------------|
| Satisfied - Item: | Final Notice of Proposed Rate Adjustment | | |
| Comments: | | | |

SERFF Tracking #:

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3q13 thru 2q14 HMO Rate Filing /

Attachment(s):

Final Plan Spon Ltr 1-25-13.pdf

Final Sub Ltr 1-25-13.pdf

Final Summary of Renl Rates 1-25-13.pdf

Item Status:

Status Date:

Satisfied - Item:

Initial Notice of Proposed Rate Adjustment

Comments:

Attachment(s):

Pre Filing Plan Spon Ltr 1-3-13.pdf

Pre Filing Sub Ltr 1-3-13.pdf

Pre Filing Summary of Renl Rates.pdf

Item Status:

Status Date:

Satisfied - Item:

Rate Summary Worksheet

Comments:

Note that the "Number of Covered Individuals" includes both "non-grandfathered" and "grandfathered members as the enrollment split between these two groups is not readily available.

Attachment(s):

HHS Rate Review.pdf

HHS Rate Review.xls

Item Status:

Status Date:

Satisfied - Item:

Standard Exhibit 1 - General Information

Comments:

Exhibits 1 thru 6 are all in a single file in this section (both pdf and xls)

Attachment(s):

AHI NY LRG Exhibits 1 thru 6.pdf

AHI NY LRG Exhibits 1 thru 6.xls

Item Status:

Status Date:

Satisfied - Item:

Standard Exhibit 7 - Historical Data

SERFF Tracking #:

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3q13 thru 2q14 HMO Rate Filing /

Comments:

Attachment(s):

AHI NY LRG Exhibit 7.pdf

AHI NY LRG Exhibit 7.xls

Item Status:

Status Date:

Satisfied - Item:

Form List and Benefit Description with Approved Contract Language

Comments:

Attachment(s):

NY LRG Description of Benefits.pdf

AHI Form Index.pdf

Aetna Health Inc.
Actuarial Memorandum

This filing pertains to Aetna Health Inc. form: HMO/NY GA-2 11/01 (HMO). Its purpose is to provide the benefit descriptions and Large Group premium rates for the various plan options offered under this product for the period 3q13 thru 2q14.

Notifications of this proposed filing have been sent to our customers and members

We have attached copies of all pages of our Large Group rate manual. Please note that pages containing rates have been provided for all 4 quarters governed by this filing. The following table is a summary of the proposed quarterly and annual rate adjustments that apply to all products governed in this filing and will be effective on the policyholder's next anniversary occurring on or after the effective dates shown:

| Effective Date | Proposed Rate Increases | |
|----------------|-------------------------|--------|
| | Quarterly | Annual |
| 07/01/2013 | 5.9% | 5.9% |
| 10/01/2013 | 3.5% | 9.6% |
| 01/01/2014 | 3.5% | 13.5% |
| 04/01/2014 | 2.5% | 16.3% |

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

- We utilized Aetna Health Inc., Large Group, non-Federal Plan, community rated NY HMO premiums and claims for the period 8/1/11 through 7/31/2012 with run-out through 10/31/12 in order to project claims for this filing.
- The historical claims are trended forward to the projection period.
- The medical trend assumptions are based on our large group experience as illustrated in Exhibit 7C.
- The experience period premium levels by renewal cohort are carried forward using filed rate changes on each cohort renewal month to produce standardized premiums.
- Trended claims are then compared to standardized premiums and the corresponding loss ratio is compared to the required target loss ratio to generate the required increase.

The attached exhibits 7, 7A, 7B, 7C, 7D, and 7E illustrate the historical experience, demonstrate the calculation of standardized premium, detail the development of the proposed rate increases, and provide detail on our most recent medical and unit cost trends. The following table summarizes the expected loss ratio including breakdown of the non-claims expense component:

3q13 New York Employer
Groups with 50 or More
Employees

| | |
|------------------|--------|
| Incurred Claims | 82.1% |
| Expenses | 8.8% |
| Premium Taxes | 2.0% |
| Commissions | 1.4% |
| HIF/RC | 1.7% |
| SIT & FIT* | 1.7% |
| After Tax Profit | 2.3% |
| Total | 100.0% |

*SIT & FIT = State Income Tax and Federal Income Tax

The non-claim expense assumptions are consistent with the 2011 New York Data Requirements/Department of Health and Human Services Medical Loss Ratio Reporting Form on a percentage of premium basis. Further adjustments are required to reflect Large Group non-FEHBP community rated HMO business. For a discussion on the impact of HIF/RC, see Attachment I.

Certain new benefit options, for which form approval already exists, have been added to the filing and highlighted within their respective rate factor tables in Section B. Factors for these benefits have been calculated on an actuarially consistent basis with that of other factors in the filing. As requested, we have included the approved contract language pages and the Department's approval letters which document that these newly added benefit options are included in the already approved contract language. The approved contract language has been included in Section A and the respective Department approval letters are attached as part of this memorandum.

Aetna Health Inc.
Actuarial Memorandum

Attachment I - Effect of PPACA Taxes and Fees on Premiums

The Patient Protection and Affordable Care Act (PPACA) created several new fees assessed on insurers or health insurance. Two of these fees go into effect in 2014, described further below. Both fees are applicable to premium earned in 2014, regardless of when the policy renews. Policies sold or renewed beginning in February 2013 will have some premium earned in 2014. For example, a policy renewed in July 2013 will have six months of premium in 2013 and six months in 2014.

1. **Reinsurance Contribution (RC):** This is a temporary fee, designed to fund the temporary reinsurance program that will cover the individual markets for the years 2014 through 2016. The fee is assessed on fully insured and self-insured group health plans. There will be a standard national assessment for the RC, as well as the option for states to assess an additional state-level assessment. The total amount to be collected under the national assessment in 2014 is \$12 billion, declining to \$8 billion in 2015 and \$5 billion in 2016. Aetna has calculated the impact for the 2014 RC fee based on the recently-issued NPRM for policies issued New York to be worth .9% of premium.
2. **Health Insurer Fee (HIF):** This permanent industry fee will be assessed based on each insurer's share of the fully insured market, in order to collect a total of \$8.0 billion for 2014. The total assessment will increase each year, to \$14.3 billion in 2018 and increasing at the rate of premium growth thereafter. Aetna has calculated the impact for the 2014 HIF fee based on current regulations to be approximately 2.4% of premium.

These two fees must be incorporated into premium rates to reflect the added costs. We will incorporate them on a "stepped" basis in order to reflect the actual portion of each policy's premium that will be subject to these fees. The table below shows the impact of these fees on premiums by renewal date.

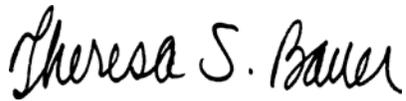
| Renewal / Effective Date | Avg. no. of Months of Premium in 2014 | RC Factor | HIF Factor | Total Premium Impact |
|--------------------------|---------------------------------------|-----------|------------|----------------------|
| 3Q13 | 6 | 1.005 | 1.012 | 1.7% |
| 4Q13 | 9 | 1.007 | 1.018 | 2.5% |
| 1Q14 | 12 | 1.009 | 1.024 | 3.3% |
| 2Q14 | 12 | 1.009 | 1.024 | 3.3% |

Aetna Health Inc.

Actuarial Certification

I, Theresa S. Bauer, am an actuary and employee of Aetna Inc. and a member of the American Academy of Actuaries.

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



Theresa S. Bauer, F.S.A., M.A.A.A.
Northeast and SG Head Actuary
January 18, 2013

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

As of 5/18/2012

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

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

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

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

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

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

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing (a new form or a revision to an existing form) must be a separate filing from the rate adjustment filing. Once a new rate has been approved (for a new policy form or for a revision to an existing policy form), such new rate can be incorporated into the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing.

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

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

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

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

It is recommended that a rate adjustment submission not be submitted more than 180 days prior to the proposed rate effective date. It is recommended that a rate adjustment submission not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing. If a company can not send the required final notice at least 60 days in advance of the rate change date for a particular renewal cohort, then the rate change implementation date for such renewal cohort will need to be deferred. Contract terms will dictate whether the rate change can be deferred to a later implementation date for that renewal cohort (e.g., for the July 2012 renewal cohort, deferring the rate change to August 2012, while retaining the next rate change date as July 2013), or deferring implementation of the newly approved rates to a later renewal cohort (e.g., assuming quarterly rolling rates are used: renewing the July 2012 renewal cohort using the previously approved second quarter 2012 rate tables, and implementing the newly approved rates with the August 2012 renewal cohort).

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

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

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

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

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

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

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

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

| | | | |
|--|--|---|--|
| | | <p>period for this table is January 1, 2012 through December 31, 2012.</p> <p>(ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2012 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2012 (mid renewal date) through February 14, 2013. If all policyholders must have a first of the month effective date, then the rate applicability period would be considered as February 1, 2012 through January 31, 2013.</p> <p>g. Standardized earned premium is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable pursuant to Regulation 146 or pursuant to a loss ratio report have no impact on the earned premiums or standardized earned premiums shown in Exhibit 7 or in the rate development analysis.</p> <p>(i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3rd and 4th quarters 2012 and 1st and 2nd quarters 2013. The 2nd quarter 2012 rates have already been approved. Therefore, the 2nd quarter 2012 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2nd quarter 2012 rate level. If the 2nd quarter 2012 rate table included a 2% increase due to the addition of a new benefit that is being added to all policyholders at renewal, the standardization for periods prior to April 1, 2012 would not reflect this 2% increase since the incurred claims for this earlier period did not reflect this additional benefit.</p> <p>(ii) Example: An insurance company uses a quarterly rolling rate structure and has been raising rates 4% each quarter as of the beginning of a new quarter. The first quarter 2011 rate for plan design A is \$100, the first quarter 2012 rate is \$116.99, and the second quarter 2012 rate is \$121.67. These increases reflect no revision to the underlying covered benefits. The second quarter 2012 rate table is the standard rate level. Contract X was paying \$100 per month for January-December 2011. At renewal January 1, 2012, the premium was scheduled to increase to \$116.99 but a change to plan design B occurred that reduced the premium by 5% to \$111.14 for January 2012 and later. The second quarter 2012 rate for plan design A is \$121.67 and the second quarter 2012 rate for plan design B is \$115.58 (\$121.67 x 0.95). The earned premium for this contract for each month from January through December 2011 is standardized to the second quarter 2012 level by adjusting by 121.67/100.00, and the</p> | |
|--|--|---|--|

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

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| | | <p align="center">January 2012 earned premium is standardized to the second quarter 2012 level by adjusting by 115.58/111.14.</p> | |
| <p>ROLLING RATE STRUCTURE</p> | | <ul style="list-style-type: none"> a. Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates). b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period. c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates). | <p>Supporting Documentation - NY LRG HMO 3q13 thru 2q14 Rate Manual.pdf</p> |
| <p>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</p> | | <ul style="list-style-type: none"> a. Beginning with rate adjustment filings that include rate tables to be effective January 1, 2012 or later, the rate adjustment filing must include all community rated policy forms within a given market segment (such as all small group products) whether or not a premium rate adjustment is requested for a particular product or rider in that market segment. All entities within the same holding company system are to submit filings for a given market segment at the same time; the filings can be submitted under different SERFF filings, but all the applicable filings must be submitted within a total of seven calendar days. b. A company can revise a previously approved non-rolling rate table provided that: <ul style="list-style-type: none"> (i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or (ii) The proposed effective date of the rate table is at least 6 months after the effective date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and all policyholders that received a final 60 day notice about the approved rates from the previously approved rate adjustment filing have also received the rate change approved from the previously approved rate adjustment filing. c. A company can revise rate tables included in a previously approved rolling rate filing provided that: (i) the rate tables being revised were never implemented, (ii) the first two quarterly rate tables, or the first six monthly rate tables, included in the previously approved rate adjustment filing are not revised, and (iii) policyholders in the renewal cohort(s) affected by the change to the previously approved rate tables did not receive a final 60 day notice informing them of the approved rates from the previously approved rate adjustment filing. The revised rate adjustment filing must include a year's worth of rates as discussed in the "Rolling Rate Structure" section above. (Example: A rolling rate filing was submitted and approved that included quarterly rolling rate tables for 1st, 2nd, 3rd | <p>Supporting Documentation - NY LRG HMO 3q13 thru 2q14 Rate Manual.pdf</p> |

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| | | and 4 th quarter of 2012. The company can not revise the 1 st and 2 nd quarter 2012 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3 rd and 4 th quarter 2012 and 1 st and 2 nd quarter 2013.) The Department may waive these requirements if the company can demonstrate to the Superintendent’s satisfaction that the solvency of the corporation is threatened. | |
| STANDARD EXHIBITS 1 - 7 | Introduction | Exhibits 1 through 7 must be submitted as part of each rate adjustment application. All exhibits, except Exhibit 3, must be submitted as a Microsoft Excel file and as an Adobe PDF file. For Exhibits 1-2 and 4-7 the supplied workbook must be used. Only use the first tab of each Excel workbook for data entry. | |
| Exhibit 1 | | <p>General information about the rate adjustment submission.</p> <p>a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit.</p> <p>b. Indicate the company type using the drop down list: Article 42 Accident and Health company (A&H – 42), HMO (HMO – 44), Article 42 Life company (Life – 42), Article 41 property/casualty company (P&C – 41), and Article 43 Non-Profit Medical and Dental Indemnity or Health and Hospital Service Corporations (Not for Profit – 43).</p> <p>c. Indicate the organization type (Org Type), for profit or not for profit, by using the drop down list.</p> <p>d. Item D – the “new rate effective date” must be a realistic implementation date given the review time allowed the Department and the requirement of the 60 day final rate notice. This date would usually be the first date the proposed rates would affect renewing policyholders. So a 1/1/2013 effective date would imply that the first renewal cohort affected by the rate submission would be January 2013.</p> <p>e. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected.</p> <p>f. This exhibit must be submitted as an Excel file and as an Adobe PDF file.</p> | <p>Supporting Documentation -</p> <p>AHI NY LRG Exhibits 1 thru 6.pdf</p> <p>AHI NY LRG Exhibits 1 thru 6.xls</p> |
| Exhibit 2 | | <p>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</p> <p>a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert more rows as needed. Only use the first tab for data entry.</p> <p>b. Use a separate row to enter information for each combination of market segment/rating pool included in this rate adjustment application. Use the drop down list to enter the market segment. Enter a description of the rating pool in the column indicated; if the rating pools vary by rating region, the rating pool identifier should include a region identifier. All market segments of Healthy New York are usually combined into one rating pool and in that case choose as market</p> | <p>Supporting Documentation -</p> <p>AHI NY LRG Exhibits 1 thru 6.pdf</p> <p>AHI NY LRG Exhibits 1 thru 6.xls</p> |

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| | | <p>segment HNY-IND or HNY-SG based on which subpopulation has the most membership.</p> <p>c. Information is for medical base plans and all associated riders combined.</p> <p>d. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rate applicability period.</p> <p>e. The administrative expense components incorporated into the proposed rates are to be entered as a percentage of gross premium and as a per member per month amount.</p> <p>f. Enter the data for the rate period included in this rate adjustment filing. This refers to the various non-claim expense components included in the proposed rates and the average annualized claim trend assumed.</p> <p>g. Enter the data for the rate period included in the immediately prior rate adjustment filing (i.e., a section 3231(e)(1) or 4308(c) rate adjustment filing). This refers to the various non-claim expense components included in the proposed rates submitted with this prior filing and the average annualized claim trend assumed in this prior filing. If there is no immediately prior rate adjustment filing, enter the data assumed in the initial or prior form and rate filing.</p> | |
| <p>Exhibit 3</p> | | <p>Narrative Summary.</p> <p>a. The format of the exhibit is illustrative, but must include the required material. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. If submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>b. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company’s policyholders and subscribers to help them understand why a rate increase is needed.</p> <p>c. The narrative summary will be a public document.</p> <p>d. It is suggested that once reviewed by the Department, the company post the narrative summary to a location on its website that is publicly available, that is, a location that can be viewed without the need for entering a user ID and password. Links should be provided on key pages of the company’s website so that the information may be easily located. Any change(s) to the narrative summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified. Narrative summaries should remain on the company’s website for at least 12 months past the proposed effective date of the rate submission.</p> <p>e. The narrative summary should include, but not be limited to, the following</p> | <p>Supporting Documentation -</p> <p>AHI NY LRG Exhibits 1 thru 6.pdf</p> <p>AHI NY LRG Exhibits 1 thru 6.xls</p> |

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| | | <p>information:</p> <ul style="list-style-type: none"> (i) The name of the company submitting the rate adjustment request, the NAIC code number for the company, and the SERFF number for the rate application. (ii) A summary of the proposed rate adjustments. (iii) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect policyholders in a certain market segment (e.g., small group), or with certain products (indicate the “street name” of the products affected), or only a certain renewal cohort (e.g., policyholders renewing from period mm/dd/yyyy – mm/dd/yyyy). (iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples: <ul style="list-style-type: none"> (a) Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy. (b) A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder’s next anniversary on or after mm/dd/yyyy. (v) The number of policyholders and members affected by the proposed rate adjustments. This can be aggregated across all market segments and products included in the rate adjustment submission. (vi) An explanation, in plain language, as to why it is necessary to request such rate change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type. <p>Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p> | |
| <p>Exhibit 4</p> | | <p>Summary of Proposed Percentage Rate Change to Existing Rate.</p> <ul style="list-style-type: none"> a. There are four different versions of this exhibit as indicated below. Not all versions may be required for a given rate filing. <ul style="list-style-type: none"> (i) Part A – Base Medical Plan information when a <u>Non-Rolling</u> Rate Structure is used. (ii) Part B – Base Medical Plan information when a <u>Rolling</u> Rate Structure is used. (iii) Part C – Drug Rider information when a <u>Non Rolling</u> Rate Structure is used. (iv) Part D – Drug Rider information when a <u>Rolling</u> Rate Structure is used. b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment filing. Use the drop down list to enter the market segment. c. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for | <p>Supporting Documentation -</p> <p>AHI NY LRG Exhibits 1 thru 6.pdf</p> <p>AHI NY LRG Exhibits 1 thru 6.xls</p> |

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

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| | | <p>Refer to Section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for the requirements to aggregate substantially similar policy forms for small group policy forms and for individual policy forms.</p> <p>e. Indicate for each base medical policy form if the policy form aggregation has changed from the previous rate filing. If yes, the actuarial memorandum must include an explanation of the change, the rationale for the change, and the percentage rate impact this change has on this policy form and on the policy forms previously aggregated with this policy form.</p> <p>f. The effective date of rate change refers to the proposed effective date of the non-rolling rate table, and/or the proposed effective date of the earliest rolling rate period of a rolling rate structure.</p> <p>g. The rate guarantee period refers to a non-rolling rate table and/or to the first rate table of a rolling rate structure. (If the rate guarantee period for the rolling rate structure is not the same for each rolling rate period, the actuarial memorandum must discuss this and explain why the length of the rate guarantee periods are not the same.)</p> <p>h. The weighted average rate change percentage proposed (from the rate currently charged the policyholder [or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application] to the proposed rate to be charged to that same cohort of policyholders) for the indicated base medical policy form, including all associated riders. The weighting should be consistent with how the average changes were calculated in Standard Exhibit 5 (i.e., based on members or contracts). For a rolling rate structure, enter the result for the first rate table in the rolling rate structure. (Example: a quarterly rolling rate filing was submitted that includes rolling rate tables for the 1st, 2nd, 3rd, and 4th quarters of 2013. Rates are for a 12 month period. Indicate the average rate change percentage from the 1st quarter of 2012 rate tables to the 1st quarter 2013 rate tables.)</p> <p>i. For the number of policyholders affected and the number of covered lives affected by this rate filing, indicate the effect of all the rate tables of a rolling rate structure included in the rate filing (but not more than 12 months of issues and renewals if more than 12 months of rolling rate tables are included in the rate filing). For group business, “policyholders” is referring to the number of groups, not the number of subscribers or contracts.</p> <p>j. The expected loss ratio is the loss ratio incorporated into the proposed rate tables for each base medical policy form (and the entire rating pool) and includes the impact of associated riders and reflects the impact of the proposed rate changes. Loss ratio is calculated on a New York statewide basis. For a rolling rate structure, enter the expected loss ratio incorporated into the rate tables of the first rolling rate</p> | |
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| | | <p>period of the rolling rate structure.</p> <p>k. The experience entered for the three indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.</p> <p>(i) Each experience period is to be for 12 months (or shorter if a new form).</p> <p>(ii) The ending date of the recent experience period cannot be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing is for a non-rolling rate table to be effective July 1, 2013. The recent experience period cannot have an ending date earlier than June 30, 2012, i.e., 12 months prior to July 1, 2013.).</p> <p>(iii) The first prior period is the immediately prior 12 month experience period (or shorter period if a new form). The second prior period is the immediately prior 12 month experience period (or shorter if a new form) prior to the first prior period.</p> <p>(iv) The incurred claims for each of the three experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of the incurred claims.</p> <p>(v) Loss ratio report refunds or refunds pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.</p> <p>l. Enter the average annual composite medical trend assumption used in the proposed rate development for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown, as well as any other component such as for case mix or intensity (identify and discuss and justify any such other component in the actuarial memorandum along with the utilization component and unit cost component).</p> <p>m. The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods.</p> <p>n. If the rating differential between the New York rating regions is being revised with</p> | |
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| | | <p>this rate filing, separate rows are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined, and the rating pool identifier is to include a rating region identifier.</p> | |
| ACTUARIAL MEMORANDUM | 11NYCRR 52.40(a)(1) | <p>Actuarial qualifications:</p> <ul style="list-style-type: none"> a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. | |
| Justification of Rates | <p>§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b) 11NYCRR 360.11</p> | <ul style="list-style-type: none"> a. Description of proposed changes in rates, including the following: <ul style="list-style-type: none"> (i) The member (or contract) weighted average proposed percentage change over the current rates charged to each renewal cohort of policyholders for each base medical policy form, including the impact of all associated riders available to that policy form (or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application). This is to be shown for each non-rolling rate table and/or each rolling rate table included in the rate filing. (The percentage change is comparable to the percentage change developed for Standard Exhibit 5.) Include comparable information for percentage rate changes implemented during the prior 24 months. (ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3rd quarter 2013. The change from each of the 2nd quarter 2013 rolling rate tables to the corresponding 3rd quarter 2013 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated. (iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment filing, indicate the aggregate (medical plus riders) percentage change between the successive non-rolling rate tables. For a rolling rate structure, indicate the aggregate (medical plus riders) percentage change between each of the successive rolling rate tables (e.g., for a quarterly rolling rate structure, the percentage change between each of the successive | <p>Supporting Documentation -</p> <p>AHI LRG Actuarial Memorandum.pdf</p> <p>AHI NY LRG Exhibits 1 thru 6.pdf</p> <p>AHI NY LRG Exhibits 1 thru 6.xls</p> <p>AHI NY LRG Exhibit 7.pdf</p> <p>AHI NY LRG Exhibit 7.xls</p> <p>Approval Ltr Prev Care.pdf</p> <p>Approval Ltr Autism.pdf</p> <p>Approval Ltr Vision.pdf</p> <p>Approval Ltr Med SOB.pdf</p> <p>Approval Ltr Transgender.pdf</p> <p>NY LRG HMO 3q13 thru 2q14 Rate Manual.pdf</p> |

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| | | <p>quarterly rate tables).</p> <ul style="list-style-type: none"> (iv) The percentage change due to any change in the expected loss ratio incorporated into the proposed rate tables from the prior rate filing for such base medical policy form or rider. Indicate the expected loss ratio incorporated into the current rate tables, the expected loss ratio incorporated into the proposed rate tables, the impact on the percentage change in items (i) and (ii) above due to this revision in the expected loss ratio, and the reason(s) and justification for the change in the pricing expected loss ratio. (v) The percentage change due to any change to the tier structure relationships included in this rate filing and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes. (vi) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate filing, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes. (vii) The percentage change due to variance in the prior incurred claim cost per member per month estimate and the impact of such variance on the percentage changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an exhibit showing how this variance and the percentage impact of this variance were developed. (viii) Changes to any of the rating differentials between the various rating regions included in this rate filing. If the rating differential between the rating regions was changed, include (a) a listing of the composition of each rating region, (b) the percentage change impact on each such rating region, and (c) justification for each such change between the rating region differentials. If the composition of any rating region is being changed with this filing, indicate (a) the current and proposed composition of the affected rating regions, (b) the percentage change impact on each of the affected rating regions, and (c) justification for the proposed change in the rating region composition. <ul style="list-style-type: none"> b. If new benefit options are being added to an existing rate table (such as additional copays or deductibles): (a) clearly indicate the additions being made, (b) include in the actuarial memorandum, a statement that the already approved contract language includes the new benefit options being added, (c) provide appropriate actuarial justification for the additional rating factors, and (d) submit a copy of the approved contract language pages and a copy of the Department’s approval letter and clearly indicate how the approved contract language covers the new benefit options being added to the existing rate table. c. Include the following (year over year exhibit): <ul style="list-style-type: none"> (i) For each non-rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change from | |
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| | | <p>the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission.</p> <p>(ii) For each rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change for each renewal cohort from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission. (Example: the rate submission includes new rate tables for third and fourth quarter 2013 and first and second quarter 2014. Rates are for 12 month periods. Show the rates for the third quarter 2012, the proposed rates for the third quarter 2013, and the dollar and percentage change from third quarter 2012 to the proposed third quarter 2013 rates. Show a similar table for the proposed fourth quarter 2013, and first and second quarter 2014 rates as well.)</p> <p>d. Discuss the standard premium development used in Standard Exhibit 7. See discussion above on Standard Exhibit 7.</p> <p>e. Discuss the source data used to develop the projected incurred claims for the renewal rate applicability period.</p> <p>(i) If the source data is actual claims experience, the experience period is to be at least 12 months long, and the unpaid claim reserve is to be based on at least 3 months of claims run-out beyond the end of the experience period.</p> <p>(ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data.</p> <p>(iii) Discuss the credibility of such source data.</p> <p>(iv) Include an exhibit showing the source data and indicate all adjustments made to this source data to develop the projected incurred claims for the renewal rate applicability period. Provide this detail for each non-rolling rate table included in the rate filing, and/or for the first rate table of each rolling rate structure included in the rate filing (for base medical rate tables and for rider rate tables) for each permitted aggregation of policy forms (i.e., rating pool). Provide justification for each such adjustment.</p> <p>f. Indicate the assumed annualized claim trend projection factors used to project the source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure) for each product within each permitted policy form aggregation (i.e., rating pool).</p> <p>(i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend.</p> | |
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| | | <ul style="list-style-type: none"> (ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components. (iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period. <p>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</p> <ul style="list-style-type: none"> (i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for a rolling rate structure, how the percentage change from the existing 2nd quarter 2013 rate table to the proposed 3rd quarter 2013 rate table was developed for each rating element in the proposed rate table.) This demonstration must clearly show how the proposed rate change was developed from the projected source data, current rate level, and expected loss ratio. Provide justification for the percentage change proposed. (ii) For each subsequent rate table of a rolling rate structure, show how the change between each of the successive rate tables was developed (e.g., the change from the 3rd quarter 2013 rate table to the 4th quarter 2013 rate table). Provide justification for these changes between the rolling rate tables. (iii) Clearly show how the proposed rate development, as applicable, reflects recoveries from the standard direct pay and Healthy New York stop loss pools (New York Insurance Law Sections 4321-a, 4322-a, and 4327), and discuss how the recovery amounts used were developed. (iv) Clearly show how the proposed rate development, as applicable, reflects payments to, or receipts from, the Department Regulation 146 (11 NYCRR 361) and New York Insurance Law Section 3233 marketing stabilization pool. Clearly discuss how the corporation has been complying with 11 NYCRR 361 (Regulation 146), Section 361.6(g), and include in the rate application any new plan pursuant to Section 361.6(g)(2)(i). Such discussion should include an exhibit showing how all monies received from the Regulation 146 pool from calendar years 2007 to date have been used to benefit consumers pursuant to the requirements of Section 361.6(g). (v) Discuss if the source data includes any very large claims on an individual, how such large claims have been handled, and any internal mechanism to pool large claims across more than the rating pool that contained the large claim. Clearly show how the rate development, if applicable, reflects this internal mechanism | |
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| | | <p>for pooling large claims.</p> <ul style="list-style-type: none"> h. If the percentage rate change by benefit option differs within a particular policy form (or rider form), include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option. Any assumed variation in utilization by benefit option within a particular policy form (or rider form) must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the policy form, and cannot be based on differences due to age, sex, health status or industry among the members selecting the different benefit options. i. If the percentage rate change by policy form differs within a permitted aggregation of policy forms, include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options among the aggregated policy forms, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option within the aggregated policy forms. Any assumed variation in utilization between policy forms within a permitted aggregation of policy forms must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the permitted aggregation of policy forms, and cannot be based on differences due to age, sex, health status or industry among the members selecting a particular benefit option within the aggregated policy forms. j. If the percentage rate change by rating region differs, the default assumption is that the rating regions are not aggregated for rate setting purposes. In order for a company to claim that certain rating regions are aggregated for rate setting purposes, it is necessary to include an actuarial demonstration that the rate changes were developed assuming the same insured population in each of the aggregated rating regions, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members in each of the aggregated rating regions. k. Discuss any significant change in the non claim expense components indicated on Standard Exhibit 2 between the prior rate adjustment filing and this rate adjustment filing, including any item where the \$mpm value exceeds \$1 and where the \$mpm value changed by more than 10% between the prior filing and the current filing. Discuss the source for the non-claim expense components indicated on Standard Exhibit 2 for the current rate filing and, for the percentage of gross premium values, how the proposed rate change was reflected in the development of those percentage of gross premium factors (e.g., as premiums increase the | |
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| | | percentage of premium should decrease for an expense that is not directly tied to premium). Discuss any revision to the expense allocation basis that has occurred since the last rate adjustment filing. | |
| Minimum Loss Ratio Requirements | §3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b) | <ul style="list-style-type: none"> a. The minimum loss ratio for community rated products, other than the official Medicare Supplemental products, is as specified in Section 3231(e)(1)(B) or 4308(c)(3)(A) of the New York Insurance Law, as amended by Chapter 107 of the Laws of 2010. b. The minimum loss ratio for the official Medicare Supplemental products is: <ul style="list-style-type: none"> (i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance Law, as amended by Chapter 107 of the Laws of 2010; and (ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52). | <p>Supporting Documentation -</p> <p>AHI NY LRG Exhibit 7.pdf</p> <p>AHI NY LRG Exhibit 7.xls</p> |
| Actuarial Certification | 11NYCRR 52.40(a)(1) | <ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio incorporated into the proposed rate tables meets the minimum requirement of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions. Specify the expected loss ratio incorporated into the proposed rate tables for each permitted aggregation of policy forms within each permitted aggregation of rating regions. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. | <p>Supporting Documentation -</p> <p>AHI LRG Actuarial Certification.pdf</p> |
| REVISED RATE MANUAL PAGES | 11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b) | <p>Rate Manual.</p> <ul style="list-style-type: none"> a. Table of contents. b. Rate pages, including a page indicating the composition of each rating region. c. Insurer/corporation name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts, as applicable. g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual, to the extent applicable. j. Expected loss ratio(s). | <p>Supporting Documentation -</p> <p>NY LRG HMO 3q13 thru 2q14 Rate Manual.pdf</p> <p>NY LRG Commission Schedule.pdf</p> <p>NY LRG Description of Benefits.pdf</p> <p>NY LRG Med RX Dental SI Flex Man.pdf</p> <p>NY LRG TOC Gen Section B D E.pdf</p> <p>AHI Form Index.pdf</p> |

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| <p>NOTICES TO POLICYHOLDERS Initial & Final</p> | <p>§3231(e)(1)(A) §4308(c)(2) Circular Letter No. 12 (2011)</p> | <p>a. As indicated in Circular Letter No. 12 (2011), a draft of the initial notice should be submitted for review by the Department prior to the rate adjustment submission. This draft should be submitted via SERFF using the “Prior Approval Prefiling” filing type code. (It is strongly recommended that the company also include a draft of the Narrative Summary in this prefiling submission.)</p> <p>b. Include with the rate adjustment filing a sample copy of the initial written notice sent to policyholders and subscribers/contract holders of the proposed rate adjustment submitted to the Department of Financial Services.</p> <p>(i) Section 3231(e)(1) and Section 4308(c) of the New York Insurance Law require that the initial notice be sent on or before the date the rate application is submitted to the Department.</p> <p>(ii) If different notices are used for different products or different rating regions, submit a sample for each such product and/or each such rating region.</p> <p>c. Include with the rate adjustment filing a sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.</p> | <p>Supporting Documentation -</p> <p>Pre Filing Plan Spon Ltr 1-3-13.pdf</p> <p>Pre Filing Sub Ltr 1-3-13.pdf</p> <p>Pre Filing Summary of Renl Rates.pdf</p> <p>Final Plan Spon Ltr 1-25-13.pdf</p> <p>Final Sub Ltr 1-25-13.pdf</p> <p>Final Summary of Renl Rates.pdf</p> |
| <p>HHS PRELIMINARY JUSTIFICATION PARTS I AND II</p> | <p>PPACA §1003</p> | <p>a. For every rate submission pursuant to section 3231(e)(1) or section 4308(c) of the New York Insurance Law, the insurer is to submit Parts I and II of the U.S. Department of Health and Human Services (HHS) Preliminary Justification, whether or not such justification material is required to be submitted to HHS.</p> <p>b. This requirement applies to large group community rated products as well as to small group and individual products, and to non-grandfathered and grandfathered products, but this requirement does not apply to a product type that would never require such justification material to be submitted to HHS (for example: Medicare Supplemental products, stand-alone dental products).</p> <p>c. The justification material is to be prepared using the template and instructions provided by HHS.</p> | <p>Rate Summary Worksheet -</p> <p>HHS Rate Review.pdf</p> <p>HHS Rate Review.xls</p> <p>Consumer Disclosure Form.pdf</p> <p>HHS Part II.pdf</p> |
| <p>PUBLIC DISCLOSURE OF THE RATE APPLICATION</p> | | <p>Posting a Redacted Version of the Rate Adjustment Application to the Department’s Website.</p> <p>a. A redacted version of this rate application will be posted to the Department’s website to aid consumers’ understanding of the reason(s) for the requested rate change(s).</p> <p>b. The Department will accept redaction of only the following information in the rate application:</p> <p>(i) personally identifiable information, including names and contact information of actuaries or other individuals, including those who work for the health plan, a consulting firm, or the Department, that are contained in the application; and</p> <p>(ii) information that identifies in reasonably precise terms specific provider</p> | <p>N/A</p> |

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

Aetna is updating its rates for Large Group HMO plans in New York to adjust for several changing factors. Our new filing proposes to raise average premium rates by 8.96%

Who This Change Will Affect

The rates will apply to all policies that renew or start from July 2013 through June 2014. Approximately 24,100 members, from both grandfathered and non-grandfathered plans, are currently enrolled in plans to which the new rates will apply.

Why We Need to Increase Premiums

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 10.3%, excluding the effect of benefit changes described below. Medical costs go up mainly for two reasons – providers raise their prices and members get more medical care. We expect 38% of the medical cost increase to come from providers raising price and 62% to come from members getting more care

For Large Group Employers in New York, examples of increasing medical costs we have experienced in 2012 include:

- Emergency Room services expenses have increased 23.9% over 2011
- Radiology services expenses have increased 35.5% over 2011
- Pharmacy expenses have increased 24.1% over 2011

What Else Affects Our Request to Increase Premiums

Required Benefit Changes

Premium rates may also include allowances to cover additional costs related to new benefits required by State and Federal law. For example, July 2013 effective date plans with an ACA non-grandfathered status will need to include enhanced coverage for Women's Preventive Health Services. These changes will increase costs to those plans by an average of approximately 1.4%.

Impact of New Taxes and Fees

The Affordable Care Act (ACA) includes several new taxes and fees payable in 2014, including two that specifically apply to insured products -- the health insurer fee and the reinsurance contribution. These new fees result in additional costs and are reflected in our updated rates for policies that extend into 2014. The overall impact of these fees is to raise average premium rates by 2.1%.

Will Premiums for All Large Groups Increase Equally?

No, the increases stated above are averages. Some premiums will increase less, others will increase more than the average. The exact rate change will depend on what benefit plan the group chooses, and when the group's contract renews.

How Does This Request Match up with Minimum Loss Ratio Requirements (MLR)?

We expect these rates will produce an MLR equal to or above the required 85% requirement for large group business – meaning that we expect at least 85% of the premiums we collect to pay for medical care and activities that improve health care quality for our members. If our actual MLR turns out to be less than 85% -- for instance, if doctors and hospitals raise prices less than we expect -- we will issue rebates as the law requires.

In addition to paying for medical claims and quality improvement activities, a portion of every member's premium goes toward covering administrative expenses such as customer service, claims and billing, and quality activities like disease management programs. Premium also includes premium taxes and Federal income tax.

What is Aetna Doing to Keep Premiums Affordable?

Our goal is to deliver competitive pricing that allows our customers and members to get the greatest value out of their health benefits. Aetna also is taking a number of steps to try to keep our products as affordable as possible, such as:

- Developing new relationships with health care providers that compensate them for the quality of care they provide, and not the quantity.
- Creating medical management programs which address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

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



Aetna
151 Farmington Ave.
Hartford, CT 06156-3010

<DATE>

<Plan sponsor first> <Plan sponsor last>

<Company Name>

<Address>

<City>, <ST> <ZIP>

<Group ID>

RE: Notice of approved rate increase

Dear <Plan sponsor name>:

We may have previously sent you notice of a proposed rate increase that we filed with the Department of Financial Services for your large group HMO plan(s) offered by Aetna Health Inc. Your final rate increase for the plan included with this renewal is shown on the attached renewal rate exhibit.

Summary of renewal rates

The resulting monthly premium is shown in the attached summary of renewal rates. The summary includes current monthly rates, renewal rates, and the percentage change between the two. These monthly premiums will be effective <DATE>.

Please note that while we try to provide you with the most accurate information possible, your final rate may differ based on the enrollment census, benefit plan design, and other features you select upon renewal.

What you need to do next

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

If you choose to continue your coverage, there is nothing you need to do at this time. We will include the new rates in your renewal bill.

If you have questions about the rate increase, please contact your insurance broker of record. If you do not use the services of a broker, please contact your Account Manager.

Thank you for choosing us for your health insurance needs.

Enclosure: Subscriber letter

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

©2011 Aetna Inc.



Aetna
151 Farmington Ave.
Hartford, CT 06156-3010

<DATE>

<Subscriber First> <Subscriber last>

<Address>

<City>, <ST> <ZIP>

<Group ID>

RE: Notice of approved rate increase

Dear <Subscriber Name>:

We may have previously sent you notice of a proposed rate increase that we filed with the Department of Financial Services for your employer's large group HMO plan(s) offered by Aetna Health Inc. Your final rate increase for the plan included with this renewal is shown on the attached renewal rate exhibit.

Summary of renewal rates

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

Please note that while we try to provide you with the most accurate information possible, your final rate may differ based on the enrollment census, benefit plan design, and other features your employer selects upon renewal.

What you need to do next

If you have questions about your contribution amounts (i.e. payroll deductions), please contact your employer. You may also call the Member Services number located on your ID card. Plan representatives are available to assist you from 8 a.m. to 5 p.m. You may also contact us by logging in at Aetna's secure website at www.aetna.com.

Thank you for choosing us for your health insurance needs.



Summary of Renewal Rates New York

<GROUP NAME as shown on list, not renewal> <Group Number, example: US001234>
<Effective Date>

| HMO Medical Only | | | |
|---------------------|---------------|-----------------------|----------|
| Coverage Categories | Current Rates | Renewal Rates | % Change |
| Emp Only | <\$000.00> | < \$000.00 > | <0.0%> |
| Emp + Spouse | <\$0,000.00> | < \$0,000.00 > | <0.0%> |
| Emp + Child(ren) | <\$0,000.00> | < \$0,000.00 > | <0.0%> |
| Emp + Family | <\$0,000.00> | < \$0,000.00 > | <0.0%> |

| HMO Medical and Rx | | | |
|---------------------|---------------|-----------------------|----------|
| Coverage Categories | Current Rates | Renewal Rates | % Change |
| Emp Only | <\$000.00> | < \$000.00 > | <0.0%> |
| Emp + Spouse | <\$0,000.00> | < \$0,000.00 > | <0.0%> |
| Emp + Child(ren) | <\$000.00> | < \$000.00 > | <0.0%> |
| Emp + Family | <\$0,000.00> | < \$0,000.00 > | <0.0%> |

Please Note:

1. Rates represent NY subscribers only
2. Rates include a <X>% increase for the Affordable Care Act (ACA) assessments
3. Rates include a <X>% increase for Women's Preventive Services Coverage



<Date>

<Plan sponsor first> <Plan sponsor last>

<Title>

<Company Name>

<Address>

<City>, <ST> <ZIP>

<Group ID>

RE: Notice of proposed rate increase

Dear <Plan sponsor name>:

New York law requires that we send you and your employees, who are certificate holders, notice when we ask the New York Department of Financial Services to approve a rate increase. We want to let you to know that we will be filing our proposed rates with the Department of Financial Services for plans renewing from July 1, 2013 through June 30, 2014.

Proposed Rates

The attached rate exhibit shows the proposed rate increase for your community rated large group HMO plans offered by Aetna Health Inc. This increase is intended to be effective upon your renewal on or after July 1, 2013.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the enrollment census, benefit plan design, and other features you select upon renewal.

Please feel free to contact your Aetna Account Manager if you have questions or concerns.

Prior Notice of Rate Change Action

The Department of Financial Services may approve, modify, or disapprove our proposed rate changes. You will receive additional notice concerning the Department of Financial Service's approval or modification of our proposed rate changes and how your rates are affected at least 60 days prior to the date of the rate change.

Why Rates Change

Every year, we spend considerable time evaluating both medical cost history and rates. We do this evaluation to ensure we account for the current cost trends in the plan premium. The requested increase is directly related to the rising cost of health care services in New York, and for new benefits and assessments resulting from the Patient Protection and Affordable Care Act (ACA). See the section below titled "Additional information" to review the narrative that provides additional details regarding the request for this proposed rate increase.

These changes have required us to request a rate increase with the Department of Financial Services for all current and new community rated large group HMO customers.

30-day Comment Period

Plan Sponsors and Subscribers have the opportunity to submit written comments to the Department of Financial Services on Aetna's rate filing application and the proposed rate changes within 30 days from the date Aetna submits the rate filing application. The rate filing application will be submitted on <insert date>. You may contact Aetna Health Inc. to confirm the start and end of this 30-day comment period.

Comments may be submitted to the Department of Financial Services or Aetna Health Inc. by contacting:

Department of Financial Services
Health Bureau-Premium Rate Adjustments
25 Beaver Street, New York, NY 10004
Email: PremiumRateIncreases@dfs.ny.gov
Online: <https://myportal.dfs.ny.gov/web/prior-approval/submit-a-comment>

Aetna
151 Farmington Avenue
Hartford, CT 06156
www.Aetna.com
1-800-227-2641

Comments should clearly identify you are commenting on the proposed rate increase for the community rated large group HMO plans offered by Aetna Health Inc. All comments submitted to the Department of Financial Services will be posted on the DFS website with personal identifying information removed.

Additional Information

Aetna has prepared a narrative summary that provides a more detailed, plain English explanation of the reasons why a premium rate adjustment is being requested. This summary will be posted on both the Aetna website and the New York State Department of Financial Services' website. You can access this information at the following sites:

Aetna website: <http://www.aetna.com/individuals-families-health-insurance/member-guidelines/stateprocess.html>

New York Department of Financial Services' website: <https://myportal.dfs.ny.gov/web/prior-approval/welcome>

Sincerely,
Aetna

Enclosure: Subscriber letter



<Date>

<Subscriber first> <Subscriber last>

<Address>

<City>, <ST> <ZIP>

<Group ID>

RE: Notice of proposed rate increase

Dear <Subscriber name>:

New York law requires that we send you notice when we ask the New York Department of Financial Services to approve a rate increase. We want to let you to know that we will be filing our proposed rates with the Department of Financial Services for plans renewing from July 1, 2013 through June 30, 2014.

Proposed Rates

The attached rate exhibit shows the proposed rate increase for your community rated large group HMO plans offered by Aetna Health Inc. This increase is intended to be effective upon your renewal on or after July 1, 2013.

Please note that while we try to provide you with the most accurate information possible, your final rate may differ based on the enrollment census, benefit plan design, and other features your employer selects upon renewal.

Also, your employer sets any contributions, in the form of payroll deductions, to your health plan. If you have questions about your plan's renewal or your payroll deductions, please contact your employer.

Prior Notice of Rate Change Action

The Department of Financial Services may approve, modify, or disapprove our proposed rate changes. You will receive additional notice concerning the Department of Financial Service's approval or modification of our proposed rate changes and how your rates are affected at least 60 days prior to the date of the rate change.

Why Rates Change

Every year, we spend considerable time evaluating both medical cost history and rates. We do this evaluation to ensure we account for the current cost trends in the plan premium. The requested increase is directly related to the rising cost of health care services in New York, and for new benefits and assessments resulting from the Patient Protection and Affordable Care Act (ACA). See the section below titled "Additional information" to review the narrative that provides additional details regarding the request for this proposed rate increase.

These changes have required us to request a rate increase with the Department of Financial Services for all current and new community rated large group HMO customers.

30-day Comment Period

You have the opportunity to submit written comments to the Department of Financial Services on Aetna's rate filing application and the proposed rate changes within 30 days from the date Aetna submits the rate filing application. The rate filing application will be submitted on <insert date>. You may contact Aetna Health Inc. to confirm the start and end of this 30-day comment period.

Comments may be submitted to the Department of Financial Services or Aetna Health Inc. by contacting:

Department of Financial Services
Health Bureau-Premium Rate Adjustments
25 Beaver Street, New York, NY 10004
Email: PremiumRateIncreases@dfs.ny.gov
Online: <https://myportal.dfs.ny.gov/web/prior-approval/submit-a-comment>

Aetna
151 Farmington Avenue
Hartford, CT 06156
www.Aetna.com

Comments should clearly identify you are commenting on the proposed rate increase for the community rated large group HMO plans offered by Aetna Health Inc. All comments submitted to the Department of Financial Services will be posted on the DFS website with personal identifying information removed.

Please feel free to contact Member Services at the number located on your ID card. Plan representatives are available to assist you from 8 a.m. to 5 p.m. You may also contact us by logging into Aetna Navigator™, or call us at 1-800-227-2641.

Additional Information

Aetna has prepared a narrative summary that provides a more detailed, plain English explanation of the reasons why a premium rate adjustment is being requested. This summary will be posted on both the Aetna website and the New York State Department of Financial Services' website. You can access this information at the following sites:

Aetna website: <http://www.aetna.com/individuals-families-health-insurance/member-guidelines/stateprocess.html>

New York Department of Financial Services' website: <https://myportal.dfs.ny.gov/web/prior-approval/welcome>

Sincerely,
Aetna



Summary of Renewal Rates New York

<GROUP NAME as shown on list, not renewal> <Group Number, example: US001234>
<Effective Date>

| HMO Medical Only | |
|---------------------|----------|
| Coverage Categories | % Change |
| Emp Only | <0.0%> |
| Emp + Spouse | <0.0%> |
| Emp + Child(ren) | <0.0%> |
| Emp + Family | <0.0%> |

| HMO Medical and Rx | |
|---------------------|----------|
| Coverage Categories | % Change |
| Emp Only | <0.0%> |
| Emp + Spouse | <0.0%> |
| Emp + Child(ren) | <0.0%> |
| Emp + Family | <0.0%> |

Please Note:

1. Rates represent NY subscribers only
2. Rates include a <X>% increase for the Affordable Care Act (ACA) assessments
3. [Rates include a <X>% increase for Women's Preventive Services Coverage]

Rate Summary Worksheet

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

OMB-0938-1141

A. Base Period Data

Start Period: 08/01/2011

End Period: 07/31/2012

| Service Categories | Member Months | Total Allowed | Net Claims | Cost Sharing | Cost Sharing PMPM | Net PMPM | Allowed PMPM |
|--------------------|----------------|--------------------------|--------------------------|-------------------------|-------------------|------------------|------------------|
| Inpatient | 311,808 | \$ 35,303,989.81 | \$ 33,718,910.14 | \$ 1,585,079.67 | \$ 5.08 | \$ 108.14 | \$ 113.22 |
| Outpatient | 311,808 | \$ 12,841,924.39 | \$ 12,095,862.46 | \$ 746,061.93 | \$ 2.39 | \$ 38.79 | \$ 41.19 |
| Professional | 311,808 | \$ 40,290,937.86 | \$ 36,844,461.80 | \$ 3,446,476.06 | \$ 11.05 | \$ 118.16 | \$ 129.22 |
| Prescription Drugs | 311,808 | \$ 14,742,499.48 | \$ 12,112,229.07 | \$ 2,630,270.41 | \$ 8.44 | \$ 38.85 | \$ 47.28 |
| Other | 311,808 | \$ 43,855,261.46 | \$ 42,040,659.98 | \$ 1,814,601.48 | \$ 5.82 | \$ 134.83 | \$ 140.65 |
| Capitation | 311,808 | \$ 5,779,488.04 | \$ 5,779,488.04 | \$ 0.00 | \$ 0.00 | \$ 18.54 | \$ 18.54 |
| Total | 311,808 | \$ 152,814,101.05 | \$ 142,591,611.50 | \$ 10,222,489.56 | \$ 32.78 | \$ 457.31 | \$ 490.09 |

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 07/01/2012

End Period: 06/30/2013

| Service Categories | Overall Medical Trend | Projected Allowed PMPM | Net Claims | Cost Sharing |
|--------------------|-----------------------|------------------------|------------------|--------------|
| Inpatient | 1.0940 | \$ 123.87 | \$ 118.54 | 0.0430 |
| Outpatient | 1.0940 | \$ 45.06 | \$ 42.52 | 0.0562 |
| Professional | 1.0940 | \$ 141.36 | \$ 129.53 | 0.0837 |
| Prescription Drugs | 1.0940 | \$ 51.73 | \$ 42.58 | 0.1768 |
| Other | 1.0940 | \$ 153.87 | \$ 147.80 | 0.0395 |
| Capitation | 1.0940 | \$ 20.28 | \$ 20.28 | 0.0000 |
| Total | | \$ 536.16 | \$ 501.25 | 0.07 |

B2. Claims Projection for Future Rate

Start Period: 07/01/2013

End Period: 06/30/2014

| Service Categories | Overall Medical Trend | Projected Allowed PMPM | Net Claims | Cost Sharing |
|--------------------|-----------------------|------------------------|------------------|--------------|
| Inpatient | 1.1030 | \$ 136.62 | \$ 131.02 | 0.0410 |
| Outpatient | 1.1030 | \$ 49.70 | \$ 47.00 | 0.0543 |
| Professional | 1.1030 | \$ 155.92 | \$ 143.16 | 0.0818 |
| Prescription Drugs | 1.1030 | \$ 57.05 | \$ 47.06 | 0.1751 |
| Other | 1.1030 | \$ 169.72 | \$ 163.35 | 0.0375 |
| Capitation | 1.1030 | \$ 22.37 | \$ 22.37 | 0.0000 |
| Total | | \$ 591.38 | \$ 553.96 | 0.06 |

B3. Medical Trend Breakout

| Factor | Impact |
|---------------|----------|
| Utilization | 62.4370% |
| Unit Cost | 37.5630% |
| Other Factors | 0.0000% |

C. Components of Current and Future Rates

| | Future Rate | | Prior Estimate of Current Rate | | Difference | |
|---------------------------|-------------|---------|--------------------------------|---------|------------|---------|
| | PMPM | % | PMPM | % | PMPM | % |
| 1. Projected Net Claims | \$ 553.96 | 82.06% | \$ 546.08 | 85.62% | \$ 7.88 | 21.16% |
| 2. Administrative Costs | \$ 107.14 | 15.87% | \$ 78.05 | 12.24% | \$ 29.09 | 78.14% |
| 3. Underwriting Gain/Loss | \$ 13.93 | 2.06% | \$ 13.67 | 2.14% | \$ 0.26 | 0.69% |
| 4. Total Rate | \$ 675.04 | 100.00% | \$ 637.80 | 100.00% | \$ 37.23 | 100.00% |
| 5. Overall Rate Increase | | 5.84% | | | | |

D. Components of Rate Increase

| | Impact on Rate | Percent |
|---|----------------|----------|
| Claims Components | | |
| 1. Inpatient | \$ 12.21 | 154.96% |
| 2. Outpatient | \$ 4.38 | 55.59% |
| 3. Professional | \$ 13.34 | 169.32% |
| 4. Prescription Drugs | \$ 4.39 | 55.66% |
| 5. Other | \$ 15.22 | 193.20% |
| 6. Capitation | \$ 2.09 | 26.51% |
| 7. Cost Share | \$ 1.09 | 13.77% |
| 8. Correction of Prior Net Claims Estimate | \$ (44.83) | -569.01% |
| 9. Total | \$ 7.88 | 100.00% |
| Claims Restatement for Current Rate Period | | |
| 8.a. Prior Net Claims Estimate for Current Rate Period | \$ 546.08 | |
| 8.b. Re-Estimate of Net Claims PMPM for Current Rate Period | \$ 501.25 | |

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

| Calendar Year | New Form | Requested | Implemented |
|---------------|----------|-----------|-------------|
| 2012 | N | 11.5712% | 8.8911% |
| 2011 | N | 7.6895% | 4.7756% |
| 2010 | N | 20.1015% | 20.1015% |

F. Range and Scope of Proposed Increase

| | |
|-------------------------------|-------------------------|
| Number of Covered Individuals | Threshold Rate Increase |
| 24,162 | 8.9576% |

| | Range of Rate Increase |
|--------------------|------------------------|
| Minimum % Increase | 5.9000% |
| Maximum % Increase | 16.3000% |

Last Updated: 8/10/12 9:54 AM

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

| | | | | |
|--|---|--|--|--|
| A. Insurer Information: | Aetna Health Inc. (NY) <small>Company submitting the rate adjustment request</small> | HMO - 44 <small>Company Type</small> | For Profit <small>Org. Type</small> | 95234 <small>Company NAIC Code</small> |
| | [REDACTED] <small>Company mailing address</small> | | | |
| B. Contact Person: | [REDACTED] <small>Rate filing contact person name, title</small> | [REDACTED] <small>Contact phone number</small> | | [REDACTED] <small>Contact Email address</small> |
| C. Actuarial Contact (If different from above): | <small>Actuary name, title</small> | <small>Actuary phone number</small> | | <small>Actuary Email address</small> |
| D. New Rate Information (See Note #1): | July 1, 2013 to June 30, 2014 <small>New rate applicability period</small> | 07/01/2013 <small>New rate effective date</small> | | AETN-128841943 <small>SERFF Tracking Number</small> |
| E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): | Large 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 (2). | No | | | |
| 2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing? | Yes | | | |
| 3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3). | Notification was sent January 25, 2013 to all Large Group NY HMO policyholders. | | | |
| 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 | | | |
| 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, SERFF Tr Num: AETN-128814745, State Tr Num: 2012120081 | | | |

Notes:

- (1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date. It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date. It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.
- (2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.
- Use the following SERFF filing types for rate adjustment filings:
- * For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
 - * For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
 - * For all other prior approval filings: Normal Pre-Approval
- (3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

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

Company Name: Aetna Health Inc. (NY)
 NAIC Code: 95234
 SERFF Number: AETN-128841943

A. Complete a separate ROW for each market segment/rating pool combination included in the current rate adjustment filing:

- Information should be for medical base plans and associated riders combined.

- Indicate the market segment the rating pool belongs to by using the drop down list. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), I

- Enter a description of the rating pool within the indicated market segment. If the rating pools vary by rating region, the rating pool description should include a region identifier (eg., SG HMO Downstate, SG HMO Upstate).

- Use a separate row for each market segment/rating pool combination included in the current rate adjustment filing.

- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

B. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components included in the proposed rates and the average annual claim trend assumed.

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

E. This form must be submitted as an Excel file and as a PDF file.

| Data Item for Specified Rating Pool | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--|---------------------------------------|---|--|---|---|---|---|--------------------------------------|---|---|---|---|--|---|---|---|--|---|-------------------------------|--|---|---|---|---|---|--|--------------------------------------|
| For the period included in this rate adjustment filing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Market Segment | 2. Description of rating pool within the market segment | 3. Period assumed - beginning date (MM/DD/YYYY) | 4. Period assumed - ending date (MM/DD/YYYY) | 5. Average annual claim trend assumed | 6.1 Regulatory authority licenses and fees, including New York State 332 assessment | 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) | 6.6 Other administrative expenses - as a % of gross premium | 6.7 Subtotal columns 6.1 through 6.6 | 7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium | 8. State income tax component - as a % of gross premium | 8.1 State income tax rate assumed (eg 3%) | 9. Federal income tax component - as a % of gross premium | 9.1 Federal income tax rate assumed (eg 30%) | 10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value) | 11. Subtotal columns 6.7 + 7 + 8 + 9 + 10 | 12.1 Regulatory authority licenses and fees, including New York State 332 assessment - as \$mpm | 12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm | 12.3 Commissions and broker fees - as \$mpm | 12.4 Premium Taxes - as \$mpm | 12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm | 12.6 Other administrative expenses - as \$mpm | 12.7 Subtotal columns 12.1 through 12.6 | 13. After tax underwriting margin (profit/contribution to surplus) - as \$mpm | 14. State income tax component - as \$mpm | 15. Federal income tax component - as \$mpm | 16. Reduction for assumed net investment income - as \$mpm (enter as a negative value) | 17. Subtotal columns 12.7 through 16 |
| LG | HMO XX | 07/01/13 | 06/30/14 | 10.3% | 1.88% | 0.56% | 1.36% | 2.05% | 0.00% | 8.05% | 13.90% | 1.98% | 0.17% | 5.03% | 1.16% | 35.00% | -2.02% | 15.19% | 12.49 | 3.75 | 9.03 | 13.61 | 0.00 | 53.51 | 92.40 | 13.15 | 1.10 | 7.68 | (13.39) | 100.94 |

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

Company Name: Aetna Health Inc. (NY)
 NAIC Code: 95234
 SERFF Number: AETN

A. Complete a separate ROW for each market segment/rating pool combination included in the current rate adjustment filing:

- Information should be for medical base plans and associated riders combined.

- Indicate the market segment the rating pool belongs to by using the drop down list. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), I

- Enter a description of the rating pool within the indicated market segment. If the rating pools vary by rating region, the rating pool description should include a region identifier (eg., SG HMO Downstate, SG HMO Upstate).
- Use a separate row for each market segment/rating pool combination included in the current rate adjustment filing.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

B. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components included in the proposed rates and the average annual claim trend assumed.

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

E. This form must be submitted as an Excel file and as a PDF file.

| | | Data Item for Specified Rating Pool | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-------------------|---|--|---|--|--|---|--|--|--|--|----------------------------|--|--|--|--|---|---|---|--|--|---|-------------------------------|--|---|---------------------------------------|---|---|---|--|--------------------------------------|-------|
| | | For the rate period included in the immediately prior rate adjustment filing (or initial form & rate filing) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Market Segment | 2. Description of rating pool within the market segment | 18. Period assumed - beginning date (MM/DD/YYYY) | 19. Period assumed - ending date (MM/DD/YYYY) | 20. Average annual claim trend assumed | 21.1 Regulatory authority licenses and fees, including New York State 332 assessment | 21.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium | 21.3 Commissions and broker fees - as a % of gross premium | 21.4 Premium Taxes - as a % of gross premium | 21.5 Other state and federal taxes and assessments (other than income taxes and covered lives) | 21.6 Other administrative expenses - as a % of gross premium | 21.7 Subtotal through 21.6 | 22. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium | 23. State income tax component - as a % of gross premium | 23.1 State income tax rate assumed (eg 3%) | 24. Federal income tax component - as a % of gross premium | 24.1 Federal income tax rate assumed (eg 30%) | 25. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value) | 26. Subtotal lines 21.7 + 22 + 23 + 24 + 25 | 27.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm | 27.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm | 27.3 Commissions and broker fees - as \$mpm | 27.4 Premium Taxes - as \$mpm | 27.5 Other state and federal taxes and assessments (other than income taxes and covered lives) | 27.6 Other administrative expenses - as \$mpm | 27.7 Subtotal lines 27.1 through 27.6 | 28. After tax underwriting margin (profit/contribution to surplus) - as \$mpm | 29. State income tax component - as \$mpm | 30. Federal income tax component - as \$mpm | 31. Reduction for assumed net investment income - as \$mpm (enter as a negative value) | 32. Subtotal columns 27.7 through 31 | |
| LG | HMO | XX | 07/01/11 | 06/30/12 | 12.40% | 0.00% | 0.00% | 3.10% | 2.04% | 0.00% | 5.60% | 10.74% | 2.44% | 0.12% | 3.10% | 1.38% | 35.00% | -1.64% | 13.03% | 0.00 | 0.00 | 16.94 | 11.13 | 0.00 | 30.59 | 58.67 | 13.31 | 0.67 | 7.53 | (8.96) | 71.21 |

EXHIBIT 3: NARRATIVE SUMMARY

Company Name: Aetna Health Inc. (NY)
 NAIC Code: 95234
 SERFF Tracking #: AETN-128841943

Aetna Health Inc. is submitting rate increases for its Large Group community rated HMO for the state of New York. As we have in the past, we will work with the New York State Insurance Department to make sure these rate changes comply with all state regulations.

The following is a summary of the proposed rate increases for policyholders' existing benefit plans, to be effective on the policyholder's next anniversary occurring on or after the effective dates shown.

Groups that renew from 7/1/2013 to 9/30/2013 will have an increase of 5.9%. Groups that renew from 10/1/2013 to 12/31/2013 will have an increase of 9.6%. Groups that renew from 1/1/2014 to 3/31/2014 will have an increase of 13.5%. Groups that renew from 4/1/2014 to 6/30/2014 will have an increase of 16.3%.

| Effective Date | Proposed Rate Increases | Policyholders | Members |
|----------------|-------------------------|---------------|---------|
| 07/01/2013 | 5.9% | 8 | 17,980 |
| 10/01/2013 | 9.6% | 15 | 686 |
| 01/01/2014 | 13.5% | 73 | 5,253 |
| 04/01/2014 | 16.3% | 9 | 243 |

In addition to the above increases, premium rates may also include allowances to cover additional costs related to new benefits required by State and Federal law.

The requested rate increases for Aetna's Large Group HMO plans are directly related to medical claim trend due to changes in unit costs and utilization. Trends were based on a review of large group data over the period March 2010 – October 2012. The table below reflects our cost trends:

| Utilization Trend | Unit Cost Trend | Other Trend | Total Trend |
|-------------------|-----------------|-------------|-------------|
| 6.4% | 3.9% | 0.0% | 10.3% |

Utilization represents the number of services per member per year across all medical expense categories. The utilization trend includes the availability and increased use of more complicated high-technology or other expensive health care equipment and procedures. Increase in Unit Cost represents the change in dollar amount per claim. Increases in Unit Cost reflect changes in our contracted rates and prescription drug costs as well as the price escalation due to usage of more intensive services or expensive technologies. Hospital unit cost is projected to increase at 6.0% and physician unit cost is projected to increase at 1.1%. Other Trend represents deductible leveraging. New York HMO plans do not contain deductibles.

EXHIBIT 3: NARRATIVE SUMMARY

Company Name: Aetna Health Inc. (NY)
NAIC Code: 95234
SERFF Tracking #: AETN-128841943

Our pricing projection and the resulting rate increases assume that 82.0% of premium is used for medical care. New York state law requires that at least 82% of premium must be used to pay medical member costs. The remaining 18.0% are used for administrative expenses, profit, taxes and the Health Insurer Fees and Reinsurance Contributions required by the Patient Protection and Affordable Care Act. Administrative costs include (but are not limited to) customer service, processing and paying claims, medical management programs, maintaining our provider networks, and complying with State and Federal regulations.

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

- Developing innovative new relationships with health care providers that compensate them for the quality of care they provide, and not the quantity.
- Creating medical management programs which address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

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

This Exhibit 3: Narrative Summary will be placed under the public Aetna.com link listed below:

<http://www.aetna.com/individuals-families-health-insurance/member-guidelines/stateprocess.html>

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

-- for Base Medical Plan with ROLLING Rate Structure

Aetna Health Inc. (NY)
Company submitting the rate adjustment request

95234
Company NAIC Code

AETN-128841943
SERFF tracking number

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

Base Medical Plan Rolling Rate Products

SERFF# AETN-128841943

| Policy Form # | Market Segment | Rating Region | Product Name | Product Street Name | Effective Date of New Rate | Effective Period of New Rate | Proposed Percentage Rate Change | | |
|------------------|----------------|---------------|---------------------------------|---------------------|----------------------------|------------------------------|---------------------------------|---------|--------------|
| | | | | | | | Lowest | Highest | Weighted Avg |
| HMO/NY GA-2 11/0 | LG | NY | Health Maintenance Organization | HMO | 07/01/2013 | Q3 2013 | 5.9% | 5.9% | 5.9% |
| HMO/NY GA-2 11/0 | LG | NY | Health Maintenance Organization | HMO | 10/01/2013 | Q4 2013 | 9.6% | 9.6% | 9.6% |
| HMO/NY GA-2 11/0 | LG | NY | Health Maintenance Organization | HMO | 01/01/2014 | Q1 2014 | 13.5% | 13.5% | 13.5% |
| HMO/NY GA-2 11/0 | LG | NY | Health Maintenance Organization | HMO | 04/01/2014 | Q2 2014 | 16.3% | 16.3% | 16.3% |

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

- for Drug Riders Available with Base Medical Products (ROLLING Rate Structure)

Aetna Health Inc. (NY)
Company submitting the rate adjustment request

95234
Company NAIC Code

AETN-128841943
SERFF tracking number

- => Use this Exhibit for the Drug Riders that are available for the base medical plan type policy forms/products with a ROLLING rate structure included in the rate adjustment submission.
- => The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
- => This form must be submitted as an Excel file and as a PDF file.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan. The effective date is the earliest date that proposed rate change will become effective. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure).
- => The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- => Provide a list of proposed rate changes for drug riders available with rolling rate base medical products. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => The "proposed percentage rate change" is just for the drug riders available with the indicated base medical product and excludes the impact of the base medical plan rates and non-drug riders.
The lowest, highest, and weighted average are just among the drug riders available to the indicated base medical product.
- => This is for the traditional drug riders, but not for minor drug related riders such as the inclusion of oral contraceptives.

Drug Riders Available With Rolling Rate Base Medical Products

SERFF:

AETN-128841943

| Base Medical Policy Form # | Market Segment | Rating Region | Drug Rider | Base Medical Product Name | Effective Date of New Rate | Effective Period of New Rate | Proposed Percentage Rate Change | | |
|----------------------------|----------------|---------------|------------------------|---------------------------------|----------------------------|------------------------------|---------------------------------|---------|--------------|
| | | | | | | | Lowest | Highest | Weighted Avg |
| HMO/NY GA-2 11/0 | LG | NY | HI NY RRXDRUGPLAN V001 | Health Maintenance Organization | 07/01/2013 | Q3 2013 | 5.9% | 5.9% | 5.9% |
| HMO/NY GA-2 11/0 | LG | NY | HI NY RRXDRUGPLAN V001 | Health Maintenance Organization | 10/01/2013 | Q4 2013 | 9.6% | 9.6% | 9.6% |
| HMO/NY GA-2 11/0 | LG | NY | HI NY RRXDRUGPLAN V001 | Health Maintenance Organization | 01/01/2014 | Q1 2014 | 13.5% | 13.5% | 13.5% |
| HMO/NY GA-2 11/0 | LG | NY | HI NY RRXDRUGPLAN V001 | Health Maintenance Organization | 04/01/2014 | Q2 2014 | 16.3% | 16.3% | 16.3% |

EXHIBIT 4 - SUPPLEMENTAL EXHIBIT

Aetna Health Inc. (NY)
Company submitting the rate adjustment request

95234
Company NAIC Code

AETN-128841943
SERFF tracking number

- => If the subscriber will need to change to a different plan design at renewal (i.e., a required change from the current plan design whether mandated by a government entity or not, but not due to the discontinuation of the current policy form or discontinuation of a particular plan design), a supplement to Exhibit 4 is to be included.
- => This Exhibit is being used to indicate (i) a high level summary of the difference in covered benefits and cost sharing between the current and replacement plan, and (ii) the estimated pricing percentage change due solely to the difference in the plan designs between the replacement plan and the existing plan.
- => This supplemental exhibit is being submitted as an Adobe PDF file.

On June 18, 2012 The Department approved a forms and rate filing submission related to ACA - Preventative Care/Women's Wellness. The approved forms were:

HI NY AHCRPrevGestG 01
HI NY AContHCRPrevNG 01
HI NY AGrpHCRPrevG 01
HI NY AGrpHCRPrevNG 01

These forms support the following benefits moving to a "zero cost share" level for members:

Routine Physical Exams and Immunizations
Well Woman Preventive Visits
Screening & Counseling Services
Routine Cancer Screenings
Prenatal Care
Comprehensive Lactation Support & Counseling Services
Family Planning Services - Female Contraceptives

The legislation was effective 8/1/12 and, as such, all non-grandfathered plans with effective dates prior to July 2013 have moved to these benefits. All non-grandfathered plans with July 2013 effective dates are required to include the indicated benefits. The average medical/pharmacy combined premium change for plans impacted by these ACA driven changes is approximately 1.5%.

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

Company Name: Aetna Health Inc. (NY)
 NAIC Code: 95234
 SERFF Tracking #: AETN-128841943

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

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

SERFF#: AETN-128841943

| Effective Date | Effective Period | Market Segment | Rating Region | Product | Weighted Avg % | Total # of Members as of 11/31/2013 | Total # of Contracts as of 11/31/2013 | Number of (*) with Proposed Percentage Rate Change at Renewal | | | | | | | | | | |
|----------------|------------------|------------------------------|---------------|---------------------------------|----------------|-------------------------------------|---------------------------------------|---|-----------|-------------|-------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| | | | | | | | | Decrease | No Change | 0.1% - 4.9% | 5.0% - 9.9% | 10.0% - 14.9% | 15.0% - 19.9% | 20.0% - 24.9% | 25.0% - 29.9% | 30.0% - 39.9% | 40.0% - 49.9% | 50.0% or higher |
| 07/01/2013 | Q3 2013 | LG | NY | Health Maintenance Organization | 5.9% | N/A | 8814 | 0 | 0 | 0 | 8,814 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Market Segment Total: | | Total | 5.9% | N/A | 8814 | 0 | 0 | 0 | 8,814 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10/01/2013 | Q4 2013 | LG | NY | Health Maintenance Organization | 9.6% | N/A | 305 | 0 | 0 | 0 | 305 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Market Segment Total: | | Total | 9.6% | N/A | 305 | 0 | 0 | 0 | 305 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 01/01/2014 | Q1 2014 | LG | NY | Health Maintenance Organization | 13.5% | N/A | 2577 | 0 | 0 | 0 | 0 | 2,577 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Market Segment Total: | | Total | 13.5% | N/A | 2577 | 0 | 0 | 0 | 0 | 2,577 | 0 | 0 | 0 | 0 | 0 | 0 |
| 04/01/2014 | Q2 2014 | LG | NY | Health Maintenance Organization | 16.3% | N/A | 119 | 0 | 0 | 0 | 0 | 0 | 119 | 0 | 0 | 0 | 0 | 0 |
| | | Market Segment Total: | | Total | 16.3% | N/A | 119 | 0 | 0 | 0 | 0 | 0 | 119 | 0 | 0 | 0 | 0 | 0 |

EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: Aetna Health Inc. (NY)

NAIC Code: 95234

SERFF Number: AETN-128841943

Instructions:

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

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

| Filing Status | SERFF # | NY State Tracking # | Date of Submission | Policy Form # | Product Name (including Street Name) | Brief Description of Benefit/Rate Change | Approval Date |
|---------------|-----------------|---------------------|--------------------|---|--------------------------------------|--|---------------|
| Approved | AENX-G128093127 | 2012020103 | 02/05/2012 | HI NY ACOCTransGender V001 | Health Maintenance Organization, HMO | Coverage for Transgender benefits | 03/20/2012 |
| Approved | AENX-G128264560 | 2012040087 | 04/12/2012 | HI AHCRPrevGest 01, HI AContHCRPrevNG 01, HI AGrpHCRPrevG 01, HI AGrpHCRPrevNG 01 | Health Maintenance Organization, HMO | Preventive Care Amendments – HCR | 06/18/2012 |
| Approved | AENX-G128723641 | 2012100090 | 11/12/2012 | HI NY AAUTISM0ABA V001. | Health Maintenance Organization, HMO | Autism Mandate | 01/10/2013 |

Exhibit 7: Historical Data by Each Policy Form Included in Rate Adjustment Filing

Company Name: Aetna Health Inc. (NY)
 NAIC Code: 95234
 SERFF Number: AETN-128841943

| Data Item for Specified Base Medical Policy Form | | | | | | | | | | | | | | |
|--|------------------------------------|---|------------------------------|---|------------------------------------|---|--|---|--|---|---|--|--|--|
| 1a. Base medical policy form number | 1b. Product Name as in Rate Manual | 1c. Product Street Name as indicated to consumers | 2. Rating Pool Identifier | 3. Effective date of rate change (MM/DD/YY) | 4. Market Segment [drop down menu] | 5. Product type (see above for examples) [drop down menu] | 6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu] | 7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu] | 8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu] | 9. Rate guarantee period incorporated into rate tables (months) (e.g., 12, for a 12 month rate guarantee period; or 0, if no rate guarantee period.) | 10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders) | 11. Number of policyholders affected by rate change. (For group business this is number of groups.) | 12. Number of covered lives affected by rate change | 13. Expected NY statewide loss ratio for base medical policy form including associated riders |
| HMO/NY GA-2 11/01 (HMO) | Health Maintenance Organization | HMO | LG AHI | 07/01/13 | LG | HMO | Yes | No | Open | 12 | 5.9% | 105 | 24,162 | 82.1% |

Exhibit 7: Historical Data by Each Policy Form Included in Rate Adjustment Filing

| | | Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders) | | | | | | | | | | | | | | | | | | | | | |
|--|------------------------------------|--|---|---|--|---|--|--|---|---|---|---|---|---|---|--|--|---|--|---|---|--|-------|
| 1a. Base medical policy form number | 1b. Product Name as in Rate Manual | 14.1 Beginning Date of the experience period (MM/DD/YYYY) | 14.2 Ending Date of the experience period (MM/DD/YYYY) | 14.3 Member months for experience period | 14.4 Earned premiums for experience period (\$) | 14.5 Standardized earned premiums for experience period (\$) | 14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$) | 14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$) | 14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$) | 14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$) | 14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$) | 14.11 Earned premiums for experience period (\$pmpm) | 14.12 Standardized premiums for experience period (\$pmpm) | 14.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$pmpm) | 14.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$pmpm) | 14.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$pmpm) | 14.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$pmpm) | 14.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$pmpm) | 14.18 Ratio: Col 14.7/ Col 14.4 (Incurred Claims / Earned Premiums) | 14.19 Ratio: Col 14.7/ Col 14.5 (Incurred Claims / Standardized Earned Premiums) | 14.20 Ratio: Col 14.10/ Col 14.4 (Administration Expenses / Earned Premiums) | 14.21 Ratio: (Col 14.7 + Col 14.8 + Col 14.10) / Col 14.4 | |
| HMO/NY GA-2 11/01 (HMO) | Health Maintenance Organization | XX | 08/01/11 | 07/31/12 | 311,808 | 182,075,882 | 196,751,503 | 140,688,952 | 141,698,519 | 0 | 0 | 22,221,270 | 583.94 | 631.00 | 451.20 | 454.44 | 0.00 | 0.00 | 71.27 | 0.778 | 0.720 | 0.122 | 0.900 |

Exhibit 7: Historical Data by Each Policy Form Included in Rate Adjustment Filing

| | | First Prior Experience Period (NY statewide experience, base medical policy form + associated riders) | | | | | | | | | | | | | | | | | | | | | |
|--|------------------------------------|--|---|---|--|---|--|--|---|---|---|--|--|--|--|---|---|--|--|---|---|--|-------|
| 1a. Base medical policy form number | 1b. Product Name as in Rate Manual | 15.1 Beginning date of the experience period (MM/DD/YYYY) | 15.2 Ending Date of the experience period (MM/DD/YYYY) | 15.3 Member months for experience period | 15.4 Earned premiums for experience period (\$) | 15.5 Standardized earned premiums for experience period (\$) | 15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$) | 15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$) | 15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$) | 15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$) | 15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$) | 15.11 Earned premiums for experience period (\$mpm) | 15.12 Standardized premiums for experience period (\$mpm) | 15.13 Paid claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 15.14 Incurred claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 15.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm) | 15.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm) | 15.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm) | 15.18 Ratio: Col 15.7/ Col 15.4 (Incurred Claims / Earned Premiums) | 15.19 Ratio: Col 15.7/ Col 15.5 (Incurred Claims / Standardized Earned Premiums) | 15.20 Ratio: Col 15.10/ Col 15.4 (Administration Expenses / Earned Premiums) | 15.21 Ratio: (Col 15.7 + Col 15.8 + Col 15.10) / Col 15.4 | |
| HMO/NY GA-2 11/01 (HMO) | Health Maintenance Organization | XX | 08/01/10 | 07/31/11 | 370,651 | 197,097,755 | 223,082,475 | 152,927,297 | 153,063,304 | 0 | 0 | 24,054,600 | 531.76 | 601.87 | 412.59 | 412.96 | 0.00 | 0.00 | 64.90 | 0.777 | 0.686 | 0.122 | 0.899 |

Exhibit 7: Historical Data by Each Policy Form Included in Rate Adjustment Filing

| | | Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders) | | | | | | | | | | | | | | | | | | | | | |
|--|------------------------------------|---|---|---|--|---|--|--|---|--|---|--|--|--|--|---|--|--|---|--|--|--|-------|
| 1a. Base medical policy form number | 1b. Product Name as in Rate Manual | 16.1 Beginning date of the experience period (MM/DD/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 the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$) | 16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$) | 16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$) | 16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value) (\$) | 16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$) | 16.11 Earned premiums for experience period (\$mpm) | 16.12 Standardized premiums for experience period (\$mpm) | 16.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 16.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 16.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm) | 16.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value) (\$mpm) | 16.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm) | 16.18 Ratio: Col 16.7/Col 16.4 (Incurred Claims / Earned Premiums) | 16.19 Ratio: Col 16.7/Col 16.5 (Incurred Claims / Standardized Earned Premiums) | 16.20 Ratio: Col 16.10/Col 16.4 (Administrative Expenses / Earned Premiums) | 16.21 Ratio: (Col 16.7 + Col 16.9 + Col 16.10) / Col 16.4 | |
| HMO/NY GA-2 11/01 (HMO) | Health Maintenance Organization | XX | 08/01/09 | 07/31/10 | 459,601 | 216,775,700 | 290,402,976 | 167,839,373 | 167,909,040 | 0 | 0 | 26,456,175 | 471.66 | 631.86 | 365.18 | 365.34 | 0.00 | 0.00 | 57.56 | 0.775 | 0.578 | 0.122 | 0.897 |

Exhibit 7: Historical Data by Each Policy Form Included in Rate Adjustment Filing

| 1a. Base medical policy form number | 1b. Product Name as in Rate Manual | Annualized Medical Trend Factors Assumed in Rate Development (%) | | | | Ratios: Most Recent Experience Period to First Prior Period | | | | | | Ratios: First Prior Period to Second Prior Period | | | | | | Ratio: Standard Premium to Earned Premium | | | | | | |
|--|------------------------------------|--|----------------------------|--------------------------|---|---|---------------------------------|---------------------------------------|---|---|---|---|---------------------------------|---------------------------------------|---|---|---|---|---------------------------------------|--|----|-------|-------|-------|
| | | 17.1 All benefits combined, composite | 17.2 Due to utilization | 17.3 Due to unit cost | 17.4 Due to case mix/intensity/other | 18.1 Member months | 18.2 Earned premiums (\$mpm) | 18.3 Standardized premiums (\$mpm) | 18.4 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 18.5 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 18.6 Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm) | 19.1 Member months | 19.2 Earned premiums (\$mpm) | 19.3 Standardized premiums (\$mpm) | 19.4 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 19.5 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm) | 19.6 Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm) | 20.1 Most Recent Experience Period | 20.2 First Prior Experience Period | 20.3 Second Prior Experience Period | | | | |
| HMO/NY GA-2 11/01 (HMO) | Health Maintenance Organization | XX | 10.3% | 6.41% | 3.86% | 0.00% | XX | 0.841 | 1.098 | 1.048 | 1.094 | 1.100 | 1.098 | XX | 0.806 | 1.127 | 0.953 | 1.130 | 1.130 | 1.127 | XX | 1.081 | 1.132 | 1.340 |

Exhibit 7A: Development of Standardized Premium

Select Accounts

| DOS Month | Cohort | | | | | | | | | | | |
|-----------|-----------|--------|--------|--------|--------|--------|---------|-------|--------|---------|---------|--------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Aug-09 | 1,016,393 | 60,780 | 46,399 | 82,485 | 84,408 | 52,814 | 187,577 | 9,759 | 67,716 | 177,507 | 58,555 | 85,742 |
| Sep-09 | 1,013,068 | 59,650 | 43,801 | 81,419 | 82,337 | 57,943 | 191,689 | 9,677 | 73,903 | 174,600 | 57,629 | 84,013 |
| Oct-09 | 999,946 | 59,174 | 43,449 | 78,449 | 82,914 | 56,695 | 190,415 | 9,600 | 67,788 | 227,314 | 57,701 | 85,525 |
| Nov-09 | 995,215 | 57,650 | 42,687 | 75,263 | 81,480 | 55,503 | 188,622 | 9,057 | 68,613 | 225,806 | 63,065 | 86,243 |
| Dec-09 | 968,851 | 56,281 | 44,453 | 72,142 | 77,383 | 54,663 | 187,716 | 8,823 | 69,747 | 219,296 | 60,849 | 79,726 |
| Jan-10 | 880,511 | 53,763 | 43,715 | 69,065 | 73,628 | 51,522 | 172,852 | 6,411 | 75,182 | 205,107 | 57,522 | 65,139 |
| Feb-10 | 971,561 | 47,344 | 54,429 | 69,061 | 72,484 | 49,902 | 72,685 | 6,397 | 75,403 | 200,057 | 53,164 | 64,340 |
| Mar-10 | 957,022 | 44,881 | 60,635 | 66,284 | 70,803 | 48,370 | 70,620 | 6,288 | 74,937 | 197,264 | 53,184 | 63,477 |
| Apr-10 | 958,599 | 43,381 | 61,926 | 61,042 | 72,251 | 50,228 | 72,167 | 6,349 | 75,732 | 200,396 | 55,213 | 63,547 |
| May-10 | 951,125 | 45,012 | 61,259 | 61,062 | 55,325 | 49,966 | 70,639 | 6,277 | 76,490 | 197,281 | 53,401 | 64,476 |
| Jun-10 | 953,000 | 44,513 | 60,652 | 61,414 | 55,604 | 7,222 | 68,193 | 6,307 | 76,515 | 200,871 | 54,247 | 64,008 |
| Jul-10 | 931,814 | 36,078 | 56,963 | 63,108 | 55,371 | 7,202 | 64,875 | 6,726 | 74,954 | 199,442 | 54,727 | 60,922 |
| Aug-10 | 999,130 | 40,783 | 66,083 | 69,632 | 61,526 | 8,531 | 71,512 | 2,920 | 83,814 | 224,763 | 60,229 | 70,635 |
| Sep-10 | 652,506 | 25,080 | 37,824 | 40,298 | 39,355 | 3,676 | 47,310 | 1,156 | 60,436 | 140,792 | 36,909 | 39,718 |
| Oct-10 | 484,107 | 17,773 | 24,120 | 24,051 | 29,208 | 2,243 | 38,001 | 291 | 40,742 | 114,021 | 24,862 | 24,956 |
| Nov-10 | 913,169 | 35,196 | 57,229 | 58,868 | 54,199 | 8,441 | 39,885 | 1,757 | 47,691 | 170,000 | 64,544 | 62,660 |
| Dec-10 | 677,430 | 24,905 | 38,338 | 39,413 | 39,686 | 5,061 | 31,130 | 835 | 33,732 | 132,007 | 76,844 | 39,755 |
| Jan-11 | 713,735 | 34,492 | 56,472 | 60,359 | 53,939 | 6,780 | 40,060 | 1,775 | 47,862 | 99,904 | 120,405 | 59,278 |
| Feb-11 | 704,837 | 36,637 | 59,389 | 57,074 | 53,077 | 6,592 | 39,847 | 1,764 | 47,295 | 100,335 | 120,209 | 59,785 |
| Mar-11 | 708,376 | 26,726 | 79,374 | 58,076 | 50,727 | 6,664 | 40,799 | 1,772 | 46,577 | 97,896 | 118,998 | 61,194 |
| Apr-11 | 702,703 | 25,275 | 80,474 | 57,867 | 50,746 | 7,037 | 40,806 | 1,774 | 46,093 | 97,951 | 116,647 | 60,936 |
| May-11 | 704,915 | 26,004 | 78,973 | 57,881 | 19,125 | 7,045 | 41,423 | 1,772 | 46,750 | 98,853 | 113,438 | 61,510 |
| Jun-11 | 698,180 | 26,047 | 79,582 | 58,014 | 5,519 | 6,137 | 41,481 | 1,777 | 46,774 | 98,283 | 112,275 | 62,503 |
| Jul-11 | 697,177 | 26,067 | 78,534 | 54,968 | 5,521 | 6,006 | 22,137 | 1,778 | 47,992 | 102,197 | 112,841 | 59,654 |
| Aug-11 | 696,291 | 26,024 | 76,749 | 54,914 | 5,513 | 5,806 | 24,212 | 1,671 | 49,468 | 94,932 | 115,753 | 58,447 |
| Sep-11 | 701,478 | 26,024 | 75,125 | 54,858 | 5,513 | 4,763 | 24,214 | 1,671 | 49,819 | 97,208 | 116,597 | 56,875 |
| Oct-11 | 697,331 | 25,924 | 76,762 | 54,614 | 5,494 | 5,356 | 22,847 | 1,664 | 49,663 | 34,772 | 117,378 | 55,324 |
| Nov-11 | 700,483 | 25,894 | 76,722 | 54,574 | 5,489 | 5,349 | 22,180 | 1,662 | 49,695 | 34,794 | 75,686 | 57,168 |
| Dec-11 | 698,988 | 25,863 | 74,515 | 55,192 | 5,484 | 5,343 | 20,147 | 1,660 | 50,038 | 34,751 | 77,037 | 28,598 |
| Jan-12 | 439,280 | 26,030 | 75,519 | 61,945 | 3,517 | 6,595 | 21,573 | 1,671 | 50,097 | 25,875 | 78,768 | 29,976 |
| Feb-12 | 440,031 | 31,849 | 76,403 | 63,271 | 3,517 | 6,595 | 19,986 | 1,671 | 49,101 | 27,343 | 77,694 | 30,190 |
| Mar-12 | 441,842 | 31,849 | 68,112 | 64,968 | 5,484 | 6,592 | 20,244 | 1,671 | 48,960 | 27,349 | 77,946 | 31,095 |
| Apr-12 | 442,828 | 31,849 | 65,629 | 86,575 | 5,484 | 6,595 | 20,228 | 1,671 | 50,233 | 27,351 | 79,830 | 30,163 |
| May-12 | 461,239 | 31,854 | 63,493 | 86,682 | 8,247 | 6,595 | 20,909 | 1,671 | 45,442 | 26,830 | 79,432 | 30,265 |
| Jun-12 | 446,496 | 32,650 | 65,687 | 86,764 | 8,228 | 4,256 | 18,772 | 1,194 | 44,367 | 26,828 | 78,623 | 31,488 |
| Jul-12 | 439,072 | 31,830 | 64,936 | 86,649 | 7,829 | 4,268 | 18,170 | 476 | 43,797 | 25,352 | 80,389 | 28,322 |

| DOS Month | Cohort | | | | | | | | | | | |
|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Aug-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 152.8% | 157.9% | 157.9% | 157.9% |
| Sep-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 157.9% | 157.9% | 157.9% |
| Oct-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 157.9% | 157.9% |
| Nov-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 157.9% |
| Dec-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Jan-10 | 124.2% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Feb-10 | 124.2% | 124.2% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Mar-10 | 124.2% | 124.2% | 124.2% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Apr-10 | 124.2% | 124.2% | 124.2% | 124.9% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| May-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Jun-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Jul-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Aug-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 142.1% | 132.2% | 132.2% | 132.2% |
| Sep-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 132.2% | 132.2% | 132.2% |
| Oct-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 132.2% | 132.2% |
| Nov-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 132.2% |
| Dec-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Jan-11 | 112.0% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Feb-11 | 112.0% | 112.0% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Mar-11 | 112.0% | 112.0% | 112.0% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Apr-11 | 112.0% | 112.0% | 112.0% | 112.0% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| May-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Jun-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Jul-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Aug-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 112.0% | 112.0% | 112.0% | 112.0% |
| Sep-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 112.0% | 112.0% | 112.0% |
| Oct-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 112.0% | 112.0% |
| Nov-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 112.0% |
| Dec-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jan-12 | 103.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Feb-12 | 103.0% | 103.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Mar-12 | 103.0% | 103.0% | 103.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Apr-12 | 103.0% | 103.0% | 103.0% | 100.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| May-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jun-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 100.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jul-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 100.0% | 100.0% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |

| Period | Increases | | | | | | | | | | | | | | | | |
|--------|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | 4q08 | 1q09 | 2q09 | 3q09 | 4q09 | 1q10 | 2q10 | 3q10 | 4q10 | 1q11 | 2q11 | 3q11 | 4q11 | 1q12 | 2q12 | 3q12 | 4q12 |
| QTRLY | -3.2% | 6.8% | 2.8% | 1.2% | 7.5% | 6.4% | -0.6% | 11.5% | 0.0% | 0.0% | 0.0% | 2.6% | 3.0% | 3.0% | 3.0% | 0.0% | 0.0% |
| Cum | 152.8% | 157.9% | 147.9% | 143.8% | 142.1% | 132.2% | 124.2% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 106.0% | 103.0% | 100.0% | 100.0% |

| Time Period | Standardized Premium | | | | | | | | | | | | Total |
|------------------|----------------------|---------|---------|-----------|-----------|---------|-----------|---------|-----------|-----------|-----------|-----------|------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 15,585,526 | 837,970 | 845,987 | 1,162,587 | 1,211,166 | 776,851 | 2,024,283 | 130,286 | 1,253,658 | 3,296,454 | 942,710 | 1,234,205 | 29,301,685 |
| 8/1/10 - 7/31/11 | 10,149,768 | 408,131 | 866,185 | 765,484 | 573,926 | 91,127 | 553,153 | 21,699 | 692,566 | 1,728,175 | 1,232,290 | 782,125 | 17,864,627 |
| 8/1/11 - 7/31/12 | 7,117,047 | 372,025 | 933,205 | 866,738 | 75,263 | 75,265 | 275,044 | 20,036 | 635,297 | 523,983 | 1,139,576 | 509,713 | 12,543,191 |

| Time Period | Earned Premium | | | | | | | | | | | | Total |
|------------------|----------------|---------|---------|---------|---------|---------|-----------|--------|---------|-----------|---------|---------|------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 11,597,103 | 608,508 | 620,369 | 840,784 | 863,989 | 542,030 | 1,438,050 | 91,671 | 876,980 | 2,424,944 | 679,255 | 867,158 | 21,450,841 |
| 8/1/10 - 7/31/11 | 8,656,265 | 344,984 | | | | | | | | | | | |

Exhibit 7A: Development of Standardized Premium

Select Accounts

| DOS Month | Cohort | | | | | | | | | | | |
|-----------|-----------|-----|---------|--------|--------|--------|--------|--------|---------|--------|--------|-------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Aug-09 | 2,152,773 | 0 | 314,827 | 19,286 | 28,830 | 18,377 | 77,572 | 13,616 | 97,431 | 15,527 | 10,672 | 1,334 |
| Sep-09 | 2,158,186 | 0 | 316,160 | 19,289 | 28,816 | 16,688 | 74,975 | 13,558 | 121,481 | 13,933 | 10,674 | 1,334 |
| Oct-09 | 2,147,955 | 0 | 316,752 | 19,317 | 28,832 | 14,530 | 72,501 | 13,075 | 122,931 | 17,074 | 10,681 | 1,335 |
| Nov-09 | 2,136,036 | 0 | 318,649 | 10,182 | 30,278 | 17,052 | 67,809 | 13,065 | 119,680 | 17,051 | 11,158 | 1,334 |
| Dec-09 | 2,056,658 | 0 | 305,626 | 9,887 | 29,217 | 16,148 | 64,338 | 12,121 | 115,584 | 15,337 | 10,811 | 1,431 |
| Jan-10 | 1,204,665 | 0 | 163,707 | 5,850 | 28,683 | 16,048 | 31,705 | 11,556 | 114,390 | 12,335 | 7,168 | 1,391 |
| Feb-10 | 1,195,179 | 0 | 162,042 | 3,295 | 28,429 | 15,918 | 29,343 | 11,332 | 112,255 | 12,228 | 7,110 | 1,382 |
| Mar-10 | 1,188,788 | 0 | 0 | 3,112 | 27,718 | 15,752 | 29,073 | 13,360 | 111,789 | 12,168 | 7,078 | 1,378 |
| Apr-10 | 1,169,802 | 0 | 0 | 635 | 27,058 | 15,933 | 27,540 | 13,686 | 110,109 | 12,657 | 5,361 | 1,371 |
| May-10 | 1,089,826 | 0 | 0 | 564 | 28,297 | 12,348 | 21,939 | 15,635 | 102,410 | 12,261 | 4,971 | 1,300 |
| Jun-10 | 1,156,469 | 0 | 0 | 317 | 30,879 | 8,479 | 25,880 | 17,556 | 114,235 | 13,277 | 5,362 | 1,371 |
| Jul-10 | 1,103,289 | 0 | 0 | 289 | 28,652 | 7,354 | 2,487 | 16,505 | 110,648 | 11,867 | 5,045 | 1,313 |
| Aug-10 | 1,324,562 | 0 | 0 | 394 | 30,782 | 9,467 | 3,434 | 11,598 | 135,593 | 13,921 | 6,201 | 1,523 |
| Sep-10 | 385,657 | 0 | 0 | 210 | 7,529 | -739 | -559 | 505 | 8,602 | 2,733 | 1,320 | 636 |
| Oct-10 | 1,053,086 | 0 | 0 | 1,087 | 25,326 | 6,536 | 2,292 | 8,427 | 20,416 | 15,035 | 4,805 | 3,171 |
| Nov-10 | 801,492 | 0 | 0 | 808 | 18,897 | 3,343 | 1,481 | 5,147 | 16,321 | 11,791 | 4,216 | 2,450 |
| Dec-10 | 999,513 | 0 | 0 | 1,211 | 25,370 | 4,767 | 2,413 | 7,385 | 22,036 | 14,893 | 5,055 | 3,155 |
| Jan-11 | 1,190,144 | 0 | 0 | 1,302 | 32,487 | 6,541 | 3,457 | 10,364 | 24,804 | 18,382 | 5,994 | 4,480 |
| Feb-11 | 1,193,906 | 0 | 0 | 1,252 | 32,122 | 7,013 | 3,325 | 10,033 | 24,940 | 17,998 | 5,875 | 4,388 |
| Mar-11 | 1,217,394 | 0 | 0 | 1,313 | 32,996 | 7,719 | 3,461 | 10,371 | 24,929 | 17,977 | 5,998 | 4,483 |
| Apr-11 | 1,212,273 | 0 | 0 | 0 | 31,692 | 9,174 | 4,831 | 9,058 | 24,270 | 17,967 | 6,001 | 3,786 |
| May-11 | 1,204,675 | 0 | 0 | 0 | 35,053 | 8,473 | 4,827 | 9,051 | 24,260 | 17,959 | 5,999 | 3,784 |
| Jun-11 | 1,204,980 | 0 | 0 | 0 | 35,107 | 8,921 | 4,839 | 9,066 | 23,583 | 17,994 | 6,005 | 0 |
| Jul-11 | 1,200,798 | 0 | 0 | 0 | 34,319 | 8,903 | 3,280 | 9,055 | 22,276 | 17,971 | 6,666 | 0 |
| Aug-11 | 1,199,182 | 0 | 0 | 0 | 34,351 | 9,372 | 3,281 | 4,648 | 22,841 | 17,985 | 6,667 | 0 |
| Sep-11 | 1,202,791 | 0 | 0 | 0 | 35,449 | 10,366 | 3,287 | 4,655 | 11,401 | 18,009 | 6,678 | 0 |
| Oct-11 | 1,193,743 | 0 | 0 | 0 | 36,150 | 9,892 | 4,220 | 4,651 | 11,390 | 17,111 | 6,673 | 0 |
| Nov-11 | 1,194,555 | 0 | 0 | 0 | 36,128 | 10,797 | 4,215 | 4,648 | 10,976 | 17,095 | 6,800 | 0 |
| Dec-11 | 1,183,707 | 0 | 0 | 0 | 33,055 | 10,332 | 4,183 | 4,622 | 10,924 | 17,017 | 6,771 | 0 |
| Jan-12 | 807,319 | 0 | 0 | 0 | 33,247 | 12,190 | 4,215 | 4,648 | 10,976 | 17,130 | 6,800 | 0 |
| Feb-12 | 805,566 | 0 | 0 | 0 | 30,777 | 13,750 | 4,215 | 4,648 | 11,699 | 17,124 | 6,801 | 0 |
| Mar-12 | 826,726 | 0 | 0 | 0 | 33,788 | 13,663 | 4,215 | 4,647 | 11,706 | 17,124 | 6,801 | 0 |
| Apr-12 | 823,057 | 0 | 0 | 0 | 35,537 | 12,309 | 4,215 | 4,657 | 13,683 | 18,248 | 6,801 | 0 |
| May-12 | 813,813 | 0 | 0 | 0 | 34,369 | 12,310 | 4,215 | 4,657 | 14,395 | 7,592 | 6,801 | 0 |
| Jun-12 | 809,383 | 0 | 0 | 0 | 32,780 | 401 | 738 | 4,657 | 14,398 | 5,138 | 6,801 | 0 |
| Jul-12 | 815,663 | 0 | 0 | 0 | 38,599 | 401 | 5,077 | 4,657 | 14,398 | 5,138 | 6,801 | 0 |

| DOS Month | Cohort | | | | | | | | | | | |
|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Aug-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 152.8% | 157.9% | 157.9% | 157.9% |
| Sep-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 157.9% | 157.9% | 157.9% |
| Oct-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 157.9% | 157.9% |
| Nov-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 157.9% |
| Dec-09 | 147.9% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Jan-10 | 124.2% | 147.9% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Feb-10 | 124.2% | 124.2% | 147.9% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Mar-10 | 124.2% | 124.2% | 124.2% | 143.8% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Apr-10 | 124.2% | 124.2% | 124.2% | 124.9% | 143.8% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| May-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 143.8% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Jun-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 142.1% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Jul-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 142.1% | 142.1% | 132.2% | 132.2% | 132.2% |
| Aug-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 142.1% | 132.2% | 132.2% | 132.2% |
| Sep-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 132.2% | 132.2% | 132.2% |
| Oct-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 132.2% | 132.2% |
| Nov-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 132.2% |
| Dec-10 | 124.2% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Jan-11 | 112.0% | 124.2% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Feb-11 | 112.0% | 112.0% | 124.2% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Mar-11 | 112.0% | 112.0% | 112.0% | 124.9% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Apr-11 | 112.0% | 112.0% | 112.0% | 112.0% | 124.9% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| May-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Jun-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Jul-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% |
| Aug-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 112.0% | 112.0% | 112.0% | 112.0% |
| Sep-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 112.0% | 112.0% | 112.0% |
| Oct-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 112.0% | 112.0% |
| Nov-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 112.0% |
| Dec-11 | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jan-12 | 103.0% | 112.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Feb-12 | 103.0% | 103.0% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Mar-12 | 103.0% | 103.0% | 103.0% | 112.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Apr-12 | 103.0% | 103.0% | 103.0% | 100.0% | 112.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| May-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 112.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jun-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 100.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jul-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 100.0% | 100.0% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |

| Period | Increases | | | | | | | | | | | | | | | | |
|--------|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | 4q08 | 1q09 | 2q09 | 3q09 | 4q09 | 1q10 | 2q10 | 3q10 | 4q10 | 1q11 | 2q11 | 3q11 | 4q11 | 1q12 | 2q12 | 3q12 | 4q12 |
| QTRLY | -2.9% | 6.9% | 2.8% | 1.4% | 7.4% | 6.5% | -0.5% | 11.6% | 0.0% | 0.0% | 0.0% | 2.6% | 3.0% | 3.0% | 3.0% | 0.0% | 0.0% |
| Cum | 152.8% | 157.9% | 147.9% | 143.8% | 142.1% | 132.2% | 124.2% | 124.9% | 112.0% | 112.0% | 112.0% | 112.0% | 109.2% | 106.0% | 103.0% | 100.0% | 100.0% |

| Time Period | Standardized Premium | | | | | | | | | | | | Total |
|------------------|----------------------|-----|-----------|---------|---------|---------|---------|---------|-----------|---------|---------|--------|------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 25,820,607 | 0 | 2,806,202 | 132,012 | 480,569 | 245,287 | 745,632 | 234,596 | 1,933,298 | 305,985 | 135,270 | 22,884 | 32,862,343 |
| 8/1/10 - 7/31/11 | 15,104,174 | 0 | 0 | 9,464 | 413,282 | 97,767 | 41,443 | 112,081 | 457,552 | 210,149 | 74,325 | 37,255 | 16,557,491 |
| 8/1/11 - 7/31/12 | 12,561,614 | 0 | 0 | 0 | 451,257 | 129,584 | 49,833 | 60,907 | 173,989 | 187,381 | 87,282 | 0 | 13,701,848 |

| Time Period | Earned Premium | | | | | | | | | | | | Total |
|------------------|----------------|-----|-----------|--------|---------|---------|---------|---------|-----------|---------|--------|--------|------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 18,759,625 | 0 | 1,897,762 | 92,023 | 345,690 | 172,628 | 525,161 | 165,064 | 1,352,941 | 225,715 | 96,092 | 16,272 | 23,648,973 |
| 8/1/10 - 7/31/11 | 12,988,480 | 0 | 0 | 7,578 | 341,681 | 80,117 | 37,082 | 100,061 | 372,030 | 184,620 | 64,135 | 31,858 | 14,207,641 |
| 8/1/11 - 7/31/12 | 11,675,505 | 0 | 0 | 0 | 414,231 | 115,783 | 46,077 | 55,795 | 158,789 | 174,711 | 81,197 | 0 | 12,722,087 |

Exhibit 7A: Development of Standardized Premium

National Accounts

| DOS Month | Cohort | | | | | | | | | | | |
|-----------|-----------|-----|---------|-------|-----|-----|------------|-------|-----|---------|--------|-----|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Aug-09 | 2,893,980 | 0 | 0 | 0 | 0 | 0 | 12,076,445 | 2,416 | 0 | 137,191 | 28,911 | 0 |
| Sep-09 | 2,847,141 | 0 | 0 | 0 | 0 | 0 | 11,794,482 | 2,419 | 0 | 139,713 | 27,413 | 0 |
| Oct-09 | 2,823,169 | 0 | 0 | 0 | 0 | 0 | 11,991,178 | 2,377 | 0 | 114,895 | 25,242 | 0 |
| Nov-09 | 2,662,578 | 0 | 0 | 0 | 0 | 0 | 12,024,042 | 1,618 | 0 | 103,692 | 0 | 0 |
| Dec-09 | 2,759,725 | 0 | 0 | 0 | 0 | 0 | 11,853,850 | 1,714 | 0 | 105,415 | 0 | 0 |
| Jan-10 | 2,542,084 | 0 | 128,994 | 2,392 | 0 | 0 | 10,958,914 | 1,671 | 0 | 91,996 | 0 | 0 |
| Feb-10 | 2,470,496 | 0 | 128,933 | 2,392 | 0 | 0 | 10,947,491 | 0 | 0 | 90,008 | 0 | 0 |
| Mar-10 | 2,364,914 | 0 | 151,495 | 2,386 | 0 | 0 | 10,886,908 | 0 | 0 | 79,351 | 0 | 0 |
| Apr-10 | 2,452,638 | 0 | 146,255 | 2,594 | 0 | 0 | 10,908,926 | 0 | 0 | 86,538 | 0 | 0 |
| May-10 | 2,445,930 | 0 | 145,026 | 2,594 | 0 | 0 | 10,902,815 | 0 | 0 | 84,691 | 0 | 0 |
| Jun-10 | 2,426,072 | 0 | 140,484 | 1,288 | 0 | 0 | 10,753,693 | 0 | 0 | 87,992 | 0 | 0 |
| Jul-10 | 2,418,818 | 0 | 134,679 | 649 | 0 | 0 | 13,176,317 | 0 | 0 | 87,854 | 0 | 0 |
| Aug-10 | 2,672,791 | 0 | 141,375 | 671 | 0 | 0 | 13,574,721 | 0 | 0 | 103,612 | 0 | 0 |
| Sep-10 | 1,732,799 | 0 | 132,556 | 642 | 0 | 0 | 12,780,090 | 0 | 0 | 28,423 | 0 | 0 |
| Oct-10 | 2,334,794 | 0 | 138,169 | 672 | 0 | 0 | 13,474,066 | 0 | 0 | 147,054 | 0 | 0 |
| Nov-10 | 2,178,349 | 0 | 138,880 | 676 | 0 | 0 | 13,510,377 | 0 | 0 | 120,913 | 0 | 0 |
| Dec-10 | 1,910,678 | 0 | 84,339 | 481 | 0 | 0 | 8,716,194 | 0 | 0 | 167,532 | 0 | 0 |
| Jan-11 | 2,202,769 | 0 | 126,583 | 660 | 0 | 0 | 10,918,455 | 0 | 0 | 163,101 | 0 | 0 |
| Feb-11 | 2,208,463 | 0 | 126,657 | 0 | 0 | 0 | 10,840,530 | 0 | 0 | 164,755 | 0 | 0 |
| Mar-11 | 2,257,864 | 0 | 140,786 | 0 | 0 | 0 | 11,181,082 | 0 | 0 | 176,655 | 0 | 0 |
| Apr-11 | 2,206,158 | 0 | 137,118 | 0 | 0 | 0 | 10,765,403 | 0 | 0 | 174,752 | 0 | 0 |
| May-11 | 2,203,450 | 0 | 137,861 | 0 | 0 | 0 | 10,716,359 | 0 | 0 | 179,593 | 0 | 0 |
| Jun-11 | 2,199,973 | 0 | 137,307 | 0 | 0 | 0 | 10,599,016 | 0 | 0 | 186,368 | 0 | 0 |
| Jul-11 | 1,977,099 | 0 | 137,504 | 0 | 0 | 0 | 11,145,349 | 0 | 0 | 149,306 | 0 | 0 |
| Aug-11 | 2,123,311 | 0 | 137,753 | 0 | 0 | 0 | 11,104,216 | 0 | 0 | 187,776 | 0 | 0 |
| Sep-11 | 2,159,151 | 0 | 137,045 | 0 | 0 | 0 | 11,060,629 | 0 | 0 | 205,674 | 0 | 0 |
| Oct-11 | 2,282,476 | 0 | 137,147 | 0 | 0 | 0 | 11,097,365 | 0 | 0 | 195,230 | 0 | 0 |
| Nov-11 | 2,284,741 | 0 | 136,092 | 0 | 0 | 0 | 11,073,204 | 0 | 0 | 187,547 | 0 | 0 |
| Dec-11 | 2,224,095 | 0 | 131,709 | 0 | 0 | 0 | 10,721,179 | 0 | 0 | 189,213 | 0 | 0 |
| Jan-12 | 2,133,552 | 0 | 129,824 | 0 | 0 | 0 | 10,383,341 | 0 | 0 | 185,231 | 0 | 0 |
| Feb-12 | 2,117,125 | 0 | 129,911 | 0 | 0 | 0 | 10,380,427 | 0 | 0 | 190,649 | 0 | 0 |
| Mar-12 | 2,116,327 | 0 | 141,865 | 0 | 0 | 0 | 10,356,056 | 0 | 0 | 195,886 | 0 | 0 |
| Apr-12 | 2,047,487 | 0 | 133,614 | 527 | 0 | 0 | 10,351,903 | 0 | 0 | 194,644 | 0 | 0 |
| May-12 | 2,042,949 | 0 | 133,523 | 527 | 0 | 0 | 10,312,698 | 0 | 0 | 194,540 | 0 | 0 |
| Jun-12 | 2,029,928 | 0 | 135,492 | 527 | 0 | 0 | 10,275,176 | 0 | 0 | 205,426 | 0 | 0 |
| Jul-12 | 2,058,960 | 0 | 134,171 | 527 | 0 | 0 | 11,030,651 | 0 | 0 | 214,257 | 0 | 0 |

| DOS Month | Cohort | | | | | | | | | | | |
|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Aug-09 | 140.0% | 140.0% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 145.4% | 150.6% | 150.6% | 150.6% |
| Sep-09 | 140.0% | 140.0% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 150.6% | 150.6% | 150.6% |
| Oct-09 | 140.0% | 140.0% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 150.6% | 150.6% |
| Nov-09 | 140.0% | 140.0% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 150.6% |
| Dec-09 | 140.0% | 140.0% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Jan-10 | 123.5% | 140.0% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Feb-10 | 123.5% | 123.5% | 140.0% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Mar-10 | 123.5% | 123.5% | 123.5% | 136.1% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Apr-10 | 123.5% | 123.5% | 123.5% | 124.3% | 136.1% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| May-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 136.1% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Jun-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 135.7% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Jul-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 135.7% | 135.7% | 131.5% | 131.5% | 131.5% |
| Aug-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 135.7% | 131.5% | 131.5% | 131.5% |
| Sep-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 131.5% | 131.5% | 131.5% |
| Oct-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 131.5% | 131.5% |
| Nov-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 131.5% |
| Dec-10 | 123.5% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Jan-11 | 111.9% | 123.5% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Feb-11 | 111.9% | 111.9% | 123.5% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Mar-11 | 111.9% | 111.9% | 111.9% | 124.3% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Apr-11 | 111.9% | 111.9% | 111.9% | 111.9% | 124.3% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| May-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Jun-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Jul-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% |
| Aug-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 111.9% | 111.9% | 111.9% | 111.9% |
| Sep-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 111.9% | 111.9% | 111.9% |
| Oct-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 111.9% | 111.9% |
| Nov-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 111.9% |
| Dec-11 | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jan-12 | 103.0% | 111.9% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Feb-12 | 103.0% | 103.0% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Mar-12 | 103.0% | 103.0% | 103.0% | 111.9% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Apr-12 | 103.0% | 103.0% | 103.0% | 100.0% | 111.9% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| May-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 111.9% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jun-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 100.0% | 109.2% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |
| Jul-12 | 103.0% | 103.0% | 103.0% | 100.0% | 100.0% | 100.0% | 100.0% | 109.2% | 109.2% | 106.0% | 106.0% | 106.0% |

| Period | Increases | | | | | | | | | | | | | | | | |
|--------|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | 4q08 | 1q09 | 2q09 | 3q09 | 4q09 | 1q10 | 2q10 | 3q10 | 4q10 | 1q11 | 2q11 | 3q11 | 4q11 | 1q12 | 2q12 | 3q12 | 4q12 |
| QTRLY | -3.5% | 7.6% | 2.8% | 0.3% | 3.2% | 6.4% | -0.6% | 11.1% | 0.0% | 0.0% | 0.0% | 2.5% | 3.0% | 3.0% | 3.0% | 0.0% | 0.0% |
| Cum | 145.4% | 150.6% | 140.0% | 136.1% | 135.7% | 131.5% | 123.5% | 124.3% | 111.9% | 111.9% | 111.9% | 111.9% | 109.2% | 106.0% | 103.0% | 100.0% | 100.0% |

| Time Period | Standardized Premium | | | | | | | | | | | | Total |
|------------------|----------------------|-----|-----------|--------|-----|-----|-------------|--------|-----|-----------|---------|-----|-------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 40,724,844 | 0 | 1,247,837 | 18,614 | 0 | 0 | 184,465,476 | 16,572 | 0 | 1,642,759 | 122,845 | 0 | 228,238,948 |
| 8/1/10 - 7/31/11 | 30,443,997 | 0 | 1,870,150 | 4,725 | 0 | 0 | 154,344,318 | 0 | 0 | 1,997,167 | 0 | 0 | 188,660,357 |
| 8/1/11 - 7/31/12 | 27,366,229 | 0 | 1,749,814 | 2,107 | 0 | 0 | 138,877,988 | 0 | 0 | 2,510,325 | 0 | 0 | 170,506,464 |

| Time Period | Earned Premium | | | | | | | | | | | | Total |
|------------------|----------------|-----|-----------|--------|-----|-----|-------------|--------|-----|-----------|--------|-----|-------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 31,107,544 | 0 | 975,867 | 14,295 | 0 | 0 | 138,275,062 | 12,215 | 0 | 1,209,337 | 81,566 | 0 | 171,675,886 |
| 8/1/10 - 7/31/11 | 26,085,187 | 0 | 1,579,133 | 3,801 | 0 | 0 | 138,221,642 | 0 | 0 | 1,762,063 | 0 | 0 | 167,651,827 |
| 8/1/11 - 7/31/12 | 25,620,102 | 0 | 1,618,146 | 2,107 | 0 | 0 | 128,146,845 | 0 | 0 | 2,346,075 | 0 | 0 | 157,733,276 |

All Segments Combined

| Time Period | Standardized Premium | | | | | | | | | | | | Total |
|------------------|----------------------|---------|-----------|-----------|-----------|-----------|-------------|---------|-----------|-----------|-----------|-----------|-------------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | |
| 8/1/09 - 7/31/10 | 82,130,977 | 837,970 | 4,900,027 | 1,313,213 | 1,691,735 | 1,022,138 | 187,235,392 | 381,455 | 3,186,956 | 5,245,198 | 1,200,825 | 1,257,090 | 290,402,976 |
| 8/1/10 - 7/31/11 | 55,697,938 | 408,131 | 2,736,334 | 779,673 | 987,207 | 188,894 | 154,938,914 | 133,780 | 1,150,118 | 3,935,491 | 1,306,615 | 819,379 | 223,082,475 |
| 8/1/11 - 7/31/12 | 47,044,890 | 372,025 | 2,683,019 | 868,845 | 526,520 | 204,849 | 139,202,865 | 80,943 | 809,286 | 3,221,689 | 1,226,858 | 509,713 | 196,751,503 |

Exhibit 7B: Development of Rate Action

| | <u>Period</u> | <u>Most Recent Experience</u> |
|-----------------------|------------------|-------------------------------|
| Earned Premium | 8/1/11 - 7/31/12 | 182,075,882 |
| Standardized Premium | To 3q13 | 196,751,503 |
| Completed Paid Claims | 8/1/11 - 7/31/12 | 141,698,519 |

| | <u>3Q13</u> | <u>4Q13</u> | <u>1Q14</u> | <u>2Q14</u> |
|-------------------------------|-------------|-------------|-------------|-------------|
| Quarterly Premium Change | 5.9% | 3.5% | 3.6% | 2.5% |
| Cumulative Premium Change | 1.0590 | 1.096 | 1.135 | 1.163 |
| Claims Trend | 1.1030 | 1.1030 | 1.1030 | 1.1030 |
| Claim Trend Months | 23.00 | 26.00 | 29.00 | 32.00 |
| Projected Premium | 208,359,842 | 215,639,647 | 223,312,956 | 228,821,998 |
| Projected Paid Claims | 170,989,081 | 175,231,531 | 179,579,242 | 184,034,825 |
| LossRatio | 82.1% | 81.3% | 80.4% | 80.4% |
| Expenses | 8.8% | 8.8% | 8.8% | 8.8% |
| Premium Taxes | 2.0% | 2.0% | 2.0% | 2.0% |
| Commissions | 1.4% | 1.4% | 1.4% | 1.4% |
| HIF/RC | <u>1.7%</u> | <u>2.5%</u> | <u>3.3%</u> | <u>3.3%</u> |
| Total Administrative Expenses | 13.9% | 14.7% | 15.5% | 15.5% |
| Pre-tax Profit | 4.0% | 4.0% | 4.1% | 4.1% |
| FIT/SIT* | 1.7% | 1.7% | 1.8% | 1.8% |
| AFIT profit | <u>2.3%</u> | <u>2.3%</u> | <u>2.3%</u> | <u>2.3%</u> |
| Total | 100.0% | 100.0% | 100.0% | 100.0% |

* FIT = Federal Income Tax, SIT = State Income Tax

Expenses, premium taxes and Commissions are the non-Fed portion of the Large group HMO expenses from the 2011 Data Requirements
HIF/RC reflect amounts for ACA assessments that did not exist in the experience period

Exhibit 7C: Trend

| Month | Total Member Months | Total RX Member Months | Medical PMPM | RX PMPM | 12 Month PMPM | 12 Month Trend |
|--------|---------------------|------------------------|--------------|---------|---------------|----------------|
| Jul-09 | 42,287 | 17,295 | 403.26 | 63.82 | | |
| Aug-09 | 42,087 | 17,171 | 372.39 | 61.49 | | |
| Sep-09 | 41,994 | 17,143 | 337.24 | 62.66 | | |
| Oct-09 | 41,907 | 17,105 | 382.86 | 66.52 | | |
| Nov-09 | 41,705 | 16,903 | 328.33 | 66.16 | | |
| Dec-09 | 41,597 | 16,852 | 335.98 | 70.18 | | |
| Jan-10 | 36,206 | 14,386 | 328.42 | 78.08 | | |
| Feb-10 | 36,175 | 14,363 | 355.23 | 51.67 | | |
| Mar-10 | 35,781 | 13,996 | 441.50 | 82.43 | | |
| Apr-10 | 35,674 | 13,914 | 377.44 | 82.17 | | |
| May-10 | 35,559 | 13,807 | 396.82 | 75.35 | | |
| Jun-10 | 35,390 | 13,663 | 425.39 | 72.61 | | |
| Jul-10 | 35,526 | 13,462 | 405.39 | 63.39 | | |
| Aug-10 | 35,031 | 13,233 | 373.57 | 70.07 | 400.01 | |
| Sep-10 | 34,591 | 12,919 | 397.23 | 70.17 | 405.33 | |
| Oct-10 | 34,535 | 12,936 | 410.07 | 67.62 | 407.26 | |
| Nov-10 | 34,257 | 12,745 | 369.21 | 67.90 | 411.29 | |
| Dec-10 | 34,259 | 12,870 | 384.76 | 78.19 | 416.13 | |
| Jan-11 | 28,523 | 11,086 | 437.98 | 75.75 | 424.60 | |
| Feb-11 | 28,473 | 11,113 | 424.74 | 69.02 | 430.82 | |
| Mar-11 | 28,430 | 11,123 | 503.35 | 82.99 | 434.44 | |
| Apr-11 | 28,326 | 11,028 | 459.37 | 78.32 | 440.70 | |
| May-11 | 28,198 | 10,945 | 444.17 | 88.46 | 444.82 | |
| Jun-11 | 28,072 | 10,888 | 457.28 | 86.63 | 447.43 | |
| Jul-11 | 27,956 | 10,712 | 433.29 | 88.50 | 450.65 | |
| Aug-11 | 27,906 | 10,700 | 441.43 | 84.48 | 457.31 | 1.143 |
| Sep-11 | 27,923 | 10,683 | 401.85 | 86.49 | 458.84 | 1.132 |
| Oct-11 | 27,769 | 10,543 | 433.38 | 85.96 | 461.72 | 1.134 |
| Nov-11 | 27,666 | 10,467 | 419.03 | 85.63 | 467.60 | 1.137 |
| Dec-11 | 27,513 | 10,366 | 435.31 | 85.97 | 473.04 | 1.137 |
| Jan-12 | 24,847 | 8,977 | 513.07 | 85.67 | 478.82 | 1.128 |
| Feb-12 | 24,832 | 8,987 | 477.87 | 85.75 | 483.43 | 1.122 |
| Mar-12 | 24,873 | 9,050 | 499.31 | 103.41 | 482.95 | 1.112 |
| Apr-12 | 24,779 | 8,965 | 441.35 | 92.61 | 481.72 | 1.093 |
| May-12 | 24,719 | 8,977 | 502.70 | 108.84 | 486.69 | 1.094 |
| Jun-12 | 24,592 | 8,886 | 497.04 | 112.41 | 490.30 | 1.096 |
| Jul-12 | 24,389 | 8,766 | 491.22 | 109.62 | 495.52 | 1.100 |

Total Projected Trend 10.3%

Exhibit 7D: Unit Cost Trend

| Reimbursement Type | Latest Estimate | Latest Estimate | |
|--------------------|-----------------|-----------------|----------------|
| | <u>2012</u> | <u>2013</u> | <u>Average</u> |
| Facility | 6.4% | 5.7% | 6.0% |
| Physician | <u>0.8%</u> | <u>1.4%</u> | <u>1.1%</u> |
| Combined | <u>3.9%</u> | <u>3.9%</u> | <u>3.9%</u> |

Weights

60% Facility:

40% Physician:

Exhibit 7E: Listing of All Commercial and Medicare Products Sold by the Company

Company Name: Aetna Health Inc. (NY)
NAIC Code: 95234
SERFF Tracking Number: AETN-128841943

Instructions:

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

| Market Segment | Policy Form Number | Product Name as in Rate Manual | Product Street Name | Product Type |
|-----------------------|---------------------------|---------------------------------------|----------------------------|---------------------|
| Large Group | HMO/NY GA-2 11/01 (HMO) | HMO | HMO | HMO |
| | | | | |

Description of Benefits

The following pages provide a description of benefits governed by this rate manual. It also includes some benefit specific contractual language.

Premier Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$2.00 |
| Non-Office Hours | \$5.00 |
| Primary Care Physician Home Visit | \$5.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$0.00 |
| Preventative Services * | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$0.00 |
| Non-Office Hours (emergency care) | \$5.00 |
| Outpatient Emergency Services | \$15.00 |
| Outpatient Alcohol and Drug Services | \$2.00 |
| Outpatient Mental Health Visits * | |
| Non-Serious - 20 visits per Member per year | \$0.00 |
| Serious - Unlimited | \$0.00 |

*Note

- Preventative Services have been defined as Routine Mammography, Routine OBGYN Exam, Routine Well Baby Exams, Routine Well Child Exams, Immunizations, New Born Testing and Monitoring, Hearing Exams, Cancer Screenings, Prostate Specific Antigen, Digital Rectal Exam, and Women's Preventative Services
 - Serious Mental Health has been defined as Biologically Based and Childhood SED. Non-Serious is all other illnesses. These definitions apply on this page and through out the remainder of the rate manual.

Patriot V Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$ 5.00 |
| Non-Office Hours | \$10.00 |
| Primary Care Physician Home Visit | \$10.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$ 5.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$ 5.00 |
| Non-Office Hours (emergency care) | \$10.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$ 5.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$5.00 |
| Serious - Unlimited | \$5.00 |

Patriot X Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$15.00 |
| Primary Care Physician Home Visit | \$15.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$15.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$15.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$15.00 |
| Serious - Unlimited | \$15.00 |

Patriot XV Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$15.00 |
| Non-Office Hours | \$20.00 |
| Primary Care Physician Home Visit | \$20.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$15.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$15.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$15.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$15.00 |
| Serious - Unlimited | \$15.00 |

Value Plus Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$15.00 |
| Primary Care Physician Home Visit | \$15.00 |
| Hospital Inpatient per Admission | \$240.00 |
| Outpatient Hospital Surgical Procedural Unit | \$75.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$15.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$15.00 |
| Non-Office Hours (emergency care) | \$15.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$15.00 |
| Serious - Unlimited | \$15.00 |
| Preventative Services | |
| Dependent Age | |

Super Value Plus Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$15.00 |
| Primary Care Physician Home Visit | \$15.00 |
| Hospital Inpatient per Admission | \$500.00 |
| Outpatient Hospital Surgical Procedural Unit | \$75.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$10.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$15.00 |
| Non-Office Hours (emergency care) | \$15.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$15.00 |
| Serious - Unlimited | \$15.00 |

\$10 Copay Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$10.00 |
| Primary Care Physician Home Visit | \$10.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$10.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$10.00 |
| Outpatient Emergency Services | \$50.00 |
| Outpatient Substance Abuse Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$10.00 |
| Serious - Unlimited | \$10.00 |

Patriot X/X Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$15.00 |
| Primary Care Physician Home Visit | \$15.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$10.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$10.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol or Drug Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 30 visits per Member per year | \$10.00 |
| Serious - Unlimited | \$10.00 |

DTC Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$10.00 |
| Primary Care Physician Home Visit | \$10.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$10.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$10.00 |
| Non-Office Hours (emergency care) | \$10.00 |
| Outpatient Emergency Services | \$15.00 |
| Outpatient Alcohol and Drug Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$10.00 |
| Serious - Unlimited | \$10.00 |

Plan I Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$15.00 |
| Non-Office Hours | \$20.00 |
| Primary Care Physician Home Visit | \$20.00 |
| Hospital Inpatient per Admission | \$240.00 |
| Outpatient Hospital Surgical Procedural Unit | \$75.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$15.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$15.00 |
| Non-Office Hours (emergency care) | \$15.00 |
| Outpatient Emergency Services | \$50.00 |
| Outpatient Alcohol and Drug Services | \$15.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$15.00 |
| Serious - Unlimited | \$15.00 |

PRU Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$15.00 |
| Primary Care Physician Home Visit | \$15.00 |
| Hospital Inpatient per Admission | \$100.00 |
| Outpatient Hospital Surgical Procedural Unit | \$75.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$15.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$15.00 |
| Outpatient Emergency Services | \$50.00 |
| Outpatient Alcohol and Drug Services | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$15.00 |
| Serious - Unlimited | \$15.00 |

KLM Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$5.00 |
| Non-Office Hours | \$10.00 |
| Primary Care Physician Home Visit | \$5.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$5.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$5.00 |
| Non-Office Hours (emergency care) | \$10.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$5.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$5.00 |
| Serious - Unlimited | \$5.00 |

High Option Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$10.00 |
| Non-Office Hours | \$15.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$10.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | \$10.00 |
| During Office Hours (with referral) | |
| Outpatient Emergency Services | \$25.00 |
| Outpatient Alcohol and Drug Services | |
| Alcohol only | \$10.00 |
| Drugs only | \$10.00 |
| Outpatient Mental Health Visits | |
| Non-Serious and Serious - Unlimited | |
| First 20 visits per Member per year | \$0.00 |
| All subsequent visits | \$10.00 |

Premier with Family Preventative Dental Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|-------------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$2.00 |
| Non-Office Hours | \$5.00 |
| Primary Care Physician Home Visit | \$5.00 |
| Primary Dentist Office Visit | \$2.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$0.00 |
| Non-Office Hours (emergency care) | \$5.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Outpatient Emergency Services | \$15.00 |
| Outpatient Alcohol and Drug Services | \$2.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$0.00 |
| Serious - Unlimited | \$0.00 |

Full Dental Plan Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$ 5.00 |
| Non-Office Hours | \$10.00 |
| Primary Care Physician Home Visit | \$10.00 |
| Primary Dentist Office Visit | \$2.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$5.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$ 5.00 |
| Non-Office Hours (emergency care) | \$10.00 |
| Outpatient Emergency Services | \$35.00 |
| Outpatient Alcohol and Drug Services | \$ 5.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$5.00 |
| Serious - Unlimited | \$5.00 |
| Lens Reimbursement | \$70.00 |

Comprehensive Plan "A" Copayment Summary

| <u>Service</u> | <u>Copayment</u> |
|---|------------------|
| Primary Care Physician Office Visit | |
| During Office Hours | \$2.00 |
| Non-Office Hours | \$5.00 |
| Primary Care Physician Home Visit | \$5.00 |
| Hospital Inpatient per Admission | \$0.00 |
| Outpatient Hospital Surgical Procedural Unit | \$0.00 |
| Routine Eye Exam by Participating Ophthalmologist or Optometrist | \$0.00 |
| Preventative Services | \$0.00 |
| Dependent Age | 26/26 |
| Specialist Physician Office Visit | |
| During Office Hours (with referral) | \$0.00 |
| Non-Office Hours (emergency care) | \$5.00 |
| Outpatient Emergency Services | \$15.00 |
| Outpatient Alcohol and Drug Services | \$2.00 |
| Outpatient Mental Health Visits | |
| Non-Serious - 20 visits per Member per year | \$0.00 |
| Serious - Unlimited | \$0.00 |
| Prescription Drugs and Medicine | \$2.50 |

**HMO MEDICAL PLAN
Form HI NY SOBSchedule V004**

| <u>[Benefit]</u> | <u>[Maximums]</u> |
|---|---|
| <p>[[Maximum Out-of-Pocket] [Copayment] Limit</p> <p>[The family [Maximum Out-of-Pocket] [Copayment] Limit is based on the required number of family members each satisfying the per Member [Maximum Out-of-Pocket] [Copayment] Limit.]</p> <p>[The family [Maximum Out-of-Pocket] [Copayment] Limit is a cumulative [Maximum Out-of-Pocket] [Copayment] Limit for all family members.]</p> <p>[The family [Maximum Out-of-Pocket] [Copayment] Limit is based on [2, 3] family Members each satisfying the per Member [Maximum Out-of-Pocket] [Copayment] Limit. Once [2, 3] family Members have each met their individual [Maximum Out-of-Pocket] [Copayment] Limit, the [Maximum Out-of-Pocket] [Copayment] Limit is considered met for all remaining family Members.]</p> <p>[Member must demonstrate the Copayment amounts that have been paid during the year.]]</p> | <p>[[\$0-10,000] per Member per [calendar year; Contract Year]]</p> <p>[[\$0-30,000] per family per [calendar year; Contract Year]]</p> <p>[The Member's [Maximum Out-of-Pocket] [Copayment] Limit is unlimited. All Covered Benefits will be paid by HMO and the Member in accordance with the cost sharing provisions on this Schedule of Benefits.]</p> |

OUTPATIENT BENEFITS
(continued)

| <u>Benefit</u> | <u>Copayment</u> |
|--|------------------------------------|
| <p>[Outpatient Rehabilitation] [(Other than [Physical Therapy,] [Occupational Therapy] [, and] [Speech Therapy])]</p> <p>[Treatment over a [60-90] consecutive day period per incident of illness or injury beginning with the first day of treatment]</p> <p>[[20-Unlimited] visits [combined for all outpatient rehabilitation therapies] [per period per incident of illness or injury beginning with the first day of treatment] per [calendar year; Contract Year]]</p> <p>[Maximum 30 combined visits per calendar year]]</p> | <p>[[\$0-50] per visit]</p> |
| <p>[Outpatient Physical Therapy] [Treatment over a [60-90] consecutive day period per incident of illness or injury beginning with the first day of treatment]</p> <p>[[20-Unlimited] visits [per period per incident of illness or injury beginning with the first day of treatment] per [calendar year; Contract Year]]</p> | <p>[[\$0-50] per visit]</p> |
| <p>[Outpatient Occupational Therapy] [Treatment over a [60-90] consecutive day period per incident of illness or injury beginning with the first day of treatment]</p> <p>[[20-Unlimited] visits [per period per incident of illness or injury beginning with the first day of treatment] per [calendar year; Contract Year]]</p> | <p>[[\$0-50] per visit]</p> |
| <p>[Outpatient Speech Therapy] [Treatment over a [60-90] consecutive day period per incident of illness or injury beginning with the first day of treatment]</p> <p>[[20-Unlimited] visits [per period per incident of illness or injury beginning with the first day of treatment] per [calendar year; Contract Year]]</p> | <p>[[\$0-50] per visit]</p> |

OUTPATIENT BENEFITS
(continued)

| <u>Benefit</u> | <u>Copayment</u> |
|--|--|
| <p>[Outpatient [Physical,] [and]] [Occupational] [and] [Speech] Therapy [Treatment over a [60-90] consecutive day period per incident of illness or injury beginning with the first day of treatment]</p> <p>[[20-Unlimited] combined [Physical] [and] [Occupational][, and] [Speech] Therapy visits [per period per incident of illness or injury beginning with the first day of treatment] per [calendar year; Contract Year]]</p> | <p>[[\$0-50] per visit]</p> |
| <p>Outpatient Facility Visits</p> <p style="padding-left: 40px;">Chemotherapy Hemodialysis</p> <p>Once 52 Chemotherapy or Hemodialysis visits are covered under a plan with a \$30 Copayment, any Chemotherapy or Hemodialysis visits after the fifty second visit will be covered without a Copayment.</p> | <p>[\$0-30] per visit [\$0-30] per visit</p> |
| Diagnostic X-Ray Testing | [\$0-50] per visit |
| Diagnostic Laboratory Testing | [\$0-50] per visit |
| Mammography | [\$0-30] per visit |
| <p>Subluxation Unlimited visits per [calendar year; Contract Year; 365 consecutive day period]</p> | <p>[\$0-50] per visit</p> |

**OUTPATIENT BENEFITS
(continued)**

| <u>Benefit</u> | <u>Copayment</u> |
|--|---|
| <p>Outpatient Emergency Services Hospital Emergency Room or Outpatient Department</p> | <p>[\$0-150] per visit (waived if admitted)</p> |
| <p>[Hospital Urgent Care Facility]</p> | <p>[\$0-35] per visit</p> |
| <p>[Non-Hospital Urgent Care Facility]</p> | <p>[\$0-35] per visit</p> |
| <p>Ambulance</p> | <p>[\$0-100] [per trip]</p> |
| <p>Outpatient Mental Health Visits [Coverage for Biologically-based Mental Illness and for Children with Serious Emotional Disturbances.</p> <p>Coverage for other than Biologically-based Mental Illness and Children with Serious Emotional Disturbances.]</p> <p>[[20-Unlimited visits*] per [calendar year; Contract Year.]</p> <p>*Visits for outpatient treatment of Biologically-based Mental Illness and Children with Serious Emotional Disturbances will count against and reduce this maximum.</p> <p>[Partial Hospitalization is limited. Please refer to the Mental Health Benefits section of your Certificate of Coverage for information on Mental Health Partial Hospitalization visit exchange limits.]</p> | <p>[Coverage is provided on the same basis as for any other medical condition]</p> <p>[\$0-50] per visit [Visits 1-2: \$0; Visits 3-10: \$10; and \$30 each visit thereafter or 50% of the cost of the visit, whichever is less]</p> <p>[\$3 visits 1-8 and \$35 each visit thereafter]</p> |

OUTPATIENT BENEFITS
(continued)

| <u>Benefit</u> | <u>Copayment</u> |
|---|--|
| <p>Outpatient Substance Abuse Visits [(Including Partial Hospitalization and Intensive Outpatient Programs)] Detoxification: [60 - Unlimited] visits per calendar year, of which up to 20 visits may be used for family members.</p> <p>[Combined with Outpatient Rehabilitation.]</p> | <p>[\$0-30] per visit/day</p> <p>[\$3 visits 1-8 and \$25 each visit thereafter]</p> |
| <p>Outpatient Substance Abuse Visits [(Including Partial Hospitalization and Intensive Outpatient Programs)] Rehabilitation: [60 - Unlimited] visits per calendar year, of which up to 20 visits may be used for family members.</p> <p>[Combined with Outpatient Detoxification. However, the benefit for Outpatient Substance Abuse Rehabilitation will never be less than the New York State mandated benefit of 60 visits for Substance abuse diagnosis and treatment, of which 20 visits may be used for family members.]</p> | <p>[\$0-30] per visit/day</p> <p>[\$3 visits 1-8 and \$25 each visit thereafter]</p> |
| Outpatient Surgery Facility | [\$0-150] per visit |
| <p>Outpatient Home Health Visits [40-Unlimited] visits per [calendar year; Contract Year; 365 consecutive day period]</p> <p>Four hours of home health aide service shall be considered one home care visit</p> | [\$0-30] per visit] |
| <p>Outpatient Hospice Care Visits [210-Unlimited] visits per [calendar year; Contract Year; 365 consecutive day period]</p> <p>Maximum Combined Inpatient and Outpatient Hospice Care Benefit</p> <p>Hospice Bereavement Counseling: 5 visits per 365-day period</p> | [\$0-50] per visit |
| [Injectable Medications] | [[0-30] per prescription or refill] |

INPATIENT BENEFITS

| <u>Benefit</u> | <u>Copayment</u> |
|--|--|
| <p>Acute Care</p> | <p>[[\$0-1,000] per Continuous Confinement]</p> <p>[[\$0-100] per day for each day of confinement to a maximum of [\$250-1,000] per [calendar year; Continuous Confinement; Contract Year] per Member [or [\$750-1,500] per family (not more than \$1,000 per Continuous Confinement per Member)], thereafter coverage is provided at 100%]</p> <p>[[\$0-100] per day for a maximum of [3-10] days per [calendar year; Continuous Confinement; Contract Year] up to a maximum of \$1,000 per Continuous Confinement, thereafter coverage is provided at 100%]</p> |
| <p>Mental Health</p> <p>[Coverage for Biologically-based Mental Illness and for Children with Serious Emotional Disturbances]</p> <p>Coverage for other than Biologically-based Mental Illness and Children with Serious Emotional Disturbances</p> <p>Maximum of [30-Unlimited] days* per [calendar year; Contract Year.]</p> <p>*Days of inpatient confinement for the treatment of Biologically-based Mental Illness and Children with Serious Emotional Disturbances will count against and reduce this maximum.]</p> | <p>[Coverage is provided on the same basis as for any other medical condition.]</p> <p>[\$0-1,000] per continuous confinement</p> <p>[[\$0-100] per day for each day of confinement to a maximum of [\$250-\$1,000] per [calendar year; Continuous Confinement; Contract Year] per person, thereafter coverage is provided at 100%.]</p> <p>[[\$0-100] per day for a maximum of [3-10] days per [calendar year; Continuous Confinement; Contract Year] up to a maximum of [\$1,000] per Continuous Confinement, thereafter coverage is provided at 100%.]</p> |
| <p>Substance Abuse</p> <p>Detoxification</p> <p>[Maximum of [7-30] days per calendar year]</p> <p>[No benefit is provided]</p> | <p>[[\$0-1,000] per Continuous Confinement]</p> <p>[[\$0-100] per day for each day of confinement to a maximum of [\$250-1,000] per [calendar year; Continuous Confinement; Contract Year] per Member [or [\$750-1,500] per family (not more than \$1,000 per Continuous Confinement per Member)], thereafter coverage is provided at 100%]</p> <p>[[\$0-100] per day for a maximum of [3-10] days per [calendar year; Continuous Confinement; Contract Year] up to a maximum of \$1,000 per Continuous Confinement, thereafter coverage is provided at 100%]</p> |

**INPATIENT BENEFITS
(continued)**

| <u>Benefit</u> | <u>Copayment</u> |
|--|--|
| Maternity | <p>[[\$0-1,000] per Continuous Confinement]</p> <p>[[\$0-100] per day for each day of confinement to a maximum of [\$250-1,000] per [calendar year; Continuous Confinement; Contract Year] per Member [or [\$750-1,500] per family (not more than \$1,000 per Continuous Confinement per Member)], thereafter coverage is provided at 100%]</p> <p>[[\$0-100] per day for a maximum of [3-10] days per [calendar year; Continuous Confinement; Contract Year] up to a maximum of \$1,000 per Continuous Confinement, thereafter coverage is provided at 100%]</p> |
| <p>Skilled Nursing Facility [Maximum of [30-Unlimited] days per [calendar year; Contract Year; 365 consecutive day period]]</p> | <p>[[\$0-1,000] per Continuous Confinement [(waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)]]</p> <p>[[\$0-100] per day for each day of confinement to a maximum of [\$250-1,000] per [calendar year; Continuous Confinement; Contract Year] per Member [or [\$750-1,500] per family (not more than \$1,000 per Continuous Confinement per Member)], thereafter coverage is provided at 100%] [(waived if a Member is transferred from a Hospital to a Skilled Nursing Facility, and the maximum has been satisfied in the Hospital)]]</p> <p>[[\$0-100] per day for a maximum of [3-10] days per [calendar year; Continuous Confinement; Contract Year] up to a maximum of \$1,000 per Continuous Confinement, thereafter coverage is provided at 100%] [(waived if a Member is transferred from a Hospital to a Skilled Nursing Facility, and the maximum has been satisfied in the Hospital)]]</p> |
| <p>Hospice Care Maximum of [210-Unlimited] days per [calendar year; Contract Year; 365 consecutive day period]</p> <p>Maximum Combined Outpatient and Inpatient Hospice Care Benefit</p> <p>Hospice Bereavement Counseling: 5 visits per 365-day period</p> | <p>[[\$0-1,000] per Continuous Confinement (waived if a Member is transferred from a Hospital to a Hospice Care facility)]</p> <p>[[\$0-100] per day for each day of confinement to a maximum of [\$250-1,000] per [calendar year; Continuous Confinement; Contract Year] per Member [or [\$750-1,500] per family (not more than \$1,000 per Continuous Confinement per Member)], thereafter coverage is provided at 100%] (waived if a Member is transferred from a Hospital to a Hospice Care facility, and the maximum has been satisfied in the Hospital)]</p> <p>[[\$0-100] per day for a maximum of [3-10] days per [calendar year; Continuous Confinement; Contract Year] up to a maximum of \$1,000 per Continuous Confinement, thereafter coverage is provided at 100%] (waived if a Member is transferred from a Hospital to a Hospice Care facility, and the maximum has been satisfied in the Hospital)]</p> |

[ADDITIONAL BENEFITS]

| <u>Benefit</u> | <u>Copayment</u> |
|---|---|
| [Eye Examination by a Specialist (including refraction) as per schedule in the Certificate] | [[\$0-50] per visit] |
| [Preventive Dental Benefit for children under age 12] | [[\$0-50] per visit] |
| <p>[Durable Medical Equipment (DME)]</p> <p>[DME Out-of-Pocket Maximum]</p> <p>[Copayments for these services do not apply to the Maximum Out of Pocket Copayment limit and those Covered Benefits are not eligible for 100% reimbursement after the [Maximum Out-of-Pocket][Copayment] Limit is reached.]</p> <p>[DME Maximum Benefit]</p> | <p>[[\$0-100] per item]</p> <p>[[0-50]% (of the cost) per item]</p> <p>[[\$0-100] plus [0-50]% (of the balance of the contracted rate) per item]</p> <p>[[\$0-500] per Member, per [calendar year; Contract Year]]</p> <p>[[\$250-Unlimited] per Member, per [calendar year; Contract Year]]</p> |
| <p>[Prosthetics]</p> <p>[Prosthetics Out of Pocket Maximum]</p> <p>[Copayments for these services do not apply to the Maximum Out of Pocket Copayment limit and those Covered Benefits are not eligible for 100% reimbursement after the [Maximum Out-of-Pocket][Copayment] Limit is reached.]]</p> | <p>[[\$0-100] per item]</p> <p>[[0-50]% (of the cost) per item]</p> <p>[[\$0-100] plus [0-50]% (of the balance of the contracted rate) per item]</p> <p>[[\$0-500] per Member, per [calendar year; Contract Year]]</p> |

[For any service or supply that is subject to a maximum visit, day, or dollar limitation, such maximums will be reduced by any services or supplies, which are covered as Non-Referred Benefits under a [Insert Product Name] Product.]

Subscriber Eligibility:

[All active full-time [and part-time] employees of the **Contract Holder** who regularly work at least the minimum number of hours per week as defined by the **Contract Holder** and agreed to by **HMO**.

Eligible for benefits [] [the date of hire].]

[All active [full-time; salaried; hourly; union; management] employees of the **Contract Holder** who regularly work at least [15-20] hours per week [and part-time employees who regularly work at least [half the weekly hours of the full-time employees but not less than] [15] hours per week][, except for; part-time employees; temporary employees; seasonal employees; or substitute employees].

Eligible for benefits [] [the date of hire].]

[All active [full-time; salaried; hourly; union; management] employees of the **Contract Holder** who regularly work at least [15-20] hours per week [and part-time employees who regularly work at least [half the weekly hours of the full-time employees but not less than] [15] hours per week][, except for; part-time employees; temporary employees; seasonal employees; or substitute employees].

Eligible for benefits [] [the date of hire].]

[All full-time [and part-time] students of the **Contract Holder**, eligible on the student's behalf to participate in or currently enrolled in a health plan offered by the **Contract Holder** to the group.

Eligible for benefits [the first of the month following; immediately upon; the first of the month following [30] days from] the date of enrollment with the **Contract Holder**.]

[An employee who, upon termination of active service with the **Contract Holder**, meets the retiree eligibility requirements as defined by the **Contract Holder** and agreed to by **HMO**.]

[An employee who, upon termination of active service with the **Contract Holder**, has reached age ____ and completed at least ____ years of service.]

[An employee who retires under the **Contract Holder's** IRS Qualified Retirement Plan, and receives pension consideration (except a deferred vested pension) under that plan.]

[An employee who retires under the **Contract Holder's** IRS Qualified Retirement Plan before the effective date of this **Group Agreement** and meets the eligibility requirements of this **Certificate**.]

[A **Subscriber** must satisfy the eligibility and waiting period requirements defined by the **Contract Holder** and agreed to by **HMO**.]

Dependent Eligibility: [A dependent unmarried child [of the **Subscriber**] as described in the Eligibility and Enrollment section of the **Certificate** who is:

- i. under [19-30] years of age; or
- ii. under [19-30] years of age [, dependent on a parent or guardian **Member**,] and attending a recognized college or university, trade or secondary school on a full-time [and part-time] basis; or
- iii. [chiefly dependent upon the **Subscriber** for support and maintenance, and] is [19-30] years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: [19-30], or if a student, [19-30].]

[A dependent unmarried child as described in the Eligibility and Enrollment section of the **Certificate** who satisfies the eligibility requirements defined by the **Contract Holder** and agreed to by **HMO**.]

[If the student is on a leave of absence due to illness and a licensed medical practitioner certifies the **Medical Necessity** of the leave of absence, coverage will be extended for one year following the last day of attendance, subject to the age limitations listed on the Schedule of Benefits.]

[Time spent in the US Military Service may be credited to the dependent student age maximum for the purpose of establishing dependent student eligibility provided that upon discharge the dependent becomes a full-time student. The age credit added to the maximum student age will equal the time spent in the US Military Service, not to exceed four years.]

[The **Group Agreement** and **Certificate** do not provide coverage for dependents. All references to “dependent” are hereby deleted.]

Termination of Coverage:

[Coverage of the **Subscriber** and the **Subscriber’s** dependents who are **Members**, if any, will terminate on the earlier of the date the **Group Agreement** terminates or [immediately] [on the next **Premium** due date] [at the end of the [second; third; fourth; fifth; sixth; seventh; eighth; ninth; tenth; eleventh] month] [at the end of the [**Contract Year**; calendar year]] [at the end of the next **Contract Year**] following the date on which the **Subscriber** ceased to meet the eligibility requirements.]

[Coverage of **Covered Dependents** will cease [immediately] [on the next **Premium** due date] [at the end of the [second; third; fourth; fifth; sixth; seventh; eighth; ninth; tenth; eleventh] month] [at the end of the [**Contract Year**; calendar year]] [at the end of the next **Contract Year**] following the date on which the dependent ceased to meet the eligibility requirements.]

[Coverage of the **Subscriber** and the **Subscriber’s** dependents who are **Members**, if any, will terminate on the earlier of the date the **Group Agreement** terminates or at the end of the period defined by the **Contract Holder** following the date on which the **Subscriber** ceased to meet the eligibility requirements.]

[Coverage of **Covered Dependents** will cease at the end of the period defined by the **Contract Holder** following the date on which the dependent ceased to meet the eligibility requirements.]

PRESCRIPTION PLAN RIDER
Form HI NY RRXDRUGPLAN V001

[Group Agreement Effective Date: [_____]]

HMO and **Contract Holder** agree to provide to **Members** the **HMO** Prescription Plan Rider, subject to the following provisions:

DEFINITIONS

Throughout this Rider the term **HMO** shall mean **HMO**, an affiliate, or a third party vendor.

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Brand Name Prescription Drug(s).** Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **HMO**. **Brand Name Prescription Drugs** do not include those drugs classified as **Generic Prescription Drugs** as defined below.
- **[Drug Formulary].** A list of prescription drugs and insulin established by **HMO**, which includes both **Brand Name Prescription Drugs**, and **Generic Prescription Drugs**. This list is subject to periodic review and modification by **HMO**. A copy of the **[Drug Formulary]** will be available upon request by the **Member** or may be accessed at the **HMO** website, at [www.aetna.com].
- **[Drug Formulary] Exclusions List.** A list of prescription drugs excluded from the **[Drug Formulary]**, subject to change from time to time by **HMO**.]
- **Generic Prescription Drug(s).** Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **HMO**.
- **Maintenance Drug(s).** A listing of prescription drugs or medications established by **HMO** which is subject to periodic review and modification by **HMO**. The list consists of prescription drugs or medications that are taken for extended periods of time, and which do not vary frequently in terms of dosage (such as high blood pressure medication).]
- **Maximum Prescription Drug Benefit.** The maximum amount (if any) of prescription drug **Covered Benefits** for any one **Member** or family in a given [quarter; calendar year; **Contract Year**]. The maximum does not reflect or include any amount **HMO** may receive under a rebate arrangement between **HMO** and a drug manufacturer for any drugs, including any drugs on the **[Drug Formulary]**.]
- **Maximum Prescription Drug Out-of-Pocket [Copayment] Limit.** The maximum amount of **Copayments** [plus the **Prescription Drug Deductible Amount**][and the difference in cost between a requested **Brand Name Prescription Drug** and an available

Generic Prescription Drug equivalent as described in the **Copayments** section of the Prescription Plan Rider] that any one **Member** or family must pay during a [**Contract Year**, calendar year]. **HMO** will pay 100% of the **Negotiated Charge** for covered outpatient **Brand Name** and **Generic Prescription Drugs** for the remainder of that [**Contract Year**, calendar year].

- **Negotiated Charge.** As to the coverage provided under this Prescription Plan Rider, the amount **HMO** has established for each **prescription drug** obtained from a **Participating Retail**[, **Mail Order**, or **Specialty Pharmacy Network**] **Pharmacy**. The **Negotiated Charge** may reflect amounts **HMO** has agreed to pay directly to the **Participating Retail**[, **Mail Order**, or **Specialty Pharmacy Network**] **Pharmacy**, or to a third party vendor for the prescription drug, [and may include an additional service or risk charge set by **HMO**].

The **Negotiated Charge** does not include or reflect any amount **HMO**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **HMO**, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the [**Drug Formulary**].

Based on its overall drug purchasing, **HMO** may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **Negotiated Charge** under this Prescription Plan Rider.

- [• [**Non-Formulary**] **Prescription Drug(s)**. A product or drug not listed on the [**Drug Formulary**] [which includes drugs listed on the [**Drug Formulary**] **Exclusions List**].]
- **Participating Mail Order Pharmacy.** A pharmacy, which has contracted with **HMO**, an affiliate, or a third party vendor, to provide covered outpatient prescription drugs or medicines, and insulin to **Members** by mail or other carrier.
- **Participating Retail Pharmacy.** A community pharmacy which has contracted with **HMO**, an affiliate, or a third party vendor, to provide covered outpatient prescription drugs to **Members**.
- [• **Precertification Program.** For certain outpatient prescription drugs, prescribing **Physicians** must contact **HMO** to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by **HMO**. An updated copy of the list of drugs requiring precertification shall be available upon request by the **Member** or may be accessed at the **HMO** website, at [www.aetna.com].]
- [• **Prescription Drug Deductible Amount.** The specified amount of **Covered Benefits** for prescription drugs which a **Member** or a family unit (as the case may be) is required to pay before **HMO** pays any benefits under this rider. **Covered Benefits** which are used in satisfying the **Prescription Drug Deductible Amount** must be incurred and applied to such **Prescription Drug Deductible Amount** within the applicable [quarter; calendar year; **Contract Year**]. This amount will not reflect or include any amount **HMO**, an affiliate or a third party vendor, may receive under a rebate arrangement between **HMO**, an affiliate or a third party vendor, and a drug manufacturer for any

drugs, including any drugs on the **[Drug Formulary]**.

The **Prescription Drug Deductible Amount** applies to each **Member**, subject to any applicable family **Prescription Drug Deductible Amount** set forth below. The **Prescription Drug Deductible Amount** must be satisfied once each [quarter; calendar year; **Contract Year**].]

- [• **[Self-injectable Drug(s)]**. Prescription drugs that are self administered by injection.]
- [• **[Specialty Care Drugs]**. Prescription drugs covered under this rider that include oral prescription drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis and which are listed in the **[Specialty Care Drug]** list].]
- [• **Specialty Pharmacy Network**. A network of **Participating** pharmacies designated to fill **[[Self-injectable Drugs]** **[Specialty Care Drugs]** prescriptions.]
- [• **Step Therapy Program**. A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by the **Member**. The list of step therapy drugs is subject to change by **HMO**. An updated copy of the list of drugs subject to step therapy shall be available upon request by the **Member** or may be accessed at the **HMO** website, at [www.aetna.com].]
- [• **Therapeutic Drug Class**. A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.]

COVERED BENEFITS

The **Covered Benefits** section of the **Certificate** is amended to add the following provision:

[[Option 1.] *(The text "Option 1" does not print.)*

A. **[Outpatient Prescription Drug [Closed] [Formulary] Benefit]**

Medically Necessary outpatient prescription drugs and insulin are covered when listed on the **[Drug Formulary]**. The **[Drug Formulary]** is subject to change by **HMO**. In addition, **Generic** and **Brand Name [Non-Formulary] Prescription Drugs** approved by **HMO**, except those listed on the **[Drug Formulary] Exclusions List** are also covered, subject to the Exclusions and Limitations section of this rider and the **Certificate**. Coverage of these **[Non-Formulary] Prescription Drugs** is subject to change from time to time by **HMO**. **Generic** and **Brand Name Prescription Drugs** on the **[Drug Formulary] Exclusions List** are excluded from coverage unless a medical exception for coverage is obtained.

Prescriptions must be written by a **Provider** licensed to prescribe federal legend prescription drugs subject to the terms, **HMO** policies, and the Exclusions and Limitations section described in this rider and the **Certificate**. [Coverage of prescription drugs may be subject to **[Precertification]**, the **Step Therapy Program** [or other]

HMO requirements or limitations.] Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail [or Mail Order] Pharmacy [or Specialty Pharmacy Network]**.

Member's Participating Physician [or Participating Retail [or Mail Order] Pharmacy or [Specialty Pharmacy Network] may seek a medical exception to obtain coverage for drugs listed on the **[Drug Formulary] Exclusions List [or drugs for which coverage is denied through [Precertification][, the Step Therapy] Program]** [or other] **HMO** requirements or limitations]. Such exception requests shall be made by the **Provider** to **HMO**. Coverage granted as a result of a medical exception shall be based on an individual, case by case **Medical Necessity** determination and coverage will not apply or extend to other **Members**.]

[[Option 2.] *(The text "Option 2" does not print.)*

A. [Outpatient Prescription Drugs [Open Formulary] Benefit]

Medically Necessary outpatient prescription drugs and insulin are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies, Exclusions and Limitations section described in this rider and the **Certificate**. Coverage is based on **HMO's** determination if a prescription drug is covered. Some items are covered only with pre-authorization from **HMO**. Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail [or Mail Order] Pharmacy [or Specialty Pharmacy Network]**.

[B. 1. Each prescription is limited to a maximum [30-34] day supply when filled at a **Participating Retail [or Mail Order] [or Specialty Pharmacy Network] Pharmacy** or [60-100] day supply when filled by the **Participating [Retail or] Mail Order Pharmacy** designated by **HMO**. [All prescription drug refills after the initial prescription must be filled at the **Participating Mail Order Pharmacy**.] [If a **Member** continues to use a **Participating Retail Pharmacy** after the [initial fill – fourth refill], the **Member's Copayment** will be increased as shown in the **Copayments** schedule for **Participating Retail [or Mail Order] Pharmacy [or Specialty Pharmacy Network]** below.] Except in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside the **HMO Service Area**, prescriptions must be filled at a **Participating Retail [or Mail Order] Pharmacy [or Specialty Pharmacy Network]**. [Coverage of prescription drugs may be subject to [the **Precertification Program**] [, the **Step Therapy Program**] [or other] **HMO** requirements or limitations.]]

[B. 2. Each prescription is limited to a maximum [30-34] day supply when filled at a **Participating Retail Pharmacy**. Coverage for **Maintenance Drugs**, in excess of the [30-34] day supply, is available under this rider. To be covered on this extended basis, the prescription drug must be a **Maintenance Drug** on the list of drugs approved by **HMO** and **Medically Necessary**. All [60-100] day supply prescriptions must be filled by a **Participating Retail [or Mail Order] Pharmacy [or Specialty Pharmacy Network]**. This **Maintenance Drug** list is subject to change without notice to **Members** or **Contract Holder**. [Coverage of prescription drugs may be subject to [the

Precertification Program] [, the **Step Therapy Program**] [or other] **HMO** requirements or limitations.]]

- C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. [Coverage of off label use of these drugs may be subject to [the **Precertification Program**] [, the **Step Therapy Program**] [or other] **HMO** requirements or limitations.]
- D. **Emergency Prescriptions** - Emergency prescriptions are covered subject to the following terms:

When a **Member** needs a prescription filled in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside of the **HMO Service Area**, **HMO** will reimburse the **Member** as described below.

When a **Member** obtains an emergency or out-of-area **Urgent Care** prescription at a non-**Participating Retail Pharmacy**, **Member** must directly pay the pharmacy in full for the cost of the prescription. **Member** is responsible for submitting a request for reimbursement in writing to **HMO** with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by **HMO** to determine if the event meets **HMO's** requirements. Upon approval of the claim, **HMO** will directly reimburse the **Member** [75-100]% of [the cost of the prescription] [the **HMO's Negotiated Charge** with **Participating** pharmacy], less the applicable **Copayment** specified below and any **Brand Name Prescription Drug** cost differentials as applicable. Coverage for items obtained from a non-**Participating** pharmacy is limited to items obtained in connection with covered emergency and out-of-area **Urgent Care** services. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

When a **Member** obtains an emergency or **Urgent Care** prescription at any **Participating Retail Pharmacy**, including an out-of-area **Participating Retail Pharmacy**, **Member** will pay to the **Participating Retail Pharmacy** the **Copayment(s)**, plus the **Brand Name Prescription Drug** cost differentials where applicable and as described below. **Members** are required to present their ID card at the time the prescription is filled. **HMO** will not cover claims submitted as a direct reimbursement request from a **Member** for a prescription purchased at a **Participating Retail Pharmacy** except upon professional review and approval by **HMO**. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

- E. **Mail Order Prescription Drugs**. Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient prescription drugs are covered when dispensed by the **Participating Mail Order Pharmacy** designated by **HMO** and when prescribed by a [**Participating**] **Provider** licensed to prescribe federal legend prescription drugs.

[**Members** are required to obtain [prescriptions greater than a [30-34] day supply] [all prescription drug refills after the [initial – fourth] prescription fill] from the designated **Participating Mail Order Pharmacy.**] [Outpatient prescription drugs will not be covered if dispensed by a **Participating Mail Order Pharmacy** in quantities that are [less than a [31-35] day supply or] more than a [60-100] day supply (if the **Provider** prescribes such amounts).]

[F. **Additional Benefits.**

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:

- **Infertility Drugs.** These include, and are subject to change by **HMO**, [urofollitropin, menotropin, human chorionic gonadotropin, progesterone and self-injectable infertility drugs to treat infertility.]
- **Lifestyle/Performance Drugs.** Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral[, self-injectable] and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally are covered for **Members**, regardless of **Medical Necessity**. Coverage includes any prescription drug in oral or topical form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

Coverage is limited to [4-15] pills or other form, determined cumulatively among all forms, for unit amounts as determined by **HMO** to be similar in cost to oral forms, per [30-34] day supply. [Mail order and [60-100] day supplies are not covered.] [The **Member** is responsible for a **Copayment** in the amount listed in this rider [for [Non-Formulary][Formulary] **Brand Name Prescription Drugs.**]]

- **[Self-injectable] [Specialty Care] Drugs.**

[Self-injectable] [Specialty Care] Drugs, eligible for coverage under this rider, are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The [initial] prescription must be filled at a **[Participating Retail Pharmacy][,] [Participating Mail Order Pharmacy]** [or] **[Specialty Pharmacy Network pharmacy]**. [All refills must be filled by a **[Participating Mail Order Pharmacy]** [or] **[Specialty Pharmacy Network pharmacy]**.] [Coverage of **[Self-injectable] [Specialty Care] Drugs** may be subject to [the **[Precertification Program],the Step Therapy Program]** [or other] **HMO** requirements or limitations.]

[With the following exceptions, the **Member** is required to obtain all covered **Self-Injectable Drugs** at a **Specialty Pharmacy Network Pharmacy**.

Exceptions:

Blood thinners (Arixtra, Fragmin, Innohep, Lovenox, Orgaran).
 Diabetic Drugs (Insulin, Byetta, Glucagon, Symlin)
 Emergency medications (Epinephrine Kits)
 Erectile Dysfunction Medications (Caverject, Edex)
 Migraine medications (Imitrex)
 Multiple Sclerosis medications (Betaseron)]

Food and Drug Administration (FDA) approved [**Self-injectable**] [**Specialty Care**] **Drugs**, eligible for coverage, are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. [Coverage of off label use of these drugs may be subject to [the **Precertification Program**], the **Step Therapy Program**] [or other] **HMO** requirements or limitations.]

[G]. Copayments:

Member is responsible for the **Copayments** specified in this rider. The **Copayment**, if any, is payable directly to the **Participating Retail**[, or **Mail Order Pharmacy**] [**or Specialty Pharmacy Network** pharmacy] for each prescription or refill at the time the prescription or refill is dispensed. [If the **Member** obtains more than a [30-34] day supply of prescription drugs or medicines at the **Participating [Retail or] Mail Order Pharmacy**, not to exceed a [60-100] day supply, [1- 3] **Copayment[s is; are]** payable for each supply dispensed.] [**1 Copayment** is payable for up to a [31-35] day supply, **2 Copayments** are payable for a [31-60] day supply, **3 Copayments** are payable for a [61-100] day supply].] The **Copayment** [does] [does not] apply to the Maximum Out-of-Pocket [**Copayment**] Limit shown in the Schedule of Benefits for the medical plan, if any.

- [• If the **Physician** prescribes, or the **Member** requests, a covered **Brand Name Prescription Drug** when a **Generic Prescription Drug** equivalent is available, the **Member** will pay the difference in cost between the **Brand Name Prescription Drug** and the **Generic Prescription Drug** equivalent, plus the applicable **Copayment**.]
- [• If the **Physician** prescribes a covered **Brand Name Prescription Drug** where a **Generic Prescription Drug** equivalent is available and specifies “Dispense As Written” (DAW), the **Member** will pay the **Copayment** for the **Brand Name Prescription Drug**. If the **Member** requests a covered **Brand Name Prescription Drug** where a **Generic Prescription Drug** equivalent is available the **Member** will pay the difference in cost between the **Brand Name Prescription Drug** and the **Generic Prescription Drug** equivalent, plus the applicable **Copayment**.]

| [Prescription Drug/Medicin e Quantity] | [Generic] [Formulary] [Preferred Drug List] [Non-Formulary] [Non-Preferred Drug List] [Prescription Drugs] | [Brand Name] [Formulary] [Preferred Drug List] [Non-Formulary] [Non-Preferred Drug List] [Prescription Drugs] | [Brand Name][Formulary] [Preferred Drug List] [Non-Formulary] [Non-Preferred Drug List] [Prescription Drugs] |
|---|--|--|--|
| [Less than a [31-35] day supply] [Each [30-34] day supply] | [\$0-75] [[10-50]%] [[the greater of] \$[0-75] or [10-50]% of the Negotiated Charge [but not more than \$[50-750]] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$0-100] [[10-50]%] [[the greater of] \$[0-75] or [10-50]% of the Negotiated Charge [but not more than \$[50-750]] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$0-100] [[10-50]%] [[the greater of] \$[0-75] or [10-50]% of the Negotiated Charge [but not more than \$[50-750]] [after the [Prescription Drug Deductible Amount][Deductible]] |
| [More than a [30-34]-day supply but] [[I;L]ess than a [61-101] day supply] | [\$0-225] [[10-50]%] [[the greater of] \$[0-225] or [10-50]% of the Negotiated Charge [but not more than \$[50-2,250]] [1-3] times the less than [31-35] day supply] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$0-300] [[10-50]%] [[the greater of] \$[0-300] or [10-60]% of the Negotiated Charge [but not more than \$[50-2,250]] [1-3] times the less than [31-35] day supply] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$0-300] [[10-50]%] [[the greater of] \$[0-300] or [10-50]% of the Negotiated Charge [but not more than \$[50-2,250]] [1-3] times the less than [31-35] day supply] [after the [Prescription Drug Deductible Amount][Deductible]] |
| [For each [initial] [30-36] day supply filled at a Participating Retail Pharmacy] | [\$0-75] [10-50]% of the Negotiated Charge] [The greater of \$[5-75] or [10-50]% of the Negotiated Charge not to exceed \$[50- | [\$0-100] [10-50]% of the Negotiated Charge] [The greater of \$[5-75] or [10-50]% of the Negotiated Charge not to exceed \$[50- | [\$0-100] [10-50]% of the Negotiated Charge] [The greater of \$[5-75] or [10-50]% of the Negotiated Charge not to exceed \$[50- |

| | | | |
|---|--|--|--|
| | 750]] [after the [Prescription Drug Deductible Amount][Deductible]] | 750]] [after the [Prescription Drug Deductible Amount][Deductible]] | 750]] [after the [Prescription Drug Deductible Amount][Deductible]] |
| [This applies to all refills after the [first-fourth] refill of up to a [30-36] day supply filled at a Participating Retail Pharmacy] | [\$5-225] [[10-50]% of the Negotiated Charge not to exceed [\$50-300]] [[1-3] times the initial [30-36] day Copayment] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$5-300] [[10-50]% of the Negotiated Charge not to exceed [\$50-300]] [[1-3] times the initial [30-36] day Copayment] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$5-300] [[10-50]% of the Negotiated Charge not to exceed [\$50-300]] [[1-3] times the initial [30-36] day Copayment] [after the [Prescription Drug Deductible Amount][Deductible]] |
| [For all fills of more than a [30-36] day supply but less than a [61-101] day supply filled at a Participating mail Order Pharmacy] | [\$5-225] [[10-50]% of the Negotiated Charge]] [The greater of [\$5-300] or [10-50]% of the Negotiated Charge not to exceed [\$50-2,250]] [[1-3] times the initial [30-36] day Copayment] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$5-300] [[10-50]% of the Negotiated Charge]] [The greater of [\$5-300] or [10-50]% of the Negotiated Charge not to exceed [\$50-2,250]] [[1-3] times the initial [30-36] day Copayment] [after the [Prescription Drug Deductible Amount][Deductible]] | [\$5-300] [[10-50]% of the Negotiated Charge]] [The greater of [\$5-300] or [10-50]% of the Negotiated Charge not to exceed [\$50-2,250]] [[1-3] times the initial [30-36] day Copayment] [after the [Prescription Drug Deductible Amount][Deductible]] |

[[H]. **Maximum Prescription Drug Benefit** - shall be **[\$500-4,000]** per Member [and **[\$500-12,000]** per family] per [quarter; calendar year; **Contract Year**].]

[[I]. Prescription Drug Deductible Amount.

[The **[Generic [Formulary] [Non-Formulary] Prescription Drug] Deductible Amount** is **[\$[0-1,000] per Member [or]] [\$[0-3,000] per family]** per [quarter; calendar year; **Contract Year**] for prescription drugs. [The **Prescription Drug Deductible Amount** [does] [does not] apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.]]

[The **[Brand Name [Formulary] [Non-Formulary] Prescription Drug] Deductible Amount** is **[\$[0-1,000] per Member [or]] [\$[0-3,000] per family]** per [quarter; calendar year; **Contract Year**] for prescription drugs. [The **Prescription Drug Deductible Amount** [does] [does not] apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.]]

[The family **Prescription Drug Deductible Amount** is a cumulative **Prescription Drug Deductible Amount** for all family **Members**.]

[The family **Prescription Drug Deductible Amount** is based on [2, 3] family **Member** each satisfying the per **Member Prescription Drug Deductible Amount**. Once [2, 3] family **Members** have each met their individual **Prescription Drug Deductible Amount**, the **Prescription Drug Deductible Amount** is considered met for all remaining family **Members**.]

[[J]. Maximum Prescription Drug Out-of-Pocket [Copayment] Limit [plus Prescription Drug Deductible Amount] – shall be \$[2,000-10,000] per Member [and \$[4,000-30,000] per family] per [Contract Year, calendar year]. The Maximum Prescription Drug Out-Of-Pocket [Copayment] Limit [does] [does not] apply to the Maximum Out-Of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.]

[The family **Maximum Prescription Drug Out-of-Pocket [Copayment] Limit** is a cumulative **Maximum Prescription Drug Out-of-Pocket [Copayment] Limit** for all family members.]

[The family **Maximum Prescription Drug Out-of-Pocket [Copayment] Limit** is based on [2, 3] family members each satisfying the per **Member Maximum Prescription Drug Out-of-Pocket [Copayment] Limit**. Once [2, 3] family members have each met their individual **Maximum Prescription Drug Out-of-Pocket [Copayment] Limit**, the **Maximum Prescription Drug Out-of-Pocket [Copayment] Limit** is considered met for all remaining family members.]

[[K]. [The Method of Payment section of the Certificate is amended to include the following provision[s]:

[A **Member** is entitled to **Covered Benefits** for prescription drugs under the Prescription Plan Rider after the **Member** has satisfied the **Prescription Drug Deductible Amount** specified in the rider. After satisfying the **Prescription Drug Deductible Amount**, the **Member** must pay any applicable **Copayment** for the prescription drug **Covered Benefits** specified in this rider.]]]

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusions and limitations:

A. Exclusions.

Unless specifically covered under this rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**.
4. Cosmetic surgery or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids. Cosmetic surgery shall not include reconstructive surgery when such surgery is incidental or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
5. Needles and syringes, including but not limited to diabetic needles and syringes.
6. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
7. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
8. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity, unless **Medically Necessary**.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this rider. Subsequent to the final determination of the external review process, experimental and investigational drugs will be covered, as required.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use, except as otherwise covered under this Certificate.
13. Test agents and devices, including but not limited to diabetic test agents.
14. [Injectable D; d]rugs used for in-vitro fertilization (IVF), gamete intra-fallopian tube transfers (GIFT) or zygote intra-fallopian tube transfers (ZIFT).

15. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
16. Replacement for lost or stolen prescriptions.
17. Performance, athletic performance or lifestyle enhancement drugs and supplies, unless **Medically Necessary**.
18. Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO** or otherwise specifically covered under this rider or the medical plan.
19. Drugs dispensed by other than a **Participating Retail** or **Mail Order Pharmacy**, except as **Medically Necessary** for treatment of an emergency or **Urgent Care** condition.
20. Medication packaged in unit dose form. (Except those products approved for payment by **HMO**).
21. Prophylactic drugs for travel.
22. Drugs recently approved by the FDA, but which have not yet been reviewed by Aetna's Therapeutics Committee, except when approved through the medical exceptions process.
23. Drugs listed on the **Formulary Exclusions List** unless otherwise covered through a medical exception as described in this rider or unless otherwise covered under this rider.
24. Brand Name Prescription Drugs [unless obtained with a medical exception].
- [25]. [Injectable drugs, except for insulin and **[Self-]injectable Drugs**.
- [26]. [Nutritional supplements.]
- [27]. [Smoking cessation aids or drugs.]
- [[28]. Growth/Height: Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones, except as **Medically Necessary**.]
- [[29]. Food and nutritional items: Any food item, including infant formulas, nutritional supplements, vitamins, [including prescription vitamins], medical foods and other nutritional items, even if it is the sole source of nutrition.]
- [[30]. Drugs, medications, injectables or supplies provided at no cost through a third party vendor contract with the [policyholder].]
- [[31]. Sexual dysfunction/enhancement: Any drug or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ, except as **Medically Necessary**.]

B. Limitations:

1. A **Participating Retail** or **Mail Order Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
2. Non-emergency and non-**Urgent Care** prescriptions will be covered only when filled at a **Participating Retail Pharmacy** or the **Participating Mail Order Pharmacy**, or the **Specialty Pharmacy Network**. **Members** are required to present their ID card at the time the prescription is filled. A **Member** who fails

to verify coverage by presenting the ID card will not be entitled to direct reimbursement from **HMO**, and **Member** will be responsible for the entire cost of the prescription. Refer to the **Certificate** for a description of emergency and **Urgent Care** coverage. **HMO** will not reimburse **Members** for out-of-pocket expenses for prescriptions purchased from a **Participating Retail Pharmacy; Participating Mail Order Pharmacy** or a non-**Participating Retail or Mail Order Pharmacy** in non-emergency, non-**Urgent Care** situations. **HMO** retains the right to review all requests for reimbursement and make reimbursement determinations subject to the [Grievance and Appeals] section of the **Certificate**.

3. **HMO** is not responsible for the cost of any prescription drug for which the actual charge to the **Member** is less than the required **Copayment** [or payment which applies to the **Prescription Drug Deductible Amount**, if any,] or for any drug for which no charge is made to the recipient.
- [4. **Member** will be charged the **Non-Formulary Prescription Drug Copayment** for prescription drugs covered on an exception basis.]
- [5. The Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision: The conversion privilege, if any, does not apply to the **HMO** Prescription Plan.]
- [6.] The copayment for diabetic equipment, supplies and insulin under the certificate will be the copayment listed in the Schedule of Benefits for the **PCP** visit.
- [7.] The grievances and appeals process, including the external appeals process, is described in detail in the **Certificate**.

CONTRACEPTIVES RIDER
Form HI AContHCRPrevNG 01

[Group Agreement Effective Date: [_____]]

HMO and **Contract Holder** agree to provide to **Members** the **HMO** Contraceptive Rider, subject to the following provisions:

1. **Family Planning Services - Female [and Male] Contraceptives Benefit.**

For females with reproductive capacity, **Covered Benefits** include those charges incurred for services and supplies that are provided to prevent pregnancy. [All contraceptive methods, services and supplies (including outpatient prescription drugs) covered under this Preventive Care benefit must be approved by the Food and Drug Administration (FDA).]

The following contraceptive methods are provided under the Preventive Care benefit:

Coverage includes counseling services on contraceptive methods provided by a **PCP, Physician**, obstetrician or gynecologist. Such counseling services are **Covered Benefits** when provided in either a group or individual setting. [They are subject to the contraceptive counseling services visit maximum shown in your Schedule of Benefits.]

[Contraceptives

Covered Benefits include charges made by a **Physician** or pharmacy for:

- Female contraceptives that are **Generic Prescription Drugs** and **Brand Name Prescription Drugs**. The prescription must be submitted to the pharmacist for processing. This contraceptives benefit covers only **Generic Prescription Drugs**.]
- Female contraceptive devices and related services and supplies that are generic prescription devices and brand name prescription devices], when prescribed in writing by a **Physician**. This contraceptives benefit covers only those devices that are generic prescription devices.]
- FDA approved female [and male] over-the-counter contraceptive methods that are prescribed by your **Physician**. The prescription must be submitted to the pharmacist for processing. These items are limited to one per day and a [30-90 day] supply per prescription.]

[Limitations:

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

- Services which are covered to any extent under any other part of this Rider.
- Services that are not given by a **Physician** or under his or her direction;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;]

[Important Notes:

- Coverage under this Preventive Care benefit for contraceptive prescription drugs and devices is limited to contraceptives that are **Generic Prescription Drugs** and devices. Contraceptives that are **Brand Name Prescription Drugs** and devices are not Covered Benefits unless a contraceptive that is a **Generic Prescription Drug** or device equivalent, or alternative, is not available with the same **Therapeutic Drug Class**. You must obtain a medical exception from [HMO].

Your **Physician** or **Health Professional(s)** may seek a medical exception to obtain coverage for contraceptives that are **Brand Name Prescription Drugs** or devices with no generic equivalent or alternative. Such exception requests shall be made by the **Physician** or **Health Professional(s)** to the [HMO precertification department]. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case **Medical Necessity** determination and coverage will not apply or extend to other covered persons.

- If a **Physician or Health Professional(s)**:
 - prescribes a covered contraceptive that is a **Brand Name Prescription Drug** or device where a contraceptive that is a **Generic Prescription Drug** or device equivalent or alternative is available within the same **Therapeutic Drug Class**; and
 - specifies “Dispense As Written” (DAW);

then coverage for the contraceptive that is a **Brand Name Prescription Drug** or device will be paid as Preventive Care benefits.

- A generic equivalent contains the identical amounts of the same active ingredients as the **Brand Name Prescription Drug** or device. A generic alternative is used for the same purpose, but can have different ingredients or different amounts of ingredients.]

2. The Definitions section of the **Certificate** is hereby amended to add the following definition(s):

- **Brand Name Prescription Drug(s)**. Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by HMO. **Brand Name Prescription Drugs** do not include those drugs classified as **Generic Prescription Drugs** as defined below.
- **Drug Formulary**. A list of prescription drugs and insulin established by HMO, which includes both **Brand Name Prescription Drugs**, and **Generic Prescription Drugs**. This list is subject to periodic review and modification by HMO. A copy of the **Drug Formulary** will be

available upon request by the **Member** or may be accessed at the **HMO** website, at [www.aetna.com].

- **Generic Prescription Drug(s).** Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **HMO**.
- **Negotiated Charge.** As to the coverage provided under this **Certificate**, the amount **HMO** has established for each prescription drug obtained from a **Participating Pharmacy**. The **Negotiated Charge** may reflect amounts **HMO** has agreed to pay directly to the **Participating Retail Pharmacy**, or to a third party vendor for the prescription drug.

The **Negotiated Charge** does not include or reflect any amount **HMO**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **HMO**, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the **Drug Formulary**.

Based on its overall drug purchasing, **HMO** may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **Negotiated Charge** under this **Certificate**.

- **Participating Pharmacy.** A pharmacy which has contracted with **HMO**, an affiliate, or a third party vendor, to provide covered outpatient prescription drugs to **Members**.
- **Therapeutic Drug Class.** A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

3. The following benefits are added to the **Outpatient Benefits** section of the **Schedule of Benefits**:

| | |
|--|--|
| [Family Planning Services – Female [and Male] Contraceptives Benefit. | |
| Female Contraceptive Counseling Services | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] either in a group or individual setting] | [1-6 visits] |

[Important Note: Visits in excess of the Female Contraceptive Counseling Services Maximum Visits as shown above, are covered under the Primary Care Physician Services or Specialist Physician Services section of the Schedule of Benefits.]

| | |
|---|---------------------------------------|
| | |
| [Female [Brand Name and] Generic Contraceptive Devices] | \$0 per prescription or refill |
| [Female [Brand Name and] Generic Contraceptive Prescription Drugs] | \$0 per prescription or refill |
| [Female [and Male] Over-the-Counter Contraceptive Methods (covered only when prescribed by a Physician)] | \$0 per prescription or refill |

4. The Continuation and Conversion section of the **Certificate** is amended to add the following provision:

The conversion privilege does not apply to the **HMO** Prescription Drug Contraceptive Rider.

DENTAL PLAN RIDER
Form HMO/NY RIDER-DEN-1 04/97

Contract Holder Group Agreement Effective Date: [_____]

[U.S. Healthcare, Inc. d/b/a Aetna U.S. Healthcare] ("HMO") and **Contract Holder** agree to offer to **Members** the **HMO** Dental Plan, subject to the following provisions:

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Participating Dental Specialist.** A dentist who limits the procedures performed to those in one of the approved ADA specialties, which include endodontics, periodontics, oral and maxillofacial surgery, pedodontics, orthodontics, oral pathology, prosthodontics, and dental public health. The **Specialist** must meet the particular educational and licensure requirements of each specialty, as stipulated by each particular specialty board and have contracted with **HMO** to provide such services to **Members**.
- **Participating Dentist.** A **Participating Primary Dentist** or a **Participating Dental Specialist**.
- **Participating Primary Dentist.** A state licensed dentist whose area of practice and training is general dentistry, and who has contracted with **HMO** to provide dental services to **Members**.

The Covered Benefits section of the **Certificate** is amended to add the following provisions:

- **Dental Benefits.**

The **Member** shall be entitled to the following dental benefits when provided by the **Member's Participating Primary Dentist**.

Copayment: The **Member** is responsible for a **Copayment** in the amount of [\$0, \$2.00, \$5.00, \$10.00, \$15.00] for each office visit to a **Participating Primary Dentist**.

Option 1.

Option 1 consists of all the benefits listed hereunder.

1. Diagnostic Services, which include:
 - Emergency exams.
 - Office visit for oral examination (limited to 2 visits every year).
 - Consultations with the **Participating Primary Dentist**.
2. Preventive Services, which include:

- Prophylaxis, treatment to include scaling and polishing (limited to 2 treatments every year).
- Topical application of fluoride (limited to 2 courses of treatment per year for **Members** under age 18).
- Oral hygiene instruction.
- Dietary advice and counseling.

[Option 2.

Option 2 consists of all the benefits listed in Option 1, plus the benefits listed hereunder.

1. Diagnostic Services, which include:
 - Diagnostic casts and photographs.
 - Bite wing x-rays (not more than twice every year).
 - Entire x-ray series or panoramic equivalent (limited to once every 3 years).
 - Periapical (individual tooth) x-rays, as necessary.
 - Other dental x-rays, as necessary.
 - Pulp vitality test.
2. Preventive Services, which include:
 - Minor occlusal (bite) adjustments.
3. Repair and Restorative Services, which include:
 - Amalgam restorations (fillings) and related medication.
 - Sedative fillings.
 - Retention pins (as necessary).
 - Minor denture adjustment.]

[Option 3.

Option 3 consists of all the benefits listed in Options 1 and 2, plus the benefits listed hereunder.

1. Preventive Services, which include:
 - Application of sealants given to **Members** under age 18 for permanent bicuspids and molars only, limited to once every 3 years.
2. Repair and Restorative Services, which include:
 - Composite restorations and related medication, but not cosmetic restorations.
3. Periodontics, which include:
 - Scaling and root planing.
4. Oral Surgery, which include:
 - Non-surgical extractions and related medications.]

Other Dental Services:

All other dental services are available at a [30%] discount from fees normally charged by the **Participating Dentists**. The **Member** is responsible for 100% of the negotiated fees, and should contact the **Participating Dentist** for the exact fee amounts.

All reduced fees for dental services must be paid by the **Member** directly to the **Participating Dentist**.

Dental services include:

- [• Dental x-rays.]
- [• Sealants.]
- [• Amalgam restorations and related medication.]
- [• Composite restorations and related medication.]
- [• Restorations and repairs (except those listed under Repair and Restorative Services).]
- [• Crowns, bridges, and dentures.]
- [• Endodontics (root canal and pulp treatment).]
- [• Periodontics (gum treatment).]
- [• Oral Surgery (excluding oral surgery covered under the **HMO** health care plan).]

- [• Orthodontics (braces).]

Emergency Service:

Member will be covered for the palliative care for the relief of acute pain in the event a **Member** is more than [50] miles outside the service area. This benefit is limited to [\$50.00], per emergency, and subject to professional review.

Exclusions:

[Replacement of a lost, missing or stolen appliance or prosthetic device.]

[Services for the treatment of any Jaw Joint Disorder.]

[Charges for dentures, crowns, inlays, onlays, bridgework, or other appliances or services to increase vertical dimension.]

Section [B] of the Continuation and Conversion section of the **Certificate** is amended to include the following provision:

The conversion privilege does not apply to the **HMO** Dental Plan.

PRESCRIPTION LENS RIDER
Form HMO NY RIDER-VIS-2 (06/06)

[Contract Holder Group Agreement Effective Date:[_____]]

[Aetna Health Inc.] ("**HMO**") and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Lens plan, subject to the following provisions:

The Covered Benefits section of the **Certificate** is amended to add the following provision:

- **Prescription Lens Benefits.**

[**Member** is eligible for an allowance up to \$[**35-350**] for the purchase of prescription lenses and frames (including prescription contact lenses). This allowance is payable once in each [12-36] month period commencing with the date of **Member's** initial use of this benefit.

Member will be reimbursed for the amount of this allowance. [However, if the prescription lenses or frames are purchased from select **Providers** who have an agreement with **HMO** to bill **HMO** directly, the allowance will be directly deducted from the cost of the prescription lenses or frames .]

[The purchase of prescription lenses and frames or prescription contact lenses will be covered in full after a \$[**25-100**] **Copayment** at **Participating Providers**. This benefit is payable once in each [12-36] month period commencing with the date of **Member's** initial use of this benefit.]

[The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

The conversion privilege does not apply to the Prescription Lens Rider.]

**ADVANCED REPRODUCTIVE TECHNOLOGY (“ART”) SERVICES RIDER
Form HMO NY RIDER 2003ART-1 (07-03)**

[Contract Holder [Group Agreement] Effective Date: [_____]]

[Aetna Health Inc.], (“HMO”) and **Contract Holder** agree to provide to **Members** the Advanced Reproductive Technology (“ART”) Services Rider subject to the following provisions:

The Definitions section of the **Certificate** is hereby amended to add the following definition(s):

- **Advanced Reproductive Technology (“ART”):**
 - a. in vitro fertilization (“IVF”);
 - b. gamete intra-fallopian transfer (“GIFT”);
 - c. zygote intra-fallopian transfer (“ZIFT”);
 - d. cryopreserved embryo transfers; or
 - e. intra-cytoplasmic sperm injection (“ICSI”) or ovum microsurgery.
- **ART Services.** **ART Services**, products, or procedures that are **Covered Benefits** under the **Certificate** and/or this Rider.
- **Infertility Case Management.** A program administered by **HMO** that consists of:
 - a. evaluation of **Infertile Members'** medical records to determine whether **ART Services** are **Medically Necessary** and are reasonably likely to result in success;
 - b. determination of whether **ART Services** are **Covered Benefits** for the **Member**;
 - c. pre-authorization for **ART Services** by a **Participating ART Specialist** when **ART Services** are **Medically Necessary**, reasonably likely to result in success, and are **Covered Benefits**; and
 - d. case management for the provision of **ART Services** for eligible **Members**.
- **Participating ART Specialist.** A **Specialist** who has entered into a contractual agreement with **HMO** for the provision of **ART Services**.

The Covered Benefits section of the **Certificate** is hereby amended to add the following benefit(s):

- **Advanced Reproductive Technology Services Benefits.**

Member Eligibility. To be eligible for benefits under this Rider, a **Member** must:

 - a. be covered under the **Certificate** as a **Subscriber** or a **Covered Dependent**;

- b. have utilized **HMO's** Comprehensive **Infertility** Services benefits; and
- c. have a condition that is a demonstrated cause of **Infertility** as recognized by a **Participating ART Specialist** and documented in the **Member's** medical records.

To obtain covered **ART Services** benefits as described in this Rider, a **Member** must be:

- a. referred by the **Member's PCP** or **Participating** gynecologist to the **Infertility Case Management** Unit, or the **Member** may directly contact **HMO's Infertility Case Management** Unit;
- b. recommended for **ART** treatment by a **Participating ART Specialist** after an initial intake evaluation and consultation with the **Participating ART Specialist**;
- c. determined by **HMO** to be eligible for participation in **HMO's Infertility** Program and pre-authorized by **HMO** for the **ART Services** benefit; and
- d. issued pre-authorization for **ART Services** from **HMO's Infertility Case Management** Unit to a **Participating ART Specialist** with appropriate **Referrals**.

The following benefits are covered when all of the above conditions are met, subject to the Exclusions and Limitations section of the **Certificate** and this Rider:

- [a. up to [2-3] cycles [and subject to the Maximum Benefit, if any, shown on the Schedule of Benefits section of this Rider] which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;]
- [a. IVF; GIFT; ZIFT; or cryopreserved embryo transfers subject to the Maximum Benefit shown on the Schedule of Benefits section of this Rider
- b. ICSI or ovum microsurgery;
- c. payment for charges associated with the care of the **Member** who is participating in a donor IVF program, including fertilization and culture; and
- d. charges associated with obtaining the **Member's** spouse's sperm for **ART**, when the spouse is also a **Member**.

The Exclusions and Limitations section of the **Certificate** is hereby amended to add the following exclusion(s):

- **Advanced Reproductive Technology Services**, including but not limited to:
 1. **ART Services** for female **Members** attempting to become pregnant who have not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for **Members** less than 35 years of age), or 6 months or

- more of timed, unprotected coitus, or 6 cycles of artificial insemination (for **Members** 35 years of age or older) prior to enrolling in **HMO's Infertility Program**;
2. **ART Services** for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
 3. Reversal of sterilization surgery;
 4. **ART Services** for female **Members** with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
 5. The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the **Member** or the gestational carrier;
 6. Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
 7. Home ovulation prediction kits;
 8. Drugs related to the treatment of non-covered benefits or related to the treatment of **Infertility** that are not **Medically Necessary**;
 9. **ART** Injectable **Infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
 10. Any service provided without a **Referral** or pre-authorization from **HMO's Infertility Case Management Unit**;
 11. **ART Services** that are not reasonably likely to result in success.

The Exclusions and Limitations section of the **Certificate** is hereby amended to add the following limitation(s):

- **ART Services** are available only from the **Participating ART Specialists** for whom the **Member** has been issued a pre-authorization by **HMO's Infertility Case Management Unit**. Treatment received from a non-participating **Provider** or without a pre-authorization will not be covered and the **Member** will be responsible for payment of all services. Coverage for **ART Services** are only provided for referred care.
- Coverage under this Rider will terminate immediately upon a **Member's** termination of coverage under the **Certificate**, subject to group continuation coverage requirements under COBRA or state continuation laws.

[The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision: The conversion privilege, if any, does not apply to the Advanced Reproductive Technology (“ART”) Services Rider.]

[The Schedule of Benefits is hereby amended to add the following:

ADVANCED REPRODUCTIVE TECHNOLOGY (“ART”) SERVICES BENEFITS

| Benefit | [Deductible][/Copayment][/Maximums] |
|---|---|
| [ART Services Deductible Amount] | [\$[0-2,500] per Member per [calendar year; Contract Year]] |
| <p data-bbox="237 680 578 709">[Outpatient ART Services]</p> <p data-bbox="285 747 578 814">[Performed at Hospital Outpatient Facility]</p> <p data-bbox="285 1024 651 1121">[Performed at Facility Other Than Hospital Outpatient Facility]</p> <p data-bbox="285 1398 675 1428">[Performed by ART Specialist]</p> | <p data-bbox="704 680 1349 709">[\$[0-500] [after ART Services Deductible] per visit]</p> <p data-bbox="704 747 1373 814">[[0-50]% (of the contracted rate) [after ART Services Deductible] per visit]</p> <p data-bbox="704 886 1443 953">[\$[0-500] [after ART Services Deductible] plus [0-50]% (of the balance of the contracted rate) per visit]</p> <p data-bbox="704 1024 1349 1054">[\$[0-500] [after ART Services Deductible] per visit]</p> <p data-bbox="704 1125 1373 1192">[[0-50]% (of the contracted rate) [after ART Services Deductible] per visit]</p> <p data-bbox="704 1264 1443 1331">[\$[0-500] [after ART Services Deductible] plus [0-50]% (of the balance of the contracted rate) per visit]</p> <p data-bbox="704 1402 1333 1432">[\$[0-75] [after ART Services Deductible] per visit]</p> <p data-bbox="704 1470 1373 1537">[[0-50]% (of the contracted rate) [after ART Services Deductible] per visit]</p> <p data-bbox="704 1608 1430 1675">[\$[0-75] [after ART Services Deductible] plus [0-50]% (of the balance of the contracted rate) per visit]</p> |

[Once the **Member** has exhausted the **ART Services** Maximum Benefit or the cycle maximum listed in this Rider, no additional **ART Services** are covered.]

[If the overall plan Maximum Benefit shown in the Schedule of Benefits is exhausted, no additional **ART Services** are covered.]]

HMO CERTIFICATE OF COVERAGE AMENDMENT

AUTISM SPECTRUM DISORDER Form HI NY AAUTISM0ABA V001

[Group Contract Holder [Group Agreement] Effective Date:[_____]]

The Covered Benefits section of the [Aetna Health Inc. (HMO)] Certificate is hereby amended to include the following:

The following services for the screening, diagnosis, and treatment of **autism spectrum disorder** are covered when such services are prescribed or ordered by a **physician** or a licensed psychologist:

“**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. Assessments, evaluations, and tests to determine whether a **Member** has **autism spectrum disorder**.
2. Assistive Communication Devices. A formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, covered services will include the rental or purchase of assistive communication devices when ordered or prescribed by a **physician** or licensed psychologist for **Members** who 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 the person with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; only charges for devices that generally are not useful to a **Member** in the absence of a communication impairment will be considered covered services. Items such as, but not limited to, laptops, desktop, or tablet computers are not covered. Also covered are 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. **HMO** will determine whether the device should be purchased or rented.

Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered **1** [; however, covered services will include one replacement or repair per device type that is necessary due to behavioral issues]. Covered services will include the device most

appropriate to the **Member's** current functional level. Coverage will not be provided for the additional cost of equipment or accessories that are not medically **Necessary**. Covered services do not include delivery or service charges or charges for routine maintenance.

1 [Coverage of assistive communication devices must be **precertified** by **HMO**.]

3. Behavioral health treatment. Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a **Member**. The services must be provided by a licensed provider. Services for applied behavior analysis will be covered when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. "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.

2 [Coverage of **applied behavior analysis** services is limited to [\$45,000 – Unlimited] per [Calendar; Plan; Contract] Year. This maximum annual benefit will increase by the amount calculated from an increase in the medical component of the Consumer Price Index (CPI) as required by New York law.]

4. Psychiatric and Psychological care. Direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.
5. Therapeutic care. Therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the **Member** 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 aggregate visit maximums applicable to services of such therapists or social workers under this **Certificate**.
6. **3** [Pharmacy care. Prescription drugs to treat **autism spectrum disorder** that are prescribed by a **provider** legally authorized to prescribe under title eight of the Education Law will be covered when prescription drugs are otherwise covered under the **Prescription Plan Rider**. Coverage of such prescription drugs is

subject to all the terms, provisions, and limitations that apply to the Prescription Plan Rider.]

Not Covered: Charges for any services or treatment set forth above, when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

You are responsible for any applicable Copayment provisions that apply to the type of service rendered. Please refer to the [Schedule of Benefits] of this Certificate.

**HMO CERTIFICATE OF COVERAGE AND
SCHEDULE OF BENEFITS
AMENDMENT**

**PREVENTIVE CARE BENEFITS
Form HI AGrpHCRPrevNG 01**

[Contract Holder Group Agreement Effective Date:[_____]]

The [Aetna Health Inc. (HMO)] Certificate and Schedule of Benefits are hereby amended as follows:

1. The section entitled Periodic Health Evaluations which appears in Section "[A.] Primary Care Physician Benefits" under the Covered Benefits section of the Certificate, is hereby deleted in its entirety from the Certificate.
2. The section entitled "[B.] Diagnostic Services Benefits" in the Covered Benefits section of the Certificate is deleted and hereby replaced with the following:

B. Diagnostic Services Benefits (Non-Routine).

Services include, but are not limited to, diagnostic, laboratory, and x-ray services provided to diagnose a suspected or identified illness or injury.

3. The following is hereby added to the Covered Benefits section of the Certificate. Any provision or exclusion in the Certificate or any amendment or rider issued to a Member for the Preventive Care Benefits described below no longer applies and is hereby deleted.

[I.] Preventive Care Benefits.

1. Routine Physical Exam Benefit.

Covered Benefits include office visits to a Member's Primary Care Physician (PCP) for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a PCP for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- a. Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- b. For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - i. Screening and counseling services, such as:
 - Interpersonal and domestic violence;

- Sexually transmitted diseases; and
 - Human Immune Deficiency Virus (HIV) infections.
 - ii. Screening for gestational diabetes.
 - iii. High risk Human Papillomavirus (HPV) DNA testing for women [age 18-30 and older] [limited to once every [six months-three years]].
- c. X-rays, lab and other tests given in connection with the exam.
- d. Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- e. [For covered newborns, an initial **Hospital** check up.]

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a **Hospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction;
- Services and supplies furnished by a non-**Participating Provider**.]

2. Well Woman Preventive Visits Benefit.

Covered Benefits include charges made by your **PCP, Physician**, obstetrician, or gynecologist for a routine well woman preventive exam office visit, including a pelvic exam and collection and preparation of Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a **Physician** for a reason other than to diagnose or treat a suspected or identified illness or injury.

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a **Hospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction;
- Services and supplies furnished by a non-**Participating Provider**.]

3. Preventive Screening and Counseling Services Benefit.

Covered Benefits include charges made by your **Physician** in an individual or group setting for the following:

Obesity Benefit.

- a. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
 - [i. Preventive counseling visits and/or risk factor reduction intervention;
 - ii. Medical nutrition therapy;
 - iii. Nutritional counseling; and
 - iv. Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.]
- b. Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits.

Misuse of Alcohol and/or Drugs Benefit.

- a. Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- b. Benefits for the screening and counseling services above are subject to the visit maximums shown in the Schedule of Benefits.

Use of Tobacco Products Benefit.

- a. Screening and counseling services to aid in the cessation of the use of tobacco products. Coverage includes:
 - i. Preventive counseling visits;
 - [ii. Treatment visits; and
 - iii. Class visits;]

to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including:

- i. Cigarettes;
- ii. Cigars;
- iii. Smoking tobacco;
- iv. Snuff;
- v. Smokeless tobacco; and
- vi. Candy-like products that contain tobacco.

- b. Benefits for the screening and counseling services above are subject to the visit maximums shown in the Schedule of Benefits.

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**; and
- Services and supplies furnished by a non-**Participating Provider**.]

4. **Routine Cancer Screenings Benefit.**

Covered Benefits include, but are not limited to, the following routine cancer screenings:

- a. Mammograms;
- b. Digital rectal exams;
- c. Prostate specific antigen (PSA) tests[;
- d. Fecal occult blood tests;
- e. Sigmoidoscopies;
- f. Double contrast barium enema (DCBE); and
- g. Colonoscopies.]

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**; and
- Services and supplies furnished by a non-**Participating Provider**.]

For details on the frequency and age limits that apply to Routine Physical Exam Benefit and Routine Cancer Screenings Benefit contact your **Physician**, [log onto the **HMO** website www.aetna.com,] or call the number on the back of your ID card.

As to routine gynecological exams performed as part of a cancer screening, the **Member** may go directly to a **Participating** obstetrician (OB), gynecologist (GYN), obstetrician/gynecologist (OB/GYN) without a **Referral** from the **PCP**. See the **Direct Access Specialist Benefits** section of the **Certificate**, amendment or rider for a description of this provision.

5. **Prenatal Care Benefit.**

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **PCP, Physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related **Physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**;
- Pregnancy expenses (other than prenatal care as described above); and
- Services and supplies furnished by a non-**Participating Provider**.]

6. Comprehensive Lactation Support and Counseling Services Benefit.

Covered Benefits include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the [60-120 day] period directly following the child's date of birth. **Covered Benefits** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **Covered Benefits** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Schedule of Benefits.

Breast Feeding Durable Medical Equipment

Covered Benefits includes the rental or purchase of breast feeding **Durable Medical Equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump

Covered Benefits include the following:

- a. The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **Hospital**.
- b. The purchase of:
 - i. An electric breast pump (non-hospital grade), if requested within [30-90 days] from the date of the birth of the child. A purchase will be covered [once-twice] every [one-five years] following the date of the birth; or

- ii. A manual breast pump, if requested within [6-12 months] from the date of the birth of the child. A purchase will be covered [once-twice] every [one-five years] following the date of the birth.
- c. If an electric breast pump is purchased within the previous [one-five year] period, the purchase of an electric or manual breast pump will not be covered until a [one-five year] period has elapsed from the last purchase of an electric pump.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

[HMO] reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of [HMO].

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**; and
- Services and supplies furnished by a non-**Participating Provider**.]

Important Note: If a breast pump service or supply that you need is covered under this Plan but not available from a **Participating Provider** in your area, your **PCP** may refer you to a non-**Participating Provider**. You will receive the In-network benefit level as shown in your Schedule of Benefits. Please contact Member Services by [logging on to Aetna Navigator at www.aetna.com] or at the toll-free number on your ID card for assistance].

- [4. The following section is added to the [HMO] **Certificate of Coverage**;

Voluntary Sterilization

Covered Benefits include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered Benefits under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of the confinement.

Limitations:

- The reversal of voluntary sterilization procedures, including any related follow-up care; and
- Services and supplies furnished by a non-**Participating Provider**.]

[5.] The [**Maternity Care and Related Newborn Care Benefits**] section of the [**HMO Certificate of Coverage**] is amended to add the following sentence:

Any **Copayment** that is collected applies to the delivery and postpartum care services provided by an obstetrician/gynecologist (OB/GYN) only. No **Copayment** that is collected applies to Prenatal care services provided by an OB/GYN.

[6.] The following benefits are hereby deleted from the **Schedule of Benefits** under the section "**Primary Care Physician Services**":

- Adult Physical Examination, including Immunizations
- Well Child Physical Examinations, including Immunizations

[7.] The following benefits are added to the **Outpatient Benefits** section of the **Schedule of Benefits**:

| Benefit | Copayments/Maximums |
|--|---|
| Preventive Care Benefits. | |
| Routine Physical Exam Benefit. | |
| Includes coverage for immunization. | \$0 per visit No Copayment applies. |
| Members through age [21-26] [Maximum Age and Visit Limit [per [calendar year; Contract Year; 365 consecutive day period] as applicable] | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your Physician, [log onto the HMO website www.aetna.com] or call the number on the back of your ID card.] |
| [Members ages [22-27] but less than [40-65] [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period; 24 month period] | [1-2 visits]] |

| | |
|---|--|
| [Members age [40-65] and over [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period; 24 month period] | [1-2 visits]] |
| Well Woman Preventive Visits Benefit. | |
| Gynecological Exams (including the Pap Smear as part of the exam) | |
| Performed at a PCP Office | \$0 per visit No Copayment applies. |
| Performed at a Specialist Office | \$0 per visit No Copayment applies. |
| Minimum Number of Visits per [calendar year; Contract Year; 365 consecutive day period] | 2 visits |
| Preventive Screening and Counseling Services Benefit. | |
| Obesity Benefit. | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] [(This maximum applies only to Members ages 22 and older.)] | [1-52 visits (however, of these only [1-52] visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*]] |
| [Daily Maximum Visits [(This maximum applies only to Members ages 22 and older.)] | [1-4 visits*]] |
| [*Note: In figuring the Maximum Visits, each session of up to [15-120 minutes] is equal to one visit.] | |
| Misuse of Alcohol and/or Drugs Benefit. | \$0 per visit |

| | |
|--|--|
| | No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] | [1-12 visits*]] |
| [Daily Maximum Visits | [1-4 visits*]] |
| [*Note: In figuring the Maximum Visits, each session of up to [15-120 minutes] is equal to one visit.] | |
| | |
| Use of Tobacco Products Benefit. | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] | [1-12 visits*]] |
| [Daily Maximum Visits | [1-4 visits*]] |
| [*Note: In figuring the Maximum Visits, each session of up to [15-120 minutes] is equal to one visit.] | |
| | |
| Routine Cancer Screenings (applies whether performed at a Primary Care Physician (PCP) or Specialist office) Benefit. | |
| Mammograms | \$0 per visit No Copayments applies. |
| All other Routine Cancer Screenings | \$0 per visit No Copayment applies. |
| [Maximum Age and Visit Limits per [calendar year; Contract Year; 365 consecutive day period], as applicable] | Subject to any age, family history and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your PCP, Physician, obstetrician (OB), gynecologist (GYN), obstetrician/gynecologist (OB/GYN), [log onto the HMO website www.aetna.com,] or call the number on the back of your</p> |

| | |
|---|--|
| | ID card.]] |
| | |
| Comprehensive Lactation Support and Counseling Services | |
| Lactation Counseling Services | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] either in a group or individual setting] | [6-12 visits*]] |
| Important Note: Visits in excess of the Lactation Counseling Services Maximum Visits as shown above, are covered under the Primary Care Physician Services or Specialist Physician Services section of the Schedule of Benefits. | |
| | |
| Breast Pumps and Supplies | \$0 per item No Copayment applies. |
| Important Note: Refer to the Comprehensive Lactation Support and Counseling Services Benefit section of this amendment for limitations on breast pumps and supplies. | |
| | |

The following benefit is added to the **Outpatient Benefits** section of the **Schedule of Benefits**:

[8.] **The First Prenatal Visit(s) by the attending Obstetrician section of the [HMO] Schedule of Benefits is hereby deleted and replaced with the following:**

| | |
|--|----------------------|
| Prenatal care services provided by obstetrician/gynecologist (OB/GYN) | \$0 per visit |
|--|----------------------|

[*Important Note: Refer to the Inpatient Maternity sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan.]

[9.] **The last sentence in the Maternity section of the [HMO] Schedule of Benefits is hereby deleted and replaced with the following:**

| <u>Benefit</u> | <u>Copayment</u> |
|----------------|---|
| Maternity | See Specialist Physician Services for prenatal care, delivery and postpartum care and services. |

[10. The following benefits are added to the **Outpatient Benefits** section of the **Schedule of Benefits**:

| Female Voluntary Sterilization | |
|---------------------------------------|--|
| Benefit | Copayment |
| Inpatient | \$0 per admission No Copayment applies. |
| Outpatient | \$0 per visit/surgical procedure No Copayment applies.] |

Important Note: The benefits on this Preventive Care Benefits Amendment replace any similar or like benefits previously issued to a Member on any Certificate, Schedule of Benefits, amendment or rider.

**HMO CERTIFICATE OF COVERAGE AND
SCHEDULE OF BENEFITS
AMENDMENT**

**PREVENTIVE CARE BENEFITS
Form HI AGrpHCRPrevG 01**

[Contract Holder Group Agreement Effective Date:[_____]]

The [Aetna Health Inc. (HMO)] Certificate and Schedule of Benefits are hereby amended as follows:

- [1. The section entitled Periodic Health Evaluations which appears in Section "[A.] Primary Care Physician Benefits" under the Covered Benefits section of the Certificate, is hereby deleted in its entirety from the Certificate.]
- [2. The section entitled "[B.] Diagnostic Services Benefits" in the Covered Benefits section of the Certificate is deleted and hereby replaced with the following:

B. Diagnostic Services Benefits (Non-Routine).

Services include, but are not limited to, diagnostic, laboratory, and x-ray services provided to diagnose a suspected or identified illness or injury.]

- [3. The following is hereby added to the Covered Benefits section of the Certificate. Any provision or exclusion in the Certificate or any amendment or rider issued to a Member for the Preventive Care Benefits described below no longer applies and is hereby deleted.

[I.] Preventive Care Benefits.

[• Routine Physical Exam Benefit.

Covered Benefits include office visits to a **Member's Primary Care Physician (PCP)** for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **PCP** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- a. Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- f. For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - iv. Screening and counseling services, such as:
 - Interpersonal and domestic violence;

- Sexually transmitted diseases; and
- Human Immune Deficiency Virus (HIV) infections.
- v. Screening for gestational diabetes.
- vi. High risk Human Papillomavirus (HPV) DNA testing for women [age 18-30 and older] [limited to once every [six months-three years]].
- g. X-rays, lab and other tests given in connection with the exam.
- h. Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- i. [For covered newborns, an initial **Hospital** check up.]

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a **Hospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction;
- Services and supplies furnished by a non-**Participating Provider**.]]

[• Well Woman Preventive Visits Benefit.

Covered Benefits include charges made by your **PCP, Physician** obstetrician, or gynecologist for a routine well woman preventive exam office visit, including a pelvic exam an collection and preparation of Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a **Physician** for a reason other than to diagnose or treat a suspected or identified illness or injury.

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a **Hospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction;
- Services and supplies furnished by a non-**Participating Provider**.]]

[• Preventive Screening and Counseling Services Benefit.

Covered Benefits include charges made by your **Physician** in an individual or group setting for the following:

[Obesity Benefit.

- b. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- [i. Preventive counseling visits and/or risk factor reduction intervention;
- ii. Medical nutrition therapy;
- v. Nutritional counseling; and
- vi. Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.]

- b. Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits.]

[Misuse of Alcohol and/or Drugs Benefit.

- a. Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- b. Benefits for the screening and counseling services above are subject to the visit maximums shown in the Schedule of Benefits.]

[Use of Tobacco Products Benefit.

- a. Screening and counseling services to aid in the cessation of the use of tobacco products. Coverage includes:
- i. Preventive counseling visits;
 - [ii. Treatment visits; and
 - iii. Class visits;]

to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including:

- i. Cigarettes;
- ii. Cigars;
- iii. Smoking tobacco;
- iv. Snuff;
- v. Smokeless tobacco; and
- vi. Candy-like products that contain tobacco

- b. Benefits for the screening and counseling services above are subject to the visit maximums shown in the Schedule of Benefits.]

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**; and
- Services and supplies furnished by a non-**Participating Provider**.]]

[• Routine Cancer Screenings Benefit.

Covered Benefits include, but are not limited to, the following routine cancer screenings:

- a. [Mammograms;
- b. Fecal occult blood tests;
- c. Prostate specific antigen (PSA) tests];
- d. Digital rectal exams;
- e. Sigmoidoscopies;
- f. Double contrast barium enema (DCBE); and
- g. Colonoscopies.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**; and
- Services and supplies furnished by a non-**Participating Provider**.]]

For details on the frequency and age limits that apply to Routine Physical Exam Benefit and Routine Cancer Screenings Benefit contact your **Physician**, [log onto the **HMO** website www.aetna.com,] or call the number on the back of your ID card.

As to routine gynecological exams performed as part of a cancer screening, the **Member** may go directly to a **Participating** obstetrician (OB), gynecologist (GYN), obstetrician/gynecologist (OB/GYN) without a **Referral** from the **PCP**. See the **Direct Access Specialist Benefits** section of the **Certificate**, amendment or rider for a description of this provision.]]

[• Prenatal Care Benefit.

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **PCP, Physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related **Physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate;**
- Pregnancy expenses (other than prenatal care as described above); and
- Services and supplies furnished by a non-**Participating Provider.**]]

[• Comprehensive Lactation Support and Counseling Services Benefit.

Covered Benefits include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the [60-120 day] period directly following the child's date of birth. **Covered Benefits** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **Covered Benefits** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Schedule of Benefits.]

[Breast Feeding Durable Medical Equipment

Covered Benefits includes the rental or purchase of breast feeding **Durable Medical Equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump

Covered Benefits include the following:

- c. The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **Hospital.**
- d. The purchase of:
 - iii. An electric breast pump (non-hospital grade), if requested within [30-90 days] from the date of the birth of the child. A purchase will be covered [once-twice] every [one-five years] following the date of the birth; or

- iv. A manual breast pump, if requested within [6-12 months] from the date of the birth of the child. A purchase will be covered [once-twice] every [one-five years] following the date of the birth.
- c. If an electric breast pump is purchased within the previous [one-five year] period, the purchase of an electric or manual breast pump will not be covered until a [one-five year] period has elapsed from the last purchase of an electric pump.]

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

[HMO] reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of [HMO].]

[Limitations:

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

- Services which are covered to any extent under any other part of this **Certificate**; and
- Services and supplies furnished by a non-**Participating Provider**.]

Important Note: If a breast pump service or supply that you need is covered under this Plan but not available from a **Participating Provider** in your area, your **PCP** may refer you to a non-**Participating Provider**. You will receive the In-network benefit level as shown in your Schedule of Benefits. Please contact Member Services by [logging on to Aetna Navigator at www.aetna.com] or at the toll-free number on your ID card for assistance].

- [4. The following section is added to the [HMO] **Certificate of Coverage**;

Voluntary Sterilization

Covered Benefits include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered Benefits under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of the confinement.

Limitations:

- The reversal of voluntary sterilization procedures, including any related follow-up care; and
- Services and supplies furnished by a non-**Participating Provider**.]

[5. The [**Maternity Care and Related Newborn Care Benefits**] section of the [**HMO**] **Certificate of Coverage** is amended to add the following sentence:

Any **Copayment** that is collected applies to the delivery and postpartum care services provided by an obstetrician/gynecologist (OB/GYN) only. No **Copayment** that is collected applies to Prenatal care services provided by an OB/GYN.]

[6. The following benefits are hereby deleted from the **Schedule of Benefits** under the section "**Primary Care Physician Services**":

- Adult Physical Examination, including Immunizations
- Well Child Physical Examinations, including Immunizations]

[7.] The following benefits are added to the **Outpatient Benefits** section of the **Schedule of Benefits**:

| Benefit | Copayments/Maximums |
|--|---|
| Preventive Care Benefits. | |
| Routine Physical Exam Benefit. | |
| Includes coverage for immunization. | \$0 per visit No Copayment applies. |
| Members through age [21-26] [Maximum Age and Visit Limit [per [calendar year; Contract Year; 365 consecutive day period] as applicable] | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your Physician, [log onto the HMO website www.aetna.com] or call the number on the back of your ID card.] |
| [Members ages [22-27] but less than [40-65] [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period; 24 month period] | [1-2 visits]] |

| | |
|---|--|
| [Members age [40-65] and over [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period; 24 month period] | [1-2 visits]] |
| Well Woman Preventive Visits Benefit. | |
| Gynecological Exams (including the Pap Smear as part of the exam) | |
| Performed at a PCP Office | \$0 per visit No Copayment applies. |
| Performed at a Specialist Office | \$0 per visit No Copayment applies. |
| [Minimum Number of Visits per [calendar year; Contract Year; 365 consecutive day period] | 2 visits |
| Preventive Screening and Counseling Services Benefit. | |
| Obesity Benefit. | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] [(This maximum applies only to Members ages 22 and older.)] | [1-52 visits (however, of these only [1-52] visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*]] |
| [Daily Maximum Visits [(This maximum applies only to Members ages 22 and older.)] | [1-4 visits*]] |
| [*Note: In figuring the Maximum Visits, each session of up to [15-120 minutes] is equal to one visit.] | |
| Misuse of Alcohol and/or Drugs Benefit. | \$0 per visit |

| | |
|--|--|
| | No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] | [1-12 visits*]] |
| [Daily Maximum Visits | [1-4 visits*]] |
| [*Note: In figuring the Maximum Visits, each session of up to [15-120 minutes] is equal to one visit.] | |
| | |
| Use of Tobacco Products Benefit. | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] | [1-12 visits*]] |
| [Daily Maximum Visits | [1-4 visits*]] |
| [*Note: In figuring the Maximum Visits, each session of up to [15-120 minutes] is equal to one visit.] | |
| | |
| Routine Cancer Screenings (applies whether performed at a Primary Care Physician (PCP) or Specialist office) Benefit. | |
| Mammograms | \$0 per visit No Copayments applies. |
| All other Routine Cancer Screenings | \$0 per visit No Copayment applies. |
| [Maximum Age and Visit Limits per [calendar year; Contract Year; 365 consecutive day period], as applicable] | Subject to any age, family history and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your PCP, Physician, obstetrician (OB), gynecologist (GYN), obstetrician/gynecologist (OB/GYN), [log onto the HMO website www.aetna.com,] or call the number on the back of your</p> |

| | |
|---|--|
| | ID card.]] |
| Comprehensive Lactation Support and Counseling Services | |
| Lactation Counseling Services | \$0 per visit No Copayment applies. |
| [Maximum Visits per [calendar year; Contract Year; 365 consecutive day period] either in a group or individual setting] | [6-12 visits*]] |
| [Important Note: Visits in excess of the Lactation Counseling Services Maximum Visits as shown above, are covered under the Primary Care Physician Services or Specialist Physician Services section of the Schedule of Benefits]. | |
| Breast Pumps and Supplies | \$0 per item No Copayment applies. |
| Important Note: Refer to the Comprehensive Lactation Support and Counseling Services Benefit section of this amendment for limitations on breast pumps and supplies. | |

[8. The First Prenatal Visit(s) by the attending Obstetrician section of the [HMO] Schedule of Benefits is hereby deleted and replaced with the following:

| | |
|--|----------------------|
| Prenatal care services provided by obstetrician/gynecologist (OB/GYN) | \$0 per visit |
|--|----------------------|

Important Note: Refer to the Inpatient Maternity sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan.]

[9. The last sentence in the Maternity section of the [HMO] Schedule of Benefits is hereby deleted and replaced with the following:

INPATIENT BENEFITS

| <u>Benefit</u> | <u>Copayment</u> |
|-----------------------|---|
| Maternity | See Specialist Physician Services for prenatal care, delivery and postpartum care and services.] |

[10. The following benefits are added to the **Outpatient Benefits** section of the **Schedule of Benefits**:

| Female Voluntary Sterilization | |
|---------------------------------------|--|
| Benefit | Copayment |
| Inpatient | \$0 per admission No Copayment applies. |
| Outpatient | \$0 per visit/surgical procedure No Copayment applies.] |

Important Note: The benefits on this Preventive Care Benefits Amendment replace any similar or like benefits previously issued to a Member on any Certificate, Schedule of Benefits, amendment or rider.

**HMO CERTIFICATE OF COVERAGE
AMENDMENT**

**SCREENING FOR GESTATIONAL DIABETES
Form HI AHCRPrevGest 01**

[**Contract Holder Group Agreement** Effective Date:[_____]]

The [**Aetna Health Inc. (HMO)**] **Certificate** is hereby amended as follows:

The **Primary Care Physician Benefits** provision under the Covered Benefits section of the **Certificate** is hereby amended to add the following:

5. Periodic health evaluations to include:
 - Screening for gestational diabetes.

**HMO CERTIFICATE OF COVERAGE
AMENDMENT**

Form HI NY ACOCTransGender V001

[Contract Holder [Group Agreement] Effective Date:[_____]]

The [Aetna Health Inc.] **Certificate** is hereby amended as follows:

The following subsection is added to the Section "Covered Benefits" of the **Certificate**:

[X.] Covered Benefits for Sex Changes:

Benefits for the treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling

Index of Applicable Forms

| <u>Form Name</u> | <u>Form Description</u> |
|---|---|
| HMO COC NY AMENDSI (2/05) | HMO COC Amendment for Self Injectables |
| HMO GEN AMEND RXCOPAY (01-05) | HMO Novartis Specific Drug Coverage Amendment |
| HMO/NY AMEND-1 DP 04/97 | HMO Domestic Partner Rider |
| HMO NY AMEND-1 MSO 05-05 | HMO Non-Custodial Care Amendment |
| HMO/NY AMEND-COMPINF-1 (11/99) | HMO Comprehensive Infertility Amendment |
| HMO/NY AMEND-NYSHIPDP-1 08/00 | HMO NYSHIP Domestic Partner Rider |
| HMO/NY AMEND-NYSHIPRX-1 08/00 | HMO NYSHIP Prescription Plan Rider |
| HMO/NY AMEND-PREM-1 04/97 | HMO Premium Adjustment Amendment to the Group Agreement |
| HMO/NY AMEND RXPFIZER (05-04) | HMO Pfizer Specific Drug Coverage Amendment |
| HMO/NY CITYNYRXAMEND-2 05/05 | HMO City of NY RX Carve Out Amendment |
| HMO/NY CLINICALREV AMEND-1 (08-05) | HMO Clinical Review Wording Update |
| HMO/NY COC-1 04/97 | HMO Certificate of Coverage |
| HMONY COC AMENDIMM (6/06) | HMO Immunizations |
| HMO/NY COC-1 w/ HMO/NY SB-1 w/ USH/NY SLC-1 | Select (Premier & Patriot V, X & XV) |
| HMO/NY COC-1 w/ HMO/NY SB-1 w/ USH/NY RCW-1 | Hybrid (Premier, Value Plus & Patriot V & X) |
| HMO/NY COC-1 w/ HMO/NY SB-1 w/ USH/NY UAW/GMC-1 | High Option Plan |
| HMO/NY COC-2 04/02 | HMO Certificate of Coverage |
| HMO/NY CONTAMEND-1 01/02 | HMO Continuation Amendment |
| HMO/NY DENAMENDCOC-1 (03/00) | HMO Dental Exclusion Amendment to the COC |
| HMO/NY DIABETIC/AMEND-1 (11/03) | HMO Diabetic Supply Amendment |
| HMO/NY ENDORSE-SEC125-1 04/97 | HMO Enrollment Endorsement to the COC |
| HMO/NY EXAPPAMEND-1 (09/99) | HMO External Appeal Amendment to the COC |
| HMO/NY GA-2 11/01 | HMO Group Agreement |
| HMO/NY GA2AMEND 03/02 | HMO Group Agreement |
| GR-23-7 (7/05) | HMO Employer Application Form |
| HMO/NY GACS-AMEND-1 04/97 | HMO Group Agreement Cover Sheet Amendment |
| HMO/NY G&A AMEND-1 (6-06) | HMO Grievances and Appeals |
| HMO GEN RTF-AMEND-1 (8/05) | HMO Residential Treatment Facility Amendment |
| HMO/NY GEN SPEECHAMEND 08/04 | HMO Optional Speech Development Delay Coverage |
| HMO/NY GRIEVEAMEND-1 09/01 | HMO Grievance Amendment |
| HMO/NY HHC-AMEND-1 (7/04) | HMO Certificate of Coverage Amendment |
| HMO/NY HHC-AMEND-1 05/08 | HMO Certificate of Coverage Amendment |
| HMO NY HIPAA-AMEND-1 (4/05) | HMO HIPAA Amendment |
| HMO NY HNOAMEND (09/06) | HMO HNO Amendment |
| HMO/NY IMMAMEND-1 (12/00) | HMO Immunization Amendment to the COC |
| HMO/NY MAMAMEND-1 (02/00) | HMO Mammogram Amendment to COC |
| HMO/NY MASTAMENDCOC-1 (06/99) | HMO Mastectomy Reconstruction Amendment to COC |
| HMO NY MENTALBENE AMEND (01/07) | HMO Mental Health Amendment |
| HMO/NY MOP-1 05/02 | HMO Method of Payment Amendment |
| HMO/NY NAMEAMEND-1 03/02 | HMO Name Change Amendment |
| HMO/NY NUSUPCOCAMEND-1 07/01 | HMO Nutritional Supplement Amendment |
| HMO/NY NUTRSUPPRXAMEND-1 07/01 | HMO Nutritional Supplement Amendment to RX2000 |
| HMO/NY OPENACCESS(09/00) | HMO Aetna Open Access Rider |
| HMO/NY OPTHERAPYAMEND-1 (07-05) | HMO Therapy Limit |
| HMO/NY PSAAMEND-1 (01/01) | HMO Prostate Cancer Screening Amendment |
| HMO/NY REHAB-AMEND-1 (7/04) | HMO Certificate of Coverage Amendment |

Index of Applicable Forms

| <u>Form Name</u> | <u>Form Description</u> |
|-----------------------------------|--|
| HMO/NY RIDER-ART-1 (08/98) | HMO Advanced Reproductive Technology Rider |
| HMO NY RIDER 2003ART-1 (07-03) | HMO Advanced Reproductive Technology Rider |
| HMO/NY RIDER-DEN-1 04/97 | HMO Dental Plan Rider |
| HMO/NY RIDER-NBR-1 04/97 | HMO Network Benefits Rider |
| HMONY RIDER-NYSHIP-2 8-03 | HMO NYSHIP Plan Rider to the COC and SOB |
| HMO/NY Amend- NYSHIP-2 (8/05) | HMO NYSHIP Plan Rider to the COC and SOB |
| HI/NY ANYSHIP-ELIG V007 | HMO NYSHIP |
| HMO/NY RIDER-RX-2000 (5/99) | HMO Prescription Plan Rider |
| HMO/NY RIDER-SHELL-1 04/97 | HMO Shell Rider |
| HMO/NY RIDER-UAW-2 (10/99) | HMO [UAW] [NOCO] Plan Rider |
| HMO NY RIDER-VIS-2 (06/06) | HMO Prescription Lens Reimbursement Rider |
| HMO/NY RX2000AMEND-1 06/01 | HMO Prescription Plan Rider |
| HMO/NY RX2000 AMEND-2 07/02 | HMO Prescription Plan Rider |
| HMO/NY RX2000 AMEND-3 10/02 | HMO Prescription Plan Rider |
| HMO/NY RX2003 8/03 | HMO Prescription Plan Rider |
| HMO/NY RX2003 10/03 | HMO Prescription Plan Rider |
| HMO/NY RX2003 4/04 | HMO Prescription Plan Rider |
| HMO/NY RX2003 2/05 | HMO Prescription Plan Rider |
| HMO/NY RX CONTRACPT RIDER-1 12/02 | HMO Contraceptive Rider |
| HMO/NY RXTHERAMEND 07/02 | HMO Prescription Drug Class Exclusion |
| HMO/NY RXVIAGRAAMEND-1 11/01 | HMO Performance Rider |
| HMO/NY SB-2 11/01 | HMO Schedule of Benefits |
| HMO/NY SB-2 11/03 | HMO Schedule of Benefits |
| HMO/NY SB-3 10-03 | HMO Schedule of Benefits |
| HMO/NY SB-PREFER-1 04/97 | HMO Schedule of Benefits (Attachment A) |
| NY SUBRO WORKERS COMP-1 (01/06) | HMO Subrogation and Workers Compensation |
| HMO/NY URGENTAMEND-1 08/01 | HMO Urgent Care Amendment |
| HMO/NY TRANSPLANT-AMEND-1 (6/03) | HMO Transplant Amendment |
| HMO/NY VESTAMENDCOC-1 (02/00) | HMO Vesting Amendment to the COC |
| HI GE ASURGERYDEF V001 | HMO Surgery Exclusion |
| HI GE FELONYEXCL V001; | HMO Felony Exclusion |
| HI NY ACOMPASSION V001 | HMO Compassionate Care |
| HI NY ACONT08400 V001 | HMO Continuation Requirements |
| HI NY AFED08MHPAR V001 | HMO Mental Health Parity Act |
| HI NY ATRANSPLANT V002 | HMO Transplants |
| HI NY ACNYRXSI V001 | HMO City of NY |
| HI NY COCNYSI V001 | HMO City of NY |
| HI NY RRXGENERICO V001 | HMO Generic Only Prescription drug |
| HI NY ARxROCKLAND V001 | HMO Prescription Drug |
| HI NY SOBSchedule V004 | HMO Summary of Benefits |
| HMO/NY TRANSPLANTS 10/08 | HMO Transplants |
| HI NY WELLINCENT V001 | HMO Wellness |
| HI NY AALTERNATES V002 | HMO Alternate Sites of Service |
| HI NY AGRIEAPPEAL V001 | HMO Grievances and Appeals |
| HI NY ACONTUMLOA V001 | HMO Michelle's Law |
| HI NY AContDeps29 V001 | HMO Dependent Age to 29 |

Index of Applicable Forms

| <u>Form Name</u> | <u>Form Description</u> |
|---------------------------|--|
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| HI NY A00ShipElig V011 | NYSHIP eligibility revision |
| HI NY A00ShipElig V010 | NYSHIP eligibility revision |
| HI NY AGRIEAPPEAL V002 | Grievances and Appeals. |
| HI NY ACLAIMooGRP v001 | AB-8402 compliance |
| HI NY AGrpAGRRxINJ V001 | Compliance with AB-12019 |
| HI NY DISCLOSURE V001 | HMO Disclosure amendment |
| HI NY A DIALYSIS V001 | Compliance with S-1803 |
| HI NY AGpAgrHCRPolProv 01 | Premium Termination and Rebate Allocation and Distribution |
| HI NY AFEES V001 | Change to Premiums and Fees provisions |
| HI ARx PLAN RIDER | Chemotherapy - to comply with S-3988 |
| HI NYACOCTransGender | To provide transgender surgery |
| HI NY AEXTENSION V001 | Revises extension of benefits |
| HI NY A00SHIP ELIG V009 | SHIP Deps to age 29 amendment |
| HI NY AGRIEAPPEAL | Grievances and Appeals amendment |
| HI NY RWELLINCENT V001 | Health incentives program |
| HI NY AReconSurgery V001 | Reconstructive Surgery |
| HI NY RRXDRUGPLAN V001 | Pharmacy |
| HI NY RRXGENERICO V002 | Generic Only |
| HI AHCRPrevGest 01 | Preventative Care |
| HI AContHCRPrevNG 01 | Preventative Care |
| HI AGrpHCRPrevG 01 | Preventative Care |
| HI AGrpHCRPrevNG 01 | Preventative Care |
| HI NY AAUTISM0ABA V001 | Autism Mandate |

Year 2012

Form Number

HI NY AFEES V001
HI ARx PLAN RIDER
HI NYACOCTransGender

YEAR 2011

HI NY ADISCLOSURE V001
HI NY AEXTENSION V001
HI NY AGpAgrHCRPolProv 01
HI NY ADIALYSIS V001

YEAR 2010

HI NY A00SHIP ELIG V009
HI NY AContDepsSG V001
HI NY ACONTOA8400 V001

HI GE AFELONYEXCL V001; HI GE ASYRGERYDEF V001; HI NY AFED08MHPAR V001
HI NY RRXGENERICO V002; HI NY RRXDRUGPLAN V001
HI NY A00Ship Elig V010
HI ASTATHCRGrp 01 NY
HI NY AGRIEAPPEAL V002
HI NY AGRIEAPPEAL

YEAR 2009

HI NY ACONTUMLOA V001
HI NY AALTERNATES V002
HI NYAGRIEAPPEAL V001
HI NY RWELLINCENT V001
HI NY A ContDeps29 V001

YEAR 2008

HI NY A00ShipElig V007
HI NY ATransplant V002
HMO/NY HHC-AMEND-1 (5/08)
HI NY ACOMPASSION V001
HMO/NY IPBENEFITS AMEND (05-08)
HI NY RRX GENERICO V001
HI NY SOBSchedule V004
HMO/NY Transplants 10/08

YEAR 2007

HMO NY MENTALBENE AMEND (01/07)
HMO GEN GP AMEND (06/07)
HMO/NY COC-SGI 10/06
HMONY MENTALBENE AMEND-1 (01/07)

HMO NY HNO AMEND (09/06); HMO NY RIDER-VIS-2 (06/06)

HMO/NY AMEND-NYSHIP-5 (4/06)

YEAR 2006

HMO GEN RTF-AMEND-1 (08/05)

HMO/NY CLINICALREV AMEND-1 (08-05)

HM)/NY G&A AMEND-1 (6-06)

YEAR 2002

HMO/NY GA-2 11/01

HMO/NY SB02 11/01

HMO/NY GA2AMEND 03/02

HMO/NY NAMEAMEND-1 03/02

HMO/NY RXVIAGREEMEND-1 11/01

YEAR 2003

HMO/NY COC-2 04/02

HMO/NY RIDER 2003ART-1 07/03

HMO/NY RX2003 8/02

HMO/NY RIDER-NYSHIP-2 8/03

HMO/NY TRANSPLANT-AMEND-1 (6/03)

HMO/NY DIABETIC-AMENFD-1 (11/03)

YEAR 2004

HMO/NY AMEND RXPFIZER (05/04)

YEAR 2005

HMO NY REHAB-AMEND-1 (7/04)

HMO/NY HHC-AMEND-1 (7/04)

HMO NY HIPPA-AMEND-1 (4/05)

HMO/NY OPTHERAPY AMEND-1 (07/05)

HMO/NY CITYNYRXAMEND-2 (05/05)

HMO GEN SPEECHAMEND (08/04)

HMO/NY RX CONTRACEPT RIDER-2 09/04

HMO/NY PREVCAREAMEND (-7/05)

HMO NY AMEND-1 MSO 05-05

| <u>File #</u> | <u>Approval Date</u> |
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| 2011100120 | 02/08/2012 |
| 2012030036 | 03/16/2012 |
| 2012020103 | 03/19/2012 |
| 2010090134 | 03/10/2011 |
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| 2003124731 | 12/19/2003 |

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| 2004070023 | 08/27/2004 |
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| 2005060092 | 09/07/2005 |
| 2005800162 | 12/14/2005 |
| 2005050146 | 07/01/2005 |
| 2004090098 | 03/16/2005 |
| 2004100284 | 04/15/2005 |
| 2005080137 | 10/11/2005 |
| 2005060116 | 09/07/2005 |

Comments

Change to Premiums and Fees provisions
Chemotherapy - to comply with S-3988
To provide transgender surgery

Disclosure document

Revises extension of benefits
To comply with PPACA - Retro terms/Premium rebates
To comply with S-1803

SHIP Deps to age 29 amendment
Deps to Age 29 for Small group
To comply with AB-8400 (Mini-Cobra)

Mental Health Parity Act, plus Felony exclusion and surgery definition
Rx Generic only and Standard Drug Riders
NYSHIP Eligibility Amendment
federal Health Care Reform
Grievances and Appeals amendment
Grievances and Appeals amendment

Michelle's Law
Walk-In Clinics
Grievances and Appeals amendment
Health incentives program
Dependents to Age 29 amendment

NY SHIP Amendment
Transplants amendment
Home Health care amendment
Revised Hospice definition
NY Community Plan IP benefits revision
Generic Prescription Drug rider
Revised Schedule of Benefits
NYC Community Plan transplants amendment

Timothy's Law
Assignment of Benefits
NY Community Plan Certificate
Timothy's Law resubmission

"Health Network Option" amendment and vision rider
NY SHIP eligibility

Residential Treatment Facility revised definition
Clinical review criteria disclosure - Section 4408)
Subrogation provision
Grievances and Appeals provision

HMO Group Agreement (Policy)
Schedule of Benefits, Method of Payment Amendment
Group Agreement Amendment (Records provision)
Name change to Aetna Health Inc.
Amendment to cover Viagra

Certificate of Coverage
Advance Reproductive Technology rider
Contraceptives rider
NY SHIP eligibility
Transplant benefits
Diabetes benefits amendment

Zero copayment for RX (intended for Pfizer)

Rehabilitation benefits amendment
Home Health Care benefits amendment
To comply with HIPAA
Outpatient Rehab amendment
City of New York
Speech Therapy (for Verizon)
Contraceptives rider
Preventive care amendment (for Pfizer)
To comply with Circular Letter 4 (2005)