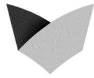

EmblemHealth®
GHI and HIP are EmblemHealth companies

55 Water Street, New York, New York 10041-8190

Important Information About Your
HIP Health Plan of New York Renewal Rates

«Date»

«Group_Name1» «Group_Name2»
«Contact First Name» «Contact Last Name»
«Street Add 1»
«Street Add 2»
«City», «State» «Zip Code»

Selling Agent
«SA First Name» «SA Last Name»
«Street Add 1»
«Street Add 2»
«City», «State» «Zip Code»

Dear «Contact First Name» «Contact Last Name»:

A new law in New York State requires us to notify you approximately 60 days in advance of certain health plan premium rate changes. Therefore, we are writing to inform you of your premium rates for your **«PLAN»** plan under group number **«GROUP_NO»** effective **«Rate_Eff_Date»**:

Type of Coverage	Monthly Rate
Individual Coverage	«Tier_ID_1»
Employee and Spouse	«Tier_ID_3»
Employee and Child(ren)	«Tier_ID_2»
Family (Employee, Spouse and Children)	«Tier_ID_4»

Please note that there are a number of components in your rate change. The first component reflects an increase of up to 4.1 percent approved by the New York State Insurance Department ("NYSID"). A second component reflects adjustments we filed prior to the third quarter of 2010. This portion of your rate change, some of which was not subject to approval by NYSID, is the result of rising health care costs. The remaining components of your rate change, which were approved by NYSID, include the elimination of the New York State subsidy for certain mental health benefits required by legislation known as Timothy's Law, and the impact of the federal health reform law (the Affordable Care Act).

EmblemHealth offers plan options that enable you to reduce your premiums. Cost-reduction options that are available to you, as well as information about additional riders you may wish to purchase, also appear on the reverse side of this letter.

As a reminder, you are required to notify your covered employees about this rate increase and any additional premium contribution as soon after receiving this letter as possible. If your benefit plan requires your employees to make a premium contribution, the notice should include the amount your employees will be expected to contribute based on the new rates.

If you have any questions about renewing your policy, please contact your broker or call EmblemHealth Account Services at **1-866-614-6040**, Monday through Friday from 9 am to 5 pm. For additional information about your premium rates, please visit us online at **www.emblemhealth.com**.

We value our relationship with you and are committed to providing your group with quality health care coverage. We look forward to continuing to meet your health coverage needs.

Sincerely,

William Dunne

William Dunne
Vice President, Commercial Account Management

Please see reverse side

A RANGE OF COVERAGE OPTIONS

Changes in benefits have an impact on your premium. If you are interested in making changes to your plan, EmblemHealth offers a range of coverage choices for your group, including flexible pharmacy and benefits designs and cost-sharing options designed to meet all budget levels. You have the option to offer your employees more than one EmblemHealth plan and can choose from among the EmblemHealth PPO, EPO, ConsumerDirect High-Deductible Health Plan and InBalance alternatives. Available statewide, these plans are served by the EmblemHealth national network and underwritten by GHI, an EmblemHealth company.

ADDITIONAL RIDERS YOU CAN PURCHASE AT RENEWAL

Extended Dependent Coverage extends to age 29 the coverage age limit for all eligible dependents of your group members.

Mental Health and Substance Use Coverage Parity. The federal Mental Health Parity and Addiction Equity Act generally mandates that large-group health plans apply the same treatment and financial limits to mental health and substance use benefits as they do to hospital and medical benefits. As a small group, you can purchase a rider to similarly extend your group's coverage.

Mental Health Coverage Parity Under Timothy's Law. All small groups receive the following mandated benefits: 20 outpatient visits and 30 inpatient days for the diagnosis and treatment of mental, nervous or emotional disorders. All member cost-sharing such as copays, deductibles and coinsurance must be the same as those that apply to comparable medical and hospital services under the applicable health benefit plan. These benefits are already included in your current coverage. Small groups may purchase coverage that exceeds the 20 outpatient visits and 30 inpatient days already provided. This additional coverage is for certain biologically-based mental illnesses (schizophrenia/psychotic disorder, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia and anorexia) and for certain serious emotional disturbances for individuals under the age of 18 (attention deficit disorder, disruptive behavior disorder and pervasive developmental disorder). If you purchase this coverage, services for biologically-based mental illnesses and serious emotional disturbances are not subject to any visit or day limit below the limits that apply to comparable medical and hospital coverage under your health benefit plan.

Inpatient Chemical Abuse and Dependence Coverage. You can purchase coverage for inpatient hospital services or inpatient rehabilitation services in a hospital-based or free-standing chemical dependence facility, for the diagnosis and treatment of chemical abuse and chemical dependence, including alcohol substance abuse.

MORE ABOUT HEALTH REFORM

The federal health reform law brings significant changes to health care coverage. The Affordable Care Act, commonly known as health reform, has a 10-year implementation period. **The most immediate product benefit changes, effective on your renewal date, are the following:**

- There are no annual and lifetime dollar limits for essential benefits[1] on policies issued or renewed after September 23, 2010.
- For policies issued or renewed after September 23, 2010, pre-existing condition limitations will be waived for enrollees under age 19. Pre-existing condition exclusions will be eliminated for all members, for policies issued or renewed January 11, 2014, or after.
- Continued coverage for dependents on their parents' health plan until age 26 (end of month) for plan years starting on or after September 23, 2010.[2]
- Elimination of in-network cost-sharing for preventive care services.
- Identical copays and coinsurance for emergency room services whether obtained in network or out of network.

For certain employers with fewer than 25 employees, the law also creates an opportunity for a tax credit of up to 35 percent of the employer's contribution toward his or her employees' health insurance premiums. For details on health care reform and how it may apply to you, or more information about the tax credit, please visit **www.emblemhealthreform.com**.

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1. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
2. If your benefit plan provides dependent coverage through age 29, that coverage will remain in effect unless you drop your extended dependent coverage rider.

cc: «Agent» Customer ID: «0000» Form: XXXX