

**NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES**

**DATA REQUIREMENTS FOR
HEALTH MAINTENANCE ORGANIZATIONS**

FOR THE YEAR ENDING DECEMBER 31, 2013

To be filed by April 1, 2014

Name of HMO

This Form bearing original signatures and notarization should be filed at the address indicated on the New York State Department of Financial Service's website (www.dfs.ny.gov).

In addition, two copies of both the annual and quarterly NAIC statements and the annual and quarterly Data Requirements should be filed with the Department of Health, one each to the following:

Mr. Whitney Reed
Principal Health Care Fiscal Analyst
Bureau of Managed Care Fiscal Oversight
Division of Health Plan Contracting & Oversight
Office of Health Insurance Programs (OHIP)
Corning Tower, Room 2040
Albany, New York 12237

Patrick Roohan, Director
Bureau of Quality Management and Outcomes Research
New York State Department of Health
Empire State Plaza
Tower Building – Room 1938
Albany, New York 12237

2013 Edition

HMO

Special attention is called to the INSTRUCTIONS at the rear of this supplement

2013

ANNUAL STATEMENT
FOR THE YEAR ENDING DECEMBER 31, 2013
OF THE CONDITION AND AFFAIRS OF

(Name)
NAIC Group Code: NAIC Company Code:
A Health Maintenance Organization organized under the laws of the State of New York
Date Incorporated or Organized: Date Certified As An HMO:
Date Federally Qualified As An HMO: Commenced Business as an HMO:
Mailing Address:
Address of Main Administrative Office:
Telephone Number: Employer's ID Number:
Principal Location of Books and Records:
Annual Statement Contact Person and Phone Number:
Annual Statement Contact E-Mail Address:
Electronic Filing Contact Person and Phone Number:
Electronic Filing Contact E-Mail Address:
Service Areas (Counties):

OFFICERS(a)

Chief Executive Officer: Other Officers:
Secretary:
Chief Financial Officer:

DIRECTORS(a)

Table with 4 columns: Name, State(b), Name, State(b)

STATE OF.....
COUNTY OF.....

Certification of the New York Annual Data Requirements - Chief Executive Officer, Secretary, Chief Financial Officer (or Corresponding person having charge of the financial records of the HMO) of the being duly sworn, each for himself deposes and says that they are the above described officers of the said Health Maintenance Organization, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said HMO, free and clear from any liens or claims thereon, except as herein stated, and that this Statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to is a full and true statement of all the assets and liabilities and of the condition and affairs of the said HMO as of the reporting period stated above, and of its income and deductions therefrom for the period reported, according to the best of their information, knowledge and belief, respectively.

Certification of the New York Annual Data Requirements Electronic Filing - The UNDERSIGNED further certify, according to the best of their information, knowledge and belief, that the New York Data Requirements electronic filing submitted for the reporting period stated above was prepared in compliance with the New York specifications, that the filing has been tested against the validations included in these specifications, and that the information contained in this filing is identical to the information contained in the 2013 New York Annual Data Requirements blank filed with the New York State Department of Financial Services. In addition, the electronic filing submitted has been scanned through a virus detection software package and no viruses are present on the submissions.

Certification of the NAIC Annual Statement Electronic Filing - The UNDERSIGNED further certify, according to the best of their information, knowledge and belief, that the NAIC Annual Health Statement electronic filing submitted for the reporting period stated above was prepared in compliance with the NAIC specification, that the filing has been tested against the validations included in these specifications, and that the annual statement information contained in this filing is identical to the information contained in the 2013 Annual Health Statement blank filed with the New York State Department of Financial Services. In addition, the electronic filing submitted has been scanned through a virus detection software package and no viruses are present on the submissions. For an HMO that is a line of business of an Article 43 Corporation, this certification applies to the NAIC Annual Health Statement electronic filing submitted for such Article 43 Corporation

Subscribed And Sworn To Before Me ThisDayChief Executive Officer
of , 2013_Secretary
.....Chief Financial Officer

NOTARY PUBLIC
(Seal)

(Corporate Seal)

- (a) Is this an original filing? Yes [] No []
(b) If no: (i) state the amendment number
(ii) date filed
(iii) number of pages attached

2013 Edition

(a) Show full name (initials not acceptable) and indicate by number sign (#) those officers and directors who did not occupy the indicated position in the previous statement.

(b) Indicate state of residency of each director. Also identify any director who is an enrollee of the HMO by using an asterisk sign (*).

REPORT 1 – PART A: ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets	4 Net Admitted Assets
1. Bonds				
2. Stocks:				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate:				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$...... encumbrances.)				
4.2 Properties held for the production of income (less \$...... encumbrances.)				
4.3 Properties held for sale (less \$...... encumbrances.)				
5. Cash (\$.....), cash equivalents (\$.....) and short-term investments (\$.....)				
6. Contract loans	XXX	XXX	XXX	XXX
7. Derivatives				
8. Other invested assets				
9. Receivable for securities				
10. Securities lending reinvested collateral assets				
11. Aggregate write-in for invested assets				
12. Subtotal cash and invested assets (Lines 1 to 11)				
13. Title Plants	XXX	XXX	XXX	XXX
14. Investment income due and accrued				
15. Premiums and considerations:				
15.1. Uncollected premiums and agents' balances in the course of collection				
15.2. Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$...... earned but unbilled premiums)				
15.3. Accrued retrospective premiums				
16. Reinsurance:				
16.1. Amounts recoverable from reinsurers				
16.2. Funds held by or deposited with reinsured companies				
16.3. Other amounts receivable under reinsurance contracts				
17. Amounts receivables relating to uninsured plans				
18.1. Current federal and foreign income tax recoverable and interest thereon				
18.2. Net deferred tax asset				
19. Guaranty funds receivable or on deposit	XXX	XXX	XXX	XXX
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets (\$.....)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parents, subsidiaries and affiliates				
24. Health care (\$.....) and other amounts receivable				
25. Aggregate write-in for other than invested assets				
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)				
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	XXX	XXX	XXX	XXX
28. Total (Lines 26 and 27)				
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page				
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)				
2501.				
2502.				
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)				

REPORT 1 – PART B: LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$..... reinsurance ceded)				
2. Accrued medical incentive pool and bonus amounts				
3. Unpaid claims adjustment expenses				
4. Aggregate health policy reserves				
5. Aggregate life policy reserves	XXX	XXX	XXX	XXX
6. Property/casualty unearned premium reserve	XXX	XXX	XXX	XXX
7. Aggregate health claim reserves				
8. Premiums received in advance				
9. General expenses due or accrued				
10.1. Current federal and foreign income tax payable and interest thereon (including \$..... on realized gains (losses))				
10.2. Net deferred tax liability				
11. Ceded reinsurance premiums payable				
12. Amounts withheld or retained for the account of others				
13. Remittances and items not allocated				
14. Borrowed money (including \$..... current) and interest thereon \$.....(including \$..... current)				
15. Amounts due to parents, subsidiaries and affiliates				
16. Derivatives				
17. Payable for securities				
18. Payable for securities lending				
19. Funds held under reinsurance treaties with (\$..... authorized reinsurers) and (\$..... unauthorized reinsurers)				
20. Reinsurance in unauthorized companies				
21. Net adjustment in assets and liabilities due to foreign exchange rates				
22. Liability for amounts held under uninsured accident and health plans				
23. Aggregate write-ins for other liabilities (including \$..... current)				
24. Total liabilities (Lines 1 to 23)				
25. Aggregate write-ins for special surplus funds	XXX	XXX		
26. Common capital stock	XXX	XXX		
27. Preferred capital stock	XXX	XXX		
28. Gross paid-in and contributed surplus	XXX	XXX		
29. Surplus notes	XXX	XXX		
30.1 Required reserves				
30.11 NYS Contingent Reserve ^(a)	XXX	XXX		
30.12 NYS Escrow Deposit ^(a)	XXX	XXX		
30.13 Total required reserves (Items 30.11 and 30.12)	XXX	XXX		
30.2. Aggregate write-ins for other surplus funds	XXX	XXX		
31. Unassigned funds (surplus)	XXX	XXX		
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26)	XXX	XXX		
32.2 shares preferred (value included in Line 27)	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX		
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX		
DETAILS OF WRITE-INS				
2301.				
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page				
2399. Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)				
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX		
30.201.	XXX	XXX		
30.202.	XXX	XXX		
30.203.	XXX	XXX		
30.298. Summary of remaining write-ins for Line 30.2 from overflow page	XXX	XXX		
30.299. Totals (Lines 30.201 through 30.203 plus 30.298)(Line 30.2 above)	XXX	XXX		

(a) Show calculation of Contingent Reserve and Escrow Deposit on Page NY36.

REPORT #2 - STATEMENT OF REVENUE AND EXPENSES (TOTAL)

	1	2	3	4
	Current Year	Previous Year	Current Year PMPM	Previous Year PMPM
1. Member Months			XXX	XXX
2. Net premium income:				
2.1 Basic				
2.2 Drugs				
2.3 Other riders				
2.4 Government programs				
2.5 Total				
3. Change in unearned premium reserves and reserve for rate credits:				
3.1 Basic				
3.2 Drugs				
3.3 Other riders				
3.4 Government programs				
3.5 Total				
4. Fee-for-service (net of \$..... medical expenses)				
5. Risk revenue				
6. Aggregate write-ins for other health care related revenues				
7. Non-health revenues	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)				
Hospital and Medical:				
9. Hospital/medical benefits				
10. Other professional services				
11. Outside referrals				
12. Emergency room and out-of-area				
13. Prescription drugs				
14.1. Aggregate write-ins for other hospital and medical				
14.2. Rider expense				
15. Incentive pool, withhold adjustments and bonus amounts				
16. Subtotal (Lines 9 to 15)				
Less:				
17.1. Net reinsurance recoveries				
17.2. Stop-loss fund recoveries				
17.3. Regulation 146 pool recoveries				
18. Total hospital and medical (Lines 16 - 17)				
19. Non-health claims	XXX	XXX	XXX	XXX
20. Claims adjustment expenses, including \$..... cost containment expenses				
21. General administrative expenses				
22. Increase in reserves for A&H contracts				
23. Total underwriting deductions (Lines 18 + 20 through 22)				
24. Net underwriting gain or (loss)(Lines 8 - 23)				
25. Net investment income earned				
26. Net realized capital gains or (losses) less capital gains taxes of \$				
27. Net investment gains or (losses)(Lines 25 + 26)				
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$.....) (amount charged off \$.....)]				
29. Aggregate write-ins for other income or expenses				
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Line 24 + 27 + 28 + 29)				
31. Federal and foreign income taxes incurred				
32. Net income (loss) (Lines 30 - 31)				
DETAILS OF WRITE-INS				
0601.				
0602.				
0603.				
0698. Summary of remaining write-ins for Line 6 from overflow page				
0699. Totals (Lines 0601 through 0603 + 0698)(Line 6 above)				
14.101.				
14.102.				
14.103.				
14.198. Summary of remaining write-ins for Line 14.1 from overflow page				
14.199. Totals (Lines 14.101 through 14.103 + 14.198)(Line 14.1 above)				
2901.				
2902.				
2903.				
2998. Summary of remaining write-ins for Line 29 from overflow page				
2999. Totals (Lines 2901 through 2903 + 2998)(Line 29 above)				

STATEMENT OF REVENUE AND EXPENSES (Continued)

CAPITAL & SURPLUS ACCOUNT	1 Current Year	2 Prior Year
33. Capital and surplus prior reporting year		
GAINS AND LOSSES TO CAPITAL & SURPLUS:		
34. Net Income or (loss) from Line 32		
35. Change in valuation basis of aggregate policy and claim reserve		
36. Change in net unrealized capital gains and losses less capital gains tax of \$.....		
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax		
39. Change in nonadmitted assets		
40. Change in unauthorized reinsurance		
41. Change in treasury stock		
42. Change in surplus notes		
43. Cumulative effect of changes in accounting principles		
44. Capital Changes:		
44.1. Paid in		
44.2. Transferred from surplus (Stock Dividend)		
44.3. Transferred to surplus		
45. Surplus adjustments:		
45.1. Paid in		
45.2. Transferred to capital (Stock Dividend)		
45.3. Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus		
48. Net change in capital and surplus (Lines 34 to 47)		
49. Capital and surplus end of reporting year (Line 33 + 48)		
DETAILS OF WRITE-INS		
4701.		
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page		
4799. TOTALS (Line 4701 thru 4703 + 4798) (Line 47 above)		

REPORT #2—PROJECTED REVENUE AND EXPENSES (TOTAL)

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service (net of \$..... medical expenses)										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 - 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses, including \$..... cost containment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
25. Net investment income earned										
26. Net realized capital gains or (losses) less capital gains taxes of \$										
27. Net investment gains or (losses)(Lines 25 + 26)										
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$.....) (amount charged off \$.....)]										
29. Aggregate write-ins for other income or expenses										
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Line 24 + 27 + 28 + 29)										
31. Federal and foreign income taxes incurred										
32. Net income (loss) (Lines 30 - 31)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 thru 14.196)										
2901.										
2902.										
2903.										
2998. Summary for Item 29 from overflow page										
2999. Totals (Lines 2901 thru 2996)										

**STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS
PART 1**

	Total (5 thru 43, amounts)		Total Excluding Gov't Programs and Healthy NY (5 thru 25, amounts)		HMO ONLY						P.O.S. IN-NETWORK ONLY (a)							
					Large Groups		Small Groups		Individual		Large Groups Community Rated		Large Groups Experience Rated		Small Groups		Individual	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM	11 Amount	12 PMPM	13 Amount	14 PMPM	15 Amount	16 PMPM	17 Amount	18 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX		XXX		XXX		XXX		XXX
2. Net premium income:																		
2.1 Basic																		
2.2 Drugs																		
2.3 Other riders																		
2.4 Government programs			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2.5 Total																		
3. Change in unearned premium reserves and reserve for rate credits:																		
3.1 Basic																		
3.2 Drugs																		
3.3 Other riders																		
3.4 Government programs			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.5 Total																		
4. Fee-for-service net of medical expenses																		
5. Risk revenue																		
6. Other health care related revenues																		
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)																		
Hospital and Medical:																		
9. Hospital/medical benefits																		
10. Other professional services																		
11. Outside referrals																		
12. Emergency room and out-of-area																		
13. Prescription drugs																		
14.1. Aggregate write-ins for other hospital and medical																		
14.2. Rider expense																		
15. Incentive pool, withhold adjustments and bonus amounts																		
16. Subtotal (Lines 9 to 15)																		
Less:																		
17.1. Net reinsurance recoveries																		
17.2. Stop-loss fund recoveries																		
17.3. Regulation 146 pool recoveries																		
18. Total hospital and medical (Lines 16 – 17)																		
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses																		
21. General administrative expenses																		
22. Increase in reserves for A&H contracts																		
23. Total underwriting deductions (Lines 18 + 20 through 22)																		
24. Net underwriting gain or (loss)(Lines 8 – 23)																		

(a) Complete this section only for point-of-service business for which the HMO provides only in-network benefits (i.e.,out-of-network benefits are provided by a separate Article 42 or Article 43 insurer).

**STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS
PART 2**

	P.O.S. IN- AND OUT-OF-NETWORK (a)								Healthy New York	Medicare Advantage Including Part D	Medicare Advantage Not Including Part D			
	Large Groups Community Rated		Large Groups Experience Rated		Small Groups		Individual							
	19 Amount	20 PMPM	21 Amount	22 PMPM	23 Amount	24 PMPM	25 Amount	26 PMPM				27 Amount	28 PMPM	29 Amount	30 PMPM	31 Amount	32 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX		XXX		XXX
2. Net premium income:														
2.1 Basic														
2.2 Drugs														
2.3 Other riders														
2.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX				
2.5 Total														
3. Change in unearned premium reserves and reserve for rate credits:														
3.1 Basic														
3.2 Drugs														
3.3 Other riders														
3.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX				
3.5 Total														
4. Fee-for-service net of medical expenses														
5. Risk revenue														
6. Other health care related revenues														
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)														
Hospital and Medical:														
9. Hospital/medical benefits														
10. Other professional services														
11. Outside referrals														
12. Emergency room and out-of-area														
13. Prescription drugs														
14.1. Aggregate write-ins for other hospital and medical														
14.2. Rider expense														
15. Incentive pool, withhold adjustments and bonus amounts														
16. Subtotal (Lines 9 to 15)														
Less:														
17.1. Net reinsurance recoveries														
17.2. Stop-loss fund recoveries														
17.3. Regulation 146 pool recoveries														
18. Total hospital and medical (Lines 16 – 17)														
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses														
21. General administrative expenses														
22. Increase in reserves for A&H contracts														
23. Total underwriting deductions (Lines 18 + 20 through 22)														
24. Net underwriting gain or (loss)(Lines 8 – 23)														

(a) Complete this section only for point-of-service business for which the HMO provides both in- and out-of-network benefits. Do not include business reported in columns 11 thru 18 of Part 1 of this report.

**STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS
PART 3**

	Medicaid		Medicaid Advantage		MAP, MLTC-Partial and PACE		Child Health Plus		Family Health Plus		Other	
	33 Amount	34 PMPM	35 Amount	36 PMPM	37 Amount	38 PMPM	39 Amount	40 PMPM	41 Amount	42 PMPM	43 Amount	44 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX		XXX
2. Net premium income:												
2.1 Basic												
2.2 Drugs												
2.3 Other riders												
2.4 Government programs												
2.5 Total												
3. Change in unearned premium reserves and reserve for rate credits:												
3.1 Basic												
3.2 Drugs												
3.3 Other riders												
3.4 Government programs												
3.5 Total												
4. Fee-for-service net of medical expenses												
5. Risk revenue												
6. Other health care related revenues												
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)												
Hospital and Medical:												
9. Hospital/medical benefits												
10. Other professional services												
11. Outside referrals												
12. Emergency room and out-of-area												
13. Prescription drugs												
14.1. Aggregate write-ins for other hospital and medical												
14.2. Rider expense												
15. Incentive pool, withhold adjustments and bonus amounts												
16. Subtotal (Lines 9 to 15)												
Less:												
17.1. Net reinsurance recoveries												
17.2. Stop-loss fund recoveries												
17.3. Regulation 146 pool recoveries												
18. Total hospital and medical (Lines 16 – 17)												
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses												
21. General administrative expenses												
22. Increase in reserves for A&H contracts												
23. Total underwriting deductions (Lines 18 + 20 through 22)												
24. Net underwriting gain or (loss)(Lines 8 – 23)												

NY9

**FOURTH QUARTER STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS
PART 1**

	Total (5 thru 43, amounts)		Total Excluding Gov't Programs and Healthy NY (5 thru 25, amounts)		HMO ONLY						P.O.S. IN-NETWORK ONLY (a)							
					Large Groups		Small Groups		Individual		Large Groups Community Rated		Large Groups Experience Rated		Small Groups		Individual	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM	11 Amount	12 PMPM	13 Amount	14 PMPM	15 Amount	16 PMPM	17 Amount	18 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX		XXX		XXX		XXX		XXX
2. Net premium income:																		
2.1 Basic																		
2.2 Drugs																		
2.3 Other riders																		
2.4 Government programs			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2.5 Total																		
3. Change in unearned premium reserves and reserve for rate credits:																		
3.1 Basic																		
3.2 Drugs																		
3.3 Other riders																		
3.4 Government programs			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.5 Total																		
4. Fee-for-service net of medical expenses																		
5. Risk revenue																		
6. Other health care related revenues																		
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)																		
Hospital and Medical:																		
9. Hospital/medical benefits																		
10. Other professional services																		
11. Outside referrals																		
12. Emergency room and out-of-area																		
13. Prescription drugs																		
14.1. Aggregate write-ins for other hospital and medical																		
14.2. Rider expense																		
15. Incentive pool, withhold adjustments and bonus amounts																		
16. Subtotal (Lines 9 to 15)																		
Less:																		
17.1. Net reinsurance recoveries																		
17.2. Stop-loss fund recoveries																		
17.3. Regulation 146 pool recoveries																		
18. Total hospital and medical (Lines 16 – 17)																		
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses																		
21. General administrative expenses																		
22. Increase in reserves for A&H contracts																		
23. Total underwriting deductions (Lines 18 + 20 through 22)																		
24. Net underwriting gain or (loss)(Lines 8 – 23)																		

(a) Complete this section only for point-of-service business for which the HMO provides only in-network benefits (i.e., out-of-network benefits are provided by a separate Article 42 or Article 43 insurer).

**FOURTH QUARTER STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS
PART 2**

	P.O.S. IN- AND OUT-OF-NETWORK (a)								Healthy New York	Medicare Advantage Including Part D	Medicare Advantage Not Including Part D			
	Large Groups Community Rated		Large Groups Experience Rated		Small Groups		Individual							
	19 Amount	20 PMPM	21 Amount	22 PMPM	23 Amount	24 PMPM	25 Amount	26 PMPM				27 Amount	28 PMPM	29 Amount	30 PMPM	31 Amount	32 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX		XXX		XXX
2. Net premium income:														
2.1 Basic														
2.2 Drugs														
2.3 Other riders														
2.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX				
2.5 Total														
3. Change in unearned premium reserves and reserve for rate credits:														
3.1 Basic														
3.2 Drugs														
3.3 Other riders														
3.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX				
3.5 Total														
4. Fee-for-service net of medical expenses														
5. Risk revenue														
6. Other health care related revenues														
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)														
Hospital and Medical:														
9. Hospital/medical benefits														
10. Other professional services														
11. Outside referrals														
12. Emergency room and out-of-area														
13. Prescription drugs														
14.1. Aggregate write-ins for other hospital and medical														
14.2. Rider expense														
15. Incentive pool, withhold adjustments and bonus amounts														
16. Subtotal (Lines 9 to 15)														
Less:														
17.1. Net reinsurance recoveries														
17.2. Stop-loss fund recoveries														
17.3. Regulation 146 pool recoveries														
18. Total hospital and medical (Lines 16 – 17)														
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses														
21. General administrative expenses														
22. Increase in reserves for A&H contracts														
23. Total underwriting deductions (Lines 18 + 20 through 22)														
24. Net underwriting gain or (loss)(Lines 8 – 23)														

(a) Complete this section only for point-of-service business for which the HMO provides both in- and out-of-network benefits. Do not include business reported in columns 11 thru 18 of Part 1 of this report.

**FOURTH QUARTER STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS
PART 3**

	Medicaid		Medicaid Advantage		MAP, MLTC-Partial and PACE		Child Health Plus		Family Health Plus		Other	
	33 Amount	34 PMPM	35 Amount	36 PMPM	37 Amount	38 PMPM	39 Amount	40 PMPM	41 Amount	42 PMPM	43 Amount	44 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX		XXX
2. Net premium income:												
2.1 Basic												
2.2 Drugs												
2.3 Other riders												
2.4 Government programs												
2.5 Total												
3. Change in unearned premium reserves and reserve for rate credits:												
3.1 Basic												
3.2 Drugs												
3.3 Other riders												
3.4 Government programs												
3.5 Total												
4. Fee-for-service net of medical expenses												
5. Risk revenue												
6. Other health care related revenues												
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)												
Hospital and Medical:												
9. Hospital/medical benefits												
10. Other professional services												
11. Outside referrals												
12. Emergency room and out-of-area												
13. Prescription drugs												
14.1. Aggregate write-ins for other hospital and medical												
14.2. Rider expense												
15. Incentive pool, withhold adjustments and bonus amounts												
16. Subtotal (Lines 9 to 15)												
Less:												
17.1. Net reinsurance recoveries												
17.2. Stop-loss fund recoveries												
17.3. Regulation 146 pool recoveries												
18. Total hospital and medical (Lines 16 – 17)												
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses												
21. General administrative expenses												
22. Increase in reserves for A&H contracts												
23. Total underwriting deductions (Lines 18 + 20 through 22)												
24. Net underwriting gain or (loss)(Lines 8 – 23)												

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**REPORT #3 – STATEMENT OF REVENUE AND EXPENSES
EXCLUDING GOVERNMENT PROGRAMS AND HEALTHY NEW YORK**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #3—PROJECTED REVENUE AND EXPENSES
EXCLUDING GOVERNMENT PROGRAMS AND HEALTHY NEW YORK**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 – 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 thru 14.196)										

**REPORT #4 – STATEMENT OF REVENUE AND EXPENSES
HEALTHY NEW YORK**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #4—PROJECTED REVENUE AND EXPENSES
HEALTHY NEW YORK**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	11 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 – 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #5 – STATEMENT OF REVENUE AND EXPENSES
MEDICARE ADVANTAGE, INCLUDING PART D**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #5—PROJECTED REVENUE AND EXPENSES
MEDICARE ADVANTAGE, INCLUDING PART D**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #6 – STATEMENT OF REVENUE AND EXPENSES
MEDICARE ADVANTAGE, NOT INCLUDING PART D**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #6—PROJECTED REVENUE AND EXPENSES
MEDICARE ADVANTAGE, NOT INCLUDING PART D**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #7 – STATEMENT OF REVENUE AND EXPENSES
MEDICAID**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #7—PROJECTED REVENUE AND EXPENSES
MEDICAID**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #8 – STATEMENT OF REVENUE AND EXPENSES
MEDICAID ADVANTAGE**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #8—PROJECTED REVENUE AND EXPENSES
MEDICAID ADVANTAGE**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #9 – STATEMENT OF REVENUE AND EXPENSES
MAP, MLTC-Partial and PACE**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #9—PROJECTED REVENUE AND EXPENSES
MAP, MLTC-Partial and PACE**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #10 – STATEMENT OF REVENUE AND EXPENSES
CHILD HEALTH PLUS**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #10—PROJECTED REVENUE AND EXPENSES
CHILD HEALTH PLUS**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199 Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

**REPORT #11 – STATEMENT OF REVENUE AND EXPENSES
FAMILY HEALTH PLUS**

	1	2	3	4	5	6	7
	Budget	Actual	Variance	Budget PMPM	Actual PMPM	Variance PMPM	12/31/12 Actual PMPM
1. Member Months				XXX	XXX	XXX	XXX
2. Net premium income:							
2.1 Basic							
2.2 Drugs							
2.3 Other riders							
2.4 Government programs							
2.5 Total							
3. Change in unearned premium reserves and reserve for rate credits:							
3.1 Basic							
3.2 Drugs							
3.3 Other riders							
3.4 Government programs							
3.5 Total							
4. Fee-for-service net of medical expenses							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 7)							
Hospital and Medical:							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14.1. Aggregate write-ins for other hospital and medical							
14.2. Rider expense							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
Less:							
17.1. Net reinsurance recoveries							
17.2. Stop-loss fund recoveries							
17.3. Regulation 146 pool recoveries							
18. Total hospital and medical (Lines 16 – 17)							
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for A&H contracts							
23. Total underwriting deductions (Lines 18 + 20 through 22)							
24. Net underwriting gain or (loss)(Lines 8 - 23)							
DETAILS OF WRITE-INS							
0601.							
0602.							
0603.							
0698. Summary of remaining write-ins for Line 6 from overflow page							
0699. Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)							
14.101.							
14.102.							
14.103.							
14.198. Summary of remaining write-ins for Line 14.1 from overflow page							
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)							

Unfavorable variances should be indicated by parentheses around the amount. Favorable and unfavorable variances of \$2.00 or more in Col. 6 should be explained in a narrative on page NY64.

**Report #11—PROJECTED REVENUE AND EXPENSES
FAMILY HEALTH PLUS**

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Total	
	1 Amount	2 PMPM	3 Amount	4 PMPM	5 Amount	6 PMPM	7 Amount	8 PMPM	9 Amount	10 PMPM
1. Member Months		XXX		XXX		XXX		XXX		XXX
2. Net premium income:										
2.1 Basic										
2.2 Drugs										
2.3 Other riders										
2.4 Government programs										
2.5 Total										
3. Change in unearned premium reserves and reserve for rate credits:										
3.1 Basic										
3.2 Drugs										
3.3 Other riders										
3.4 Government programs										
3.5 Total										
4. Fee-for-service net of medical expenses										
5. Risk revenue										
6. Aggregate write-ins for other health care related revenues										
7. Non-health revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8. Total revenues (Lines 2 to 6)										
Hospital and Medical:										
9. Hospital/medical benefits										
10. Other professional services										
11. Outside referrals										
12. Emergency room and out-of-area										
13. Prescription drugs										
14.1. Aggregate write-ins for other hospital and medical										
14.2. Rider expense										
15. Incentive pool, withhold adjustments and bonus amounts										
16. Subtotal (Lines 9 to 15)										
Less:										
17.1. Net reinsurance recoveries										
17.2. Stop-loss fund recoveries										
17.3. Regulation 146 pool recoveries										
18. Total hospital and medical (Lines 16 – 17)										
19. Non-health claims	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
20. Claims adjustment expenses										
21. General administrative expenses										
22. Increase in reserves for A&H contracts										
23. Total underwriting deductions (Lines 18 + 20 through 22)										
24. Net underwriting gain or (loss)(Lines 8 - 23)										
DETAILS OF WRITE-INS										
0601.										
0602.										
0603.										
0698. Summary for Item 6 from overflow page										
0699. Totals (Lines 0601 thru 0696)										
14.101.										
14.102.										
14.103.										
14.198. Summary for Item 14.1 from overflow page										
14.199. Totals (Lines 14.101 through 14.103 plus 14.198)(Line 14.1 above)										

REPORT #12 ANNUAL EXPENSES FOR OUT OF PLAN SERVICES^(a)

Enrollment:

Total HMO: _____

Point of Service Product: _____

	1 Total Plan	2 Out of Plan	3 Percent of Out-of-Plan Expenses to Total Plan Expense (Col. 2/Col. 1)
Hospital and Medical:			
1. Hospital/Medical benefits			XXX
2. Other professional services			XXX
3. Outside referrals			XXX
4. Emergency room and out-of-area		XXX	XXX
5. Prescription drugs		XXX	XXX
6. Other hospital and medical			XXX
7. Rider expense			XXX
8. Incentive pool, withhold adjustments and bonus amounts		XXX	XXX
9.. Subtotal (Items 1 to 8)			XXX
LESS:			
10. Net reinsurance recoveries			XXX
11. Stop-loss fund recoveries			XXX
12. Regulation 146 pool recoveries			XXX
13. TOTAL HOSPITAL AND MEDICAL (Line 9 less 10 through 12)			

(a) The HMO must use the accrual method for reporting expenses using its standard methodology for estimating claims incurred but not reported and other accruals.

The Annual Balance Sheet and Revenue and Expense Statements must show that the HMO meets the 2% Point of Service Contingent Reserve Requirement in addition to the standard contingent reserve requirement of 10 NYCRR 98.11(e) if the HMO writes out-of-network coverage for POS contracts aside from individual “standardized” POS contracts. Do not complete this exhibit if the HMO only writes the individual “standardized” POS contracts.

Pursuant to Section 4406 of the Public Health Law, exclude individual “standardized” Point of Service contracts issued under New York Insurance Law Section 4322 from column 2 of this exhibit.

REPORT #12 4th QUARTER EXPENSES FOR OUT OF PLAN SERVICES^(a)

Enrollment:

Total HMO: _____

Point of Service Product: _____

	1 Total Plan	2 Out of Plan	3 Percent of Out-of-Plan Expenses to Total Plan Expense (Col. 2/Col. 1)
Hospital and Medical:			
1. Hospital/Medical benefits			XXX
2. Other professional services			XXX
3. Outside referrals			XXX
4. Emergency room and out-of-area		XXX	XXX
5. Prescription drugs		XXX	XXX
6. Other hospital and medical			XXX
7. Rider expense			XXX
8. Incentive pool, withhold adjustments and bonus amounts		XXX	XXX
9. Subtotal (Items 1 to 8)			XXX
LESS:			
10. Net reinsurance recoveries			XXX
11. Stop-loss fund recoveries			XXX
12. Regulation 146 pool recoveries			XXX
13. TOTAL HOSPITAL AND MEDICAL (Line 9 less 10 through 12)			

(a) The HMO must use the accrual method for reporting expenses using its standard methodology for estimating claims incurred but not reported and other accruals.

The Annual Balance Sheet and Revenue and Expense Statements must show that the HMO meets the 2% Point of Service Contingent Reserve Requirement in addition to the standard contingent reserve requirement of 10 NYCRR 98.11(e) if the HMO writes out-of-network coverage for POS contracts aside from individual “standardized” POS contracts. Do not complete this exhibit if the HMO only writes the individual “standardized” POS contracts.

Pursuant to Section 4406 of the Public Health Law, exclude individual “standardized” Point of Service contracts issued under New York Insurance Law Section 4322 from column 2 of this exhibit.

FOR EACH RISK-BEARING ENTITY

Report #13 – Part A: BALANCE SHEET as of the Most Recently Ended Fiscal Year

NAME OF RISK BEARING ENTITY:

	1 Current Year End	2 Previous Year End
ASSETS:		
1. Cash		
2. Investments		
3. Accrued Interest Receivable		
4. Capitation Refund Receivable		
5. Stop-loss Insurance Receivable ^(a)		
6. Accounts Receivable		
7. Intercompany Clearing		
8. Aggregate Write-ins for Other Assets		
9. TOTAL ASSETS		
LIABILITIES AND FUND BALANCE:		
LIABILITIES:		
10. Claims Payable – Reported		
11. Claims Payable – Incurred But Not Reported		
12. Reserve for Contingency		
13. Accrued Expenses		
14. Withhold Payable		
15. Other Accrued Expenses		
16. Aggregate Write-ins for Other Liabilities		
17. TOTAL LIABILITIES		
FUND BALANCE		
18. Fund Balance (Deficit)		
19. TOTAL LIABILITIES AND FUND BALANCE		
DETAILS OF WRITE-INS		
0801.		
0802.		
0803.		
0898. Summary of items for 8 from overflow page		
0899. Total (Items 0801 thru 0803 plus 0898)(Item 8 above)		
1601.		
1602.		
1603.		
1698. Summary of items for 16 from overflow page		
1699. Total (Items 1601 thru 1603 plus 1698)(Item 16 above)		

(a) Stop-loss insurance provider:NAIC No.:

Report #13 – Part D: Regulation 164 Risk Transfer Arrangement Required Data For the Year

NAME OF RISK BEARING ENTITY:

- 1. Name of the Chief Financial Officer of Risk-bearing entity.
.....
- 2. Effective date of the Risk Transfer Arrangement: _____
- 3. This year’s total estimated annual in-network capitation from all HMO’s: \$ _____
- 4. This year’s total estimated annual in-network capitation from reporting HMO: \$ _____
- 5.1. This year’s total estimated annual in-network capitation from reporting HMO excluded from financial security deposits: \$ _____
- 5.2. Reason for exclusion: (see footnote) _____
- 6.1. Amount of financial security deposit with reporting HMO: \$ _____
- 6.2. Form of financial security deposit: (see footnote) _____
- 7.1 Has the risk transfer agreement been approved by the Insurance Department pursuant to Regulation 164? Yes [] No []
- 7.2 If Yes, what was the date approved? _____

Enter corresponding number for Line 5.2 Response:

- 1. Health care services provided directly by health care provider that is not an intermediary.
- 2. Health care services provided directly by health care provider’s guaranteeing parent corp., which is a health care facility.
- 3. Health care services provided by employees of the health care provider.
- 4. Health care services provided directly by employees of the health care provider’s guaranteeing parent corp. which is a health care facility.
- 5. Health care services provided by sub-capitated participating provider who is paid by the health care provider no later than the first day of the month following receipt by the health care provider.
- 6. Health care services provided by a participating provider who is paid a salary by the health care provider.
- 7. Health care provider is eligible for elimination of financial security deposit, per Regulation 164, Part 101.5(c).

Enter corresponding number for Line 6.2 Response:

- 1. Letter of Credit
- 2. Trust Arrangement
- 3. Stop Loss Insurance
- 4. Funds Withheld
- 5. Guaranteeing Parent Corporation
- 6. Other Method, per Reg. 164, Part 101.5(b)(5)

Funds held by the reporting HMO, owed to a health care provider pursuant to a risk-sharing arrangement in satisfaction of the financial security deposit requirement of Regulation 164, Section 101.5(b), should be reported on Page NY2 in the appropriate category of invested assets (e.g., cash). The HMO should establish a corresponding liability, which should be reported on Page NY3 as write-in to Line 23 under the account title “Funds Held Per Reg. 164, Section 101.5(b)(3).

Pursuant to Insurance Department Regulation 164 [11 NYCRR 101.5(b)(3)], financial security deposits in the form of funds held must be kept in individual accounts separate from all other funds. If the HMO is holding more than one such security deposit, they must be kept in different accounts, or in different, clearly identifiable subaccounts of the same master account. The HMO should itemize the accounts in the NAIC Annual Statement, Schedule E – Part 3 – Special Deposits. The total amount of such deposits in Schedule E – Part 3 should agree with the corresponding liability on page NY3.

Report #14A

**Calculations Of The Escrow Deposit And Contingent Reserve
Health Department Regulation Part 98-1.11(e) and (f)**

1. Escrow Deposit requirement (5% of 12/31/12 Data Requirements, Page NY6, Line 16, Col. 9) ^(a) _____
2. Direct Business (NAIC Health Blank, Page 8, Underwriting and Investment Exhibit, Part 1 – Premiums, Column 1, Line 12) _____
3. Approved Reinsurance Ceded (Report #14B, Column 2). ^(b) _____
4. Net Premium Income (Net of approved reinsurance) for:
 - i) All lines of business EXCEPT the Medicaid managed care, Family Health Plus, HIV SNP, Medicaid Advantage and MLTC - Data Requirements for HMOs – Statement of Revenue and Expenses by Line of Business – Parts 1, 2, & 3 Line 8, All columns EXCEPT Columns 33, 35, 37 & 41 _____
 - ii) Medicaid managed care, Family Health Plus, HIV SNP and Medicaid Advantage programs – Data Requirements for HMOs – Statement of Revenue and Expenses by Line of Business – Parts 1, 2, & 3 Line 8, Columns 33, 35, 41 _____
 - iii) MLTC Program (PACE, MLTC-Partial, and MAP-Medicaid Advantage Plus) – Data Requirements for HMOs – Statement of Revenue and Expenses by Line of Business – Parts 1, 2, & 3, Line 8, Column 37 _____
5. Contingent Reserve, not including the 2% Point of Service Contingent Reserve Requirement. ^(c) _____
6. 2% Point of Service Contingent Reserve Requirement. ^(d) _____
7. Total Contingent Reserve (Line 5 + Line 6, should equal Page NY3, Line 30.11, Column 3). _____
8. Escrow Deposit, after offset of the Contingent Reserve (Line 1 less Line 5; minimum of \$0, should equal Page NY3, Line 30.12, Column 3). _____
9. Total minimum net worth (Line 7 + Line 8; should equal Page NY3, Line 30.13, Column 3). _____

(a) Department of Health Regulation 10 NYCRR 98-1.11(f), amended effective 6/29/05, requires the HMO to establish an escrow account, in the form of a trust account with a custodian, for which a deed of trust has been approved by the superintendent. Also, based on the added pharmacy benefits to the Medicaid, Family health Plus and HIV SNP benefits packages on October 1, 2011, MCO's must include 35% of the projected pharmacy expenses in the calculation of the 5% escrow requirement that must be on deposit, as of March 31, 2014. Details of the account should be reported in the NAIC Health Blank, Schedule E – Part 3, Special Deposits.

(b) This entry will equal Net Premium Income, Page NY4, Line 2.5 only if all reinsurance contracts have been approved by the Insurance Department.

(c) For HMO's certified prior to June 29, 2005, Line 5 equals 12½% of line 4(i) **PLUS** 8¼% of Line 4(ii) **PLUS** 5% of Line 4(iii).

For HMOs certified after June 29, 2005:

If as of 12/31/2013, the HMO has not been certified for a full calendar year, then Line 5 equals 5% of projected premium revenue for the first full year of calendar year of operations, i.e., 5% of Page NY6 Line 2.5, column 9 to which the HMO is to add back reinsurance premiums ceded pursuant to a reinsurance contract that that has not been approved by the Insurance Department.

If as of 12/31/2013, the HMO has been certified for at least one full calendar year, then Line 5 is determined in accordance with the following schedule:

The provisions below pertain to the contingent reserve for the Medicaid managed care, Family Health Plus and HIV SNP programs and apply ONLY to HMOs and PHSPs which started operations in 2010 or prior.

Completed Calendar Years of Operations	Line 5 should include This Percent of the amount of Premium in Line 4(i).	PLUS	For calendar Year Ending	Line 5 should include the Percent of the amount of Premium in Line 4(ii)	PLUS	Line 5 should include the Percent of the amount of Premium in Line 4(iii)
1 year	5%		2012	7.25%		5.00%
2 years	6.50%		2013	8.25%		5.00%
3 years	7.50%		2014	9.25%		5.00%
4 years	8.50%		2015	10.25%		5.00%
5 years	9.50%		2016	11.25%		5.00%
6 years	10.50%		2017	12.25%		5.00%
7 years	11.50%		After 2017	12.50%		5.00%
8 or more years	12.50%					5.00%

(d) The calculation of the Contingent Reserve must show that the HMO meets the 2% Point of Service Contingent Reserve requirement in addition to the standard contingent reserve requirement of 10 NYCRR 98-1.11(e) if the HMO writes out-of-network coverage for POS contracts aside from individual "standardized" POS contracts.

Report #14B
Approved Reinsurance Ceded

1	2	3
Name of Assuming Company	2013 Ceded Premiums	Date of Insurance Department Approval
TOTAL		XXX

Per Department of Health Regulation 10 NYCRR 98-1.11(e), amended effective 6/29/05, an HMO may reduce net premium income by reinsurance ceded, for the purpose of calculating the contingent reserve, only resulting from reinsurance contracts that have been approved by the Superintendent of Insurance.

Report #14B, Columns 1 and 2, should agree with the NAIC Health Blank Page 46, Schedule S – Part 3 – Section 2, Reinsurance Ceded, except that Report #14B should not include contracts that have not been approved by the Superintendent.

SCHEDULE 4 – HOSPITAL COST ANALYSIS BY AGE AND SEX

	1 Total	2 Male	3 Female	4 Total PMPM	5 Male PMPM	6 Female PMPM
1. Member Months				XXX	XXX	XXX
2. Under 1						
3. 1-4						
4. 5-14						
5. 15-19						
6. 20-24						
7. 25-44						
8. 45-64						
9. 65 & Over						
10. Unknown						
11. TOTAL						

12. GRAND TOTAL ^(a)						
--------------------------------	--	--	--	--	--	--

(a) Total of Schedule 3 plus Schedule 4 (Medical and Hospital Cost) must equal Report Number 2, Line 18, Col. 1–TOTAL HOSPITAL AND MEDICAL

SCHEDULE 5 – HOSPITAL SERVICES

Type of Services (Excluding Medicare) ^(a)	1 Number of Cases	2 Total Inpatient Days Incurred	3 Total Cost	4 Average Cost Per Case
1. General Medical.				
2. Surgical				
3. Obstetrical				
4. Pediatric				
5. Mental Health				
6. Newborn				
7. Other				
8. TOTAL				
9. C.O.B				
10. TOTAL				
11. Medicare ^(a)				
12. Medicaid				
13. GRAND TOTAL				

**SCHEDULE 6 – AMBULATORY ENCOUNTERS BY TYPE
AND MEMBERSHIP STATUS (Participants)**

Encounters	1 Prepaid General Membership	2 Prepaid Medicare	3 Prepaid Medicaid	4 Total
1. Medical Center Medical Care Encounters (Items 2 and 3)				
2. Physician (including psychiatry)				
3. Other Clinician Provider Staff				
4. Referrals				
5. Hospital Emergency Service Encounters (in service area)				
6. Home Health Services—number of patients who used any (HMO paid) home health services				
7. TOTAL (Items 1, 4, 5 and 6)				

NOTE: (1) Activity to be reported in this table does not include laboratory tests, x-ray procedures, pharmacy activity, optometric services, social work activity, nutritionist consultations, health education programs or group-based mental health services. The HMO may attach supplementary exhibits summarizing these activities, however; such reporting is not mandatory.

**SCHEDULE 7 – FREQUENTLY USED HOSPITALS
(Excluding Medicare)**

1 Hospital	2 Number of Cases	3 Total Cost	4 Cost Per Case
9999999 Total			

SCHEDULE 8 – Enrollment Data by County
(Number of members at end of year)

County	1 Total	2 Direct Pay	3 Large Group	4 Small Group	5 Healthy New York	6 Medicare Advantage Including Part D	7 Medicare Advantage Not Including Part D	8 Medicaid	9 Medicaid Advantage	10 Medicaid Advantage Plus	11 Child Health Plus	12 Family Health Plus	13 Other
1. Albany													
2. Allegany													
3. Bronx													
4. Broome													
5. Cattaraugus													
6. Cayuga													
7. Chautauqua													
8. Chemung													
9. Chenango													
10. Clinton													
11. Columbia													
12. Cortland													
13. Delaware													
14. Dutchess													
15. Erie													
16. Essex													
17. Franklin													
18. Fulton													
19. Genesee													
20. Greene													
21. Hamilton													
22. Herkimer													
23. Jefferson													
24. Kings													
25. Lewis													
26. Livingston													
27. Madison													
28. Monroe													
29. Montgomery													
30. Nassau													
31. New York													
32. Niagara													
33. Oneida													
34. Onondaga													

SCHEDULE 8 – Enrollment Data by County (Continued)
(Number of members at end of year)

County	1 Total	2 Direct Pay	3 Large Group	4 Small Group	5 Healthy New York	6 Medicare Advantage Including Part D	7 Medicare Advantage Not Including Part D	8 Medicaid	9 Medicaid Advantage	10 Medicaid Advantage Plus	11 Child Health Plus	12 Family Health Plus	13 Other
35. Ontario													
36. Orange													
37. Orleans													
38. Oswego													
39. Otsego													
40. Putnam													
41. Queens													
42. Rensselaer													
43. Richmond													
44. Rockland													
45. Saratoga													
46. Schenectady													
47. Schoharie													
48. Schuyler													
49. Seneca													
50. Steuben													
51. St. Lawrence													
52. Suffolk													
53. Sullivan													
54. Tioga													
55. Tompkins													
56. Ulster													
57. Warren													
58. Washington													
59. Wayne													
60. Westchester													
61. Wyoming													
62. Yates													
63. NY Total													
64. Other States		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
65. Total		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

The total of Schedule 8, Column 1 should agree with the total of Schedule 1, Column 5.
For group policies, use location of employer. For individual policies, use location of residence.

SCHEDULE 9 – Gross Premium by County

County	1 Total	2 Direct Pay	3 Large Group	4 Small Group	5 Healthy New York	6 Medicare Advantage Including Part D	7 Medicare Advantage Not Including Part D	8 Medicaid	9 Medicaid Advantage	10 Medicaid Advantage Plus	11 Child Health Plus	12 Family Health Plus	13 Other
1. Albany													
2. Allegany													
3. Bronx													
4. Broome													
5. Cattaraugus													
6. Cayuga													
7. Chautauqua													
8. Chemung													
9. Chenango													
10. Clinton													
11. Columbia													
12. Cortland													
13. Delaware													
14. Dutchess													
15. Erie													
16. Essex													
17. Franklin													
18. Fulton													
19. Genesee													
20. Greene													
21. Hamilton													
22. Herkimer													
23. Jefferson													
24. Kings													
25. Lewis													
26. Livingston													
27. Madison													
28. Monroe													
29. Montgomery													
30. Nassau													
31. New York													
32. Niagara													
33. Oneida													
34. Onondaga													

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SCHEDULE 9 – Gross Premium by County (Continued)

County	1 Total	2 Direct Pay	3 Large Group	4 Small Group	5 Healthy New York	6 Medicare Advantage Including Part D	7 Medicare Advantage Not Including Part D	8 Medicaid	9 Medicaid Advantage	10 Medicaid Advantage Plus	11 Child Health Plus	12 Family Health Plus	13 Other
35. Ontario													
36. Orange													
37. Orleans													
38. Oswego													
39. Otsego													
40. Putnam													
41. Queens													
42. Rensselaer													
43. Richmond													
44. Rockland													
45. Saratoga													
46. Schenectady													
47. Schoharie													
48. Schuyler													
49. Seneca													
50. Steuben													
51. St. Lawrence													
52. Suffolk													
53. Sullivan													
54. Tioga													
55. Tompkins													
56. Ulster													
57. Warren													
58. Washington													
59. Wayne													
60. Westchester													
61. Wyoming													
62. Yates													
63. NY Total													
64. Other States		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
65. Total		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

The total of Schedule 9, Column 1 should agree with the total of NAIC Health Blank, page 8, Part 1 – Premiums, Column 1 – Direct Business.
 For group policies, use location of employer. For individual policies, use location of residence.

NEW YORK INTERROGATORIES

1. Is the HMO directly or indirectly affiliated with or owned or controlled by any other company, corporation, group of companies, partnership or individual? Yes [] No []
 1.1 If "Yes", give particulars and attach chart and table of organization.....

2. Did the HMO, directly or indirectly, pay any commission on the business transactions of the HMO? Yes [] No []
 If "Yes", complete schedule:

Type of Subscriber	% of Premium Paid as Commission
2.1 Large Group	
2.2 Small Group	
2.3 Direct Pay	
2.4 Medicare	

3. Annual level subscriber rates (in force): Does the HMO have guaranteed rates in force? Yes [] No []
 If "Yes," complete the following and answer questions below:

	Anniversary Date Month	Premium Volume, Rolling Rates	Premium Volume, Annualized Subscriber Rates	Total Guaranteed Rates
3.1	January	_____	_____	_____
3.2	February	_____	_____	_____
3.3	March	_____	_____	_____
3.4	April	_____	_____	_____
3.5	May	_____	_____	_____
3.6	June	_____	_____	_____
3.7	July	_____	_____	_____
3.8	August	_____	_____	_____
3.9	September	_____	_____	_____
3.10	October	_____	_____	_____
3.11	November	_____	_____	_____
3.12	December	_____	_____	_____
3.13	Total	_____	_____	_____

- 3.14. Are the premiums in force for the guaranteed rates higher than the currently approved subscriber rates? Yes [] No []
 3.15. Is any change in the volume of guaranteed rates contemplated for next year? Yes [] No []
 3.16. Are guaranteed rates only available in group contracts? Yes [] No []
 3.17. Is a contingent liability for any short-fall in premium established in writing for employer groups that are given annual level rates? Yes [] No []
 3.18. Does the HMO set up a liability for funds collected in excess of approved premium rates? Yes [] No []
 3.19. Are guaranteed rates issued for periods in excess of one year? Yes [] No []
 3.20. In the year covered by this report, did the HMO recover all short-falls in premium? Yes [] No []

4. Does the HMO offer a point of service contract to groups? Yes []
 No []

If "Yes", who covers the out-of-network benefits?

- 4.1 Affiliated Licensed Insurer or Health Service Corporation (Give Name) _____
 4.2 Unaffiliated Licensed Insurer or Health Service Corporation (Give Name) _____
 4.3 HMO itself _____

5. Was money loaned, directly or indirectly, during the period covered by this report to any employee, officer or director of the HMO? Please complete Interrogatory Schedule 5 on page NY48. Yes [] No []

6. Does the HMO, directly or indirectly, own or control any other company or corporation? Yes [] No []
 If "Yes," please complete Interrogatory Schedule 6 on page NY48.

- 6.1 If the answer to 6 is "Yes," has the HMO submitted the filing required pursuant to Regulation 115 (NYCRR 81-2) of the Insurance Department? Yes [] No []

7. Does the HMO have a contract with the CMS to serve Medicare Members? Yes [] No []
 If "Yes," please indicate what type of contract on Interrogatory Schedule 7.

8. Provide the following information with respect to Administrative Services Only (ASO) contracts:
 8.1. Administrative fees earned. \$ _____
 8.2. Administrative expenses. \$ _____
 8.3. Net income from ASO contracts \$ _____

9. The net liability (contra liability) reported on Line 2 of Page NY3 includes:
- 9.1 bonus/incentives payable to physicians/IPA's in the amount of \$ _____
 - 9.2 and withholds debits from physicians/IPA's in the amount of \$ _____
10. Will the liability (contra liability) reported on Line 2 of Page NY3 be settled via direct payment (receipt)? Yes [] No []
 10.1 If "No", explain.....

11. Complete Interrogatory Schedule 11, Itemization of Stop-loss Fund Recoveries, on page NY48.
12. Complete Interrogatory Schedule 12, Itemization of Regulation 146 Pool Activity, on page NY48.
13. Has the HMO established a liability or a contra liability for amounts payable to or due from the Regulation 146 Market Stabilization Pools? Yes [] No []
- 13.1 Such liability or contra liability should be included on Page 3, line 1, claims unpaid. Has such liability or contra liability been so reported? Yes [] No []
 - 13.2 Please state the amount of such liability / contra liability. \$ _____
14. Has the HMO been subject to any administrative orders, cease and desist order, fines or suspensions by any government entity during the reporting year? Yes [] No []
- 14.1 If "Yes," give details.(You need not report an action, either formal or informal, if a confidentiality clause is part of the agreement).....

15. Does the HMO cover any groups whose membership accounts for 10% or more of total enrollment? Yes [] No []
 If "Yes," please complete Interrogatory Schedule 15 on page NY48.
16. Did any person, while an officer, director or trustee of the reporting entity, receive directly or indirectly, during the period covered by this statement, any commission on the business transactions of the reporting entity? Yes [] No []
17. Has the HMO entered an amount for admitted health care receivables on page NY2, line 24? Yes [] No []
- 17.1 If "Yes," please provide details, including a description of the health care receivable, and the specific paragraph of SSAP 84, or other SSAP, on which the HMO is relying on to admit the receivable.

18. Is the HMO currently party to financial risk transfer agreements that are subject to Regulation 164 (i.e., that Result in the payment of in-network capitation of more than \$250,000 during any 12 month period)? (Note – Each such agreement requires completion of a separate Report #13.) Yes [] No []
- If Yes
- 18.1. How many such agreements? _____
 - 18.2. Total amount of capitation paid under all such agreements during the year. \$ _____
 - 18.3. Total amount of Financial Security Deposits held by the HMO (Should agree with the corresponding write-in liability for Page NY3, line 23 (See Instructions on Page NY66) \$ _____
 - 18.4. Total amount of withholds under all such agreements. \$ _____
 - 18.5. Has any such agreement been terminated during the year? _____ Yes [] No []
19. Has the Company elected to value its real estate at ninety percent of its current market value, less encumbrances, pursuant to Section 4310(l) of the Insurance Law and Section 83.4(j)(i) of Regulation 172 (11 NYCRR 83)? Yes [] No []
- 19.1. If "Yes," the company is required to complete Supplemental Schedule A (NY) on Page NY49. Has the Company done so? Yes [] No []
 - 19.2. Are all the independent appraisers engaged to determine the current market value of each property valued pursuant to Section 4310(l), members of the Appraisal Institute? Yes [] No []

NEW YORK INTERROGATORIES SCHEDULES

INTERROGATORY SCHEDULE 5

1 Name of Borrower	2 Position with HMO	3 Original Loan Amount	4 Amount of Loan Principal Outstanding at Year End
0599999. Totals			

INTERROGATORY SCHEDULE 6

1 Name of Controlled Entity	2 % Owned by HMO

INTERROGATORY SCHEDULE 7

Type of Contract	1 Number of Members at Year End	2 Premium Volume in Report Year
7.1 Cost		
7.2 Risk		
7.3 Other		

INTERROGATORY SCHEDULE 11, ITEMIZATION OF STOP-LOSS FUND RECOVERIES

	1 Current Year	2 Prior Year	3 Projected
1. Direct Payment Stop-Loss Fund Per Insurance Law § 4321-a			
2. Direct Payment Out-of-Plan Stop-Loss Fund Per Insurance Law § 4322-a			
3. Small Employer Stop-Loss Fund Per Insurance Law § 4327			
4. Qualifying Individual Stop-Loss Fund Per Insurance Law § 4327			
5. TOTAL			

Line 5, Columns 1 and 2 should agree with Page NY4, Report #2, Statement of Revenue and Expenses, Line 17.2, columns 1 and 2.
Line 5, Column 3 should agree with Page NY6, Report #2, Projected Revenue and Expenses, Line 17.2, column 9.

INTERROGATORY SCHEDULE 12, ITEMIZATION OF REGULATION 146 POOL ACTIVITY

	1 Current Year	2 Prior Year	3 Projected
1. Demographic Pool Income (Expense)			
2. SMC Pool Income (Expense)			
3. TOTAL			

Line 3, Columns 1 and 2 should agree with Page NY4, Report #2, Statement of Revenue and Expenses, Line 17.3, columns 1 and 2.
Line 3, Column 3 should agree with Page NY6, Report #2, Projected Revenue and Expenses, Line 17.3, column 9.

INTERROGATORY SCHEDULE 15

Type of Account	1 Percentage of Total Enrollment	2 Renewal Date
15.1 Federal		
15.2 State		
15.3 Municipal Employees		
15.4 Corporate		

**N.Y. SCHEDULE F – CLAIMS PAYABLE ANALYSIS
SECTION 1 – CLAIMS INCURRED**

Description of Claims	1 Paid During Year	2 Unpaid Prior Year	3 Unpaid Current Year	4 Incurred This Year ^(a) (1 - 2 + 3)
1. Comprehensive (hospital and medical).				
2. Medicare supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Benefits Plan Premiums				
6. Title XVIII-Medicare				
7. Title XIX-Medicaid				
8. Other.				
9. TOTAL				

(a) Must equal net hospital and medical expenses incurred which are reported on Page NY4, Report #2, Line 18 less line 15 (include capitation payments).

SECTION 2 – ANALYSIS OF UNPAID CLAIMS – CURRENT

Description of Claims	1 Reported Claims in Process of Adjustment	2 Estimated Incurred but Unreported	3 Amounts Withheld from Paid Claims and Capitation	4 Total—Claims Payable ^(a) (Columns 1 + 2 + 3)
1. Comprehensive (hospital and medical).				
2. Medicare supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Benefits Plan Premiums				
6. Title XVIII-Medicare				
7. Title XIX-Medicaid				
8. Other				
9. TOTAL				

(a) Must equal Section 1, Col. 3. Include on Line 8 amounts payable for occupancy of medical clinics.

SECTION 3 – ANALYSIS OF UNPAID CLAIMS – PREVIOUS YEAR

Description of Claims	Claims Paid During the Year ^(a)		Claims Unpaid Dec. 31 of Current Year Viz: Estimated Liability Dec. 31 of Current Year		5 Total Claims Paid During the Year and Claims Unpaid at Dec. 31 of Current Year on Claims Incurred in Prior Years (1 + 3)	6 ^(b) Estimated Liability of Unpaid Claims Dec. 31 of Previous Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Previous Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical).						
2. Medicare supplement						
3. Dental only						
4. Vision only						
5. Federal Employees Health Benefits Plan Premiums						
6. Title XVIII-Medicare						
7. Title XIX-Medicaid						
8. Other health.						
9. Health Subtotal						
10. Healthcare receivables						
11. Other non-health	XXX	XXX	XXX	XXX	XXX	XXX
12. Medical Incentive Pool Accruals and Disbursements						
13. TOTAL						

(a) Lines 1 thru 9 must equal Section 1, Col. 1, lines 1 thru 9.

(b) Lines 1 thru 9 must equal Section 1, Col. 2, lines 1 thru 9.

NOTE: Claims are to include amounts paid or accrued for capitation and any other means of payments for medical or other health care services including, on Line 8, amounts for occupancy, depreciation and amortization as it relates to medical and hospital expenses. The sum of the amounts reported on Line 9, Column 3 + 4 must equal the amount reported on Schedule F, Section 2, Line 9, Column 4.

N.Y. SCHEDULE G

Showing (1) all payments in excess of \$5,000 to each Trade Association, Service Organization, Statistical, Actuarial or Rating Bureau or Organization during the year; (2)* all salaries^(a), bonuses and other compensation, except commissions paid to or retained by agents, paid in the current year to (a) each director or trustee regardless of the amount thereof, (b) each of the ten officers or employees receiving the largest amounts, (include in this schedule the aggregate amount received by the officer or employee attributable to his services to the reporting insurer whether paid directly by the insurer or by related or affiliated companies) and (c) any other employees, officers, who received in excess of \$160,000; and (3) any other person, firm or corporation, excluding medical providers, in excess of \$160,000 .

(a) Salaries should be reported gross before any adjustments for tax sheltered programs and the like.

Report in Column 5 gross bonus & all other compensation including any amounts deferred pursuant to a deferred compensation plan and/or employee saving plan.

*For categories 2(a), 2(b) and 2(c) – If the reporting entity does not belong to a holding company system, column 7 should equal column 6.

1 Title	2 Name of Payee	3 Location of Payee	4 Salary Paid by Company and All Other Companies in Holding Company System	5 Bonus & all other Compensation Deferred or Paid by Company and All Other Companies in Holding Company System	6 Total Amount Paid by Company and All Other Companies in Holding Company System (4)+(5)	7 Amount Paid by or Amount Allocated to Company
(1) Trade Association, Service Organization, Statistical, Actuarial or Rating Bureau or Organization	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
0199999 Total	XXX	XXX	XXX	XXX	XXX	
(2a) Directors or Trustees				
				
				
				
				
				
				
0299999 Totals	XXX	XXX				
(2b) Ten Officers or Employees Receiving the Largest Amounts				
				
				
				
				
				
				
0399999 Total	XXX	XXX				
(2c) Remaining Officers & Employees in excess of \$160,000				
				
				
				
				
				
				
0499999 Total	XXX	XXX				
(3) Any Other Person, Firm or Corporation, Excluding Medical Providers, in excess of \$160,000.	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
	XXX	XXX	XXX	
0599999 Total	XXX	XXX	XXX	XXX	XXX	
9999999 Grand Total						

(Name)

SCHEDULE H (NY)

Individually list in Section 1 write-in boxes all health care creditors of \$5,000 or more or 10% of total claims payable (reported, excluding amounts withheld), whichever is larger. Group the total of all other payables and enter on line titled, "Aggregate Accounts Not Individually Listed." For both Sections 1 and 2, age reported claims payable from date of receipt by Company or, in the case of capitation and other non-fee-for-service claim expenses, from the date payment is required under contract or from the date bill is received by Company.

Section 1 - Aging Analysis of Claims Unpaid

Account	1-30 Days		31-60 Days		61-90 Days		91-120 Days		Over 120 Days		Total	
	1 Claim Count	2 Dollar Value	3 Claim Count	4 Dollar Value	5 Claim Count	6 Dollar Value	7 Claim Count	8 Dollar Value	9 Claim Count	10 Dollar Value	11 Claim Count	12 Dollar Value
1. Reserve for Reported Claims Due and Unpaid^a												
1.1 Aggregate write-ins for Individually Listed Claims Payable (line 1.199)												
1.2 Aggregate Accounts Not Individually Listed												
1.3 Subtotal (Lines 1.1 plus 1.2)												
2. Reserve for Reported Claims in Course of Settlement^b												
2.1 Aggregate write-ins for Individually Listed Claims Payable (line 2.199)												
2.2 Aggregate Accounts Not Individually Listed												
2.3 Subtotal (Lines 2.1 plus 2.2)												
3. Reserve for Reported Resisted Claims^c												
3.1 Aggregate write-ins for Individually Listed Claims Payable (line 3.199)												
3.2 Aggregate Accounts Not Individually Listed												
3.3 Subtotal (Lines 3.1 plus 3.2)												
4. Total Reported Claims Unpaid (line 1.3 + 2.3 + 3.3)												
5. Unreported Claims and Other Claim Reserves^d	xxx	xxx	xxx	xxx	Xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
6. Total Amounts Withheld	xxx	xxx	xxx	xxx	Xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
7. Total Claims Unpaid (Lines 4 through 6)	xxx	xxx	xxx	xxx	Xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
8. Accrued Medical Incentive Pool and Bonus Amounts	xxx	xxx	xxx	xxx	Xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx

NY52

DETAILS OF WRITE-INS AGGREGATED AT LINE 1.1 FOR INDIVIDUALLY LISTED CLAIMS PAYABLE												
1.101												
1.102												
1.103												
1.198 (Summary of remaining write-ins for 1.1 from overflow page)												
1.199 Totals (Lines 01.101 through 01.103 plus 1.198)(Line 1.1 above)												
DETAILS OF WRITE-INS AGGREGATED AT LINE 2.1 FOR INDIVIDUALLY LISTED CLAIMS PAYABLE												
2.101												
2.102												
2.103												
2.198 (Summary of remaining write-ins for 2.1 from overflow page)												
2.199 Totals (Lines 2.101 through 2.103 plus 2.198)(Line 2.1 above)												
DETAILS OF WRITE-INS AGGREGATED AT LINE 3.1 FOR INDIVIDUALLY LISTED CLAIMS PAYABLE												
3.101												
3.102												
3.103												
3.198 (Summary of remaining write-ins for 3.1 from overflow page)												
3.199 Totals (Lines 3.101 through 3.103 plus 3.198)(Line 3.1 above)												

Totals shown in Section 1, cols. 11 and 12, lines 4 through 8 must be identical to those of Section 2, cols. 5 and 6, lines 4.5 through 8. Total Claims Unpaid on line 7 of Section 1 and line 7 of Section 2 must agree with N.A.I.C Annual Statement page 3, line 1, col. 3, Unpaid Claims. See further notes after Section 3 of this Schedule.

SCHEDULE H (NY)
Section 2 - Statutory Aging Analysis

Account	1-45 days		Over 45 days		Total	
	1	2	3	4	5	6
	Claim Count	Dollar Value	Claim Count	Dollar Value	Claim Count	Dollar Value
1. Reserves for Reported Claims Due and Unpaid^a						
1.11 Payable to Physicians (capitated) ^e	xxx		xxx		xxx	
1.12 Payable to Physicians (other than capitated)						
1.21 Payable to Hospitals (capitated)	xxx		xxx		xxx	
1.22 Payable to Hospitals (other than capitated)						
1.3 Payable to Subscribers						
1.41 Payable to Others (capitated) ^f	xxx		xxx		xxx	
1.42 Payable to Others (other than capitated) ^f						
1.5 Subtotal (Lines 1.11 through 1.42)						
2. Reserves for Reported Claims in Course of Settlement^b						
2.1 Payable to Physicians (including capitation)						
2.2 Payable to Hospitals (including capitation)						
2.3 Payable to Subscribers						
2.4 Payable to Others (including capitation) ^f						
2.5 Subtotal (Lines 2.1 through 2.4)						
3. Reserves for Reported Resisted Claims^c						
3.1 Payable to Physicians (including capitation)						
3.2 Payable to Hospitals (including capitation)						
3.3 Payable to Subscribers						
3.4 Payable to Others (including capitation) ^f						
3.5 Subtotal (Lines 3.1 through 3.4)						
4. Total Reported Claims Unpaid (lines 1 through 3)						
4.1 Payable to Physicians (including capitation)(Line 1.11+1.12.+2.1+3.1)						
4.2 Payable to Hospitals (including capitation)(Line 1.21+1.22+2.2+3.2)						
4.3 Payable to Subscribers (Line 1.3+2.3+3.3)						
4.4 Payable to Others (including capitation) ^f (Line1.41+1.42+2.4+3.4)						
4.5 Subtotal (Lines 4.1 through 4.4)						
5. Unreported Claims and Other Claim Reserves^d	xxx	xxx	xxx	xxx	xxx	
6. Total Amounts Withheld	xxx	xxx	xxx	xxx	xxx	
7. Total Claims Unpaid (Lines 4.5 through 6)	xxx	xxx	xxx	xxx	xxx	
8. Accrued Medical Incentive Pool and Bonus Amounts	xxx	xxx	xxx	xxx	xxx	

Totals shown in Section 1, columns 11 and 12, lines 4 through 8 must be identical to those of Section 2, columns 5 and 6, lines 4.5 through 8. Total Claims Unpaid on line 7 of Section 1 and line 7 of Section 2 must agree with N.A.I.C Annual Statement page 3, line 1, col. 3, Unpaid Claims . See further notes after Section 3 of this Schedule.

(Name)

**SCHEDULE H (NY)
Section 3 - Claims and Interest Penalties Paid During Year**

Account	Claims Paid During Year		N.Y.I.L. Section 3224-a Interest	
	1 Claim Count	2 Dollar Value	3 Claim Count ⁱ	4 Interest Paid During Year
1.1. Paid to Physicians (capitated)	xxx		xxx	xxx
1.2. Paid to Physicians (other than capitated)				
2.1. Paid to Hospitals (capitated)	xxx		xxx	xxx
2.2. Paid to Hospitals (other than capitated)				
3. Paid to Subscribers				
4.1. Paid to Others (Benefits) (capitated)	xxx		xxx	xxx
4.2. Paid to Others (Benefits) (other than capitated)				
5.1. Total Capitated (Lines 1.1 + 2.1 + 4.1)	xxx		xxx	xxx
5.2. Total Other than Capitated (Lines 1.2 + 2.2 + 3 + 4.2)				
5.3. Paid to Others (Miscellaneous. ^g)	xxx		xxx	xxx
6. Subtotal (Lines 5.1 + 5.2 + 5.3)	xxx			
7. Medical Incentive Pool and Bonus Amounts	xxx		xxx	xxx
8. Grand Total (Line 6 + 7) ^h	xxx			

Footnotes:

- a- Reserves for Reported Claims Due and Unpaid: A reserve for due and unpaid claims is established to pay claims which have been approved, but for which payment checks have not been sent.
- b- Reserves for Reported Claims in Course of Settlement: Reserves for claims in the course of settlement are established for claims that are on file in the company at the time the valuation is done, but have not yet been approved or paid.
- c- Reserves for Reported Resisted Claims: Reserves for resisted claims are established for those claims in dispute and/or where the obligation to pay such claim is not reasonably clear as of the statement date.
- d- Unreported Claims and Other Claim Reserves: Include reserves for IBNR claims and other claim reserves. Other Claim Reserves include non-benefit-related liabilities required to be reported as claims, e.g. Regulation No. 146 pool liabilities.
- e- Line 1.11 should include Doctors and IPA corporations reimbursed on a capitated basis.
- f- Payable to Others: Include all claim-related payments to intermediaries (other than those to IPA corporations, which are to be accounted for as "Payable to Physicians") and other vendors, such as suppliers of durable medical equipment. Include reported claims payable not classified as payable to physicians, hospitals, or subscribers.
- g- Includes Regulation 146 pool payments, payments to bad debt and charity pools, prompt payment claim interest penalties, etc.
- h- Total Dollar Value (line 8, col. 2) should agree with Page NY50, NY Schedule F, Section 3 – Analysis of Unpaid Claims – Previous Year, line 9, Col. 1 + Col. 2.
- i- Line 8, col. 3, Grand Total Claim Count pertains to the number of claims upon which N.Y.I.L. Section 3224-a interest penalties have been paid.

Name of Contact Person for Schedule H (NY): _____
 Telephone Number: _____
 E-mail Address: _____

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(Name)

SCHEDULE H (NY)

OVERFLOW PAGE FOR WRITE-INS FROM SECTION 1

Creditor Name	1-30 Days		31-60 Days		61-90 Days		91-120 Days		Over 120 Days		Total	
	1 Claim Count	2 Dollar Value	3 Claim Count	4 Dollar Value	5 Claim Count	6 Dollar Value	7 Claim Count	8 Dollar Value	9 Claim Count	10 Dollar Value	11 Claim Count	12 Dollar Value
1. Reserves for Reported Claims Due and Unpaid - Companies individually listed (continued from Section 1)												
Totals overflow for line 1.1 (enter also on page 1, line 1.198)												
2. Reserves for Reported Claims in Course of Settlement - Companies individually listed (continued from Section 1)												
Totals overflow for line 2.1 (enter also on page 1, line 2.198)												
3. Reserves for Reported Resisted Claims - Companies individually listed (continued from Section 1)												
Totals overflow for line 3.1 (enter also on page 1, line 3.198)												

NY55

Health care creditors should be individually listed only if the claim is for \$5,000 or more or 10% of total claims payable (reported, excluding amounts withheld), whichever is larger. See instructions on page NY50, above Section 1 heading.

N.Y. SCHEDULE K – RECAPITULATION – PART 1

Regular Membership Excluding Medicare, Medicaid, Child Health Plus and Family Health Plus	1 Current Year	2 Previous Year
1. Enrollment		
1.01 Member months per year		
1.02 Contract months per year		
1.03 Average family size ^a		
1.04 Average contract size ^a		
1.05 Contract mix (single contracts / total contracts) ^a		
1.06 Individual contract months		
1.07 Husband & Wife contract months		
1.08 Family contract months		
2. Income		
2.01 Basic premium (pm/pm)		
2.02 Riders premium (pm/pm)		
2.03 Unmarried Dependent Children (UDC) riders (pm/pm)		
2.04 Prescription drug (pm/pm)		
2.05 Optical (pm/pm)		
2.06 Dental (pm/pm)		
2.07 Other (pm/pm)		
2.08 Total rider capitation (pm/pm)		
2.09 Investment income (pm/pm)		
2.10 Fee-for-service (pm/pm)		
3. Loans		
3.01 Federal		
3.02 Other		
4. Miscellaneous Data		
4.01 Number of FTE physicians		
4.02 Number of FTE other medical personnel		
4.03 Inpatient days		
4.04 Ambulatory encounters		
5. Expenses		
5.01 Medical service (pm/pm)		
5.02 Medical occupancy & overhead (pm/pm)		
5.03 Hospital–inpatient (pm/pm)		
5.04 Outside Medical (pm/pm)		
5.05 Outpatient (pm/pm)		
5.06 Emergency room (pm/pm)		
5.07 Referral (pm/pm)		
5.08 Laboratory (pm/pm)		
5.09 X-ray (pm/pm)		
6. Administrative Expenses		
6.01 Marketing cost (pm/pm)		
6.02 Administrative cost (pm/pm)		
6.03 Occupancy and overhead (pm/pm)		
6.04 Debt Service (pm/pm)		
7. Ratios		
7.01 Percentage of Current Assets to Current Liabilities		
7.02 Average length of stay–Regular ^b		
7.03 Average length of stay–Medicare ^b		
7.04 Average length of stay–Medicaid ^b		

a Express to the nearest one-tenth.

b Express in days, to the nearest one-tenth.

N.Y. SCHEDULE K – RECAPITULATION – PART 2

Regular Membership Including Medicare, Medicaid, Child Health Plus and Family Health Plus	Current Year		Previous Year	
	1 Amount	2 ^(a) %	3 Amount	4 ^(a) %
REVENUE				
1. Basic premium				
2. Aggregate write-ins for other premium revenues				
3. Medicare (directly from subscribers)				
4. Rider income				
5. Medicare(from CMS)				
6. Medicaid				
7. Fee-for-Service				
8. All Other Revenue				
9. Total Revenue ^(b)		100%		100%
EXPENSES				
10. Physician services ^(c)		XXX		XXX
11. Inpatient		XXX		XXX
12. All other medical		XXX		XXX
13. Total hospital and medical		XXX		XXX
14. Administration		XXX		XXX
15. Total Expenses		XXX		XXX
16. Net underwriting gain (loss)		XXX		XXX
17. Projected break-even enrollment		XXX		XXX
DETAILS OF WRITE-INS				
2.01				
2.02				
2.03				
2.98 Summary of remaining write-ins for Item 2 from overflow page				
2.99 Totals (Items 2.01 thru 2.03 plus 2.98) (Item 2, above)				

(a) For each item, indicate % of total revenue.
 (b) Total should agree with Report #2 (Page NY4) Line 8.
 (c) Includes: (Other professional services and outside referrals).

N.Y. SCHEDULE L – FIVE-YEAR HISTORICAL DATA

	1 2013	2 2012	3 2011	4 2010	5 2009
BALANCE SHEET ITEMS (PAGE NY2, NY3)					
1. Total Admitted Assets					
2. Total Liabilities					
3. Required Reserves					
4. Total Capital and Surplus					
RISK BASED CAPITAL					
5. Total Adjusted Net Worth					
6. Authorized Control Level Risk Based Capital.					
INCOME STATEMENT ITEMS (Page NY4)					
7. Premium & Related Revenue					
8. Total Revenue					
9. Total Hospital and Medical Expenses					
10. Claim Adjustment Expenses					
11. General Administrative Expenses					
12. Net Income (Loss)					
13. Member Months					
14. Premium & Related Revenue (PMPM)					
15. Total Revenue (PMPM)					
16. Total Hospital and Medical Expenses (PMPM)					
17. Claim Adjustment Expenses (PMPM)					
18. General Administrative Expenses (PMPM)					
19. Total Underwriting Deductions (PMPM)					
20. Net Income (Loss) (PMPM)					
ENROLLMENT & UTILIZATION					
21. Total Membership					
22. Annualized Hospital Days/1,000					
23. Average Length of Stay					
24. Total Hospital Discharges					
25. Total Inpatient Days Incurred					
FORMULAS					
26. Percentage of Total Hospital & Medical Expenses/Premium (Page NY4, lines 2 + 3)					
27. Percentage of Administration Expenses/Premium (Page NY4, lines 2 + 3)					
UNPAID CLAIMS ANALYSIS					
28. Total Claims Paid During the Year etc. (From NY Schedule F, Section 3, Col. 5, Line 13)					
29. Estimated Liability of Unpaid Claims – Previous Year (From NY Schedule F, Section 3, Col. 6, Line 13)					

N.Y. SCHEDULE M

Section 4408-a of the Public Health Law requires all health maintenance organizations to establish and maintain a grievance procedure. Article 49 of the Public Health Law requires HMOs to establish a utilization review procedure to evaluate whether a health care treatment is medically necessary. Article 49 also allows for enrollees to have external appeals under certain circumstances.

Tables 1, 2 and 3 should not include grievances under Medicare Cost Contracts, Medicare Risk Contracts, Medicare Plus Choice Contracts or Medicaid Contracts.

Table 1: Section 4408-a Grievances

	(1)	(2)	(3)	(4)	(5)	(6)
	Pending as of 12/31/12.	Filed in 2013.	Closed in 2013 (Whether filed in 2013 or earlier). Col. 4 + Col. 5	Closed in 2013 resulting in a reversal (in whole or in part) of the HMO's original determination.	Closed in 2013 in which the HMO's original determination was upheld.	Pending on 12/31/13. Col. 1 + Col. 2 – Col. 3
1. Actual Number						
2. Number per 1,000 members ^(a)						

(a) For all tables the number per 1,000 members, excluding Medicare and Medicaid members, should be based on the number of members as of June 30, 2013. The number per 1,000 members should be carried to one decimal point, e.g. "3.6"

(1) State the number of members at June 30, 2013, as shown in the June 2013 Data Requirements, excluding Medicare and Medicaid members. _____

NY60

Table 1a. Appeals of grievances closed in 2012 (These should not be reported in Table 1 above.)

1. Please state the number of grievances reported as closed in the 2012 schedule M which were appealed in a timely manner in 2013 _____

Of the above, please state: (2) the number reversed in 2013 _____

(3) the number upheld in 2013 _____

(4) the number still pending at 12/31/13 _____

N.Y. SCHEDULE M (continued)

Table 2: Utilization Review Appeals

	(1)	(2)	(3)	(4)	(5)	(6)
	Pending as of 12/31/12.	Filed in 2013.	Closed in 2013 (Whether filed in 2013 or earlier). Col. 4 + Col. 5	Closed in 2013 resulting in a reversal (in whole or in part) of the HMO's original determination.	Closed in 2013 in which the HMO's original determination was upheld.	Pending on 12/31/13. Col. 1 + Col. 2 – Col. 3
1. Actual Number						
2. Number per 1,000 members ^(a)						

Table 2a. Appeals of expedited utilization review appeals closed in 2012 (These should not be reported in Table 2 above.)

1. Please state the number of expedited utilization review appeals reported as closed in the 2012 schedule M which were appealed in a timely manner in 2013 _____
 Of the above, please state: (2) the number reversed in 2013 _____
 (3) the number upheld in 2013 _____
 (4) the number still pending at 12/31/13 _____

NY61

Table 3: External Appeals

	(1)	(2)	(3)	(4)	(5)	(6)
	Pending as of 12/31/12.	Filed in 2013.	Closed in 2013 (Whether filed in 2013 or earlier). Col. 4 + Col. 5	Closed in 2013 resulting in a reversal (in whole or in part) of the HMO's original determination.	Closed in 2013 in which the HMO's original determination was upheld.	Pending on 12/31/13. Col. 1 + Col. 2 – Col. 3
1. Actual Number						
2. Number per 1,000 members ^(a)						

(a) For all tables the number per 1,000 members, excluding Medicare and Medicaid members, should be based on the number of members as of June 30, 2013, as shown in the June 2013 Data Requirements. The number per 1,000 members should be carried to one decimal point, e.g. "3.6"

Name ----- and telephone number ----- of HMO contact person regarding this schedule.

**N.Y. SCHEDULE P – PART 1
HMO
(\$000 OMITTED)**

Year in which Premiums were Earned and Claims were Incurred	(1) Premiums Earned	(2) Claim Payments	(3) (Col. 2/1) Percent	(4) Claims Unpaid	(5) Total Claims Incurred (Col. 2+4)	(6) (Col. 5/1) Percent
1. Prior to 2010	XXX		XXX		XXX	XXX
2. 2010						
3. 2011						
4. 2012						
5. 2013						
6. Totals (LINE 1+2+3+4+5)	XXX	XXX	XXX		XXX	XXX
7. Totals (LINE 2+3+4+5)						

**N.Y. SCHEDULE P – PART 2
HMO
(\$000 OMITTED)**

Year in which Claims were Incurred	CLAIMS INCURRED REPORTED AT YEAR END				DEVELOPMENT ^(b)	
	(1) 2010	(2) 2011	(3) 2012	(4) 2013	(5) One Year (Col. 4 - 3)	(6) Two Year (Col. 4 - 2)
1. Prior to 2010	(a)					
2. 2010						
3. 2011	XXX					
4. 2012	XXX	XXX				XXX
5. 2013	XXX	XXX	XXX		XXX	XXX
				6. Totals		

(a) Reported reserves only. Subsequent development relates only to subsequent payments and reserves.

(b) Current year less first or second year, showing (redundant) or adverse.

CERTIFICATE OF COMPLIANCE

Filed pursuant to requirements of Regulation No. 34 (11 NYCRR 215)
Regarding Advertisements of Accident and Health Insurance

State of)
) SS:
County of)

_____ being duly sworn
deposes and says that (he, she) is the _____ of the

_____ Company and hereby
certifies that, to the best of (his, her) knowledge, information and belief, advertisements disseminated
by said insurer during the past calendar year complied, or were made to comply, with the provisions
of the Insurance Law of the State of New York and the requirements of Regulation No. 34
promulgated pursuant to said Law.

Subscribed and sworn to before me this
_____ day of _____ 20 _____

VARIANCE NARRATIVES

Please provide explanations for favorable and unfavorable PMPM variances greater than \$2.00, appearing in column 6 on pages NY13, NY15, NY17, NY19, NY21, NY23, NY25, NY27 or NY29.

OVERFLOW PAGE FOR WRITE-INS

GENERAL INFORMATION AND INSTRUCTIONS

For Filing The New York Data Requirements For HEALTH MAINTENANCE ORGANIZATIONS:

GENERAL

1. Two hard copies of this report are to be filed with the Department of Health, to the addresses shown on the cover of this report. One hard copy of this report, and one electronic copy, are to be filed with the Department of Financial Services (see the Department's web site, at www.dfs.ny.gov, for further information). All filings are to be received on or before April 1st for the preceding calendar year.
2. The Data Requirements must be filed with pages that are 8 1/2" wide x 14" long, and must be filed in the same sequence as presented by the Department in the electronic prototypes available to each insurer through the Department's web site.
3. All pages of the Data Requirements **MUST** be bound together along the left margin and **MUST** have a cover sheet that precedes the Jurat page. Supplements returned as loose pages without covers or in a larger or smaller size will not be accepted as meeting the filing requirements.
4. Unanswered questions and blank lines or schedules will not be accepted as meaning anything. If no answers or entries are to be made, write "None", "Not Applicable (N/A)", or "-0-" in the space provided.
5. Any item that cannot be readily classified under one of the printed items should be entered as a special item and adequately described.
6. If additional supporting statements or schedules are added in connection with answering interrogatories or providing information on the financial statement, the additions should be properly keyed to the item being answered (Example – "Interrogatories, 24") and indicate the reporting date and the name of the HMO.
7. The jurat (Page 1) of all filed statements must be manually signed by the appropriate corporate officers, have the corporate seal affixed thereon where appropriate and be properly notarized.
8. If this report does not contain the information asked for in the blanks or is not prepared in accordance with these instructions, it will not be accepted.
9. All PMPM entries are to be entered in dollars and cents. All other dollar entries are to be entered to the nearest whole dollar. All percent entries are to be entered to the one-tenth of one percent. All other ratios are to be entered to the nearest one-tenth.
10. All entries in columns titled "Prior Year" are to reflect the prior year filed annual statement.

SPECIAL INSTRUCTIONS FOR HMOs THAT ARE LINES OF BUSINESS OF ARTICLE 43 HEALTH SERVICE CORPORATIONS

An Article 43 Health Service Corporation that operates a line of business HMO **SHOULD NOT** submit a NAIC Annual Health Statement solely for the HMO line of business. However, such a corporation **SHOULD** submit the Annual New York Data Requirements for the HMO line of business. Additionally, the Article 43 Health Service Corporation is required to complete the NAIC Annual Health Statement and the New York Annual Article 43 Corporation Supplement for its entire book of business, which includes its HMO business.

JURAT PAGE

The "Service Area (Counties)" entry should state the counties in which the HMO is authorized to do business, pursuant to its Certificate of Authority issued pursuant to Public Health Law Article 44. Limitations shown on the COA, such as "Medicaid Only" for certain counties, should also be shown.

FINANCIAL STATEMENT

The Balance Sheet and Statement of Revenues and Expenses follow the format of the NAIC Annual Health blank. Therefore, these schedules should be completed in accordance with the NAIC Annual Statement Instructions for the Health blank, and with the NAIC Accounting Practices and Procedures Manual, except where New York law or regulations or Insurance Department policy would require or allow a different treatment.

LIABILITIES

Funds held by the reporting HMO, owed to a health care provider pursuant to a risk-sharing arrangement in satisfaction of the financial security deposit requirement of Regulation 164, Section 101.5(b), should be reported as write-ins to Line 23 under the account title "Funds Held Per Reg. 164, Section 101.5(b)(3)." See additional instructions on page NY35.

Reporting of liabilities associated with minimum loss ratio (MLR) requirements:

NAIC instructions require the liability for rebates payable under the Public Health Service Act to be reported on Page 3, Line 4 (Aggregate health policy reserves - with the liability disclosed in the inset) of the NAIC balance sheet, and require the change in the liability to be reported on Page 4, Line 3 (Change in unearned premium reserves and reserve for rate credits).

The NAIC instructions should be followed only for product rebates payable under the Public Health Service Act. Medicare Supplemental is not subject to such Act, and MLR rebates for Medicare Supplemental should be reported as follows:

The liability shall appear as a write-in item on page 3, in an account titled: New York Insurance Law section 3231(e)(1) or section 4308(c) Dividend/Credit Payable for Medicare Supplemental. The distribution of such dividends and credits are to be reported as a negative write-in for other income or expenses in the Statement of Revenue and Expenses on page 4, line 29, Aggregate write-ins for income and expenses.

SURPLUS

Lines:

29. Surplus Notes – Include loans under Section 1307 of the New York Insurance Law. Such loans should be accompanied by the following footnote, which is to be manually typed at the bottom of Page NY3:

“Pursuant to Section 1307 of the New York Insurance Law, no liability appears in this statement for a loan in the amount of \$..... of principal and \$.....of interest accrued thereon. The principal and interest may be repaid only with the permission of the Superintendent of Insurance.

- 30.1 Required Reserves –N.Y.S. Contingent Reserve, pursuant to 10 NYCRR 98-1.11(e); and N.Y.S. Escrow Deposit, pursuant to 10 NYCRR 98-1.11(f). The HMO is required to maintain a net worth equal to at least the greater of the contingent Reserve or the Escrow Deposit. The Contingent Reserve amount should be shown in its entirety. The Escrow Deposit should be offset by the Contingent Reserve; therefore, the Escrow Deposit should be shown only to the extent that it exceeds the Contingent Reserve. The calculations for these entries appear on Page NY36, Report #14A.

IMPORTANT NOTE – The amounts that appear on line 30.1 are to also appear on page 3 of the NAIC Health Blank, as write-ins to line 30.

REVENUE AND EXPENSES

Lines:

1. Member-Months
A member-month is equivalent to one person for whom the HMO has recognized premium revenue for one month. (A family of four persons enrolled for one month constitutes four member-months.) Where the revenue is recognized for only part of a month (or other relevant time period) for a given individual, a pro-rated partial member may be counted for that month.
2. Net Premium Income:
- 2.1. Basic, 2.2 Drugs, 2.3 Other Riders
Include the portion of premiums directly from subscribers for government-subsidized programs (i.e., Medicare, Child Health Plus, Family Health Plus).
- 2.4. Government Programs
Include the portion of premiums from Government agencies for coverage pursuant to Medicare, Medicaid, Child Health Plus and Family Health Plus.
- 2.5. Total: This line should equal line 2 of the Statement of Revenue and Expenses in the NAIC Health blank.
- 3.5. Change in Unearned Premium Reserves and Reserves for Rate Credits, Total
This line should equal line 3 of the Statement of Revenue and Expenses in the NAIC Health blank.
13. Prescription Drugs
This line should agree with the corresponding line in the NAIC Health blank, and should be determined in accordance with the NAIC Annual Statement instructions.
- 14.2. Rider Expense Expenses for all riders other than prescription drugs.
- 17.2. Stop-Loss Fund Recoveries
Anticipated recoveries from the Insurance Law Section 4321-a direct payment stop-loss fund, the Section 4322-a direct payment out-of-plan stop-loss fund, the Section 4327 small employer stop-loss fund and the Section 4327 qualifying individual stop-loss fund, for claims paid during the current period.
- 17.3. Regulation 146 Pool Recoveries
Anticipated net recoveries (net expenses) pertaining to the Demographic and SMC pools.

Page NY4 – REPORT #2 - STATEMENT OF REVENUE AND EXPENSES (TOTAL)

Reflects operating results of the entire HMO. Columns 1 and 3 should agree with columns 1 and 2 of the Statement of Revenue and Expenses by Line of Business on page NY7.

Page NY6 – REPORT #2 - PROJECTED REVENUE AND EXPENSES (TOTAL)

Reflects quarterly projections of operating results of the entire HMO for the upcoming year.

Pages NY7 thru NY9 – STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS

Columns 1 and 2 should agree with page NY4, Report #2 – Statement of Revenue and Expenses (Total), columns 1 and 3. Columns 1 and 2 are the sums of columns 3 and 4 plus 27 thru 44.

Columns 3 and 4 should agree with page NY13, Report #3 – Statement of Revenue and Expenses Excluding Government Programs and Healthy New York, columns 2 and 5. Columns 3 and 4 are the sums of columns 5 thru 26.

Columns 5 thru 10 should reflect HMO Only business, i.e. contracts with no point-of-service option.

Columns 11 thru 18 should reflect point-of-service business in which the reporting HMO writes only the in-network portion of a point-of-service service contract. An affiliated insurance company would generally write the out-of-network portion.

Columns 19 thru 26 should reflect point-of-service business in which the reporting HMO writes both the in-network and out-of-network portions of a point-of-service service contract. These columns should not duplicate any experience that is already reported in columns 11 thru 18.

Columns 27 and 28 should agree with page NY15, Report #4 – Statement of Revenue and Expenses – Healthy New York, columns 2 and 5.

Columns 29 and 30 should agree with page NY17, Report #5 – Statement of Revenue and Expenses – Medicare Advantage Including Part D, columns 2 and 5.

Columns 31 and 32 should agree with page NY19, Report #6 – Statement of Revenue and Expenses – Medicare Advantage Not Including Part D, columns 2 and 5.

Columns 33 and 34 should agree with page NY21, Report #7 – Statement of Revenue and Expenses – Medicaid, columns 2 and 5.

Columns 35 and 36 should agree with page NY23, Report #8 – Statement of Revenue and Expenses – Medicaid Advantage, columns 2 and 5.

Columns 37 and 38 should agree with page NY25, Report #9 – Statement of Revenue and Expenses – Medicaid Advantage Plus, columns 2 and 5.

Columns 39 and 40 should agree with page NY27, Report #10 – Statement of Revenue and Expenses – Child Health Plus, columns 2 and 5.

Columns 41 and 42 should agree with page NY29 Report #11 – Statement of Revenue and Expenses – Family Health Plus, columns 2 and 5.

Pages NY10 thru NY12 –FOURTH QUARTER STATEMENT OF REVENUE AND EXPENSES BY LINE OF BUSINESS

This statement should show underwriting results for the fourth quarter, rather than the entire year. All columns should parallel the experience shown in the Statement of Revenue and Expenses by Line of Business on pages NY7 thru NY9.

Page NY13 – REPORT #3 - STATEMENT OF REVENUE AND EXPENSES EXCLUDING GOVERNMENT PROGRAMS AND HEALTHY NEW YORK

Reflects operating results for the HMO's individual (direct pay), commercial small group and large group contracts. Do not include experience resulting from Medicare, Medicaid, Child Health Plus, Family Health Plus or the Healthy New York programs. Columns 2 and 5 should agree with columns 3 and 4 of the Statement of Revenues and Expenses by Line of Business on page NY7.

Pages NY33 through NY35 – REPORT #13 – Parts A through D

Report #13 is to be completed for risk-bearing entities (for example, IPA's and hospitals that assume risk pursuant to a contract entered into with the reporting HMO to provide member benefits) that have received or are projected to receive in-network capitation from the reporting HMO of more than \$250,000 during any twelve-month period. "Capitation" shall be defined per Insurance Department Regulation 164, Section 101.3(a); i.e., contractually based prepayments (any payments made prior to the last day of the month shall be deemed a payment of the entire month's capitation) made to a healthcare provider, on a per member per month or a percentage of premium basis.

The HMO should complete separate Parts A through D for each risk-bearing entity for which Report #13 is required. The Data Requirements can accommodate up to thirteen Report #13s. If the HMO is required to complete more Report #13's than the Data Requirements can accommodate, the HMO should manually complete the additional reports and attach them to the Data Requirements.

Report #13 – Part A is the balance sheet of the risk-bearing entity.

Report #13 – Part B is the income statement of the risk-bearing entity. Columns 1 and 2 should reflect the entire operations of the risk-bearing entity. Columns 3 and 4 should reflect the risk-bearing entity's activity with regards to the reporting HMO, for which only line #1, Capitation Revenue, and line #6, Claims Incurred, need to be completed.

Report #13 – Part D tests compliance with the risk-bearing entity's required demonstration of financial responsibility, per Insurance Department Regulation 164, Section 101.5. Lines 5.2 and 6.2 are to be completed with numerical references to the appropriate footnotes at the bottom of page NY35.

Pages NY36 and 37 – Report #14A and 14B

Department of Health Regulation 10 NYCRR 98-1.11(e) and (f), concerning the Contingent Reserve and the Escrow Account, have been amended effective 6/29/05.

Section 10 NYCRR 98-1.11(f) requires the HMO to establish an escrow deposit account, in the form of a trust account with a custodian, for which a deed of trust has been approved by the superintendent. Details of the account should be reported in the NAIC Health Blank, Schedule E – Part 3, Special Deposits. Furthermore, the escrow deposit amount is used in the calculation of the HMO's minimum net worth, and therefore should be entered in Report #14A, Line 1.

In addition to this requirement, the HMO is to establish a reserve for the Escrow Account in the capital and surplus section of its Annual Statement. This reserve may be offset by the Contingent Reserve established pursuant to NYCRR 98-1.11(e). HOWEVER – even though the escrow deposit might not be shown in its entirety in the capital and surplus portion of the balance sheet, the HMO is required to fund the ENTIRE escrow deposit asset account.

As of the March 31 Data Requirements,, the escrow deposit shall equal at least the greater of 5% of total projected expenditures for health care services for the current calendar year as shown in the most recently filed Annual Data Requirements, with no deductions for reinsurance, or \$100,000. The escrow deposit amount will be recalculated similarly each March 31 thereafter. For instance, as of the March 31, 2014 Data Requirements, the escrow deposit should equal at least the greater of 5% of projected 2014 health care expenditures as shown in the December 31, 2013 Data Requirements, or \$100,000. The HMO is then not required to adjust the escrow account amount until the March 31, 2015, at which time must equal at least the greater of 5% of projected 2015 health care expenditures as shown in the December 31, 2014 Data Requirements, or \$100,000.

Section 10 NYCRR 98-1.11(e) indicates that the Contingent Reserve is based on net premium income, net of reinsurance ceded only for reinsurance contracts that have been approved by the Superintendent of Insurance. The Contingent Reserve was initially established at 5% of net premium income. This percentage increases over time in accordance with the schedule set forth in 10 NYCRR 98-1.11(e).

Per 10 NYCRR 98-1.11(e), the Contingent Reserve for HMO's that were certified before 6/29/05 is to equal at least 12.5% of net premium income during 2013. Therefore in the 12/31/13 Data Requirements, the Contingent Reserve will be 12.5% of 2013 net premium income, net of reinsurance ceded only for reinsurance contracts that have been approved by the Superintendent of Insurance.

For HMO's certified after 6/29/05, the Contingent Reserve should comply with the instructions in footnote (c) for Report #14A, on page NY36.

COMPUTATION OF FINAL PREMIUM BASE – PAGE NY45

This form is required to be filed by all New York domiciled companies. The form is due by April 1.

SUPPLEMENTAL SCHEDULE A (NY) – PAGE NY49

Section 4310(1) of the Insurance Law and Section 83.4(j)(1) of Regulation 172 (11 NYCRR 83) permit not-for-profit HMO's to value real estate owned and held at ninety percent of its current market value, less encumbrances. For purposes of these Data Requirements, "market value, less encumbrances" shall have the same meaning as "fair value, less encumbrances." If the reporting HMO elects this option, the HMO must value all eligible real estate accordingly. Furthermore, the HMO must complete Supplemental Schedule A (NY) for what the current amortized book value would have been had the election not been made. Supplemental Schedule A (NY) is for informational purposes only and does not supersede the NAIC Schedule A, which should be completed demonstrating the market value election. Notwithstanding the valuation methodology permitted in Section 83.4(j)(1) of Regulation 172 and the instructions of Section 83.4(j)(1), properties that the reporting entity has the intent to sell, or is required to sell, shall be classified as properties held for sale and carried at the lower of depreciated cost or current market value less encumbrances and estimated sales costs consistent with the requirement of paragraph 10 of SSAP No. 40.

SCHEDULE G (NY) - PAGE NY51

Nothing in these instructions shall obviate the basic Schedule G (NY) instructions included on page NY51.

Column 2, Name of Payee: Payees should be listed in the following order: (1) Trade Association, Service Organization, Statistical, Actuarial or Rating Bureau or Organization, (2a) Directors or Trustees, (2b) Ten Officers or Employees Receiving the Largest Amounts, (2c) the remaining Officers and Employees, if the amount received was in excess of \$160,000 and (3) Any Other Person, Firm or Corporation, Excluding Medical Providers, in excess of \$160,000. Each of the aforementioned categories is to be listed separately. Within each category, the payees are to be listed in descending order from the highest paid to the lowest paid.

Column 3, Location of Payee: For directors, officers and employees state the principal work location (city and state) of person listed. For vendors, also state the city and state where the vendor is located.

Column 4, Salary Paid by the Company and All Other Companies in the Entire Holding Company System: With respect to directors, officers and employees, column 4 will include salaries excluding commissions, before any adjustment for tax sheltered programs, paid by the entire holding company.

Column 5, Bonus & all other Compensation Paid by the Company and All Other Companies in the Entire Holding Company System: Report gross bonus & all other compensation including any amounts deferred pursuant to a deferred compensation plan and/or employee saving plan. Exclude commissions.

The \$160,000 trigger in Schedule G's instructions is applicable not only to officers and employees who are employees of the reporting entity. **It is also applicable to individuals who are employees of the parent or an affiliate of the reporting entity and whose salaries are then allocated wholly or partially to the reporting entity.** Thus, even if the salary allocated to the reporting entity in column 7 is under \$160,000, column 6 requires the reporting of the total compensation of officers and employees of parents and affiliates if they are in excess of \$160,000.

Column 6, Total Amount Paid by the Entire Holding Company: Sum of columns 4 and 5.

Column 7, Amount Paid or Amount Allocated to Company: Amount Paid to category (1) the Trade Association, Service Organization, Statistical, Actuarial or Rating Bureau or Organization, and category (3) Any Other Person, Firm or Corporation, Excluding Medical Providers, in excess of \$160,000.

With respect to directors, officers and employees, if the amount paid was in excess of \$160,000, indicate the amount of compensation allocated to the reporting entity as a joint expense.

For categories 2(a), 2(b) and 2(c) – If the reporting entity does not belong to a holding company system, column 7 should equal column 6.

SPECIAL INSTRUCTIONS FOR FOR-PROFIT HMO'S ONLY: IMPORTANT NOTE – Schedule G is to be completed for all applicable employees. This differs from prior years' Data Requirements for which For-Profit HMO's were instructed to complete Schedule G only for certain employees.

N.Y. SCHEDULE M- PAGES NY60 and NY61

Sale of Business, Assumption or Merger:

- If the HMO is in the process of a sale, assumption or merger, the plan offering the contract under which a grievance or UR appeal arises should still report the grievance or UR appeal data.

Medicare:

- Do not include the number of grievances and UR appeals under Medicare Cost Contracts, Medicare Risk Contracts or Medicare Plus Choice Contracts.

Medicaid:

Do not include the number of grievances and UR appeals under Medicaid contracts.

Table 1: Section 4408(a) Grievances – Page NY60

Pursuant to Section 4408-a of the Public Health Law, the grievance procedure is used to seek a reversal of any determination other than a utilization review determination. Grievances may include, but are not limited to, denials of access to a referral or a determination that a benefit is not covered.

Report the number of grievance determinations that have been subject to the formal grievance procedure. Do not include complaints that are not related to a plan determination or that are not subject to the formal grievance procedure when reporting information in their annual statements. In addition, do not include oral complaints that are not acknowledged in writing, or otherwise subject to the formal grievance procedure.

Section 4408-a of the Public Health Law provide for two levels of internal review of grievances, an initial (first level) grievance review and an appeal of that initial grievance determination. When a grievance is subject to the two levels of review, only count the grievance once (i.e., include only the number of initial grievances filed and not the number of grievance appeals).

A first level grievance should be considered closed if the subscriber does not appeal the grievance determination within the timeframe required by the HMO in the calendar year in which the first level grievance determination was rendered. The first level grievance should be considered closed even if the calendar year ends before the timeframe established by the HMO for filing grievance appeals expires. Report the disposition of the first level grievance.

If the subscriber appeals the first level grievance determination in a subsequent calendar year, and the appeal is considered timely by the HMO, report the grievance appeal as either a grievance closed resulting in a reversal or as a grievance that was upheld. Do not count the grievance appeal in the number of grievances filed column in the annual statement for that subsequent year.

If a subscriber files a grievance appeal within the same calendar year as the initial first level grievance determination is made, and the plan renders a determination on the grievance appeal, the grievance should be reported as upheld or overturned based only on the disposition of the appeal.

If a subscriber files a grievance appeal within the same calendar year as the initial first level grievance determination, and the appeal is pending when the calendar year ends, the grievance should be reported as pending.

Point of Service Contracts:

- Several HMOs offer point of service contracts where the HMO provides the in-network coverage and an indemnity carrier, which may or may not be an affiliated company, provides the out-of-network coverage. Grievances should be attributed to the contract providing the in-network portion of coverage for purposes of the annual statement.

Table 2: Utilization Review Appeals – Page NY61

A UR appeal is an appeal of an adverse determination concerning the medical necessity of health care services.

The law provides for expedited and standard review of UR appeals. A subscriber who is unsuccessful with an expedited review of a UR appeal may pursue a standard review subject to non-expedited time frames. However, only count a UR appeal once if it is subject to both an expedited and standard review.

A non-expedited UR appeal should be considered closed when the utilization review agent notifies a subscriber of the appeal determination.

An expedited UR appeal should be considered closed when the UR agent notifies a subscriber of the expedited appeal determination and the subscriber does not further appeal the determination through the standard UR appeal process in the calendar year in which the expedited appeal determination was rendered. The utilization review appeal should be considered closed even if the calendar year ends before the timeframe established by the HMO for filing a standard UR appeal expires. Report the disposition of the expedited UR appeal.

If the subscriber appeals the expedited determination in a subsequent calendar year, and the appeal is considered timely by the HMO, report the appeal determination as either an appeal closed resulting in a reversal or as an appeal closed in which the plan determination was upheld. Do not count the appeal in the number of appeals filed column of the annual statement for that subsequent year.

If a subscriber files a utilization review appeal, and the appeal is pending when the calendar year ends, report the UR appeal as pending in the annual statement.

Utilization Review Agents:

- If the HMO contracts with a utilization review agent to conduct UR, the HMO is still responsible for reporting utilization review appeal data and grievance data.

Point of Service Contracts:

- Attribute the UR appeal to the HMO contract or insurance contract that the complaint arises under. If the HMO is unable to identify the contract that the complaint arises under, attribute the UR appeal to the contract providing the in-network portion of coverage.

N. Y. SCHEDULE P – PART 1 – PAGE NY62

Schedule P – Part 1 is intended to display a summary containing four years of historical data for all unpaid claims liabilities. Schedule P – Part 1 is designed to provide retrospective tests of reported liabilities through four subsequent calendar years. All premiums and claims are to be recorded in Schedule P – Part 1.

Generally, the columnar headings of Schedule P – Part 1 provide adequate instructions for completion. However, the following clarifications should be of assistance:

1. Report all dollar amounts in Schedule P – Part 1 in thousands of dollars (000 omitted), by either rounding or truncating.
2. Earned premium is on a calendar year basis. Premiums earned, once entered into column 1, will become “frozen.” No retrospective adjustments are to be made.
3. Claims incurred should be assigned to the year in which the event occurred that triggered coverage under the contract. Unpaid claims reported are expected to represent the ultimate amounts to be paid, including anticipated inflation, and are to agree in total with total unpaid claims on page 3 lines 1 plus 2 of the N.A.I.C. Annual Statement.
4. With the exception of line 1 entitled, “Prior to 2010”, claim payments are to be maintained on a cumulative basis. Thus, incurral year 2010 will represent claim payments made from inception, January 1, 2010, to date, December 31, 2013. Incurral year 2010 will represent claim payments made from inception, January 1, 2010, to date, December 31, 2013 and so on.

Claim payments reported on line 1, “Prior to 2010”, should not be cumulative, but should only pertain to payments made in 2013 on incurral year 2010 and prior claims. The purpose of this instruction is to account for all claim and expense payments in 2013 without reflecting a large cumulative to inception number of questionable value in the “Prior to 2010” line.

The following completion chart describes what to include in Columns 2 and 4.

Years in which Premiums were Earned and Claims were Incurred	(2) Claim Payments	(4) Claims Unpaid
1. Prior to 2010	Paid in 13 on <10	Reserve on <10 @ Year end 13
2. 2010	Paid through 13 on 10	Reserve on 10 @ Year end 13
3. 2011	Paid through 13 on 11	Reserve on 11 @ Year end 13
4. 2012	Paid through 13 on 12	Reserve on 12 @ Year end 13
5. 2013	Paid through 13 on 13	Reserve on 13 @ Year end 13

N.Y. SCHEDULE P – PART 2 (PAGE NY62)

Schedule P – Part 2 displays claims incurred data reported in Schedule P – Part 1 of the current and prior years, except as directed in the footnotes. The schedule format provides a retrospective test of all unpaid claims reported in the Annual Statement that will show developments through twelve and twenty-four months.

Report all amounts in thousands of dollars (000 omitted), by either rounding or truncating.

Column 5, the twelve-month development, is equal to column 4 minus column 3 for lines 1 through 4 only. Column 6, the twenty-four month development, is equal to column 4 minus 2 for lines 1 through 3 only. Line 6, totals for columns 5 and 6 is the sum of lines 1 through 5 of the respective columns.

Line 1, “Prior,” column 1 is equal to unpaid claim reserves at year end 2010 for all incurral years prior to 2010.

Line 1, "Prior," column 2, is equal to unpaid claim reserves at year end 2010 for all incurral years prior to 2010 plus claim payments made during 2013 for all incurral years prior to 2010.

Line 1, "Prior," columns 3 and 4 are equal to the same outstanding reserves at the specified year-end for all incurral years prior to 2010 plus the cumulative claim payments made after 2010 and before the specified year end for all incurral years prior to 2010.

The following completion chart describes what to include in 1 through 4:

Claims Incurred Reported at Year End				
	(1)	(2)	(3)	(4)
Years in which Claims were Incurred	2010	2011	2012	2013
Prior	Unpaid Claims reserves on <10@ year end 10 only	Paid in 11 + reserves on <10 @ year end 11	Paid thru 12 + reserve on <10 @ year end 12	Paid thru 13 + reserve on <10 @ year end 13
2010	Paid in 10 + reserves on 10@ year end 10	Paid thru 11+ reserves on 10 @ year end 11	Paid thru 12 + reserves on 10 @ year end 12	Paid thru 13 + reserves on 10 @ year end 13
2011		Paid in 11 + reserves on 11 @ year end 11	Paid thru 12 + reserves on 11 @ year end 12	Paid thru 13 + reserves on 11 @ year end 13
2012			Paid in 12 + reserves on 12 @ year end 12	Paid thru 13 + reserves on 12 @ year end 13
2013				Paid in 13 + reserves on 13 @ year end 13

SPECIAL INSTRUCTIONS

All PMPM entries are to be entered in dollars and cents. All other dollar entries are to be entered to the nearest whole dollar. All percent entries are to be entered to the one-tenth of one percent. All other ratios are to be entered to the nearest one-tenth.

MS2013JURAT1

COMPANY INFORMATION

Column 1 = Current Period Group Code
Column 2 = Prior Period Group Code
Column 3 = NAIC Company Code
Column 4 = FEIN
Column 5 = State of Domicile

MS2013JURAT2

COMPANY NAME INFORMATION

MS2013JURAT3

COMPANY ADDRESS INFORMATION

Column 1 = Street Address
Column 2 = City
Column 3 = State
Column 4 = Zip Code
Column 5 = Internet Website Address (applies to Line 1 only). If a company does not have an Internet Website Address, enter N/A in this field.

Line 01 = Statutory Home Office
Line 02 = Main Administrative Office
Line 03 = Mail Address
Line 04 = Primary Location of Books and Records
Line 05 = Electronic Contact Address

MS2013JURAT4

COMPANY CONTACT INFORMATION

Column 1 = Contact Last Name
Column 2 = Contact First Name
Column 3 = Contact Middle Name
Column 4 = Phone Number
Column 5 = E-Mail Address

Line 1 = Annual Statement Contact
Line 2 = Electronic Filing Contact

MS2013JURAT5

Table Length: Variable

COMPANY OFFICERS/DIRECTORS/TRUSTEES

Column 1 = Last Name
Column 2 = First Name
Column 3 = Middle Name
Column 4 = Suffix
Column 5 = New Officer Indicator
Column 6 = State of Residency*
Column 7 = Enrollee/Representative*

Value of Column 5 is YES if New Officer
Value of Line 5, Column 7 is * if Director is Enrollee
* Columns 6 & 7 are only required if company is an Article 44 HMO (see footnote (b) on Jurat Page)

Line 1 = Chief Executive Officer
Line 2 = Secretary
Lines 3 = Chief Financial Officer
Line 4.01 - 4.99 = Other Officers
Line 5.01 - 5.99 = Directors
Line 6 = Administrator

MS2013JURAT6

VENDOR INFORMATION

Column 1 = Vendor Name
Column 2 = Vendor Version Number
Column 3 = Vendor Code

MS2013JURAT7

HMO DATE INFORMATION

Column 1 = HMO Certified Date (MMDDYYYY)
Column 2 = Federally Qualified Date (MMDDYYYY)
Column 3 = Fiscal Year End Date (MMDDYYYY)
Column 4 = Date Incorporated (MMDDYYYY)
Column 5 = Date Commenced Business (MMDDYYYY)

MS2013JURAT8

SERVICE AREAS OR COUNTIES

Table Length: Variable

MS2013RP2ANN1

REPORT #2 STATEMENT OF REVENUE, EXPENSES AND NET WORTH (Excluding Medicare and Medicaid)

Columns 3 and 4 should be reported as dollars/cents

<u>MS2013RP2ANN1W</u> Table Length: Variable.	Columns 3 and 4 should be reported as dollars/cents
<u>MS2013RP2ANN2W</u> Table Length: Variable.	REPORT #2 STATEMENT OF REVENUE, EXPENSES AND NET WORTH (Excluding Medicare and Medicaid)
<u>MS2013RP2PRJ</u>	REPORT #2 - TOTAL PROJECTED REVENUES AND EXPENSES
<u>MS2013RP2PRJW</u> Table Length: Variable	Columns 2, 4, 6, 8 and 10 should be reported as dollars/cents Columns 2, 4, 6, 8 and 10 should be reported as dollars/cents
<u>MS2013RP3ANN</u> Through <u>MS2013RP8ANN</u>	REPORTS # - STATEMENT OF REVENUES AND EXPENSES Columns 4, 5, 6 and 7 should be reported as dollars/cents
<u>MS2013RP#ANNW</u> Table Length: Variable	Columns 4, 5, 6 and 7 should be reported as dollars/cents
<u>MS2013RP3PRJ</u> Through <u>MS2013RP8PRJ</u>	REPORTS # - TOTAL PROJECTED REVENUES AND EXPENSES Columns 2, 4, 6, 8 and 10 should be reported as dollars/cents
<u>MS2013RP#PRJW</u> Table Length: Variable	Columns 4, 5, 6 and 7 should be reported as dollars/cents
<u>MS2013RP9F &</u> <u>MS2013RP9QRT4F</u>	REPORT #9 & REPORT #9 QUARTER 4 - INTERROGATORY Column 1F = Total HMO Column 2F = Point of Service Product
<u>MS2013RP10A</u>	REPORT #10A BALANCE SHEET as of Most Recently Ended Fiscal Year 0000001 Column 1F = Name of Risk Bearing Entity. 0000002 Column 1F = Name of Stop-Loss Insurance Provider 0000002 Column 2F = NAIC#
<u>MS2013RP10B</u>	REPORT #10B STATEMENT of OPERATIONS 0000001 Column 1F = Describe the Prior Period Adjustment. 0000002 Column 1F = Describe the Extraordinary Adjustment 0000003 Column 2F = DATE (MM/DD/YYYY format).
<u>MS2013RP10C</u>	REPORT #10C Lines 0000001-9999996 = Names of HMO's, insurers, PHSP's and other entities with which the risk bearing entity contracts to assume risk.
<u>MS2013RP10D</u>	REPORT #10D Regulation 164 Risk Transfer Arrangement Required Data For the Year Lines 2 and 7.2 = DATE (MM/DD/YYYY format).
<u>MS2013SC3</u>	SCHEDULE 3 - TOTAL MEDICAL COST ANALYSIS BY AGE AND SEX Columns 4, 5, and 6 should be reported as dollars/cents
<u>MS2013SC4</u>	SCHEDULE 4 - TOTAL HOSPITAL COST ANALYSIS BY AGE AND SEX Columns 4, 5, and 6 should be reported as dollars/cents
<u>MS2013SC5</u>	SCHEDULE 5 - HOSPITAL SERVICES Columns 4 should be rounded to the nearest dollar.
<u>MS2013SC7</u>	SCHEDULE 7 - FREQUENTLY USED HOSPITALS (EXCLUDING MEDICARE) Columns 4 should be rounded to the nearest dollar.
<u>MS2013INTER</u>	NEW YORK INTERROGATORIES COLUMN 1 = YES/NO/NA COLUMN 2 = % OF PREMIUM PAID AS COMMISSION COLUMN 3 = NUMERICAL VALUE (Premium Volume, Rolling Rates) COLUMN 4 = NUMERICAL VALUE (Premium Volume, Annualized Subscriber Rates) COLUMN 5 = NUMERICAL VALUE (Total Guaranteed Rates) COLUMN 6 = NAME COLUMN 7 = EXPLANATION COLUMN 8 = \$ VALUE COLUMN 9 = NUMERICAL VALUE (Number of agreements) Lines 2.1, 2.2, 2.3 & 2.4 is a percentage and should be entered to one-tenth of one percent.
<u>MS2013INTERSC5</u> Table Length: Variable	NEW YORK INTERROGATORIES - SCHEDULE 5 COLUMN 1 = NAME OF BORROWERS COLUMN 2 = POSITION WITH HMO COLUMN 3 = ORIGINAL LOAN AMOUNT COLUMN 4 = AMOUNT OF LOAN PRINCIPAL OUTSTANDING AT YEAR END
<u>MS2013INTERSC6</u> Table Length: Variable	NEW YORK INTERROGATORIES - SCHEDULE 6 Column 2 is a percentage and should be entered to one-tenth of one percent.

MS2013INTERSC15

NEW YORK INTERROGATORIES - SCHEDULE 15

COLUMN 1 is a percentage and should be entered to one-tenth of one percent.
COLUMN 2 = MMDD/DDMM/YYYY format

MS2013SCANY

Table Length: Variable

SUPPLEMENTAL SCHEDULE A (NY)

Column 1 = Description of Property
Column 2 = Code. (See NAIC Instructions)
Column 3 = City
Column 4 = State
Column 5 = Date Acquired (MMDDYYYY)
Column 6 = Date of last appraisal (MMDDYYYY)

Lines 0100001-0199996 = Properties occupied by the reporting entity – Health Care Delivery.
Lines 0200001-0299996 = Properties occupied by the reporting entity – Administrative.
Lines 0399999 = Total properties occupied by the reporting entity.
Lines 0400001-0499996 = Properties held for the production of income.
Lines 0500001-0599996 = Properties held for sale.
Lines 9999999 = Totals

If this schedule is not used, or any section thereof, all xx00001 lines are required and all columns must be left blank.

MS2013SCG

SCHEDULE G

Column 1 = Title of Payee
Column 2 = Name
Column 3A = City
Column 3B = State Abbreviation
Column 4 = Amount Paid
Column 5 = Gross Salary Paid
Column 6 = Salary Allocated to HMO

Lines 0100001-9999996 = Ten Officers or Employees Receiving the Largest Amounts.
Lines 0200001-0299996 = Directors or Trustees.
Lines 0300001-0399996 = Any Other Person, Firm or Corporation, Excluding Medical Providers, in excess of \$160,000. (List Remaining Officers and Employees First)
Lines 0400001-0599996 = Trade Association, Service Organization, Statistical, Actuarial or Rating Bureau or Organization
Line 9999999 = Total

MS2013SCHSN1W

Table Length: Variable

SCHEDULE H - SECTION 1 AGING ANALYSIS OF CLAIMS UNPAID

MS2013JURAT11

CONTACT INFORMATION

SCHEDULE H - SECTION 3 - CLAIMS AND INTEREST PAID, CURRENT YEAR TO DATE,

Line 01 = Schedule H Contact
Column 1 = Last Name
Column 2 = First Name
Column 3 = Middle Name
Column 4 = Phone Number
Column 5 = E-Mail Address

MS2013SCI

SCHEDULE I - LOANS AND NOTES PAYABLE (Other than Affiliates)

Column 2 is a percentage and should be entered to one-tenth of one percent.

MS2013SCJ

SCHEDULE J - SURPLUS NOTES

COLUMN 3 = MMDD/DDMM/YYYY format

MS2013SCKPT1

SCHEDULE K - PART 1 - RECAPITULATION

All Lines 2, 5 and 6 should be reported as dollars/cents (13,2)
Line 1.03, 1.04, 1.05 & 7.02 thru 7.04 are ratios and should be entered to the nearest one-tenth. (13,1)
Line 7.01 is a percentage and should be entered to the nearest one-tenth. (13,1)

MS2013SCKPT2

SCHEDULE K - PART 2 - RECAPITULATION

Columns 2 and 4 are percentages and should be entered to one-tenth of one percent.

MS2013SCKPT2W

Table Length: Variable

Columns 2 and 4 are percentages and should be entered to one-tenth of one percent.

MS20135YRHIST

FIVE YEAR HISTORICAL DATA

Lines 14 thru 20 all columns should be reported as dollars/cents (13,2)
Lines 26 and 27 all columns are percentages and should be entered to the nearest one-tenth. (13,1)

MS2013SCMPT1

MS2013SCMPT2

MS2013SCMPT3

SCHEDULE M

Line 2 all columns are ratios and should be entered to the nearest one-tenth. (13,1)

MS2013JURAT9

SCHEDULE M

Line 01 = HMO Contact person regarding this schedule
Column 1 = Last Name

Column 2 = First Name
Column 3 = Middle Name
Column 4 = Phone Number

MS2013SCPPT1

NEW YORK SCHEDULE P - PART 1 - HMO

Lines 2 thru 5 and 7, Columns 3 and 6 are percentages and should be entered to the nearest one-tenth.

(13,1)

MS2013PREMTAXI COMPUTATION of SECTION 206 PREMIUM BASE

Line 02.3, Column 1 = Description of Other Addition on line 2.3

Line 03.7, Column 1 = Description of Other Deduction on line 3.7

MS2013JURAT10 COMPUTATION of SECTION 206 PREMIUM BASE

Line 01 = Column 1 = Schedule Contact Name

Column 2 = Schedule Contact Title

Column 3 = Phone Number

Column 4 = E-Mail Address