Filing at a Glance

Company:	Independent Health Benefits Corporation
Product Name:	IHBC Individual Off Exchange 2015 Prior Approval
State:	New York
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Prior Approval Off Exchange Form & Rate Filing
Date Submitted:	06/13/2014
SERFF Tr Num:	NDPD-129588074
SERFF Status:	Pending Industry Response
State Tr Num:	2014060227
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2015
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *Independent Health Benefits Corporation*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *IHBC Individual Off Exchange 2015 Prior Approval*
Project Name/Number: *IHBC Individual Off Exchange 2015 Prior Approval/*

General Information

Project Name: IHBC Individual Off Exchange 2015 Prior Approval
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: [redacted]

Status of Filing in Domicile:

Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 06/18/2014
State Status Changed:
Created By: [redacted]
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Include Exchange Intentions: No

Filing Description:
2015 IHBC Prior Approval Filing for Article 43. This submission includes Individual Off Exchange products.

If you need any additional information or have questions, please call [redacted]

Company and Contact

Filing Contact Information

[redacted]

Filing Company Information

Independent Health Benefits Corporation
511 Farber Lakes Drive
Buffalo, NY 14221
[redacted]

CoCode: 47034
Group Code: -99
Group Name:
FEIN Number: 16-1483784

State of Domicile: New York
Company Type: Health Article 43
State ID Number: 16-1483784

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

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

Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is a group prefiling notification, out-of-state, or a report filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate Only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: Yes, Prior Approval Rate Adjustment
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary, a draft initial notification letter, and a draft numerical summary associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes, NDPD-129574328 2014060112

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: IHBC Individual Off Exchange 2015 Prior Approval
Project Name/Number: IHBC Individual Off Exchange 2015 Prior Approval/

Rate Information

Rate data applies to filing.

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

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Independent Health Benefits Corporation	Increase	5.530%	5.530%	$26,168	26	$141,539	6.890%	3.820%

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: IHBC Individual Off Exchange 2015 Prior Approval
Project Name/Number: IHBC Individual Off Exchange 2015 Prior Approval/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Material	IHBC-C1035, IHBC-C1024, IHBC-C1025, IHBC-C1038, IHBC-C1026, IHBC-SBP014-4, IHBC-SBP005-4, IHBC-SBP001-4, IHBC-SBP003-4, IHBC-SBG009-4, IHBC-SBG005-4, IHBC-SBG001-4, IHBC-SBG002-4, IHBC-SBS015-4, IHBC-SBS009-4, IHBC-SBS029-4, IHBC-SBS001-4, IHBC-SBS002-4, IHBC-SBB005-4, IHBC-SBB007-4, IHBC-SBB014-4, IHBC-SBB001-4, IHBC-SBB002-4, IHBC-SBC001-4, IHBC-R1064	New		A43_Ind_offEx_Manual_2015_6_16_2014.pdf,

Independent Health Benefits Corporation

Independent Health's Individual Rate Manual

For Plans offered off New York State's Health Insurance Exchange

Effective January 1, 2015

Independent Health Benefits Corporation
511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange

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B.	Benefit Grids	2
C.	Rating Region / Expected Loss Ratio	7
D.	Broker Commissions	8
E.	Underwriting Guidelines	8

Independent Health Benefits Corporation
Individual Off Exchange Premium Rates Effective January 1, 2015

HIOS Plan ID	Form Numbers		Marketing Name	Product Description	Single (2.85)	Double (1.00)	Employee / Child(ren) (2.00)	Family (1.70)
Platinum Plans				**OF = Off Exchange IN = Individual DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1180077-00	IHBC-C1035	IHBC-SBP014-4		Choice Plus Platinum	OFIN.DEP25.SNF365.DPY.FPY	$549.57	$1,099.14	$934.27	$1,566.27
18029NY1180078-00	IHBC-C1035	IHBC-SBP014-4	IHBC-R1064	Choice Plus Platinum	OFIN.DEP29.SNF365.DPY.FPY	$554.84	$1,109.68	$943.23	$1,581.29
18029NY1180021-00	IHBC-C1024	IHBC-SBP005-4		FlexFit Platinum	OFIN.DEP25.SNF365.DPY.FPY	$618.25	$1,236.50	$1,051.03	$1,762.01
18029NY1180022-00	IHBC-C1024	IHBC-SBP005-4	IHBC-R1064	FlexFit Platinum	OFIN.DEP29.SNF365.DPY.FPY	$624.17	$1,248.34	$1,061.09	$1,778.88
18029NY1180001-00	IHBC-C1024	IHBC-SBP001-4		Standard Platinum	OFIN.DEP25.SNF200.DPY.FPY	$643.95	$1,287.90	$1,094.72	$1,835.26
18029NY1180008-00	IHBC-C1024	IHBC-SBP001-4		Standard Platinum	OFIN.DEP25.SNF365.DPY.FPY	$643.95	$1,287.90	$1,094.72	$1,835.26
18029NY1180002-00	IHBC-C1024	IHBC-SBP001-4	IHBC-R1064	Standard Platinum	OFIN.DEP29.SNF200.DPY.FPY	$650.12	$1,300.24	$1,105.20	$1,852.84
18029NY1180010-00	IHBC-C1024	IHBC-SBP001-4	IHBC-R1064	Standard Platinum	OFIN.DEP29.SNF365.DPY.FPY	$650.12	$1,300.24	$1,105.20	$1,852.84
18029NY1180009-00	IHBC-C1025	IHBC-SBP003-4		Standard Platinum(CO)	OFIN.DEP25.SNF200.DPY.FPY	$265.30	N/A	N/A	N/A
18029NY1180012-00	IHBC-C1025	IHBC-SBP003-4		Standard Platinum(CO)	OFIN.DEP25.SNF365.DPY.FPY	$265.30	N/A	N/A	N/A
Gold Plans				**OF = Off Exchange IN = Individual DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1220025-00	IHBC-C1035	IHBC-SBG009-4		Choice Plus Gold	OFIN.DEP25.SNF365.DPY.FPY	$472.03	$944.06	$802.45	$1,345.29
18029NY1220026-00	IHBC-C1035	IHBC-SBG009-4	IHBC-R1064	Choice Plus Gold	OFIN.DEP29.SNF365.DPY.FPY	$476.54	$953.08	$810.12	$1,358.14
18029NY1220021-00	IHBC-C1024	IHBC-SBG005-4		iDirect Gold	OFIN.DEP25.SNF365.DPY.FPY	$535.90	$1,071.80	$911.03	$1,527.32
18029NY1220022-00	IHBC-C1024	IHBC-SBG005-4	IHBC-R1064	iDirect Gold	OFIN.DEP29.SNF365.DPY.FPY	$541.02	$1,082.04	$919.73	$1,541.91
18029NY1220001-00	IHBC-C1024	IHBC-SBG001-4		Standard Gold	OFIN.DEP25.SNF200.DPY.FPY	$558.01	$1,116.02	$948.62	$1,590.33
18029NY1220005-00	IHBC-C1024	IHBC-SBG001-4		Standard Gold	OFIN.DEP25.SNF365.DPY.FPY	$558.01	$1,116.02	$948.62	$1,590.33
18029NY1220002-00	IHBC-C1024	IHBC-SBG001-4	IHBC-R1064	Standard Gold	OFIN.DEP29.SNF200.DPY.FPY	$563.35	$1,126.70	$957.70	$1,605.55
18029NY1220006-00	IHBC-C1024	IHBC-SBG001-4	IHBC-R1064	Standard Gold	OFIN.DEP29.SNF365.DPY.FPY	$563.35	$1,126.70	$957.70	$1,605.55
18029NY1220009-00	IHBC-C1025	IHBC-SBG002-4		Standard Gold(CO)	OFIN.DEP25.SNF200.DPY.FPY	$229.90	N/A	N/A	N/A
18029NY1220007-00	IHBC-C1025	IHBC-SBG002-4		Standard Gold(CO)	OFIN.DEP25.SNF365.DPY.FPY	$229.90	N/A	N/A	N/A
Silver Plans				**OF = Off Exchange IN = Individual DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1260127-00	IHBC-C1035	IHBC-SBS015-4		Choice Plus Silver	OFIN.DEP25.SNF365.DPY.FPY	$406.79	$813.58	$691.54	$1,159.35
18029NY1260128-00	IHBC-C1035	IHBC-SBS015-4	IHBC-R1064	Choice Plus Silver	OFIN.DEP29.SNF365.DPY.FPY	$410.66	$821.32	$698.12	$1,170.38
18029NY1260037-00	IHBC-C1024	IHBC-SBS009-4		iDirect Silver Coinsurance	OFIN.DEP25.SNF365.DPY.FPY	$460.31	$920.62	$782.53	$1,311.88
18029NY1260038-00	IHBC-C1024	IHBC-SBS009-4	IHBC-R1064	iDirect Silver Coinsurance	OFIN.DEP29.SNF365.DPY.FPY	$464.71	$929.42	$790.01	$1,324.42
18029NY1350067-00	IHBC-C1038	IHBC-SBS029-4		Max Silver	OFIN.DEP25.SNF365.DPY.FPY	$474.91	$949.82	$807.35	$1,353.49
18029NY1350068-00	IHBC-C1038	IHBC-SBS029-4	IHBC-R1064	Max Silver	OFIN.DEP29.SNF365.DPY.FPY	$479.45	$958.90	$815.07	$1,366.43
18029NY1260001-00	IHBC-C1024	IHBC-SBS001-4		Standard Silver	OFIN.DEP25.SNF200.DPY.FPY	$482.16	$964.32	$819.67	$1,374.16
18029NY1260005-00	IHBC-C1024	IHBC-SBS001-4		Standard Silver	OFIN.DEP25.SNF365.DPY.FPY	$482.16	$964.32	$819.67	$1,374.16
18029NY1260002-00	IHBC-C1024	IHBC-SBS001-4	IHBC-R1064	Standard Silver	OFIN.DEP29.SNF200.DPY.FPY	$486.76	$973.52	$827.49	$1,387.27
18029NY1260006-00	IHBC-C1024	IHBC-SBS001-4	IHBC-R1064	Standard Silver	OFIN.DEP29.SNF365.DPY.FPY	$486.76	$973.52	$827.49	$1,387.27
18029NY1260009-00	IHBC-C1025	IHBC-SBS002-4		Standard Silver(CO)	OFIN.DEP25.SNF200.DPY.FPY	$198.65	N/A	N/A	N/A
18029NY1260007-00	IHBC-C1025	IHBC-SBS002-4		Standard Silver(CO)	OFIN.DEP25.SNF365.DPY.FPY	$198.65	N/A	N/A	N/A
Bronze Plans				**OF = Off Exchange IN = Individual DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1310025-00	IHBC-C1035	IHBC-SBB005-4		Choice Plus Bronze	OFIN.DEP25.SNF365.DPY.FPY	$355.78	$711.56	$604.83	$1,013.97
18029NY1310026-00	IHBC-C1035	IHBC-SBB005-4	IHBC-R1064	Choice Plus Bronze	OFIN.DEP29.SNF365.DPY.FPY	$359.17	$718.34	$610.59	$1,023.63
18029NY1310033-00	IHBC-C1024	IHBC-SBB007-4		iDirect Bronze	OFIN.DEP25.SNF365.DPY.FPY	$387.34	$774.68	$658.48	$1,103.92
18029NY1310034-00	IHBC-C1024	IHBC-SBB007-4	IHBC-R1064	iDirect Bronze	OFIN.DEP29.SNF365.DPY.FPY	$391.03	$782.06	$664.75	$1,114.44
18029NY1360069-00	IHBC-C1038	IHBC-SBB014-4		Max Bronze	OFIN.DEP25.SNF365.DPY.FPY	$408.27	$816.54	$694.06	$1,163.57
18029NY1360070-00	IHBC-C1038	IHBC-SBB014-4	IHBC-R1064	Max Bronze	OFIN.DEP29.SNF365.DPY.FPY	$412.16	$824.32	$700.67	$1,174.66
18029NY1310009-00	IHBC-C1024	IHBC-SBB001-4		Standard Bronze	OFIN.DEP25.SNF200.DPY.FPY	$414.14	$828.28	$704.04	$1,180.30
18029NY1310001-00	IHBC-C1024	IHBC-SBB001-4		Standard Bronze	OFIN.DEP25.SNF365.DPY.FPY	$414.14	$828.28	$704.04	$1,180.30
18029NY1310010-00	IHBC-C1024	IHBC-SBB001-4	IHBC-R1064	Standard Bronze	OFIN.DEP29.SNF200.DPY.FPY	$418.09	$836.18	$710.75	$1,191.56
18029NY1310002-00	IHBC-C1024	IHBC-SBB001-4	IHBC-R1064	Standard Bronze	OFIN.DEP29.SNF365.DPY.FPY	$418.09	$836.18	$710.75	$1,191.56
18029NY1310013-00	IHBC-C1025	IHBC-SBB002-4		Standard Bronze(CO)	OFIN.DEP25.SNF200.DPY.FPY	$170.63	N/A	N/A	N/A
18029NY1310003-00	IHBC-C1025	IHBC-SBB002-4		Standard Bronze(CO)	OFIN.DEP25.SNF365.DPY.FPY	$170.63	N/A	N/A	N/A
Catastrophic Plans				**OF = Off Exchange IN = Individual DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1290001-00	IHBC-C1026	IHBC-SBC001-4		Catastrophic	OFIN.DEP25.SNF200.DPY.FPY	$220.95	$441.90	$375.62	$629.71

	Choice Plus Platinum	FlexFit Platinum	Standard Platinum
In-Network Deductible	A: $0 B:$1,000	$0	$0
Integrated Medical and Drug Deductible	Yes	Yes	No
In-Network Coinsurance	A: 0% B: 40%	N/A	N/A
In-Network OOP Maximum	A: $5,000 B: $6,450	$5,000	$2,000
Emergency Room Services	A: $150 ND B: $150 ND	$150 ND	$100 ND
All Inpatient Hospital Services (inc. MHSA)	A: $500 ND B: 40%	$500 ND	$500 ND
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: $10 ND B: 40%	$10 ND	$15 ND
Specialist Visit	A: $30 ND B: 40%	$30 ND	$35 ND
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: $30 ND B: 40%	$30 ND	$15 ND
Imaging (CT/PET Scans, MRIs)	A: $75 ND B: 40%	$75 ND	$35 ND
Rehabilitative Speech Therapy	A: $30 ND B: 40%	$30 ND	$25 ND
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: $30 ND B: 40%	$30 ND	$25 ND
Laboratory Outpatient and Professional Services	A: $0 ND B: 40%	$10 ND	$35 ND
X-ray and Diagnostic Imaging	A: $30 ND B: 40%	$30 ND	$35 ND
Skilled Nursing Facility	A: $500 ND B: 40%	$500 ND	$500 ND
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: $150 ND B: 40%	$150 ND	$100 ND
Outpatient Surgery Physician/Surgical Services	A: $30 ND B: 40%	$30 ND	$100 ND
Generics	A: $4 ND B: $4 ND	$4 ND	$10 ND
Preferred Brand Drugs	A: $30 ND B: $30 ND	$30 ND	$30 ND
Non-Preferred Brand Drugs	A: 50% ND B: 50% ND	50% ND	$60 ND
Specialty Drugs (i.e., high cost)	A: 50% ND B: 50% ND	50% ND	$60 ND
Out-of-Network Deductible	$2,000	$2,000	$2,000
Out-of-Network Coinsurance	40%	40%	40%
OON OOP Maximum	Unlimited	Unlimited	Unlimited

ND: No Deductible

	Choice Plus Gold	iDirect Gold	Standard Gold
In-Network Deductible	A: $1,000 B: $2,000	$750	$600
Integrated Medical and Drug Deductible	No	No	No
In-Network Coinsurance	A: 0% B: 50%	N/A	N/A
In-Network OOP Maximum	A: $5,450 B: $6,450	$6,350	$4,000
Emergency Room Services	A: $150 B: $150	$150	$150
All Inpatient Hospital Services (inc. MHSA)	A: $500 B: 50%	$1,000	$1,000
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: $20 ND B: 50%	$15 ND	$25
Specialist Visit	A: $40 B: 50%	$45	$40
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: $40 B: 50%	$45	$25
Imaging (CT/PET Scans, MRIs)	A: $75 B:50%	$100	$40
Rehabilitative Speech Therapy	A: $40 B: 50%	$45	$30
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: $40 B: 50%	$45	$30
Laboratory Outpatient and Professional Services	A: $20 B: 50%	$25	$40
X-ray and Diagnostic Imaging	A: $40 B: 50%	$45	$25
Skilled Nursing Facility	A: $500 B: 50%	$1,000	$1,000
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: $150 B:50%	$150	$100
Outpatient Surgery Physician/Surgical Services	A: $40 B: 50%	$45	$100
Generics	A: $4 ND B: $4 ND	$4 ND	$10 ND
Preferred Brand Drugs	A: $30 ND B: $30 ND	$30 ND	$35 ND
Non-Preferred Brand Drugs	A: 50% ND B: 50% ND	50% ND	$70 ND
Specialty Drugs (i.e., high cost)	A: 50% ND B: 50% ND	50% ND	$70 ND
Out-of-Network Deductible	$2,500	$2,500	$2,500
Out-of-Network Coinsurance	50%	40%	40%
OON OOP Maximum	Unlimited	Unlimited	Unlimited

ND: No Deductible

	Choice Plus Silver	iDirect Silver Coinsurance	Max Silver	Standard Silver
In-Network Deductible	A: $2,000 B: $4,000	$2,000	$2,000	$2,000
Integrated Medical and Drug Deductible	Yes	Yes	Yes	No
In-Network Coinsurance	A: 20% B: 50%	20%	N/A	N/A
In-Network OOP Maximum	A: $5,900 B: $6,450	$6,000	$6,000	$5,500
Emergency Room Services	A:20% B:20%	20%	$200	$150
All Inpatient Hospital Services (inc. MHSA)	A: 20% B: 50%	20%	$1,000	$1,500
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: 20% B: 50%	20%	$35 ND	$30
Specialist Visit	A: 20% B: 50%	20%	$50	$50
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: 20% B: 50%	20%	$50	$30
Imaging (CT/PET Scans, MRIs)	A: 20% B: 50%	20%	$100	$50
Rehabilitative Speech Therapy	A: 20% B: 50%	20%	$50	$30
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: 20% B: 50%	20%	$50	$30
Laboratory Outpatient and Professional Services	A: 20% B: 50%	20%	$30	$50
X-ray and Diagnostic Imaging	A: 20% B: 50%	20%	$50	$50
Skilled Nursing Facility	A: 20% B: 50%	20%	$1,000	$1,500
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: 20% B: 50%	20%	$150	$100
Outpatient Surgery Physician/Surgical Services	A: 20% B: 50%	20%	$50	$100
Generics	A: $4 B: $4	$4	$10 ND	$10 ND
Preferred Brand Drugs	A: $30 B: $30	$30	$45	$35 ND
Non-Preferred Brand Drugs	A: 50% B: 50%	50%	50%	$70 ND
Specialty Drugs (i.e., high cost)	A: 50% B: 50%	50%	50%	$70 ND
Out-of-Network Deductible	$5,000	$3,000	Not Applicable	$3,000
Out-of-Network Coinsurance	50%	40%	100%	40%
OON OOP Maximum	Unlimited	Unlimited	Not Applicable	Unlimited

ND: No Deductible

	Choice Plus Bronze	iDirect Bronze	Max Bronze	Standard Bronze
In-Network Deductible	A: $3,500 B: $5,000	$4,750	$5,500	$3,000
Integrated Medical and Drug Deductible	Yes	Yes	Yes	Yes
In-Network Coinsurance	A: 30% B: 50%	40%	25%	50%
In-Network OOP Maximum	A: $6,350 B: $6,450	$6,350	$6,600	$6,350
Emergency Room Services	A: 30% B: 30%	40%	$0	50%
All Inpatient Hospital Services (inc. MHSA)	A: 30% B: 50%	40%	25%	50%
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: 30% B: 50%	40%	$40 ND	50%
Specialist Visit	A: 30% B: 50%	40%	25%	50%
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: 30% B: 50%	40%	25%	50%
Imaging (CT/PET Scans, MRIs)	A: 30% B: 50%	40%	25%	50%
Rehabilitative Speech Therapy	A: 30% B: 50%	40%	25%	50%
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: 30% B: 50%	40%	25%	50%
Laboratory Outpatient and Professional Services	A: 30% B: 50%	40%	25%	50%
X-ray and Diagnostic Imaging	A: 30% B: 50%	40%	25%	50%
Skilled Nursing Facility	A: 30% B: 50%	40%	25%	50%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: 30% B: 50%	40%	25%	50%
Outpatient Surgery Physician/Surgical Services	A: 30% B: 50%	40%	25%	50%
Generics	A: 50% B: 50%	50%	$10 ND	$10
Preferred Brand Drugs	A: 50% B: 50%	50%	50%	$35
Non-Preferred Brand Drugs	A: 50% B: 50%	50%	50%	$70
Specialty Drugs (i.e., high cost)	A: 50% B: 50%	50%	50%	$70
Out-of-Network Deductible	$5,000	$5,000	Not Applicable	$5,000
Out-of-Network Coinsurance	50%	50%	100%	50%
OON OOP Maximum	Unlimited	Unlimited	Not Applicable	Unlimited

ND: No Deductible

	Catastrophic
In-Network Deductible	$6,600
Integrated Medical and Drug Deductible	Yes
In-Network Coinsurance	0%
In-Network OOP Maximum	$6,600
Emergency Room Services	0%
All Inpatient Hospital Services (inc. MHSA)	0%
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	0% 3 Visits ND
Specialist Visit	0%
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0%
Imaging (CT/PET Scans, MRIs)	0%
Rehabilitative Speech Therapy	0%
Rehabilitative Occupational and Rehabilitative Physician Therapy	0%
Laboratory Outpatient and Professional Services	0%
X-ray and Diagnostic Imaging	0%
Skilled Nursing Facility	0%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0%
Outpatient Surgery Physician/Surgical Services	0%
Generics	0%
Preferred Brand Drugs	0%
Non-Preferred Brand Drugs	0%
Specialty Drugs (i.e., high cost)	0%
Out-of-Network Deductible	Not Applicable
Out-of-Network Coinsurance	100%
OON OOP Maximum	Not Applicable

ND: No Deductible

Independent Health Benefits Corporation
511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange

Rating Regions

The rating region for this rate manual is the Western New York service area including Erie, Chautauqua, Cattaraugus, Genesee, Niagara, Wyoming, Allegany, and Orleans Counties.

Expected Loss Ratio

The Expected Loss Ratio for all products in this manual is 87%

Since this rate manual applies to individual business only, broker commissions do not apply. However, IHBC has filed it's broker commissions on SERFF under state tracking number 2013030147.

Independent Health Benefits Corporation
511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange

Underwriting Guidelines

Eligible Individual –

Means an individual, who is seeking to enroll in a qualified health plan in the individual market, but not offered through the Exchange, and lawfully resides in the eight counties of WNY. Incarcerated individuals are excluded, except for individuals pending the disposition of charges.

Rating arrangement –

Community rated, meaning a rate methodology in which the premium for all persons covered is the same and based on the experience of the entire pool without regard to age, sex, health status or occupation.

Out of area Individuals –

IHBC products are limited to individuals who reside within the WNY service area.

Off cycle plan changes –

All product changes must occur on the anniversary date.

Pre-existing conditions limitations –

Per Section 1501 of PPACA, pre-existing conditions limitations are waived for all enrollees.

Supporting Document Schedules

Satisfied - Item:	Rate Filing Instructions for On and Off Exchange Plans
Comments:	
Attachment(s):	EXCHANGE CHECKLIST 04-25-14 453PM.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 13-Narrative Summary and Numerical Summary
Comments:	
Attachment(s):	Exhibit 13_IND IHBC_OffExchange.pdf Exhibit 13_IND IHBC_OffExchange.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 14A-Indiv Requested Percentage Changes
Comments:	
Attachment(s):	Exhibit 14A_IHBCIndividual_OffExchange.pdf Exhibit 14A_IHBCIndividual_OffExchange.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 15A-Indiv Distribution by Rate Adj Percentages
Comments:	
Attachment(s):	Exhibit 15A_IHBCIndividual_OffExchange.pdf Exhibit 15A_IHBCIndividual_OffExchange.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 16-Summary of Policy Form & Product Changes
Comments:	
Attachment(s):	Exhibit 16_IHBCIndividual_OffExchange.pdf Exhibit 16_IHBCIndividual_OffExchange.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 17-Claims Experience for 2011-13 (Sm Grps)
Comments:	

Attachment(s):	Exhibit 17_IND IHBC_OffExchange.pdf Exhibit 17_IND IHBC_OffExchange.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 18-Index Rate Plan-Design Development
Comments:	
Attachment(s):	Exhibit 18 - Ind IHBC Off Final.pdf Exhibit 18 - Ind IHBC Off Final.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 20-HIOS ID Mapping
Comments:	
Attachment(s):	Exhibit 20_IHBCIndividual_OffExchange.pdf Exhibit 20_IHBCIndividual_OffExchange.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 21A-Hospital Inpatient-Unit Costs
Comments:	
Attachment(s):	Exhibit 21A_IHBCIndividual_OffExchange.xlsx Exhibit 21A_IHBCIndividual_OffExchange.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 21B-Hospital Outpatient-Unit Costs
Comments:	
Attachment(s):	Exhibit 21B_IHBCIndividual_OffExchange.xlsx Exhibit 21B_IHBCIndividual_OffExchange.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 23-Requested 2015 Premium Rates
Comments:	
Attachment(s):	Exhibit 23_IHBCIndividual_OffExchange.pdf Exhibit 23_IHBCIndividual_OffExchange.xlsx
Item Status:	
Status Date:	

State: New York **Filing Company:** Independent Health Benefits Corporation
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: IHBC Individual Off Exchange 2015 Prior Approval
Project Name/Number: IHBC Individual Off Exchange 2015 Prior Approval/

Satisfied - Item:	Initial Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	TEMPLATE - Individual Plan Subscribers - 2015 Proposed Premium Notice.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Final Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	Individual Plan Subscriber - 2015 Approved Premium Rates.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Documents for Web Posting
Comments:	
Attachment(s):	Exhibit 11 - IHBC Ind Off_Redacted.pdf Actuarial Memorandum - Individual IHBC Off - Redacted.pdf
Item Status:	
Status Date:	

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

Attachment Exhibit 13_IND IHBC_OffExchange.xls is not a PDF document and cannot be reproduced here.

Attachment Exhibit 14A_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 15A_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 16_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 17_IND IHBC_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 18 - Ind IHBC Off Final.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 20_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 21A_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 21B_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 23_IHBCIndividual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment 2015 URRT IHBC Individual Off Exchange.xlsm is not a PDF document and cannot be reproduced here.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2015 Premium Rates
For On-Exchange Plans and Off-Exchange Plans

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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

A. General Introduction:

For the Exchange plan rate filings submitted in calendar year 2013 for premium rates effective in calendar year 2014, the Department (DFS) had issued two separate Checklists, one checklist for Small Group Exchange plans and a second checklist for Individual Exchange plans, as there are unique differences between Small Group plans and Individual plans, including for example the Federal reinsurance program, applicable only for Individual plans. This dual approach has however created confusion for some companies.

For the Exchange plan rate filings to be submitted in calendar year 2014 for premium rates effective in calendar year 2015, there will be only one checklist, applicable for both Small Group Exchange plans and Individual Exchange plans. All instructions and guidelines included in this year's checklist apply to both Small Group Exchange plans and Individual Exchange plans, with some annotations where required to reflect the unique differences between these two types of Exchange plans.

These instructions are to be used for the filings of 2015 Small Group/ Individual Exchange premium rates for both 'standard' and 'non-standard' (as those terms are used in the 'Invitation to Participate in the New York Health Benefit Exchange') On-Exchange and Off-Exchange products.

For premium rates effective in calendar year 2014, On and Off Exchange plans were considered new or amended products, and therefore the rate filings were submitted under **Insurance Law § 3231(d) or § 4308(b) (Rate and Form filings).**

For companies that submitted rate filings for products with premium rates effective in calendar year 2014, the rate filings for those products with premium rates effective in calendar year 2015 will be submitted under **Insurance Law § 3231(e)(1) or § 4308(c)** (**Prior Approval Adjustment filings)**. Additional requirements, as specified under Insurance Law § 3231(e)(1) or § 4308(c) will apply, including a notice of proposed rates changes to impacted policyholders at the time a rate filing is submitted, a notice of the approved rates to impacted policyholders 60 days prior to the effective date of the renewals on inforce policies, and specified time limits.

For companies (a) that did not submit any rate filings for premium rates effective in calendar year 2014, or (b) that are submitting rate filings for new products with premium rates effective in calendar year 2015, On and Off Exchange plans will be considered new or amended products, and therefore the rate filings will be submitted under Insurance Law § 3231(d) or § 4308(b) (Rate and Form filings). Instructions are provided in this checklist as to the differences in the rate filing process.

This rule applies separately for Small Group Exchange plans and for Individual Exchange plans; for example, if a company submitted a rate filing only for Individual Exchange plans last year, and is submitting rate filings for both Individual Exchange plans and Small Group Exchange plans this year, the filing for the Individual plans will be submitted under Insurance Law § 3231(e)(1) or § 4308(c) (Prior Approval Adjustment filings) while the filing for the Small Group plans will be submitted under Insurance Law § 3231(d) or § 4308(b) (Rate and Form filings), and vice versa.

For the purpose of application of the rules discussed above, a rate filing last year under either On Exchange or Off Exchange or both On/Off will be considered as a rate and form filing last year and any rate filing this year either On Exchange or Off Exchange or both On and Off Exchange will be considered under a Prior Approval Adjustment filing.

Lastly, for the purpose of the application of the rules discussed above, each company is treated as a separate company, even if both companies are subsidiaries of the same parent company. Consult DFS if there are any questions as to the application of these rules.

This checklist does not apply to (a) the rate filings for Grandfathered plans sold outside the Exchange, (b) community-rated large group HMO products and (c) stand-alone dental plans. Some instructions are provided in this checklist for categories (a) and (b). A separate checklist is applicable to (c).

Note that the 2015 version of the rate filings includes newly added exhibits, which were not included in the 2014 version of the rate filings.

B. Essential Health Benefits:

Companies must provide the Essential Health Benefits specified by DOH for calendar years 2014 and 2015.

C. Separate Rate Filings for On and Off Exchange Plans:

Separate rate filings need to be submitted for On Exchange plans and for Off Exchange plans. This means separate rate manuals, separate exhibits, separate actuarial memorandums, etc.

Only On Exchange plans are to be shown in the Rate Manuals for the On Exchange rate filings, and only Off Exchange plans are to be shown in the Rate Manuals for the Off Exchange rate filings.

D. HHS Proposed Notice of Benefit and Payment Parameters for 2015:

Proposed regulations were released in December 2013. For the most part, HHS instructions for 2015 are similar to the instructions for 2014. Final HHS Regulations were released on March 4, 2014. Specifically, there are no changes in the requirements for the Index Rate and the Single Risk Pool.

Some changes introduced include:

(a) Changes in the Parameters for the Federal reinsurance program;
(b) Changes in the fees for PCORI (Patient Centered Outcomes Research Institute);
(c) Changes in Maximum Deductible and Maximum OOP Limits;
(d) Changes in some of the provisions for the Risk Corridors; and
(e) Very minor changes in the AV Calculator.

The final version of the 2015 Notice of Benefit and Payment Parameters can be found in the following location:

https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-05052.pdf

D (a) HHS AV Calculator for Calendar Year 2015:

Maximum OOP that can be inputted is $6,850 for calendar year 2015, as compared to $6,350 for calendar year 2014.

D (b) Reinsurance Program on Individual Plans:

(1) Amounts of fees scheduled to be collected are $12B in calendar year 2014, $8B in calendar year 2015 and $5B in calendar year 2016;
(2) Attachment point revised for calendar year 2014 from $60,000 to $45,000; Coinsurance unchanged at 80%; Maximum unchanged at $250,000;
(3) Attachment point for calendar year 2015 at $70,000; Coinsurance reduced to 50%, which may be raised if allowed by the level of the fees collected; Maximum unchanged at $250,000;
(4) Reinsurance Fee reduced from $63.00 per year ($5.25 per month) in calendar year 2014, to $44.00 per year ($3.67 per month) in calendar year 2015.

The 2015 $3.67 PMPM reinsurance fees ($5.25 PMPM in 2014) may not be deducted from the impact of the Federal reinsurance factors. The PMPM reinsurance fees must be incorporated with the expenses.

Impact of reinsurance program estimated by HHS at -6.0% for calendar year 2015, as compared to -12.0% for calendar year 2014.

D (c) Patient-Centered Outcomes Research Institute (PCORI) Fees

The PCORI fee was set by the ACA as $1 for plan years ending by Oct. 1, 2013, $2 for plan years ending by Oct 1. 2014. For policy years ending in later years (through Oct 1. 2019) the $2 fee will be increased annually to reflect the rate of inflation in National Health Expenditures, as determined by the Secretary of HHS. This fee for 2015 has not yet been announced.

D (d) Changes in Deductibles and Maximum Out of Pocket (MOOP) Limits:

The annual limit on deductible for Small Groups ($2,000/$4,000 for single/family in calendar year 2014) has been repealed, retroactive to the effective date of the Affordable Care Act.

For 2015, the HHS prescribed self-only coverage MOOP limit for 2015 is $6,600, and the family limit is $13,200. For 2014 these limits were $6,350 and $12,700.

D (e) ACA Fees:

In addition to the Reinsurance fees and the PCORI fees referred to above, other ACA fees remain applicable, including:

(1) Annual Health Insurance Industry fee (ACA Insurer fee);
(2) Risk Adjustment User fee of $0.96 per member per year in 2015; and
(3) NYS Exchange fees (Refer to Instructions for Exhibit 19).

E. New York State Standard Benefit Design:

The Standard Benefit Design for calendar year 2015 is the same as the Standard Benefit Design for calendar year 2014, except for (a) revisions in the Cost Sharing provisions for Silver CSR plans at 200% to 250% of Federal Poverty Level, where the deductible (single) is reduced from $1,750 to $1,200, and the Maximum Out of Pocket Limit (single) is increased from $4,000 to $5,200, and (b) revisions in the deductible and maximum out of pocket limit from $6,350 (single) in 2014 to $6,600 (single) in 2015 for the Catastrophic plan.

Note that the $6,600 Out of Pocket (Single) limit is an amount prescribed by HHS for calendar year 2015. The Internal Revenue Service in Revenue Procedure 2014-30 issued in April 2014 has set this limit to $6,450 (single) for 2015. The family deductible and the family maximum out of pocket amounts remain at 200% of the single amounts.

No changes are being introduced by DFS in the average coinsurance factors for calendar year 2015, as used in the AV calculator, on outpatient facility fees and on outpatient surgery/surgical services, as HHS introduced no claim trending beyond 2014. Impact on AV values would be minimal.

F. Actuarial Value (AV) Metal Values:

Except for the impact of cost-sharing reduction subsidies, each product must fall within one of the following specified actuarial value (AV) levels based on cost sharing features of the product and determined using the HHS AV Calculator (2015 version) .

Bronze:	60% AV
Silver:	70% AV
Gold:	80% AV
Platinum:	90% AV

A *de minimus* variation of +/- 2% AV is permissible.

For Silver Cost Sharing Reduction (CSR) plans, each product must also fall within one of the following specified actuarial value (AV) levels based on Federal Poverty Level (FPL):

200% to 250% FPL	73% AV
150% to 200% FPL	87% AV
100% to 150% FPL	94% AV

For CSR plans, a *de minimus* variation of +/- 1% AV is permissible.

The AV Metal Values determine what metal level a particular plan-design belongs in, and the 2015 HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

The final version of the 2015 AV Calculator and accompanying documentation can be found in the following locations:

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-final.xlsm

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-methodology.pdf

G. Actuarial Value (AV) Pricing Values:

(To eliminate confusion, the actuarial values developed using the HHS Actuarial Value Calculator are referred to as the AV Metal Values, while the actuarial values developed for pricing are referred to as the AV Pricing Values.)

For premium rates based on claims experience under inforce plan-designs, DFS's review will rely on the relationships in the AV Pricing Values between (a) inforce plan-designs and (b) On-

Exchange standard and non-standard plans and Off-Exchange plans, AND on adjustments to reflect Induced Demand as expressed by HHS in their regulations.

For inforce plan-designs, the metal identification level is defined as described below:

Bronze: Less than 65% AV Metal Value
Silver: AV Metal Value of 65% to 75%
Gold: AV Metal Value of 75% to 85%
Platinum: AV Metal Value more than 85%

(Note: this is for pricing purposes only. All On/Off Exchange non-grandfathered products will have to fall within one of the ranges in the AV Metal Values specified above, e.g. between 78% to 82% for Gold metal level plans)

The final AV Pricing Values developed by the Company's actuary should include not just the pure change in cost sharing, but should also reflect a component for induced demand. The induced demand component must be the same for all plans in a given metal tier, and the induced demand component utilized for each metal tier must be disclosed in the Actuarial Memorandum.

A Company may, but does not have to, use the HHS 2015 AV Calculator to determine AV Pricing Values. A Company may use external sources or guidelines, such as the Milliman Guidelines, or internal guidelines developed by the Company. If such alternate guidelines are used, details as to the pricing differentials, their development and the source of the data must be provided in the Actuarial Memorandum. Note that some of these alternate guidelines would reflect the impact of Induced Demand (see Section H just below) directly in the Actuarial Values calculated, which is not the case for the Actuarial Value Calculator developed by HHS. Therefore, care should be exercised so as not to double count the impact of the adjustments for Induced Demand.

H. Induced Demand:

Induced Demand reflects differences in a standard population's spending pattern attributable to differences in the richness of the plan of benefits, but should not reflect differences in health status.

Regardless of the source of information for calculating the AV Pricing Values, the induced demand adjustment factors adopted may not exceed the induced demand adjustment factors used by HHS in its final regulation issued in March 2014 on Notice of Benefits and Payment Parameters for 2015, which are detailed below. Furthermore, the variations in the adopted induced demand adjustment factors between any two metal plans may not exceed similar variations in the HHS induced demand adjustment factors.

- 1.00 for Catastrophic metal level (Individual Exchange Only);
- 1.00 for Bronze metal level;
- 1.03 for Silver metal level;
- 1.08 for Gold metal level and
- 1.15 for Platinum metal level.

While Induced Demand may be reflected in the development of the AV Pricing Values, any Induced Demand factor may not reflect differences in the health status of enrollees. Therefore, any Induced Demand factor would have to be determined on a basis consistent with the concept that the Individual market or the Small Group market is one rating pool and that the same standard population enrolls in each of the plan-designs offered. The rating differential between plan-designs in a given rating region cannot, in whole or in part, be based upon differences due to age, sex, occupation or health status among the actual or assumed enrollees in a particular plan-design (with the limited exception for catastrophic plans included in the Individual Exchange as mentioned in the HHS Regulations).

Note: The Continuance Tables incorporated in HHS's 2015 AV Calculator reflect the impact of Induced Demand, but the impact on the AV Metal Values is minimal -- less than 1.0%. On the other hand, the impact of induced demand is far more significant on the 'claim costs'.

Example: Assuming that a plan qualifies as a Gold level plan, the AV Metal Value based on the Gold level continuance table would be 80.0%. Running the same 'Gold' plan through the Platinum level continuance table would produce an AV Metal Value very similar to the 80.0% AV Metal Value obtained through the Gold level continuance table.

Assuming that two plans qualify as a Gold level plan and as a Platinum level plan, respectively, the 'AV Metal Values' obtained by running such plans through their own respective metal continuance tables would produce Actuarial Values at about 80.0% and 90.0% respectively. The 'claim costs' for the Platinum plan should be (a) 112.5% (90% over 80%) of the 'Claim Costs' for the Gold plan, <u>plus</u> (b) an adjustment to reflect the <u>differences</u> in the Induced Demand Adjustment. Using the scale published by HHS would yield another adjustment of up to 106.5% (1.15 over 1.08) for a total adjustment of 119.8% (112.5% times 106.5%).

Simply said, the relationships in the claim provisions included in the premium rates for the various metal plans will not be consistent with the AV Metal Values, but rather with a combination of external or internal guidelines <u>plus</u> adjustments for the induced demand adjustment factors. These last two elements determine the AV Pricing Values. Note that if the external or internal guidelines have built-in induced demand adjustment factors, care needs to be exercised so that the aggregate induced demand adjustment factors, including both the built-in factors and the additional factors do not exceed the HHS induced demand adjustment factors.

I. Single Risk Pool / Index Rate:

Under the ACA and applicable regulations, a Company (i.e., licensed entity) must consider all of its enrollees in all health plans (other than grandfathered health plans) offered by the Company to be members of a single risk pool in the Individual market or Small Group market, respectively. This requirement applies to health plans both inside and outside the Exchange for both markets. HHS regulations require each Company to determine the 'index rate' for the risk pool and make permissible adjustments, both Market-Wide (uniform for all plans) and Plan-Level (varying at the plan-design level) to the index rate.

For Small Groups, the single risk pool must incorporate all Small Groups, excluding Sole Proprietors and including the Small Group Healthy New York plans.

Accordingly, the pricing basis used must be consistent with the concept that the Individual market or the Small Group market is now one rating pool, and that the same standard population enrolls in each of the plan-designs offered, and that the rating differentials between plan-designs in a given rating region cannot, in whole or in part, be based upon differences due to age, sex, occupation or health status among the actual or assumed enrollees in a particular plan-design. (The rating differential for the catastrophic plans pool can reflect the impact of specific eligibility categories for those plans.)

While rate filings must be submitted separately for On Exchange plans and for Off Exchange plans, the concept of a single risk pool must be maintained in aggregate for combined On Exchange and Off Exchange plans.

J. Market-Wide Index Rate Adjustments:

All Market-Wide adjustments must be discussed and supported in the Actuarial Memorandum (each of the following items must be discussed in the actuarial memorandum even if no adjustment is deemed warranted). Market-Wide adjustments include, but are not limited to, the following:

(a) Impact of compliance with Essential Health Benefits (e.g., not all inforce plans include all the required Essential Health Benefits, and additional benefits need to be eliminated);
(b) Impact of changes in the provider network, fee schedule levels, or utilization management that apply to the entire market-wide risk pool not included in the claim trend;
(c) Impact on claim costs from quality improvements and cost containment initiatives **(New in 2015 premium rates)**;
(d) Impact of anticipated changes in the expected covered membership risk characteristics of the market-wide risk pool;
(e) Impact of anticipated changes in the distribution of membership in the risk pool by the standard rating regions;
(f) Total expected market-wide payments and charges under the Federal risk adjustment program and Federal transitional reinsurance program;

(g) Impact of adjustments for the experience period claim data not being sufficiently credible;
(h) Total expected Exchange user fees (Note: The 2014-2015 Executive Budget does not include any Exchange user fees, so companies cannot include an adjustment for these fees in 2015 premium rates. If the final budget changes this proposal, companies will be informed);
(i) Impact of other changes that affect the entire market-wide risk pool as detailed by the Company's actuary.

K. Plan-Level Adjustments:

Plan-Level adjustments include, but are not limited, to the following:

(a) The actuarial value and cost-sharing design of the plan (e.g., based on the various Pricing AV Values);
(b) The Company's provider network, delivery system characteristics, and utilization management practices specific to that product or plan-design beyond what is reflected in the index rate;
(c) Impact on claim costs from quality improvements and cost containment initiatives **(New in 2015 rate filings)**;
(d) The benefits provided under the plan that are in addition to the Essential Health Benefits. These additional benefits must be pooled with similar benefits within the single pool and the claims experience from those benefits must be utilized to determine the rate variations for plans that offer those benefits in addition to essential health benefits;
(e) Administrative costs, excluding Exchange user fees, and provisions for Profit or Contribution to Surplus margins **(New Details in Instructions to Exhibit 19)**;
(f) Addition of Out-of-Network Benefit Option (e.g. POS or PPO);
(g) The anticipated Stop Loss reimbursements from New York State for Small Group Healthy New York plans;
(h) Impact of other Plan-Level adjustments, as detailed by the Company's actuary.

L. Standardized Rating Regions:

The ACA requires standardized rating regions. New York has standardized the geographic rating regions as specified in the Appendices to the 'Invitation and Requirements for Insurer Certification and Recertification for Participation in 2015' released by the Department of Health in April 2014. Companies may make adjustments to premiums in the different standardized rating regions, based on HHS regulations on rate review.

Companies need to develop a table of area factors for each applicable standard rating region, which must be included with each rate filing.

Note that the definition of the Standardized Rating Regions applicable for calendar year 2015 premium rates is **unchanged** from the definition for calendar year 2014 premium rates. Also note that no counties were reclassified.

M. Claims Experience Data:

M (a) Small Group Exchange Plans:

For Companies currently participating in the Small Group market, the premium rates for the Small Group On Exchange and Off-Exchange plans should be based on recent claims experience for the combined Non-Grandfathered plans and Grandfathered plans. A Company may exclude the claims experience for Grandfathered plans due, for instance, to low membership, which must be so indicated in the Actuarial Memorandum.

As discussed above, the claims experience for Small Groups must incorporate all Small Groups, excluding Sole Proprietors and including the Small Group Healthy New York plans. Information on these two blocks must be shown separately from the information on the remaining Small Groups. More details are provided in the Instructions on Exhibits as to what is to be reflected in Exhibit 17.

This process is to be determined for all policy forms providing comprehensive benefits for hospital, medical and prescription drugs charges, including dental and vision benefits if such benefits are included within the medical plan, i.e. for all plans providing benefits similar to the benefits provided in the Standard Design Exchange plans. Some policy forms must be excluded from this phase, for example hospital only plans, medical only plans, limited benefit plans, some closed group policy forms, and low membership grandfathered plans.

If the source data for determining the premium rates is other than the actual claims experience under a Company's inforce plans, the Company must indicate the source of that data (e.g., publication, preparing organization, or consultant), and the applicability of that source data.

For Companies that do not currently participate in the Small Group market (which would preclude them from basing their premium rates on claims experience under inforce plans), the Actuarial Memorandum should specifically describe the methodology used for determining anticipated claims experience.

M (b) Individual Exchange Plans:

For companies currently participating in the Small Group market, the premium rates for the Exchange Individual Exchange plans must be based on the claims experience under Small Group plans, through the application of a ratio of Post-ACA Individual morbidity to Post-ACA Small Group morbidity. Factors pertaining to administrative costs, profit margins, claim trends, etc. would be specific to the Individual market pool.

The actuarial memorandum must provide information as to the approach used in the development of the Post-ACA morbidity ratio of Individual risks to Small Group risks.

For Companies that do not currently participate in the Small Group market (which would preclude them from basing their premium rates for Individual Exchange plans on claims

experience under inforce Small Group plans), the Actuarial Memorandum should specifically describe the methodology used for determining anticipated claims experience.

If the source data for determining the premium rates is other than the actual claims experience under a Company's inforce Small Group plans, the Company must indicate the source of that data (e.g., publication, preparing organization, or consultant), and the applicability of that source data.

N. Small Group Healthy New York Plans:

While Healthy New York plans were eliminated for Individuals and for Sole Proprietors with the introduction of the Exchange on January 1, 2014, the Small Group Healthy New York plans have remained in effect and are still be eligible for stop loss reimbursements.

Such Small Group Healthy New York plans, available only for the Off-Exchange, have been designated as Gold Metal level plans.

Premium rates for these Healthy New York plans will not be determined based on the claims experience for such plans, but rather the pricing has to be consistent with the Single Risk Pool and Index Rate requirements prescribed by HHS.

Appropriate adjustments are required to be introduced for these plans for the impact of the Stop Loss reimbursements from New York State. This adjustment will be reflected as one of the Plan-Level Adjustments.

Additionally, such Healthy New York plans have to comply with the provisions of the Essential Health Benefits, and must include Prescription Drugs for all plans.

O. Standardized Census Tiers:

All plans must make provisions for premium rates for all four census cell tiers, including the Individual Exchange Catastrophic plans since individuals under such plans could have eligible dependents.

Companies must use the following census tiers and relativities:

- Single = 1.00
- Single + Spouse = 2.00
- Single + Child(ren) = 1.70
- Single + Spouse + Child(ren) = 2.85

Census tier factors for calendar year 2015 are **unchanged** from those applicable for calendar year 2014.

P. Child-Only Plans (Individual Exchange Plans Only):
All metal plans, except the Individual Exchange Catastrophic plan, must make provision for Child-Only premium rates. This applies to Individual plans, but not to Small Group plans.

Companies must offer a child-only product in each metal tier that conforms with the Standard Product designs. Only one child-only product is required per metal tier level. A separate policy must be created and provided to enrollees of child-only products. The child-only premium rate must be set at 41.2% of the corresponding Individual Single premium rate. This 41.2% factor is **unchanged** from the factor applicable for calendar year 2014.

For a child-only plan that covers two children in a family, the premium rate will be twice the child-only premium rate. For a child-only plan that covers three or more children in a family, the premium rate will be three times the child-only premium rate, per HHS Regulations.

Q. HHS Rate Filing Requirements:
The information specified in these instructions is in addition to any rate review information and data required by HHS. Companies should submit to DFS all information that is submitted to HHS.

The completion of HHS's Unified Rate Review Template must be done on a basis consistent with the various assumptions incorporated in the development of the premium rates and with Exhibit 18 Worksheet on Index Rate/Plan-Design Adjustments.

R. General Overview of Pricing Development:
In the development of the Exchange premium rates, DFS requires the following simplified process. More details are provided in the Section T(a) below.

(a) For each Inforce plan-design, determine the applicable Metal Level, using HHS Actuarial Value Calculator, with ranges described above, (for example Silver Level with a range of AV Metal Value of 65% to 75%).

(b) For each Inforce plan-design, determine the AV Pricing Value using the guidelines/calculator(s) selected by the Company, and the scale of Induced Demand factors. As indicated above, this scale may not have variations between any two metal levels greater than variations in the HHS induced demand scale reflected in the Notice of Benefits and Payments Parameters for 2015 pertaining to risk adjustment.

(c) For all inforce plans, determine the weighted-average 'AV Pricing Value' and the weighted-average 'Induced Demand' adjustment factor, using as weights the member months in the most recent experience period as submitted in Exhibit 17. The weighted-average AV Pricing Value would include the Induced Demand component.

(d) For all inforce plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for Regulation 146 and Stop-Loss Reimbursements Pools). In accordance with the concept of a Single Risk Pool and market-wide Index Rate as mandated by HHS; PMPM incurred claims are not to be determined by Metal Tier Level or by Plan Level.

(e) Project the average PMPM Incurred Claims in (d) above for the impact of claim trends, from the mid-point of the experience period to the midpoint of the applicability period for full calendar year 2015 for Individual plans, and for the first quarter 2015 premium rates for Small Group plans.

(f) For all inforce plans combined, determine the 'Index' PMPM Claim Rate applicable for all Non-Grandfathered plans combined (to be sold on the Exchange and off the Exchange). This step reflects all Market-Wide adjustments. Note that such adjustments may not vary by the plan-design level.

(g) Determine the provisions for incurred claims for each Non-Grandfathered plan (to be sold both On-Exchange and Off-Exchange) based on the Index PMPM Claim Rate determined in (f) above, times (A) over (B), where (A) and (B) are:

(A) The AV Pricing Value determined for each Non-Grandfathered plan; and

(B) The Average AV Pricing Value (per (c) above) for all inforce plan

(h) Determine composite premium rates for each Non-Grandfathered plan based on (g) above, plus Plan-Level adjustments for administrative costs and profit margins and all other Plan-Level changes, not already reflected, as discussed above. Note that such adjustments may vary at the product and plan-design level.

The AV Pricing Values used in (A) and (B) per (g) above would be the AV Pricing Values that include the Induced Demand component.

The process described above is simplified and does not discuss details by (a) Census Cells, (b) Regions, and (c) Applicable Effective Quarters. Description below in Section T(a) incorporates such details.

S. Material to be Included in Rate Filing:

Each rate filing must incorporate basic documents as described below. The exhibits referenced below are similar to those submitted for rate adjustment filings submitted pursuant to Insurance Law § 3231(e)(1) or § 4308(c).

Supplementary instructions are provided in subsequent pages of this checklist for all exhibits. Additionally, the actual worksheets also provide further details.

(a) Exhibit 11: This exhibit, labeled as 'General Information' provides general information about the filing. Information must be provided as to the identification of the actuary responsible for the preparation of the rate filing, (which identification may be redacted).

(b) Exhibit 13: This Exhibit labeled as 'Narrative Summary and Numerical Summary' provides a plain English summary of the rate change and the reasons for the rate change, together with a summary of key numerical values incorporated in the current rate filing and in prior rate filings on the same market segment.

(c) Exhibit 14A-14B (New in 2015 rate filings): These Exhibits, labeled as 'Summary of Requested Percentage Changes,' provides details as to the changes in premium rates between the approved 2014 premium rates and the requested 2015 premium rates. A similar Exhibit has been used in the Prior Approval Rate Adjustment filings for premium rates effective in calendar years 2012-13 on community-rated products.

(d) Exhibit 15 (New in 2015 rate filings): These Exhibits, labeled as 'Distribution of Contracts by Requested Percent Adjustments,' provides details as to the distribution of the rate changes by percentage brackets. A similar Exhibit has been used in the Prior Approval Rate Adjustment filings for premium rates effective in calendar years 2012-13 on community-rated products.

(e) Exhibit 16: This Exhibit, labeled as 'Summary of Policy Form and Product Changes,' provides details as to form filings that may impact the current rate filing.

(**f**) **Exhibit 17**: This Exhibit, labeled as 'Historical Claim Data by Policy Forms' provides details as to the premiums and claims information for the prior three completed 12 month periods for all Small Group policy forms. While the HHS regulations on rate review prescribe that all rating pools be combined for the purpose of the determination of premium rates, information on rating pools as last used in the most recent or current Insurance Law § 3231(e)(1) or § 4308(c) rate adjustment filings is requested by DFS in this transitional phase.

(g) Exhibit 18: This Exhibit, labeled as 'Index Rate/Plan Design Level Adjustment Worksheet,' summarizes all the market wide adjustment factors and all plan-level adjustment factors used to develop the premiums PMPM for each of all the non-grandfathered plan-designs to be sold On or Off the Exchange.

Minor changes were introduced for Exchange 2015 rate filings, including adjustments for the impact on claim costs from quality improvement and from cost containment initiatives, for:

a. Market-Wide Adjustments (Line 17); and
b. Plan-Level Adjustments (Line 34).

(h) Exhibit 19: This Exhibit, labeled as 'Summary of Average Claim Trend and Administrative Expenses and Profit Margin,' provides details as to the assumptions for annual claim trend rates, the various administrative costs, and the profit margins, on a percent of premium basis. Two sets of assumptions are required, including the current set of assumptions for use in the determination of the 2015 premium rates, and a second set of assumptions used in the determination of the 2014 premium rates.

(i) Exhibit 20 (New in 2015 rate filings): This Exhibit, labeled as 'HIOS Mapping to Product Names' provides details as to the key benefit provisions for each HIOS ID plan.

(j) Exhibits 21A-21B (New in 2015 rate filings): These Exhibits, labeled as 'Hospital Unit Cost Development,' provides details as to the average changes in the level of hospital charges, separately for the last three calendar years (2013-15), by providers, and separately for Inpatient services (Exhibit 21A) and for Outpatient Services (Exhibit 21B).These exhibits also incorporated information on allowed claims under Small Group Market.

(k) Exhibit 22 (New in 2015 rate filings): This Exhibit, labeled as 'Small Groups Medical and Hospital Utilization Data for,' provides details as to number of services, allowed charges and membership for the last three calendar years (2011-13), by types of services. A similar exhibit is currently required in rate filings for Child Health Plus products. This exhibit is developed based on allowed claims under Small Group Market.

(l) Exhibit 23 (New in 2015 rate filings): This Exhibit, labeled as 'Summary of Requested 2015 Premium Rates,' provides information on 2015 requested premium rates for all plans. Information is requested separately for Small Groups and for Individual plans, by metal levels and by geographical regions, separately for On and Off Exchange plans.

(m) AV Calculations (Snapshots):

As an attachment to the actuarial memorandum, provide printouts of all AV calculation pages (snapshots) using the final HHS 2015 AV Calculator for all standard and non standard plans. Each page should clearly indicate the plan identifier so that DFS can cross check the calculator input to the cost sharing parameters for that particular plan-design.

For the Standard plans, DFS will release its 2015 version of the calculations. DFS's versions may be submitted by carriers in their rate filings.

If adjustments are required for special benefit features, the snapshots must be marked to indicate the adjustments introduced.

Calculations must be based on the benefit provisions incorporated in the rate manuals. Care must be exercised so that all boxes are properly checked, or not checked, as applicable.

(n) Quality Improvements:

As an attachment to the actuarial memorandum, provide a description of all quality improvements/cost containment programs that impact the various plans included in the risk pool, specified by plans if the programs only affect certain plans. This should tie in with the activities that improve health care quality, as specified in Exhibit 19, the HHS MLR report and the Supplemental Health Care Exhibit.

(o) Actuarial Memorandum (See Section T just below):

(p) Premium Rate Manuals (See Section U Below):

T. Actuarial Memorandum:

This Actuarial Memorandum section is divided into two subsections, including:

(a) Process used in the development of the Index Rate; and
(b) Supporting Details on Key Assumptions.

T (a) Process in Development of Index Rates and Premium Rates:

The process used for the determination of the Index Rate and premium rates for both On-Exchange and Off-Exchange plans is described below. A simplified description of this process was provided above in the sections dealing with the Induced Demand and the General Overview of Pricing Development. This process includes:

(1) Average PMPM Incurred Claims for the latest experience period (typically 1/1/13 – 12/31/13, but needs to be 12 months with 3 months of claims runout unless DFS has agreed to 2 months of claims runout) for all inforce plans combined. The Company's actuary should exclude from this PMPM amount any adjustments for the impact of the current Regulation 146 risk adjustment pool and Stop-Loss Reimbursement pool. Discuss whether Grandfathered plans were included or excluded, and any particular product excluded, and any particular products that were excluded.

(2) Average AV Pricing Value determined for all inforce plans in effect during the latest experience period, based on member-months in the experience period for each inforce plan. Note that this average AV Pricing Value reflects the impact of Induced Demand.

(3) Average Induced Demand Adjustment factor determined based on member-months in the experience period for each inforce plan. Note that this average included demand factor is reflected in step (2) above.

(4) Assumptions as to average annual claim trend rates for all components, including inflation, utilization, leverage, and other factors.

(5) Projection claim trend factor from midpoint of experience period to midpoint of applicability for full calendar year 2015 for Individual plans, and for the first quarter 2015 for Small Group plans.

(6) Projected Average PMPM Incurred Claims determined from steps (1) and (5) above.

(7) Market-wide index rate adjustments as discussed in Section J above. The Actuarial Memorandum must explain how the Company developed its adjustment for the Federal Risk Adjustment, including any modifications introduced on the adjustments based on the simulations prepared by DFS. No estimate of Exchange User Fees anticipated for calendar year 2015 may be included as a market-wide adjustment.

(8) For all inforce plans combined, determine the 'Index' PMPM Claim Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed in HHS regulation per step (7) above. Note that such adjustments do not vary by the plan-design level.

(9) Determine the starting point PMPM Claim Rate for each Non-Grandfathered Plan (both On-Exchange and Off-Exchange) by multiplying the Index PMPM Claim Rate for all inforce plans combined per step (8) above by the ratio of (A) to (B), where (A) and (B) are:

(A) The AV Pricing Value for each Non-Grandfathered Plan, both On-Exchange and Off-Exchange, at each of the Metal Tier levels; and

(B) The Average AV Pricing Value per step (2) above for all inforce plans.

The AV Pricing Values used in (A) and (B) are the total AV Pricing Values that include the induced demand component.

(10) Plan-Level Adjustments for the various differences in characteristics as described above. Full details need to be provided in the Actuarial Memorandum for each such item, including an indication that there is no adjustment for an item, if so determined by the Company's actuary. The adjustments, and the result after these adjustments, needs to be indicated.

(11) Plan-Level Adjustments for Administrative Expenses and Profit Margins per Exhibit 19. Note that such adjustments may vary at the plan level and by Metal Tier Levels, but may not vary by rating region.

(12) Preliminary PMPM Premium Rate for each Non-Grandfathered Plan, as determined from steps (10) and (11) above, e.g., (10) divided by 100% less (11).

(13) Final (all regions combined) Premium Rates for all Non-Grandfathered Plans for Individuals/Employees only, for Individuals/Employees and Spouse, for Individuals/Employees and Child (ren) and for /Individuals/Employees and Spouse and Child(ren), based on census factors prescribed by DFS. The development of the conversion factor (PMPM rate to Individuals/Employees premium rate) must be included in the actuarial memorandum and must be based on the distribution of members and subscribers (individuals/employees) by census cells during the experience period used in step (1) above as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the actuarial memorandum.

(14) Final Premium Rates for each Non-Grandfathered Plan for each applicable rating region, based on the area factors by region as determined by the Company's' actuary, and as explained in the Actuarial Memorandum. This step yields the Final Premium Rates for each Non-Grandfathered plan for the full calendar year 2015 for Individual plans, and for the first quarter 2015 premium rates for Small Group plans, by census tier and by rating region. If any product or plan-design is not to be offered in a particular rating region, that should be mentioned in the actuarial memorandum.

(15) Final Premium rates for Small Group plans for subsequent quarters in calendar year 2015 are determined by the Company's actuary on a basis consistent with the annual trend rates in Exhibit 19, applied to step (14) above.

T (b) Supporting Details on the Key Assumptions:

The Actuarial Memorandum must provide details as to the key assumptions and additional information based on the following;

(1) Assumptions on annual **claim trend rates**, for all components, including inflation, utilization, leverage impact and other factors as applicable, and including, if available, information on experienced annualized claim trend rates on allowed charges;

(2) Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the

utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;

(3) Assumptions on **administrative expenses components**, including (a) explanations for differences in expense components between the current Exhibit 19 for 2015 Exchange Plans, and the current Exhibit 19 (prior year) components applicable to the 2014 Exchange Plans, and (b) reconciliation with information on administrative costs reported in latest financial statements;

(4) Assumptions on **profit margins** or contribution to surplus, including a discussion on Return on Equity;

(5) Details as to **adjustments to Actuarial Values** determined based on HHS AV Calculator for inforce plans;

(6) Details as to the **conversion factors** or the restructuring of the various 'composite' PMPM premium rates into separate premium rates for the various census cells, i.e. Individuals/Employees only, Indidivuals/Employees and Spouse, Individuals/Employees and Child(ren) and Individuals/Employees and Spouse and Child(ren), using the census factor tier factors prescribed by DFS. Such details should include information as to the distribution of both individuals/subscribers and members by the various census cells. The premium rates for individuals/employees only are determined by dividing the composite premiums rates by the average prescribed census factors, weighted by individuals/ subscribers; the premium rates for other census cells are determined by multiplying the premium rates for individuals/employees only by the prescribed census factors;

(7) Details as to the determination of the premium rates by the **standardized rating regions**. Companies need to determine regional or area factors for all applicable rating regions and use these factors to arrive at Non-Grandfathered premium rates by rating regions:

(a) Details also need to be provided in support of the regional factors selected by the Company's actuary, including some confirmation that such regional or area factors are in compliance with HHS regulations on rate review.

(b) Specifically, such factors may not reflect, in whole or in part, differences due to age, sex, occupation or health status among the actual or assumed enrollees in that rating region. Differences may however reflect differences in Provider Network Characteristics,

differences in Delivery System Characteristics, and differences in Utilization Management Practices.

(c) Details as to the differences between the regional factors developed above and the regional factors illustrated in the simulations prepared by DFS.

(8) Details as to the **AV guidelines** (internal or external) used in the determination of the AV 'Pricing Values'.

(9) Details as to the development of the **Federal reinsurance adjustment** factors on Individual plans.

(10) Details as to adjustments to the premium rates for the impact of **Federal risk adjustments**, including the results for the simulations performed by DFS and the support for the adjustments introduced.

(11) Details supporting the **key pricing ratios on the morbidity level**, including:

1. Ratios of Post ACA to Pre ACA morbidity for Small Groups; and
2. Ratios of Post ACA morbidity for Individuals to Post ACA morbidity for Small Groups.

(12) Care should be exercised so as to avoid any inconsistencies between the information in the actuarial memorandum and the information in Exhibit 18 (Index Rates).

(13) Details on the development of adjustment factors for **Out-of-Network benefits**.

(14) Details as to any **significant premium rate differences** between plans in the same metal level, in terms of provider characteristics or other factors.

(15) Details need to be provided on any results obtained from **'Propriety' Studies**'.

(16) Details need to be provided on any adjustments introduced under the label of **'Management Adjustments'**, including support that such adjustments are in compliance with HHS regulations.

(17) Details and support on any **other adjustments** deemed necessary by the Company's actuary.

(18) If the source data for the determination of the premium rates for the Exchange plans is other than the actual claims experience under Non-

Grandfathered/Grandfathered plans, indicate the source of this data (e.g., the publication, organization, or consultants), and the applicability of this source data.

U. Rate Manuals:

U (a) Premium Rate Manuals – General Instructions:

Rate manuals must be submitted with the rate filings, not a later date.

Premium rates for Individual plans, On or Off the Exchange may not vary by quarter. Premium rates are set for the whole calendar year.

Premium rates for Small Groups, On or Off the Exchange must vary by quarter. Quarterly step up factors for changes from the first quarter to subsequent quarters must be included in the actuarial memorandum, with appropriate support for these factors.

The rate manuals should only contain the premium rates for the rate filings for which they are being submitted. No 'Joint' rate manuals covering combined On and Off Exchange and/or combined Individual and Small Groups plans should be submitted.

The rate manuals must include premium rates for both the standard and non-standard plans, for all 4-tier census cells and for child only (Individual plans), for all applicable regions. Small Group rate manuals must include premium rates for all quarters during calendar year 2015.

For rate filings under the Prior Approval Adjustment process on premium rates effective in calendar years 2012-13 under community-rated products, separate information was included in the rate manuals for the 'prior' rates, and the 'change in premium rates', both as amounts and as percentages were illustrated. <u>This type of additional information will not be required for rate manuals submitted in filings for premium rates effective in calendar year 2015 under Exchange plans.</u>

The rate manuals are to be attached to the Rate / Rule Schedule tab of the initial SERFF filing.

U (b) Premium Rate Manuals – Contents:

Rate manuals should include:

(1) Table of Contents;
(2) Insurer/corporation name on each consecutively numbered rate page;
(3) Identification by form number of each policy, rider or endorsement to which the rates apply;
(4) A page on Commission Schedule and/or Fees;
(5) An expected loss ratio page; the expected loss ratio is to be calculated by the traditional New York State methodology, not the Federal rebate methodology;
(6) Underwriting Guidelines or Underwriting Manual;
(7) A page showing how the rate manual is used to find the premium rate for a plan design;
(8) Example of a rate calculation, i.e. how the rate tables and formulas included in the rate manual are used to determine the final rate for a given plan design;
(9) Detailed description of the cost sharing applicable for each plan-design, including details on prescription drugs;
(10) Premium rates for plans with/without Domestic Partner rider;
(11) Premium rates for plans with/without Family Planning rider;
(12) Description of counties included in each region, in which the Company plans to market the exchange products; and
(13) Other information as applicable.

U (c) Premium Rate Manuals – Prescription Drug Premium Rates:

Premium rates for prescription drugs must follow the same variation patterns as for premium rates for medical coverage, including:

(1) Variations by geographical regions: if medical premium rates for region x are set at 15% above medical premium rates for region z, then prescription drug premium rates for region x must be set at 15% above prescription drug premium rates for region z;
(2) Prescribed census factors for variations in premium rate relationships apply to both medical and to prescription drug premium rates; and
(3) Premium rates in the rate manuals and in the binder filings must be for combined medical and prescription drug rates. A company may show separate premium rates for medical and for prescription drugs, but in that case, combined premium rates must also be shown in the rate manuals.

U (d) Premium Rate Manuals - Adjustments for the Age 29 Rider:

The premium rate adjustments for the Through Age 29 rider may not be applied solely to the census cells with children. The premium rate adjustments must be spread over all census cells.

Such premium rate adjustments must also vary by regions based on the same variation patterns as for the premium rates for the basic medical benefits.

Such premium rate adjustments must also vary by census cells, based on the factors prescribed for the basic medical benefits.

DFS will review the differentials in premium rates between 'To Age 26' and 'Through Age 29' incorporated in the 2015 Exchange premium rates.

U (e) Premium Rate Manuals - Adjustments for Pediatric Dental Coverage:

The premium rate adjustments for inclusion of the Pediatric Dental coverage may not be applied solely to the census cells with children. The premium rate adjustments must be spread over all census cells.

Such premium rate adjustments must also vary by regions based on the same variation patterns as for the premium rates for the basic medical benefits.

Such premium rate adjustments must also vary by census cells, based on the factors prescribed for the basic medical benefits.

U (f) Premium Rate Manuals –Presentation:

Many companies' pages of premium rates for calendar year 2014 were 'reduced' to such an extent that DFS had major problems reading these pages of premium rates and/or printing these pages for review. DFS's actuaries had to increase the magnification to 200% or even 300%, but then heading and line designations were lost. Companies must submit manual of premium rates in an unreduced version, even if this means that multiple pages must be used. Companies submitting such 'reduced' versions for calendar year 2015 will be asked to resubmit their rate filings.

Similarly, many companies' summary of benefit charts for calendar year 2014 were 'reduced' to such an extent that DFS had major problems reading these benefit charts and/or printing these benefit charts for review. DFS's actuaries had to increase the magnification to 200% or even 300%, but then heading and line designations were lost. Companies must submit such benefit charts in an unreduced version, even if this means that multiple pages must be used. Companies submitting such 'reduced' version for calendar year 2015 will be asked to resubmit their rate filings.

V. Actuarial Memorandum - Actuarial Qualifications:

(a) Member of the Society of Actuaries or member of the American Academy of Actuaries; and

(b) Meets the 'Qualification Standards of Actuarial Opinion' as adopted by the American Academy of Actuaries

W. Actuarial Certification: The filing should include an actuarial certification that states the following:

(a) The filing is in compliance with all applicable laws and regulations of the State of New York;

(b) The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 41, Actuarial Communications

(c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(d) The benefits are reasonable in relation to the premiums charged; and

(e) The rates are not unfairly discriminatory.

X. Objection Letters:

The rate filings are subject to objection letters being raised by DFS.

For Prior Approval Rate Adjustments, such rate objections are governed by the provisions of Insurance Law § 3231(e)(1) or § 4308(c), including the special provisions applicable for objections raised between the 50th and 60th day after the filing date (20 additional days added to the initial 60 days).

For Rate and Form Rate Filings, such rate objections are governed by the provisions of Insurance Law § 3231(d) or § 4308(b), which provisions do not include time limit periods. Due to the tight timeframes required for Exchange certification of QHPs, DFS requests that due diligence be exercised by the Companies in responding promptly to DFS's objection letters on such Rate and Form filings.

Y. Additional Requirements:

Y (a) Filing Type Code

New filing type codes have been added to SERFF which are to be used for this year's rate filings, for On-Exchange and Off-Exchange form and rate product filings:

Prior Approval Rate Adjustment Filings:
Prior Approval Exchange Form & Rate Filing for On Exchange plans; and
Prior Approval Off Exchange NG Form & Rate Filing for Off Exchange plans.

Rate and Form Filings:
Exchange Form & Rate Filing for On Exchange plans; and
Off Exchange NG Form & Rate Filing for Off Exchange plans.

Y (b) Format of Attachments:

Each attachment to the rate adjustment filing must be compatible with the following software: Microsoft Word 2010, Microsoft Excel 2010, or Adobe Acrobat 9.

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

Y (c) SERFF/HHS Requirements:

This rate filing for the Exchange plans is also subject to other SERFF and HHS requirements.

Y (d) Amendment to Filing:

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

A revision to a previously submitted schedule item made in response to an objection letter from DFS is to use the 'Revising Schedule Items' process described in the SERFF Industry Manual. This is the method that is to be used when any schedule item needs to be revised in response to a letter, including a revised rate manual to be submitted in

response to DFS's decision. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, etc.) needs to be revised in response to a letter from DFS, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be revised.

New or revised commission schedules or broker fee schedules must first be placed on file using a rate filing with a 'Normal Pre-Approval' SERFF filing type code. Once the new or revised schedule has been placed on file, any rate impact can be included in the filing for On-Exchange plans and Off-Exchange plans, and change and its impact on the premium rates is to be discussed in the actuarial memorandum.

Z. Other Miscellaneous Items:

Z (a) Risk Adjustment Simulations:

DFS has worked in conjunction with Deloitte in performing various assignments:

(1) Simulation of the estimated impact that the risk adjustment program based on plans in force during calendar 2013;
(2) Analysis of impact of the Federal reinsurance program based on paid claims in calendar year 2013; and
(3) Calculation of health-risk neutral geographic rating region factors based on paid claims in calendar year 2013;

Z (b) Membership Survey as of March 31, 2014:

DFS has worked with all companies that are participating on the Exchange, either On or Off, in developing a survey of all membership data as of March 31, 2014, by age and gender, by quinquennial age brackets, by metal levels and by regions; this survey may be used by companies in estimating the impact of the Federal Risk Adjustment. This survey has been distributed to all companies early in April 2014.

Z (c) Minimum Loss Ratio:

Loss ratio should be calculated using the New York State definition, i.e. Incurred Claims to Earned Premiums, without the adjustments introduced in the HHS definition.

Minimum loss ratio is 82%, for both Individual plans and for Small Groups plans. This means that the provisions for administrative expenses, premiums taxes, commissions and fees, including ACA fees and for pre-tax profit provision may not exceed 18.0%.

The provision for all expenses and profit may not vary by regions; however such provision for expenses and profit may vary by metal level plans.

If there are differences in expenses by regions, as discussed above, then the regional or area factors may be determined so as to absorb any such differences.

Of course, such variations by regions may not reflect any elements like age, sex, health status, etc.

Z (d) Minor/Major Changes in Benefits:

Rate adjustment filings for existing products (i.e. products approved last year by DFS) will be submitted as Prior Approval Adjustment filings under Insurance Law § 3231(e)(1) or § 4308(c). Minor benefit changes, i.e. tweaking in the cost sharing provisions within a given metal level will be handled within the same Prior Approval Adjustment filings. Major benefit changes, i.e. introduction of new metal level plans not offered in 2014 would require an additional Rate and Form filing. However, the premium rates for such major changes in benefits will be handled as part of the same Prior Approval Adjustment filings, while the policy forms approval will be handled under a Form filing.

With respect to companies that are not participating in the Exchange in calendar year 2014, rate filings for premium rates to be effective in calendar year 2015 will be handled as Rate and Form filings under Insurance Law § 3231(d) or § 4308(b), as described in Section A on General Introduction above.

Z (e) Mental Health Parity:

Regulations were released in November 2013 on Mental Health Parity and Addiction Equity Act of 2008.

ACA provides that Mental Health and Substance Abuse benefits are one of the Essential Health Benefits categories. However, mental health treatment in residential facilities is being added, per final regulations.

With respect to Individual plans, this additional benefit will be introduced for new plans effective on or after July 1, 2014 and to existing plans on January 1, 2015. With respect to Small Groups, this additional benefit will be introduced to new groups and renewing groups effective on or after July 1, 2014.

DFS is not providing any estimate as to the premium rate impact of this additional benefit.

Z (f) Uniform Rate Review Template (URRT):

URRT worksheets and accompanying actuarial memorandum must be completed based on HHS requirements.

DFS made some objections on the filings for the Exchange 2014 premium rates, dealing with reconciliations between the values in the URRT worksheets and the comparable values in DFS's Exhibits 17, 18 and 19, regarding Incurred Claims, Risk Sharing Adjustments, Impact of Reinsurance, Expenses and Profit Provision, and other items.

Care should be exercised in the preparation of the filing for the Exchange 2015 premium rates, so as to reconcile the values for the various components between the URRT worksheets and the comparable values in DFS's Exhibits 17, 18 and 19.

Z (g) Rate Review Detail Data (R2D2)

Rate Review Detail Data screen must be completed based on HHS requirements. HHS reviews these screens and requests DFS to have companies correct any emerging inconsistencies in the values for the various components.

DFS made some objections on the filings for the Exchange 2014 premium rates, dealing with some inconsistencies, illustrated below. Care should be exercised in the preparation of these required HHS Screens. Examples of inconsistencies include:

(1) Rate Review Detail screen is incomplete;
(2) Average values are less than the Minimum values;
(3) Maximum values appear to be too high;
(4) Minimum, Maximum, and Average values are not annualized premium rates, but PMPM premium rates;
(5) Screen shows 'N/A' under 'Forms, Affected Forms and Other Affected Forms'; these items are to be left blank if they do not apply, since making an entry implies that such a form is affected;
(6) Requested Rate Period data is all zeros – the projected premiums and claims need to be corrected to reflect the projected membership, and complete the Minimum PMPM, Maximum PMPM, and Average PMPM values.

Note that for the 2015 premium rates, the Rate Review Detail needs to be completed in a manner more consistent with the preparation of the Rate Review Details completed for 2013 premium rates, i.e. for pre-Exchange premium rates, rather than for the 2014 Exchange premium rates, which incorporated premium rates for new policy forms, rather than changes in premium rates for existing forms.

Z (h) Dental Coverage

DFS is developing updated checklists for Dental Coverage. Please consult http://www.dfs.ny.gov/insurance/ihealth.htm for two separate releases under DFS Web site, including the Checklist on Stand-Alone Dental plans, and Questions and Answers on Pediatric Dental, Bundled Dental, Imbedded Dental, etc, under 'Dental Filing Guidance'.

Z (i) Item SMC:

§ 361.6(g) of Regulation 146 includes provisions for the distribution of monies from the Market Stabilization Pool [MSP].

Undistributed amounts currently held by companies for years 2007-2012 with respect to Direct Pay plans, together with estimated amounts arising from the operation of the SMC Pool for calendar year 2013, are to be distributed as adjustments to premium rates effective

in calendar year 2015-16. Those amounts that were generated from the small group market should be distributed as adjustments to Small Group plans, and those generated from the individual market should be distributed as adjustments to Individual plans.

Furthermore, there are additional undistributed payments arising from the Specified Medical Conditions Pool for calendar years 1999-2004 which will be distributed to companies, for redistribution to Individual plans.

DFS will provide details to each affected company.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2015 Premium Rates
For On-Exchange Plans and Off-Exchange Plans

Checklist – Definitions:

a. **Company** refers to the licensed entity providing the insurance coverage reflected in the rate filing.

b. A Company's **commercial book of business** includes all of the following: large group, Small Group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.

c. **Loss ratio** refers to incurred claims divided by earned premiums for a given period of time. Incurred claims includes the impact of the Regulation 146 (11 NYCRR 361), covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including 'quality improvement expenses' or 'community benefit expenses'. Earned premiums do not include any adjustment for assessments or taxes. For the new plans to be sold through the Exchange, incurred claims includes the impact of new individual reinsurance program and the new risk adjustment mechanism instead of the prior state sponsored Regulation 146 pool.

d. **Market segment** refers to Small Group or Individual (Direct Pay) as defined in New York Insurance Law and Regulations.

e. **Product street name** refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with DFS.

f. **Rate applicability period** refers to the length of time in which the rates in a rate table are assumed to remain in effect.
   (i) Example 1(Individual Plans): A non-rolling rate table is developed to be effective January 1, 2015 and is expected to be revised January 1, 2016. The rate applicability period for this table is January 1, 2015 through December 31, 2015.
   (ii) Example 2(Small Group Plans): A quarterly rolling rate table is developed for issues and renewals in January – March 2015 and incorporates a 12 month rate guarantee period.

The average rate applicability period for this table is February 1, 2015 (mid renewal date) through January 31, 2016.

g. **Standardized earned premiums** is the earned premiums for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan-designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable pursuant to Regulation 146 or pursuant to a loss ratio report have no impact on the earned premiums or standardized earned premiums shown in Exhibit 17 or in the rate development analysis.

For this rate filing, the Standardized earned premiums are applicable only for the Non-Grandfathered/Grandfathered plans, and the standard rate scale to be used is the rate scale for the Fourth Quarter of 2013 for a quarterly rolling rate structure, and the premium rates for calendar year 2013 for a non-rolling rate structure. The historical experience shown in Exhibit 17 would include the experience for each of the three 12 month periods requested, even though the policyholder/contract holder may have had 'grandfathered' status during some part of that experience periods.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2015 Premium Rates
For On- Exchange Plans and Off-Exchange Plans

Additional Instructions on Exhibits to be Included in Rate Filings

General:
Summary information was provided in the checklist above. Additional instructions for each Exhibit are provided in this section of the checklist, specifically as to their applicability for Individual plans and for Small Group plans, and for On Exchange plans and Off Exchange plans.

Instructions are also provided at the end of this section as to the required exhibits for Rate and Form filings for Exchange plans, and for Prior Approval Adjustment filings for (a) Grandfathered plans sold outside the Exchange and (b) community-rated large group HMO products.

Special Rules are also provided at the end of this section for the preparation of the required exhibits, so as to potentially reduce the number of different exhibits to be submitted by companies.

For all Exhibits, indicate on the top-left corner Company identification, Company's NAIC Number, SERFF Number and Market Segment.

All Exhibits must be submitted as an Excel file and as an Adobe PDF file.

Exhibit 11: General Information about the Rate Filing:
This exhibit provides general information about the rate filing.

Information must be provided as to not only the Contact Person, but also the Actuarial Contact, i.e. the identification of the actuary responsible for the preparation of the rate filing, including telephone number and e-mail address. The information on the actuarial contact may be redacted.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

In most instances, the same exhibit may be used for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit.

Exhibit 12: (Not Applicable):

Exhibit 13: Narrative Summary and Numerical Summary:
This exhibit provides some instructions as to a Narrative Summary explaining the reasons for the requested rate adjustments. This narrative summary provides a plain English summary of the rate change and the reasons for the rate change, and is to be attached to this Exhibit 13.

The Initial Notices to be sent to policyholders, per this Exhibit 13, must be sent to all On/Off Exchange policyholders inforce as of the date of the submission of the rate filing, or as of the most practical date preceding the date of the filing.

This Exhibit also provides a Numerical Summary in the bottom half of the Exhibit, illustrating a summary of selected information about the current rate filing and of the prior rate filings for the same market segment.

If the particular product under review in the current rate filing was not offered in the prior years, an indication of Not Applicable or N/A should be inserted in the applicable sections of this numerical summary.

Additional Details:

A. Average 2014 and 2015 Premium Rates:
This information needs to be completed for all rate filings, for both Individual plans and Small Group plans. The average premium rates are to be determined as the arithmetic average of all premium rates for the applicable metal level plan described in Exhibit 13, for all plans, both On and Off, and for all regions combined.

B. Weighted Annual Percentage Adjustments (2014 to 2015):
This information needs to be completed for all rate filings, for both Individual plans and Small Group plans. This information is as illustrated in Exhibits 14A or 14B.

C. Weighted Annual Percentage Adjustments (Prior Years):
This information needs to be completed for Small Group plans, based on information as illustrated in Prior Years' filings in Exhibits 4A-4D. With respect to the adjustment for '2013-14', enter N/A unless the actuary has estimated an overall change in premium rates from 2013 premium rates on Pre-ACA products to 2014 premium rates on Post-ACA products.

For Individual plans, this information is not generally available, as the current product was not offered in prior years and the actuary should enter 'N/A' in the applicable boxes.

D. Average Medical Loss Ratios for 2011-13:
For Small Group plans, enter the MLR's as illustrated in the current year Exhibit 17, including the impact of SMC and Stop Loss adjustments. If the experience periods in

Exhibit 17 are different then calendar years 2011-13, enter the MLR's from Exhibit 17 in the closest calendar year.

For Individual plans, refer to comments in Section C just above.

E. Claim Trend Rates and Ratios to Earned Premiums (2013-15):

E 1 Claim Trend Rates (2013-15):

For Small Group plans, enter the claim trend rates for 2015 and 2014 as illustrated in the current year Exhibit 19. For 2013, enter the claim trend rate for 2013 as illustrated in Exhibit 2 of the Prior Approval rate filing submitted in calendar year 2012 for premium rates effective in 2013. If not applicable, enter 'N/A'.

For Individual plans, follow the same instructions as above for 2015 and 2014 for Small Groups. For 2013, enter Not Applicable or 'N/A'.

E 2 Ratios to Earned Premiums (2013-15):

For Small Group plans, enter the various ratios as illustrated in the current year Exhibit 19, for 2015 and for 2014; for 2013, enter the ratios as illustrated in Exhibit 2 of the Prior Approval rate filing submitted in calendar year 2012 for premium rates effective in calendar year 2013. If not applicable, enter 'N/A'.

For Individual plans, follow the same instructions as above for 2014 and 2015 for Small Groups. For 2013, enter Not Applicable or 'N/A'.

Note that Exhibit 19 does not specifically illustrate the ratios for Pre Tax Profit provision, and this item needs to be determined as the sum of the Post Tax Profit provision plus the components for State and Federal taxes.

This Exhibit is applicable only for Prior Approval Adjustment filings. This Exhibit is not applicable for Rate and Form filings.

In most instances, the same exhibit may be used for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit.

Exhibits 14: Summary of Requested Percentage Changes:
This exhibit provides details as to the changes in premium rates between the approved 2014 premium rates and the requested 2015 premium rates.

Information is requested by (a) Metal Level; by (b) Region; and by (c) Effective Date of the premium rates.

Effective dates are 01/01/2015 for all Individual plans, and 01/01/2015, 04/01/2015, 07/01/2015 or 10/01/2015 for Small Group plans.

Information requested includes Lowest, Highest and Weighted Average requested percentage rate changes.

This Exhibit is not to be prepared by HIOS ID plan. Rather, what is requested in these Exhibits are the Average Percentage Rate Changes for all 'combinations of market segment, rating period, metal level, and rating region and product name', as specified in Notes 4 and 5 in Exhibits 14-A and 14-B.

Exhibit 14A applies to Individual Plans.

Exhibit 14B applies to Small Group Plans.

This Exhibit is applicable only for Prior Approval Adjustment filings.

This Exhibit is not applicable for Rate and Form filings.

In most instances, the same exhibit may be used for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit. Specifically, DFS is not requiring that the changes in premium rates be identified separately for On Exchange plans and for Off Exchange plans.

Exhibits 15: Distribution of Contracts by Requested Percent Adjustments:
This exhibit provides details as to the distribution by percentage brackets of the changes in premium rates between the approved 2014 premium rates and the requested 2015 premium rates.

Information is requested by (a) Metal Level; by (b) Region; and by (c) Effective Date of the premium rates.

Effective dates are 01/01/2015 for all Individual plans, and 01/01/2015, 04/01/2015, 07/01/2015 or 10/01/2015 for Small Group plans.

Exhibit 15A applies to Individual Plans.

Exhibit 15B applies to Small Group Plans.

This Exhibit is applicable only for Prior Approval Adjustment filings.

This Exhibit is not applicable for Rate and Form filings.

In most instances, the same exhibit may be used for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit. Specifically, DFS is not requiring that the changes in premium rates be identified separately for On Exchange plans and for Off Exchange plans.

Exhibit 16: Summary of Policy Form and Product Changes:
This exhibit provides details as to other rate filings which may impact the current rate filing.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

In most instances, the same exhibit may be used for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit.

Exhibit 17 – Historical Claim Experience Data by Policy Forms:
This exhibit illustrates the premiums and claims experience for the prior three (3) calendar years (2011-13) for selected policy forms.

The policy forms selected are those policy forms for Non -Grandfathered plans, and if included, for Grandfathered plans providing comprehensive benefits for hospital, medical and prescription drugs charges. As indicated earlier, some policy forms, previously included in Insurance Law § 3231(e)(1) or § 4308(c) Prior Approval Adjustment filings may be excluded, for example hospital only plans, medical only plans, limited benefit plans, plans supplementing Medicare benefits, and other discontinued or closed group policy forms.

Note that discontinued plans within a policy form being continued are not to be excluded.

Also note that Small Group Sole Proprietors and Small Group Healthy New York plans must be included in this Exhibit 17, although the information on Small Group Sole Proprietors will be excluded from the development of the Index rate/Single Risk Pool, in Exhibit 18.

This Exhibit 17 is to be used in the analysis of the claims experience for prior years and will be used for the development of the 2015 premium rates for the On/Off Exchange plans for Small Group plans, and indirectly for Individual plans, as DFS is requiring that premium rates for such Individual plans be based on claims experience under Small Group plans for companies in the Small Group Market during calendar year 2013.

This exhibit is similar to the Exhibit 7 as used in prior years on Prior Approval Adjustment filings.

a. The format of this Standard Exhibit is fixed; inset additional rows as needed. Use only the first tab for data entry.

b. Policy Form: Use a separate row for each base medical policy form. Data is to be shown for each policy form for Non-Grandfathered/Grandfathered plans. The distinctions as to 'rating pools' must be the same as the most recent/pending Insurance Law § 3231(e)(1) or § 4308(c) Prior Approval Adjustment filings.

c. Columns 1a, 1b and 1c: Indicate the form number for each base medical policy form, the product name as in the rate manual, and the street product name.

d. Column 2 Rating Pool Identification: Enter same response as in the most recent/pending Insurance Law § 3231(e)(1) or § 4308(c) Prior Approval Rate Adjustment filings.

e. Column 3 Effective Date of Rate Change: Indicate January 1, 2015.

f. Columns 4 through 7: Use drop down menu to identify Market Segment, Product Type, Rolling/Non Rolling rate structure and Open/Closed Policy Form.

g. Columns 8 and 9: Enter the number of policyholders (number of Small Group accounts) and the number of covered lives (members) affected by this rate filing, as of December 31, 2013.

h. Experience Data: The experience entered for the three (3) indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.

i. Each experience period is to be for 12 months (or shorter if a new form).

j. The ending date of the recent experience period is December 31, 2013. For most Companies, this experience period will be from January 1, 2013 through December 31, 2013. If necessary, DFS will accept an experience period earlier than described above; companies would need to provide support for this modification.

k. The first prior experience period is the immediately prior 12 month experience period (or shorter period if a new form). The second prior experience period is the immediately prior 12 month experience period (or shorter if a new form) prior to the first prior period.

l. The paid claims for each of the three experience periods are all claims paid in each experience period regardless of incurred dates. This at variance with the 'Paid Claims' to be used in the determination of the Incurred Claims just below, where such 'Paid Claims' should be all claims incurred in the experience period and paid through the end of the 2 months or 3 months runout period after the close of the last experience period.

m. The incurred claims for each of the three experience periods must be based on at least 3 months of claims run out beyond the end of the experience period, plus a remaining reserve. DFS will accept 2 months of claims runout, provided an appropriate adjustment is introduced in the remaining reserve. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim runout were reflected in the development of the incurred claims.

n. Loss ratio report refunds or refunds/payments pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.

o. Standard Premiums: The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods. This standard rate scale corresponds to Calendar Year 2013 rates for non-rolling structure and to Fourth Quarter 2013 for rolling rate structure.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings, except in situations where a company did not participate in the Small Group Market in calendar year 2013, where this Exhibit is not required.

In most instances, the same exhibit may be used for both Individual plans and for Small Group plans, and for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit.

For Individual plans, where a company participated in the Small Group Market in calendar year 2013, it is required that this exhibit be submitted illustrating the claim experience under Small Groups, as this claim experience is used at the basis for the determination of the premium rates for Individual plans.

Exhibit 18: Index Rate /Plan Design Adjustment Worksheet:
Exhibit 18 must be prepared on a PMPM basis, not on a PEPM basis.

Use separate columns for each of the Exchange plan-designs, separately for Standard and Non-Standard plans.

Do not Merge/Center Lines 1 and 2. Do not enter multiple Plan ID's on Line 8.

Information on Lines 1 through 9 is to be entered for each plan-design.

For Companies that participated in the Small Group Market during calendar year 2013:

a1. Information on lines 10A through 10B is to be entered in the left most column, for all in force plans combined. This information is as illustrated in Exhibit 17, for combined Small Groups, excluding Small Groups Sole Proprietors, but including Small Groups Healthy New York plans. Line 10C will be calculated as the ratio of line 10A to Line 10B. Other columns on lines 10A through 10C are to be left blank.

a2. Information on line 11 (Average Pricing Actuarial Value) is to be entered in the left most column, for all inforce plans combined. Other columns on line 11 are to be left blank. Information on line 12 is to be carried to all other columns used for the various plan-designs.

a3. Go to step b.

For Other Companies:

a4. Information on lines 10A through 12 is to be entered in the left most column, based on a premium rate development which must be specifically identified in the Actuarial Memorandum, including the source of the data (e.g. publications, preparing organizations, consultants, etc).

a5. Information on lines 10A through 12 must correspond to the experience period on which this rate development is being based, excluding any projection for claim trends from the mid-point of this experience period to the mid applicability date of the 2015 premium rates, and excluding any provision for expenses and profit margin. The annual claim trend used must be shown in the appropriate column in Exhibit 19, and the impact of the claim trends must be shown on line 24 of this Exhibit 18. The expense and profit provisions must be shown in Exhibit 19, and the expense and margin factors must be shown on lines 36 and 37 of this Exhibit 18.

a6. Go to step b.

b. Information on lines 13 through 27 is to be entered in the left most column, for all inforce plans combined. This information corresponds to adjustments to be introduced as Market-Wide adjustments as prescribed by HHS regulations. Other columns on lines 13 through 27 are to be left blank.

c. Information on line 28 is to be determined based on the prescribed formula in the left most column and this information is to be carried to all other columns used for the various plan-designs.

d. Information on lines 29 through 42 is to be entered in all columns for each plan.

e. Information on line 43 is to be determined based on the prescribed formula for all columns for the various plan-designs.

f. Information on line 44 is determined as line 12 times line 28 times line 43.

g. If additional lines are required at bottom of Exhibit 18 below Line 44, submit a second version of Exhibit 18 with these additional lines and any explanatory information.

h. Information on lines 36 and 37 on Expenses and Profit must be entered in all columns for each plan. Some problems arose last year in the determination of the required entries for lines 36 and 37; therefore, some instructions are provided in (i) and (j) just below.

i. Information on line 36 for Administrative Expenses and on line 37 for Profit and Contribution to Surplus must be consistent with the information in Exhibit 19 on Administrative Expenses and Pre Tax Profit and Contribution to Surplus.

j. For example, if Administrative Expense factor in Exhibit 19 is 13.00% and Profit factor in Exhibit 19 is 2.00%, then Factor on Line 36 should be 1.1529 (i.e. the ratio of 98% to 85%, where 98% is 100% less 2.00%, and 85% is 100% less 13.00% less 2.00%), and Factor on Line 37 should be 1.0204 (i.e. the ratio of 100% to 98%, where 98% is 100% less 2.00%, and 100% is given.

k. Lines 36 and 37 may not be reported as 1.000, with the provisions for expenses and profit reflected elsewhere in this Exhibit.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

Separate exhibits are required for On Exchange plans and for Off Exchange plans.

Exhibit 19: Summary of Claim Trends, Administrative Costs and Profit Margins:
This exhibit applies to the non-grandfathered plans to be sold on the Exchange and off the Exchange.

The format of this exhibit is fixed; insert more rows as needed. Only use the first tab for data entry. Information in this exhibit may not vary by region.

All applicable ACA fees are to be entered in this Exhibit 19 in columns 6.5 and 16.5, including the impact of the Federal reinsurance fees $44.00/$63.00 per year applicable for calendar years 2015/2014. This reinsurance fee may not be deducted from the impact of the Federal reinsurance adjustment on incurred claims.

The 2014-15 Executive Budget does not include any Exchange user fees, so companies cannot include an adjustment in Exhibit 19 for these fees. If the final budget changes this proposal, companies will be informed

Administrative expenses may not include adjustments for HCRA surcharges nor for Covered Lives assessments [GME]; such items are to be reflected in Incurred Claims.

All ACA fees must be incorporated in the administrative expenses, in columns 6.5 and 16.5, including the reinsurance fees, which may not be deducted from the impact of the Federal reinsurance factors.

For all the On/Off-Exchange plans, use a separate row to enter information for each plan at each metal level (including catastrophic). This includes both the standard plans and the non-standard design plans to be sold through the On-Exchange plans and the Off-Exchange plans.

Information is for medical base plans and all associated riders combined.

a. Column 1: Enter Metal Tier Level using drop-down menu.
b. Column 2: Enter On/Off-Exchange Designation using drop-down menu.
   Column 2: Enter Standard/Non Standard designation using drop-down menu.
c. Column 3: Enter Estimated Membership at mm/dd/yyyy, excluding Pre ACA members.
d. Columns 4.1 - 4.2: Enter the applicability period.
e. Column 5: The average claim trend is the average annualized claim trend rate to adjust source data forward to the applicable applicability period.
f. Columns 6.1 through 6.7: The administrative expense components must reflect the anticipated expenses for applicability in calendar year 2015.
g. Columns 7 through 10: The profit margins components must reflect the provision for profit margin required for applicability in calendar year 2015.

h. Both the administrative expenses and the profit margins are to be entered as percentages of premiums in columns 6.1 through 11.
i. Columns 14.1 through 21 must be proposed on a basis consistent with the basis used for columns 4.1 through 11.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

Separate exhibits are required for On Exchange plans and for Off Exchange plans.

Exhibit 20: HIOS ID Mapping to Product Names:
This exhibit provides for all 14 digit HIOS ID plan numbers, details as to:
(a) Exchange On or Off;
(b) Standard Design or Non Standard Design;
(c) Limiting Child Age 26 or 29;
(d) Domestic Partner Coverage Included or Excluded;
(e) Family Planning Coverage Included or Excluded;
(f) Pediatric Dental Coverage Included or Excluded;
(g) Out of Network Benefits Included Yes or No; and
(h) Additional Benefits to EHB Yes or No.

The purpose of this exhibit is to facilitate the mapping of premium rates in the Rate Manuals to the premium rates in the Binder filings.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings. Separate exhibits are required for On Exchange plans and for Off Exchange plans.

Exhibit 21: Hospital Unit Cost Development:
This exhibit provides details as to the average changes in the level of the charge reimbursements on Hospital services by Providers:
(a) From calendar year 2014 to calendar year 2015;
(b) From calendar year 2013 to calendar year 2014; and
(c) From calendar year 2012 to calendar year 2013.

Additional Information requested is the allowed charges by Providers based on allowed charges applicable in calendar year 2013 for the Small Group Market.

Exhibit 21A applies to Inpatient Services.

Exhibit 21B applies to Outpatient Services.

For hospital contracts with risk sharing features or incentive payments for performance, e.g. meeting quality improvements, the financial impact of such features should not be taken into consideration in the determination of the average changes.

The information in these Exhibits 21 may be redacted, specifically columns (4) through (7).

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings, except in situations where a company did not participate in the Small Group Market in calendar year 2013, where this Exhibit is not required.

In most instances, the same exhibit may be used for both Individual plans and for Small Group plans, and for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit.

Exhibit 22: Medical and Hospital Utilization:

This exhibit provides details as to the medical/hospital services provided under the Small Group Market, separately for calendar years 2013, 2012 and 2011. This type of Exhibit is similar to a comparable exhibit currently requested in rate filings for Child Health Plus programs.

Information requested includes:

(a) Number of Services;
(b) Amounts of Allowed Charges;
(c) Average Membership;
(d) Average Allowed Charges per Service (=(b)/(a));
(e) Average Utilization per Member (=(a)/(c)); and
(f) Average Allowed Charge per Member (= (b)/(c)).

This information is requested for Small Groups, excluding Small Group Sole Proprietors, but including Small Group Healthy New York plans.

The information in this Exhibit 22 may be redacted.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings, except in situations where a company did not participate in the Small Group Market in calendar year 2013, where this Exhibit is not required.

In most instances, the same exhibit may be used for both Individual plans and for Small Group plans, and for both On Exchange plans and for Off Exchange plans, except for the information in the top-left corner of this exhibit.

Exhibit 23: Summary of Requested 2015 Premium Rates:

The purpose of this exhibit is to provide DFS immediate feedback as to the level of the variations in the level of the 2015 requested premium rates by metal levels and by geographical regions.

Information requested includes:

(a) HIOS ID Number (14 Digit);
(b) Metal Level (Excluding Silver CSR plans);
(c) Individuals or Small Groups;
(d) Standard or Non Standard Design plan;
(e) On or Off Exchange;
(f) Pediatric Dental Included (Yes or No); and
(g) Premium Rates by Geographical Regions.

For Individual plans, the premium rates will be the calendar year 2015 requested premium rates for the Individual Only Census Tier cells.

For Small Group plans, the premium rates will be the first quarter 2015 requested premium rates for the Employee Only Census Tier cells.

To simplify the preparation of this exhibit, the only plans to be submitted are those with all of the following benefit features:

(a) Child Through Age 29 (to Age 30); and
(b) Domestic Partner coverage included; and
(c) Family Planning coverage included.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

Rate and Form Filings for Exchange Plans:

As discussed in Section A on General Introduction, most filings for premium rates effective in calendar year 2015 will be of the Prior Approval Adjustment type of filing (Insurance Law § 3231(e)(1) and § 4308(c)), as most companies submitted rate filings for Exchange plans in 2013 for premium rates effective in calendar year 2014. The required Exhibits to be submitted are described in this checklist.

For companies that did not submit a rate filing for Exchange plans in 2013 for premium rates effective in calendar year 2014, a Rate and Form type of filing (Insurance Law § 3231(d) and § 4308(b)) is required in 2014 for premium rates effective in calendar year 2015. The required Exhibits to be submitted are described below. Refer to the instructions in Section A on General Introduction and on the provisions of the applicable Insurance Law sections.

Note that the requirements below apply to both Individual plans and Small Groups, and to both On Exchange plans and Off Exchange plans.

For companies that participated in the Small Group Market in calendar year 2013:
Exhibit 11: General Information (Required to be submitted);
Exhibit 13: Narrative Summary and Numerical Summary(Not required to be submitted);
Exhibit 14A-B: Requested Percentage Changes (Not required to be submitted);
Exhibit 15A-B: Distribution by Percentage Changes (Not required to be submitted);
Exhibit 16: Summary of Policy Form Changes (Required to be submitted);
Exhibit 17: Claims Experience Data (Required to be submitted);
Exhibit 18: Index Rate/Plan Design Level Adjustment (Required to be submitted);
Exhibit 19: Claim Trend and Administrative Expenses (Required to be submitted);
Exhibit 20: HIOS Mapping to Product (Required to be submitted);
Exhibit 21A-B: Hospital Unit Costs (Required to be submitted);
Exhibit 22: Medical and Hospital Utilization Data (Required to be submitted);
Exhibit 23: Summary of Requested 2015 Premium Rates (Required to be submitted);

For companies that did not participate in the Small Group Market in calendar year 2013:
Exhibit 11: General Information (Required to be submitted);
Exhibit 13: Narrative Summary and Numerical Summary (Not required to be submitted);
Exhibit 14A-B: Requested Percentage Changes (Not required to be submitted);
Exhibit 15A-B: Distribution by Percentage Changes (Not required to be submitted);

Exhibit 16: Summary of Policy Form Changes (Required to be submitted);
Exhibit 17: Claims Experience Data (Not required to be submitted);
Exhibit 18: Index Rate/Plan Design Level Adjustment (Required to be submitted);
Exhibit 19: Claim Trend and Administrative Expenses (Required to be submitted);

Exhibit 20: HIOS Mapping to Product (Required to be submitted);
Exhibit 21A-B: Hospital Unit Costs (Not required to be submitted);
Exhibit 22: Medical and Hospital Utilization Data (Not required to be submitted);
Exhibit 23: Summary of Requested 2015 Premium Rates (Required to be submitted);

When an exhibit is required, it is required for both Individual plans and for Small Group plans, and for both On Exchange plans and Off Exchange plans.

The instructions for the preparation of the required exhibits are similar to the instructions described above for Prior Approval Adjustment filings.

Non Exchange Filings for Community Rated Products:
As discussed in Section A on General Introduction, the instructions in this checklist do not apply for filings for (a) Grandfathered plans sold outside the Exchange and (b) community-rated Large Group HMO products.

Instructions for these filings are covered in the applicable checklist provided in DFS's public Web site. This checklist is being revised from the checklist applicable in calendar year 2013 for premium rates effective in calendar year 2014 and the revised version will be posted on the website in May 2014.

These filings must be submitted as a Prior Approval Adjustment rate filings (Insurance Law § 3231(e)(1) and § 4308(c)), and the required Exhibits are the same as used in calendar year 2013, as follows:

Exhibit 1: General Information (Required to be submitted);
Exhibit 2: Claim Trend and Administrative Expenses (Required to be submitted);
Exhibit 3: Narrative Summary (Required to be submitted);
Exhibit 4A-B-C-D: Requested Percentage Changes (Required to be submitted);
Exhibit 5A-B: Distribution by Percentage Changes (Required to be submitted);
Exhibit 6: Summary of Policy Form Changes (Required to be submitted);
Exhibit 7: Claims Experience Data (Required to be submitted);

The instructions for the preparation of the required exhibits are provided in the applicable checklist referred to just above.

Special Rules for the Preparation of the Required Exhibits:
As discussed in Section B on Separate Filings for On and Off Exchange plans, separate rate filings need to be submitted for On Exchange plans and for Off Exchange plans, including separate exhibits. Additionally, separate filings need to be submitted for Individual plans and for Small Group plans.

This would mean that companies submitting rate filings for both Individual plans and for Small Group plans, both for On Exchange plans and for Off Exchange plans, a total of four separate sets of Exhibits would need to be submitted.

To simplify the process, DFS has adopted some special rules as described in the table below, where the same exhibit may be used for more than one filing, when a given Exhibit is required to be submitted. Instructions were provided above as to when the various Exhibits have to be submitted.

Exhibits	Subject	SG / Ind.	On / Off	Number
11	General Information	Different	Same	2
13	Narrative Summary	Different	Same	2
14A-B	Requested % Changes	Different	Same	2
15A-B	Distribution by Percent	Different	Same	2
16	Forms and Products	Different	Same	2
17	Claims Experience	Same	Same	1
18	Index Rate	Different	Different	4
19	Expenses and Profit	Different	Different *	4 or 2
20	HIOS ID Mapping	Different	Different	4
21A-B	Hospital Charges	Same	Same	1
22	Utilization Date	Same	Same	1
23	Rate Summary	Different	Different	4

SG / Ind: Small Groups / Individuals.
Same: The same exhibit may be used for both SG/Ind or for both On/Off.
Different: The same exhibit may not be used for both SG/Ind or for both On/Off.
Number: Total number of different exhibits to be prepared.

* Designation would be 'Same', if company uses same expense provisions for both On and Off Exchange plans, which is most likely to be the case.

INDIVIDUAL NARRATIVE SUMMARY

Company: **Independent Health Benefits Corporation.**
NAIC Code: **47034**
SERFF Tracking #: **NDPD-129574328**

Summary:
Independent Health Benefits Corporation (IHBC) is requesting premium rate adjustments for its individual products for 2015. All products within this rate filing are community-rated, which means that all members holding the same coverage pay the same approved premium. The number of members affected by the proposed premium adjustments is 3,380.

The overall average requested increase is as follows:

	2014 to 2015
Requested Rate Adjustment	3.17%

These proposed rate adjustments will be submitted to the New York State Department of Financial Services on approximately June 13th 2014. You will be notified of the final approved premium adjustment at least 60 days prior to your effective date of renewal.

Claim Trends:
The total annual claim trend is 7.0%. This is the same claim trend that IHBC is using in its small-group filing, since individual rates were set relative to small-group rates by comparing the relative morbidities between the two populations. Claim trend is driven by both projected changes in utilization (the frequency of use of healthcare services) and the average cost for those services (based on anticipated negotiated changes in reimbursement to our hospitals, physicians, and other medical providers). This average cost component of trend also includes a modest adjustment for the intensity of the services being provided; e.g. it assumes some increasing level of complexity in the mix of services.

Administration, Taxes and Fees, Other:
The following Affordable Care Act taxes and fees are included in the proposed 2015 premium rates:

- Contributions to the Federal Transitional Reinsurance Program $3.67 PMPM[1]
- Patient Centered Outcomes Research Fee $0.18 PMPM[1]
- Risk Adjuster User Fee $0.08 PMPM[1]
- Health Insurance Tax (Percent of Premium) 2.90%

87% of the premium dollar, after the above ACA taxes and fees, is utilized for medical expense. The remaining 13% of premium is available to IHBC to cover administrative expenses. Administrative expenses include (but are not limited to) customer service, processing and paying claims, care management programs focused on quality and community benefits.

[1] Per Member Per Month

IHBC also generates income from invested funds. The size of the portfolio and income generated from it vary from year to year. For 2015, 100% of IHBC's investment income will be utilized to partially offset anticipated losses on the government programs lines of business.

IHBC is also allocating 30% of prior year refunds from the Department of Financial Services to the 2015 premium rates. These refunds reduced the premiums 6.46% for 2015. The balance of the refunds will be utilized to reduce premiums in subsequent years.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Tra NDPD-129588074
Market Segment: Individuals Off Exchange

1) Please complete this Narrative Summary and Numerical Summary for each market segment for which you are submitted a rate filing.
2) The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment.
3) The purpose of the Narrative Summary is to provide a written explanation to the company's policyholders to help them understand the reasons why a rate increase is needed.
4) The purpose of the Numerical Summary is to provide a clear and simple overview of the requested rate adjustment.
5) These Summaries will be public documents and will be posted on DFS's website and furnished by DFS to the public upon request.
6) The company should submit the these Summaries to DFS ten (10) days before submitting a rate adjustment filing.
7) A draft of these Summaries and of the Initial Notice must be included in a "Prior Approval Prefiling" submitted to DFS via SERFF.
8) Once reviewed by DFS, these Summaries must be posted to a location on its website that is publicly available and accessible without the need for a user ID/password.
9) Links should be provided on key pages of the company's website so that the information may be easily located.
10) Any change(s) made to the Narrative Summary/Numerical Summary subsequent to the posting must be submitted to DFS with the specific change(s) identified.
11) This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2014 and 2015 Premium Rates:

1) Average Monthly Premium Rates for Individual Only on Individual Plans and First Quarter Rates for Employee Only on Small Group Plans.
2) Premium Rates are Average Arithmetic Premium Rates for All Plans Combined and for all Regions combined.
3) Premium Rates are with Through Age 29, with Domestic Partner and with Family Planning Coverage.
4) Premium Rates for 2015 should be Consistent with the Premium Rates reflected in Exhibit 23.
5) Premium Rates for 2014 should be on a Consistent Basis as the Premium Rates for 2015.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	$604.92	$519.36	$453.43	$391.95	199.36
2015 Premium Rates	$609.71	$526.97	$471.90	$396.05	N/A

B. Weighted Average Annual Percentage Requested Adjustments [Per Exhibit 14A for Individual Plans and Exhibit 14B for Small Group Plans]*:

	2014 to 2015
Requested Rate Adjustment	3.17%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [Per Exhibits 4A-4D] [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	N/A	N/A	N/A

D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]*:

2011		2012	2013
MLR	N/A	N/A	N/A

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2014-15 and Comparable Exhibits for 2013] [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	N/A	N/A	7.00%
Expense Ratios	N/A	15.79%	16.22%
Pre Tax Profit Ratios	N/A	-0.90%	1.03%

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

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

-- for Individual Medical Plans

Company Name Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Tracking # NDPD-129588074
Market Segment: Individuals Off Exchange

1) Use this Exhibit for Individual Medical Plans. Individual market ACA compliant plans must use non-rolling rates where rates change each January 1.
2) The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
3) Market segment refers to Individual plans.
4) The requested percentage rate change reflects the expected change in premium rates that would apply to the contract holder on that contract holder's next rate change date for each contract holder within the indicated combination of metal level, rating region, and product name.
5) The product name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/metal level when communicating with DFS). A separate row is to be used for each combination of metal level, rating region and product name.
6) If the percentage changes (lowest and highest and weighted average) are identical for all the rating regions, then separate rows by rating region need not be used, and "All Regions" can be shown in the Rating Region column. If the rate change range information differs by rating region, then separate rows need to be used for each rating region the insurer uses. Rating region
7) The "requested rate change" includes the impact of any riders (such as: age 29, domestic partner, family planning, pediatric dental, etc.).
8) Lowest should be the smallest percentage change that could affect any contract holder due to the submitted rate filing with that metal level, and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
9) Highest should be the largest percentage change that could affect any contract holder due to the submitted rate filing with that metal level, and rating region, including any applicable riders. This includes plan designs included in this rate filing which have no actual members.
10) The weighted average percentage should be developed based on annualized premium volume or membership for that metal level, and rating region, including any applicable riders.
11) This exhibit must be submitted as an Excel file and as a PDF file.

Individual Medical Plan Products

Market Segment	Effective Date of New Rate	Metal Level (or Catastrophic)	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Individual	01/01/15	Platinum	2 - Buffalo Area			5.45%	6.07%	5.45%
Individual	01/01/15	Bronze	2 - Buffalo Area	Standard Bronze	Standard Bronze	6.27%	6.89%	6.27%
Individual	01/01/15	Gold	2 - Buffalo Area	Standard Gold	Standard Gold	5.12%	5.75%	5.13%
Individual	01/01/15	Silver	2 - Buffalo Area	Standard Silver	Standard Silver	3.82%	4.43%	3.82%
Individual	01/01/15	Platinum	2 - Buffalo Area	FlexFit Platinum Option 6	FlexFit Platinum	4.13%	4.74%	4.13%
Individual	01/01/15	Silver	2 - Buffalo Area	iDirect Silver Option 1	iDirect Silver	3.58%	4.19%	3.58%
Individual	01/01/15	Catastrophic	2 - Buffalo Area	Standard Catastrophic	Standard Catastrophic	11.22%	11.22%	11.22%
Individual	01/01/15	Bronze	2 - Buffalo Area	Choice Plus Bronze Option 1	Choice Plus Bronze	-3.22%	-2.65%	-3.22%
Individual	01/01/15	Gold	2 - Buffalo Area	Choice Plus Gold Option 6	Choice Plus Gold	-2.33%	-1.76%	-2.33%
Individual	01/01/15	Silver	2 - Buffalo Area	iDirect Silver Option 1	iDirect Silver	3.58%	4.19%	3.58%

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

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Tracking #: NDPD-129588074
Market Segment: Individuals Off Exchange

Instructions:

1) The percentage rate change reflects the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
2) The distribution is by number of members or number of contracts. The Company should fill in the appropriate column below (members or contracts) and replace the mm/dd/yy placeholder with the applicable as of date.
3) The Weighted Average Percentage change should be developed based on the distribution of annualized premiums for that Market Segment/Metal Level/Rating Region and for the market segment in total.
4) Market segment refers to Individual market segment.
5) Rating region refers to the standard rating regions applicable to this filing. If the percentage change for each plan design does not vary by region, then "All Regions" can be used in the rating region column; otherwise indicate the applicable rating region.
6) Under each market segment, the table should provide the distribution by metal level (platinum, gold, silver, bronze, catastrophic).
7) Provide the distribution of contracts or members affected by proposed rate change for all contracts by metal level/rating region.
8) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
9) Enter the sum of the counts in the various columns, and the market segment weighted avg change %.
10) This exhibit must be submitted as an Excel file and a PDF file.

Distribution by Requested Rate Adjustment

Market Segment	Effective Date	Metal Level (or Catastrophic)	Rating Region	Weighted Avg Change %	Annualized Premiums as of	Total # of Members as of	Total # of Contracts as of	Number of (*) with Requested Percentage Rate Change at Renewal										
					3/31/2014			Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
Individual	1/1/2015	Platinum	2 - Buffalo Area	4.84%	$625.96	1,647				774	873							
Individual	1/1/2015	Gold	2 - Buffalo Area	1.08%	$508.16	982		500		240	242							
Individual	1/1/2015	Silver	2 - Buffalo Area	3.69%	$468.46	3,535				3,535								
Individual	1/1/2015	Bronze	2 - Buffalo Area	-1.71%	$363.50	945		795			150							
Individual	1/1/2015	Catastrophic	2 - Buffalo Area	11.22%	$220.95	116						116						
Market Segment Total:				3.01%	$492.06	7,225		1,295		4,549	1,265	116						

EXHIBIT 16: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: Independent Health Benefits Corporation

NAIC Code: 47034

SERFF Number: NDPD-129588074

Market Segment: Individuals Off Exchange

Instructions:

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

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

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

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segment: Individual Off Exchange

1) Complete a separate ROW for each base medical policy form included in the rate adjustment filing.
- Information requested applies to New York State business only and for all rating regions combined.
- Include riders that may be available with that policy form in each policy form response. Discontinued policy forms and products are to be included in the Exhibit.
- Insert additional rows as needed to include all base medical policy forms included in a particular market segment for Small Groups, Small Group Sole Proprietors and Small Group HNY Business.
- Add a row with the aggregate values for that entire market segment (including any Small Group Healthy NY and enter an appropriate identifier in column 1b (such as TOTAL).

2) In Column 4, market segment refers to Small Group, Small Group Sole Proprietors and Small Group Healthy NY Business.

3) Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, and Consumer Health Plans. Indicate appropriate designation for policy form, etc.

4) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with DFS.
5) Paid claims in Columns 14.6, 15.6 and 16.6 are all claims paid during experience period regardless of incurred dates.
6) Note that many cells include a drop down list. Use the drop down list for entries.
7) If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
8) This exhibit must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form												Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identification	3. Effective date of rate change (mm/dd/yy)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change		14.1 Beginning Date of the experience period (mm/dd/y)	14.2 Ending Date of the experience period (mm/dd/yy)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	14.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	14.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) ($)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
IHBC-C1009	In-Network Product	Encompass Essential Plus, Easy Access	POS SM	01/01/15	SG-All Others	Non-HMO based POS	Yes	Closed	183	1,213	XX	01/01/13	12/31/13	35,782	$14,005,002.59	$14,733,750.48	$11,635,101.11	$12,139,756.00	$0.00	$0.00	$1,952,905.25	XX
IHBC-POSC-001	Encompass Plus D	Encompass Plus D	POS SM	01/01/15	SG-All Others	Non-HMO based POS	Yes	Closed	359	2,504	XX	01/01/13	12/31/13	60,466	$24,912,048.30	$26,106,761.69	$25,945,188.28	$26,048,073.61	$0.00	$0.00	$3,473,897.80	XX
IHBC-C-601	FlexFit Select 43	FlexFit Select	POS SM	01/01/15	SG-All Others	Non-HMO based POS	Yes	Closed	0	0	XX	01/01/13	12/31/13	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
IHBC-C1005	FlexFit Select 43	FlexFit Select	POS SM	01/01/15	SG-All Others	Non-HMO based POS	Yes	Closed	643	5,642	XX	01/01/13	12/31/13	149,323	$60,491,458.93	$63,492,204.05	$54,311,538.79	$54,532,444.53	$0.00	$0.00	$8,435,321.89	XX
500103-43	Passport Plan Select	Passport Plan Select	POS SM	01/01/15	SG-All Others	PPO	Yes	Closed	145	1,057	XX	01/01/13	12/31/13	24,648	$8,928,891.76	$9,336,368.80	$7,298,695.63	$8,348,300.38	$0.00	$0.00	$1,170,769.27	XX
			POS SM						1,330	10,416	XX			270,219	$108,337,401.58	$113,669,085.01	$99,190,523.82	$101,068,574.52	$0.00	$0.00	$15,032,894.22	XX
IHBC-HSAQE-C-001	1Series HSA Qual	iDirect 1Series	HDHP SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	409	4,517	XX	01/01/13	12/31/13	105,997	$30,116,259.75	$32,060,544.40	$24,004,712.56	$24,118,729.89	$0.00	$0.00	$4,936,497.17	XX
IHBC-HSAQP-C-001	2Series HSA Qual	iDirect 2Series	HDHP SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	13	232	XX	01/01/13	12/31/13	5,586	$1,503,595.85	$1,584,235.77	$972,828.03	$977,055.96	$0.00	$0.00	$246,461.44	XX
IHBC-HSAQ-C-003	3Series HSA Qual	iDirect 3Series	HDHP SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	88	1,009	XX	01/01/13	12/31/13	21,346	$5,464,349.02	$5,824,251.55	$5,415,978.86	$5,438,630.99	$0.00	$0.00	$895,687.04	XX
IHBC-HSAQ-C-004	4Series HSA Qual	iDirect 4Series	HDHP SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	25	95	XX	01/01/13	12/31/13	1,474	$418,428.88	$444,866.61	$328,058.84	$329,711.70	$0.00	$0.00	$68,586.64	XX
IHBC-C1001	5Series HSA Qual	iDirect 5Series	HDHP SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	12	105	XX	01/01/13	12/31/13	1,965	$524,789.38	$550,700.72	$437,684.98	$439,183.27	$0.00	$0.00	$86,020.69	XX
IHBC-HRAE-C-001B	1Series B-Style non-HSA Qual	iDirect 1Series	HDHP SM	01/01/15	SG-All Others	Non-HSA Qualified HDHP	Yes	Closed	162	1,708	XX	01/01/13	12/31/13	33,916	$9,681,908.33	$10,303,895.43	$9,796,147.38	$9,858,623.47	$0.00	$0.00	$1,587,006.93	XX
IHBC-HRAE-C-001C	1Series C-Style non-HSA Qual	iDirect 1Series	HDHP SM	01/01/15	SG-All Others	Non-HSA Qualified HDHP	Yes	Closed	238	4,015	XX	01/01/13	12/31/13	82,306	$23,422,042.91	$25,075,277.84	$18,922,145.71	$19,005,506.62	$0.00	$0.00	$3,839,216.74	XX
IHBC-HRAP-C-001	2Series non-HSA Qual	iDirect 2Series	HDHP SM	01/01/15	SG-All Others	Non-HSA Qualified HDHP	Yes	Closed	26	341	XX	01/01/13	12/31/13	4,444	$1,260,857.01	$1,334,978.90	$1,079,184.69	$1,084,117.94	$0.00	$0.00	$206,672.98	XX
IHBC-C1008	Evolve	Evolve	HDHP SM	01/01/15	SG-All Others	HDHP	Yes	Closed	191	1,268	XX	01/01/13	12/31/13	13,632	$3,833,449.29	$4,023,309.63	$2,952,152.47	$2,968,078.32	$0.00	$0.00	$628,358.63	XX
IHBC-C1021	Empower HDHP	Empower HDHP	HDHP SM	01/01/15	SG-All Others	HDHP	Yes	Closed	7	19	XX	01/01/13	12/31/13	1,153	$326,005.21	$347,193.24	$178,985.72	$179,381.85	$0.00	$0.00	$53,437.04	XX
IHBC-C1022	Primary Connection	Primary Connection	HDHP SM	01/01/15	SG-All Others	HDHP	Yes	Closed	15	77	XX	07/01/13	12/31/13	273	$80,530.34	$81,931.86	$50,765.85	$51,488.22	$0.00	$0.00	$13,200.11	XX
IHBC-C1023	Choice Plus	Choice Plus	HDHP SM	01/01/15	SG-All Others	HDHP	Yes	Closed	8	52	XX	07/01/13	12/31/13	196	$54,777.43	$55,806.81	$7,506.62	$7,531.32	$0.00	$0.00	$8,978.83	XX
			HDHP SM						1,194	13,438	XX			272,288	$76,686,993.40	$81,686,992.75	$64,146,151.71	$64,458,039.54	$0.00	$0.00	$12,570,124.22	XX
IHBC-C1019	Passport Plan Select Out of Area	Passport Plan Select Out of Area	PPO OOA SM	01/01/15	SG-All Others	PPO	Yes	Closed	2	8	XX	01/01/13	12/31/13	152	$100,286.45	$105,602.45	$135,163.31	$135,470.65	$0.00	$0.00	$13,149.70	XX
			PPO OOA SM						2	8	XX			152	$100,286.45	$105,602.45	$135,163.31	$135,470.65	$0.00	$0.00	$13,149.70	XX
IHBC-C1014	iDirect 1Series B Style HSA Qual Out of Area	iDirect 1Series Out of Area	HDHP OOA SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	0	0	XX	01/01/13	12/31/13	16	$9,450.45	$10,134.87	$3,374.49	$3,379.01	$0.00	$0.00	$1,549.07	XX
IHBC-C1015	iDirect 1Series C Style HSA Qual Out of Area	iDirect 1Series Out of Area	HDHP OOA SM	01/01/15	SG-All Others	HSA Qualified HDHP	Yes	Closed	2	3	XX	01/01/13	12/31/13	272	$141,240.55	$149,401.11	$31,133.40	$31,287.99	$0.00	$0.00	$23,151.40	XX
			HDHP OOA SM						2	3	XX			288	$150,691.00	$159,535.99	$34,507.89	$34,667.00	$0.00	$0.00	$24,700.47	XX

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

	First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)											Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
	15.1 Beginning date of the experience period (mm/dd/yy)	15.2 Ending Date of the experience period (mm/dd/yy)	15.3 Member months for experience period	15.4 Earned premiums for experience period ($)	15.5 Standardized earned premiums for experience period ($)	15.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	15.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	15.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) ($)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)		16.1 Beginning date of the experience period (mm/dd/yy)	16.2 Ending Date of the experience period (mm/dd/yy)	16.3 Member months for experience period	16.4 Earned premiums for experience period ($)	16.5 Standardized earned premiums for experience period ($)	16.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	16.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	16.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) ($)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
XX	01/01/12	12/31/12	43,476	$15,985,704.11	$17,825,162.08	$14,133,931.61	$14,133,931.61	$0.00	$171,078.13	$2,088,571.48	XX	01/01/11	12/31/11	52,749	$18,473,841.41	$22,651,908.25	$15,484,025.85	$15,484,025.85	$0.00	$111,925.38	$2,474,239.12	XX
XX	01/01/12	12/31/12	64,781	$25,025,151.01	$27,804,059.99	$25,384,424.66	$25,384,424.66	$0.00	$346,480.74	$3,301,348.17	XX	01/01/11	12/31/11	67,448	$24,897,306.50	$30,344,456.63	$25,004,647.55	$25,004,647.55	$0.00	$227,059.92	$3,339,820.34	XX
XX	01/01/12	12/31/12	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX	01/01/11	12/31/11	66,569	$22,422,993.55	$28,313,149.38	$19,986,083.09	$19,986,083.09	$0.00	$147,844.88	$3,007,906.49	XX
XX	01/01/12	12/31/12	158,278	$59,888,107.97	$66,607,565.74	$51,268,173.75	$51,268,173.75	$0.00	$587,426.56	$7,900,511.61	XX	01/01/11	12/31/11	119,482	$41,365,121.46	$49,182,134.90	$37,080,682.11	$37,080,682.11	$0.00	$274,300.33	$5,548,876.29	XX
XX	01/01/12	12/31/12	26,598	$8,444,023.18	$9,391,564.90	$7,230,116.14	$7,230,116.14	$0.00	$123,891.79	$1,034,558.73	XX	01/01/11	12/31/11	31,292	$10,318,812.72	$12,151,233.85	$9,199,360.09	$9,199,360.09	$0.00	$94,784.50	$1,444,244.44	XX
XX			293,133	$109,342,986.27	$121,628,352.71	$98,016,646.16	$98,016,646.16	$0.00	$1,228,877.22	$14,324,989.99	XX			337,540	$117,478,075.64	$142,642,883.00	$106,754,798.68	$106,754,798.68	$0.00	$855,915.01	$15,815,086.68	XX
XX	01/01/12	12/31/12	113,474	$29,849,965.72	$34,675,176.13	$23,968,408.40	$23,968,408.40	$0.00	$310,134.84	$3,917,823.91	XX	01/01/11	12/31/11	107,433	$24,659,724.50	$31,866,876.55	$21,495,205.18	$21,495,205.18	$0.00	$212,804.58	$3,549,372.29	XX
XX	01/01/12	12/31/12	5,170	$1,266,335.20	$1,458,595.18	$785,039.99	$785,039.99	$0.00	$10,157.88	$166,207.17	XX	01/01/11	12/31/11	4,685	$984,965.60	$1,250,314.38	$571,783.03	$571,783.03	$0.00	$5,660.71	$141,770.02	XX
XX	01/01/12	12/31/12	22,263	$5,260,716.66	$6,197,651.29	$5,416,466.37	$5,416,466.37	$0.00	$70,085.38	$690,471.87	XX	01/01/11	12/31/11	19,904	$4,052,581.40	$5,322,620.90	$3,865,571.33	$3,865,571.33	$0.00	$38,269.52	$583,304.17	XX
XX	01/01/12	12/31/12	1,042	$281,164.87	$307,642.37	$158,607.10	$158,607.10	$0.00	$2,052.27	$36,903.04	XX	01/01/11	12/31/11	1,425	$325,642.85	$403,978.39	$686,786.73	$686,786.73	$0.00	$6,799.25	$46,871.07	XX
XX	01/01/12	12/31/12	1,939	$492,693.52	$553,042.21	$434,540.24	$434,540.24	$0.00	$5,622.65	$64,666.29	XX	01/01/11	12/31/11	538	$115,908.25	$136,801.52	$190,246.28	$190,246.28	$0.00	$1,883.46	$16,683.14	XX
XX	01/01/12	12/31/12	27,040	$7,289,342.78	$8,367,743.04	$6,252,860.00	$6,252,860.00	$0.00	$80,907.74	$956,730.12	XX	01/01/11	12/31/11	22,448	$5,543,191.26	$6,832,283.51	$5,537,408.58	$5,537,408.58	$0.00	$54,820.87	$797,853.58	XX
XX	01/01/12	12/31/12	65,713	$17,996,618.99	$20,575,981.48	$14,874,078.16	$14,874,078.16	$0.00	$192,460.42	$2,362,065.83	XX	01/01/11	12/31/11	42,489	$10,472,107.71	$12,905,354.71	$9,637,831.64	$9,637,831.64	$0.00	$95,415.45	$1,507,292.14	XX
XX	01/01/12	12/31/12	2,841	$751,170.93	$854,325.80	$575,282.29	$575,282.29	$0.00	$7,443.76	$98,591.59	XX	01/01/11	12/31/11	939	$219,042.85	$261,370.26	$98,498.99	$98,498.99	$0.00	$975.15	$31,527.71	XX
XX	01/01/12	12/31/12	2,492	$654,811.65	$722,908.42	$461,261.34	$461,261.34	$0.00	$700.02	$85,944.38	XX	07/01/11	12/31/11	6	$1,665.50	$1,785.30	$255.90	$255.90	$0.00	$0.00	$239.72	XX
XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX			241,974	$63,842,820.33	$73,713,065.93	$52,926,543.90	$52,926,543.90	$0.00	$679,564.95	$8,379,404.20	XX			199,867	$46,374,829.92	$58,981,385.52	$42,083,587.65	$42,083,587.65	$0.00	$416,628.99	$6,674,913.84	XX
XX	04/01/12	12/31/12	16	$6,654.73	$6,808.57	$553.65	$553.65	$0.00	$9.49	$815.34	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX			16	$6,654.73	$6,808.57	$553.65	$553.65	$0.00	$9.49	$815.34	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX	04/01/12	12/31/12	9	$6,610.51	$7,402.61	$581.46	$581.46	$0.00	$7.52	$867.63	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX	04/01/12	12/31/12	3	$1,693.62	$1,779.99	$63.10	$63.10	$0.00	$0.82	$222.29	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX
XX			12	$8,304.13	$9,182.60	$644.56	$644.56	$0.00	$8.34	$1,089.92	XX			0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	XX

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

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segment : Individual Off Exchange

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

Line #	General																													
1	Product*	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
2	Product ID*	18029NY118	18029NY118	18029NY118	18029NY118	18029NY118	18029NY118	18029NY118	18029NY118	18029NY118	18029NY118	18029NY122	18029NY122	18029NY122	18029NY122	18029NY122	18029NY122	18029NY122	18029NY122	18029NY122	18029NY122	18029NY126	18029NY126	18029NY126	18029NY126	18029NY126	18029NY126	18029NY126	18029NY126
3	Metal Level (or catastrophic)*	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	88.3%	88.3%	88.3%	88.3%	88.3%	88.3%	88.2%	88.2%	88.2%	88.2%	79.6%	79.6%	79.6%	79.6%	79.6%	79.6%	78.8%	78.8%	78.8%	78.5%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	68.7%	68.7%
5	AV Pricing Value (total, risk pool experience based)*	94.5%	94.5%	94.5%	94.5%	94.5%	94.5%	90.5%	90.5%	89.4%	89.4%	86.9%	86.9%	86.9%	86.9%	86.9%	86.9%	83.3%	83.3%	81.7%	81.7%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	75.1%	75.1%
6	Plan Type*	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	Standard Platinum	Standard Platinum	Standard Platinum	Standard Platinum (Child Only)	Standard Platinum	Standard Platinum (Child Only)	FlexFit Platinum	FlexFit Platinum	Choice Plus Platinum	Choice Plus Platinum	Standard Gold	Standard Gold	Standard Gold	Standard Gold	Standard Gold (L/H/D Only)	Standard Gold (L/H/D Only)	iDirect Gold	iDirect Gold	Choice Plus Gold	Choice Plus Gold	Standard Silver	Standard Silver	Standard Silver	Standard Silver	Standard Silver (L/H/D Only)	Standard Silver (L/H/D Only)	iDirect Silver	iDirect Silver
8	HIOS Plan ID*	18029NY1180001	18029NY1180002	18029NY1180008	18029NY1180009	18029NY1180010	18029NY1180012	18029NY1180021	18029NY1180022	18029NY1180077	18029NY1180078	18029NY1220001	18029NY1220002	18029NY1220005	18029NY1220006	18029NY1220007	18029NY1220009	18029NY1220021	18029NY1220022	18029NY1220025	18029NY1220026	18029NY1260001	18029NY1260002	18029NY1260005	18029NY1260006	18029NY1260007	18029NY1260009	18029NY1260037	18029NY1260038
9	Exchange Plan?*	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate	
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	$140,827,910
10B	Member-Months for Latest Experience Period	527,624
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	266.91
11	Average Pricing Actuarial Value reflected in experience period	0.785
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**340.01**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																													
13	Impact of adjusting experience period data to EHB benefit level	1.010																												
14	Market wide adjustment for changes in provider network **	1.000																												
15	Market wide adjustment for fee schedule changes **	1.000																												
16	Market wide adjustment for utilization management changes **	1.000																												
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000																												
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ****	1.000																												
19	**Post ACA Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.543**																												
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000																												
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery)	0.925																												
22	Federal transitional reinsurance program recovery (less than 1.00 to reflect a recovery)	0.953																												
23	Impact of adjustment due to experience period claim data not being sufficiently credible	1.000																												
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.145																												
25	OON Adjustment	0.991																												
26	Other 2 (specify)	1.000																												
27	Other 3 (specify)	1.000																												
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments																													
29	Pricing actuarial value (without induced demand factor) #	0.948	0.948	0.948	0.948	0.948	0.948	0.911	0.911	0.901	0.901	0.877	0.877	0.877	0.877	0.877	0.877	0.843	0.843	0.829	0.829	0.799	0.799	0.799	0.799	0.799	0.799	0.765	0.765
30	Pricing actuarial value (only the induced demand factor) #	1.075	1.075	1.075	1.075	1.075	1.075	1.075	1.075	1.075	1.075	1.010	1.010	1.010	1.010	1.010	1.010	1.010	1.010	1.010	1.010	0.963	0.963	0.963	0.963	0.963	0.963	0.963	0.963
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.945	0.945	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.945	0.945	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.974	0.974	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.974	0.974	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.985	0.985	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.010	1.000	1.000	1.010	1.000	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.000	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.000	1.000	1.010
36	Administrative costs (excluding Exchange user fees and profits)	1.183	1.183	1.183	1.183	1.183	1.183	1.183	1.183	1.184	1.184	1.184	1.184	1.184	1.184	1.184	1.184	1.185	1.185	1.186	1.186	1.186	1.186	1.186	1.186	1.186	1.186	1.186	1.186
37	Profit/Contribution to surplus margins	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.005	1.005	1.006	1.006	1.006	1.006	1.006	1.006	1.007	1.007
40	Reinsurance	0.979	0.979	0.979	0.979	0.979	0.979	0.980	0.980	0.979	0.979	0.979	0.979	0.979	0.979	0.979	0.979	0.979	0.979	0.977	0.977	0.977	0.977	0.977	0.977	0.977	0.977	0.975	0.975
41	Reg 146	0.953	0.953	0.953	0.953	0.953	0.953	0.951	0.951	0.945	0.945	0.946	0.946	0.946	0.946	0.946	0.946	0.944	0.944	0.937	0.937	0.938	0.938	0.938	0.938	0.938	0.938	0.935	0.935
42	CSR	1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.024	1.024	1.024	1.024	1.024	1.024	1.024	1.024	1.025	1.025	1.028	1.028	1.027	1.027	1.027	1.027	1.027	1.027	1.028	1.028
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.147**	**1.158**	**1.147**	**1.147**	**1.158**	**1.147**	**1.101**	**1.112**	**0.979**	**0.988**	**0.994**	**1.003**	**0.994**	**1.003**	**0.994**	**0.994**	**0.954**	**0.964**	**0.941**	**0.949**	**0.859**	**0.867**	**0.859**	**0.867**	**0.859**	**0.867**	**0.829**	**0.828**

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

\## Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**608.11**	**613.97**	**608.11**	**608.11**	**613.97**	**608.11**	**593.85**	**589.43**	**519.00**	**524.00**	**526.95**	**532.02**	**526.95**	**532.02**	**526.95**	**526.95**	**506.07**	**510.95**	**445.77**	**459.06**	**455.33**	**459.71**	**455.33**	**459.71**	**455.33**	**455.33**	**434.70**	**438.85**

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

Company Name: Independent Health Benefits Co
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segment : Individual Off Exchange

Line #	General																	
1	Product*	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
2	Product ID*	18029NY135	18029NY135	18029NY126	18029NY126	18029NY131	18029NY131	18029NY131	18029NY131	18029NY131	18029NY131	18029NY136	18029NY136	18029NY131	18029NY131	18029NY131	18029NY131	18029NY129
3	Metal Level (or catastrophic)*	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
4	AV Metal Value (HHS Calculator)*	68.7%	68.7%	68.3%	68.3%	62.5%	62.5%	62.5%	62.5%	62.5%	62.5%	59.4%	59.4%	60.0%	60.0%	61.7%	61.7%	61.7%
5	AV Pricing Value (total, risk pool experience based)*	76.6%	76.6%	73.8%	73.8%	69.6%	69.6%	69.6%	69.6%	69.6%	69.6%	67.8%	67.8%	65.2%	65.2%	66.41%	66.41%	57.68%
6	Plan Type*	EPO	EPO	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
7	Plan Name*	New Independent Health Product Silver	New Independent Health Product Silver	Choice Plus Silver	Choice Plus Silver	Standard Bronze	Standard Bronze	Standard Bronze Only)	Standard Bronze	Standard Bronze	Standard Bronze (L/H8 Only)	New Independent Health Product Bronze	New Independent Health Product Bronze	iDirect Bronze	iDirect Bronze	Choice Plus Bronze	Choice Plus Bronze	Catastrophic
8	HIOS Plan ID*	18029NY1350067	18029NY1350068	18029NY1260127	18029NY1260128	18029NY1310001	18029NY1310002	18029NY1310003	18029NY1310009	18029NY1310010	18029NY1310013	18029NY1360069	18029NY1360070	18029NY1310023	18029NY1310034	18029NY1310025	18029NY1310026	18029NY1290001
9	Exchange Plan?*	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate																	
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period																	
10B	Member-Months for Latest Experience Period																	
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)																	
11	Average Pricing Actuarial Value reflected in experience period																	
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**	**340.01**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																	
13	Impact of adjusting experience period data to EHB benefit level																	
14	Market wide adjustment for changes in provider network **																	
15	Market wide adjustment for fee schedule changes **																	
16	Market wide adjustment for utilization management changes **																	
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives **																	
18	**Post/Pre ACA Impact on risk pool of changes in expected covered membership risk characteristics **																	
19	**Post ACA Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**																	
20	Adjustment for changes in distribution of risk pool membership by rating regions **																	
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery)																	
22	Federal Transitional Reinsurance Program recovery (less than 1.00 to reflect a recovery)																	
23	Impact of adjustment due to experience period claim data not being sufficiently credible																	
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)																	
25	ACN Adjustment																	
26	Other 2 (specify)																	
27	Other 3 (specify)																	
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**	**1.560**

** Not included in Claim Trend Adjustment

	Plan Level Adjustments																	
29	Pricing actuarial value (without induced demand factor) #	0.787	0.787	0.754	0.754	0.714	0.714	0.714	0.714	0.714	0.714	0.704	0.704	0.673	0.673	0.685	0.685	0.615
30	Pricing actuarial value (only the induced demand factor) #	0.963	0.963	0.963	0.963	0.935	0.935	0.935	0.935	0.935	0.935	0.935	0.935	0.935	0.935	0.935	0.935	0.935
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.945	0.945	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.974	0.974	1.000
33	Impact of utilization management practices ##	0.986	0.986	0.941	0.941	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.986	0.987	0.987	0.968	0.968	0.987
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.006	1.015	1.000	1.010	1.000	1.010	1.000	1.000	1.010	1.000	1.007	1.016	1.000	1.010	1.000	1.010	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.186	1.186	1.187	1.187	1.187	1.187	1.187	1.187	1.187	1.187	1.188	1.188	1.188	1.188	1.189	1.189	1.198
37	Profit/Contribution to surplus margins	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007	1.007
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.626
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	0.951	0.951	1.006	1.006	1.006	1.006	1.006	1.006	1.000	1.000	1.006	1.006	1.005	1.005	1.000
40	Reinsurance	0.977	0.977	0.974	0.974	0.972	0.972	0.972	0.972	0.972	0.972	0.972	0.972	0.967	0.967	0.969	0.969	0.995
41	Reg 146	0.937	0.937	0.927	0.927	0.929	0.929	0.929	0.929	0.929	0.929	0.928	0.928	0.924	0.924	0.918	0.918	0.873
42	CSR	1.028	1.028	1.032	1.032	1.032	1.032	1.032	1.032	1.032	1.032	1.032	1.032	1.034	1.034	1.036	1.036	1.057
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**0.846**	**0.854**	**0.724**	**0.731**	**0.737**	**0.745**	**0.737**	**0.737**	**0.745**	**0.737**	**0.727**	**0.734**	**0.690**	**0.696**	**0.634**	**0.640**	**0.393**

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

\## Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**448.49**	**452.81**	**384.16**	**387.86**	**391.09**	**394.86**	**391.09**	**391.09**	**394.86**	**391.09**	**385.54**	**389.26**	**365.78**	**369.27**	**335.99**	**339.22**	**208.66**

EXHIBIT 20: HIOS ID MAPPING TO PRODUCT NAMES

Company Name: Independent Health Benefits Corporat
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segmen: Individual Off Exchang

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

1 HIOS ID	2 Rate Manual Plan Name	3 Metal Level	4 Exchange Plan? (on, off, both)	5 Standard Plan Design? (yes, no)	6 Limiting Child Age? (26 or 30)	7 Domestic Partne Coverage Included? (yes, no)	8 Family Planning Coverage? (included, excluded)	9 Pediatric Dental Coverage Included? (yes, no)	10. Out of Network Benefits? (yes, no)	11 Include Benefits in Addition to EHB? (yes, no)
18029NY118000	Standard Platinur	Platinum	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY118000	Standard Platinur	Platinum	OFF	YES	30	YES	INCLUDED	NO	YES	YES
18029NY118000	Standard Platinur	Platinum	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY118000	Standard Platinur	Platinum	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY118001	Standard Platinur	Platinum	OFF	YES	30	YES	INCLUDED	NO	YES	YES
18029NY118001	Standard Platinur	Platinum	OFF	YES	26	YES	INCLUDED	NO	YES	YES
18029NY118002	FlexFit Platinun	Platinum	BOTH	NO	26	YES	INCLUDED	NO	NO	YES
18029NY118002	FlexFit Platinun	Platinum	BOTH	NO	30	YES	INCLUDED	NO	YES	YES
18029NY118007	Choice Plus Platinum	Platinum	BOTH	NO	26	YES	INCLUDED	NO	YES	YES
18029NY118007	Choice Plus Platinum	Platinum	OFF	NO	30	YES	INCLUDED	NO	YES	YES
18029NY122000	Standard Gol	Gold	OFF	YES	26	YES	INCLUDED	NO	YES	YES
18029NY122000	Standard Gol	Gold	BOTH	YES	30	YES	INCLUDED	NO	YES	YES
18029NY122000	Standard Gol	Gold	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY122000	Standard Gol	Gold	BOTH	YES	30	YES	INCLUDED	NO	YES	YES
18029NY122000	Standard Gol	Gold	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY122000	Standard Gol	Gold	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY122002	iDirect Gol	Gold	BOTH	NO	26	YES	INCLUDED	NO	YES	YES
18029NY122002	iDirect Gol	Gold	BOTH	NO	30	YES	INCLUDED	NO	YES	YES
18029NY122002	Choice Plus Gold	Gold	BOTH	NO	26	YES	INCLUDED	NO	YES	YES
18029NY122002	Choice Plus Gold	Gold	BOTH	NO	30	YES	INCLUDED	NO	YES	YES
18029NY126000	Standard Silve	Silver	OFF	YES	26	YES	INCLUDED	NO	YES	YES
18029NY126000	Standard Silve	Silver	OFF	YES	30	YES	INCLUDED	NO	YES	YES
18029NY126000	Standard Silve	Silver	OFF	YES	26	YES	INCLUDED	NO	YES	YES
18029NY126000	Standard Silve	Silver	BOTH	YES	30	YES	INCLUDED	NO	NO	YES
18029NY126000	Standard Silve	Silver	BOTH	YES	26	YES	INCLUDED	NO	NO	YES
18029NY126000	Standard Silve	Silver	OFF	YES	26	YES	INCLUDED	NO	NO	YES
18029NY126003	iDirect Silver	Silver	BOTH	NO	26	YES	INCLUDED	NO	NO	YES
18029NY126003	iDirect Silver	Silver	OFF	NO	30	YES	INCLUDED	NO	YES	YES
18029NY126012	Choice Plus Silver	Silver	OFF	NO	26	YES	INCLUDED	NO	YES	YES
18029NY126012	Choice Plus Silver	Silver	OFF	NO	30	YES	INCLUDED	NO	YES	YES
18029NY129000	Catastrophic	Catastrophic	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY131000	Standard Bronz	Bronze	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY131000	Standard Bronz	Bronze	OFF	YES	30	YES	INCLUDED	NO	YES	YES
18029NY131000	Standard Bronz	Bronze	OFF	YES	26	YES	INCLUDED	NO	YES	YES
18029NY131000	Standard Bronz	Bronze	BOTH	YES	26	YES	INCLUDED	NO	YES	YES
18029NY131001	Standard Bronz	Bronze	OFF	YES	30	YES	INCLUDED	NO	YES	YES
18029NY131001	Standard Bronz	Bronze	OFF	YES	26	YES	INCLUDED	NO	YES	YES
18029NY131002	Choice Plus Bronze	Bronze	BOTH	NO	26	YES	INCLUDED	NO	YES	YES
18029NY131002	Choice Plus Bronze	Bronze	BOTH	NO	30	YES	INCLUDED	NO	YES	YES
18029NY131003	iDirect Bronze	Bronze	BOTH	NO	26	YES	INCLUDED	NO	YES	YES
18029NY131003	iDirect Bronze	Bronze	BOTH	NO	30	YES	INCLUDED	NO	YES	YES
18029NY135006	U40 Silver	Silver	BOTH	NO	26	YES	INCLUDED	NO	YES	YES
18029NY135006	U40 Silver	Silver	BOTH	NO	30	YES	INCLUDED	NO	YES	YES
18029NY136006	U40 Bronze	Bronze	OFF	NO	26	YES	INCLUDED	NO	YES	YES
18029NY136007	U40 Bronze	Bronze	OFF	NO	30	YES	INCLUDED	NO	YES	YES

EXHIBIT 21A: HOSPITAL UNIT COST DEVELOPMENT - INPATIENT SERVICES

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segment: Individuals Off Exchange

1) This exhibit shows a history of fee schedule increases by hospital for **INPATIENT services**.
2) Enter in column 1 the provider number for the hospital, in column 2 the provider tax ID, and in column 3 the provider name.
3) Enter in column 4 the allowed charges by hospital over a recent 12 month period which will be used as the hospital weights.
4) Enter the Small Group Market allowed charges for calendar year 2013; Charges should be only be for hospital inpatient services.
5) Enter in column 5 the actual or estimated percentage fee increase for that hospital over the proposed rate period (2015 over 2014).
6) Enter in column 6 the actual or estimated percentage fee increase for that hospital for the year immediately preceding the rate period (2014 over 2013).
7) Enter in column 7 the actual or estimated percentage fee increase for that hospital for the second year immediately preceding the rate period (2013 over 2012).
8) At the end, add a total row and show the sum of the weights and the weighted average of columns 5, 6, and 7.
9) The provider list need not include all hospitals but must include data for the hospitals comprising 90% of the New York State total allowed charges for the Small Group Market in calendar year 2013 used to develop the weights.
10) A redacted version of this exhibit can be created for posting on the DFS website as part of posting the rate adjustment submission.
11) This exhibit must be submitted as an Excel and as a PDF file.

1. Provider Number	2. Provider Tax ID	3. Provider Name	4. 2013 Small Groups Allowed Charges	5. % Change for Rate Year	6. % Change for Prior Year	7. % Change for Second Prior Year
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

EXHIBIT 21B: HOSPITAL UNIT COST DEVELOPMENT - OUTPATIENT SERVICES

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segment: Individuals Off Exchange

1) This exhibit shows a history of fee schedule increases by hospital for **OUTPATIENT services.**
2) Enter in column 1 the provider number for the hospital, in column 2 the provider tax ID, and in column 3 the provider name.
3) Enter in column 4 the allowed charges by hospital over a recent 12 month period which will be used as the hospital weights.
4) Enter in Small Group Market allowed charges for calendar year 2013; Charges should be only be for hospital outpatient services.
5) Enter in column 5 the actual or estimated percentage fee increase for that hospital over the proposed rate period (2015 over 2014).
6) Enter in column 6 the actual or estimated percentage fee increase for that hospital for the year immediately preceding the rate period (2014 over 2013).
7) Enter in column 7 the actual or estimated percentage fee increase for that hospital for the second year immediately preceding the rate period (2013 over 2012).
8) At the end, add a total row and show the sum of the weights and the weighted average of columns 5, 6, and 7.
9) The provider list need not include all hospitals but must include data for the hospitals comprising 90% of the New York State total allowed charges for the Small Group Market in calendar year 2013 used to develop the weights.
10) A redacted version of this exhibit can be created for posting on the DFS website as part of posting the rate adjustment submission.
11) This exhibit must be submitted as an Excel and as a PDF file.

1. Provider Number	2. Provider Tax ID	3. Provider Name	2013 Small Groups Allowed Charges	% Change for Rate Year	% Change for Prior Year	% Change for Second Prior Year
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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EXHIBIT 23: SUMMARY OF REQUESTED 2015 PREMIUM RATES

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Number: NDPD-129588074
Market Segment: Individuals Off Exchange

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

SUMMARY OF REQUESTED 2015 PREMIUM RATES													
						Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
1. HIOS ID PLAN (14 Digits)	2. Metal Level or Catastrophic	3. Exchange [Ind/Sml Grp]	4. On/Off Exchange	5. Plan Type [Std or Non Std]	6. Pediatric Dental [Yes/No]	Albany	Buffalo	Mid-Hudson	New York	Rochester	Syracuse	Utica	Long Island
18029NY1180002-00	Platinum	IND Off		Standard	No		$650.12						
18029NY1180010-00	Platinum	IND Off		Standard	No		$650.12						
18029NY1310026-00	Bronze	IND Off		Non-Standard	No		$359.17						
18029NY1220026-00	Gold	IND Off		Non-Standard	No		$476.54						
18029NY1180078-00	Platinum	IND Off		Non-Standard	No		$554.84						
18029NY1260128-00	Silver	IND Off		Non-Standard	No		$410.66						
18029NY1180022-00	Platinum	IND Off		Non-Standard	No		$624.17						
18029NY1310034-00	Bronze	IND Off		Non-Standard	No		$391.03						
18029NY1220022-00	Gold	IND Off		Non-Standard	No		$541.02						
18029NY1260038-00	Silver	IND Off		Non-Standard	No		$464.71						
18029NY1360070-00	Bronze	IND Off		Non-Standard	No		$412.16						
18029NY1350068-00	Silver	IND Off		Non-Standard	No		$479.45						
18029NY1310010-00	Bronze	IND Off		Standard	No		$418.09						
18029NY1310002-00	Bronze	IND Off		Standard	No		$418.09						
18029NY1220002-00	Gold	IND Off		Standard	No		$563.35						
18029NY1220006-00	Gold	IND Off		Standard	No		$563.35						
18029NY1260002-00	Silver	IND Off		Standard	No		$486.76						
18029NY1260006-00	Silver	IND Off		Standard	No		$486.76						

Individual Plan Subscriber Letter
[Date] Subscriber Number:

[Subscriber Name]
[Address 1]
[Address 2]
[City State Zip]

Re: Notice of 2015 Proposed Premium Rate Change
[Product Name]
[Health Insurance Oversight System (HIOS) identification number]

Dear [Subscriber Name]:

Independent Health Benefits Corporation is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

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

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features you select on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change
It is necessary for Independent Health to adjust rates for a number of reasons, such as aging population of the region, which contributes to the increase in the use and amount of medical services needed, projected increases in hospital, physician and pharmacy utilization, based on past years' trends, and increases in reimbursement fees to providers, including hospitals and physicians.

In addition, your plan's 2015 proposed rate includes most of the applicable taxes and fees associated with the Affordable Care Act (i.e., the Health Insurance Tax, the Patient-Centered Outcomes Research Institute fee, user fees for operation of the federal risk adjustment program and fees to fund the federal reinsurance pool).

30-Day Comment Period
You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Independent Health for additional information at:

Independent Health Servicing Department
Attn: Proposed Rates
Independent Health
511 Farber Lakes Drive
Buffalo, NY 14221
(716) 631-8072 or 1-800-755-5802
premiumrates@independenthealth.com

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: PremiumRateIncreases@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

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

1. The name of your insurer, which is Independent Health Benefits Corporation
2. The name of your plan, which is [Product Name]
3. Indicate you have individual coverage
4. Your HIOS identification number, which is [Insert the HIOS ID #]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change
We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

Independent Health website: www.independenthealth.com (click on the "2015 Proposed Rates" link in the "Help Center" section).

DFS website: www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate
After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Verbal translation, alternate formats of written materials, and/or assistance for those with special needs, may be available upon request. (Traducción verbal, formatos alternativos de materiales escritos y/o asistencia para quienes tienen necesidades especiales, disponibles a solicitud.)

Premium Rate Comparison

This chart compares your current plan's 2014 monthly premium rate and the proposed 2015 monthly premium rate.

[PLAN NAME]

	2014 Monthly Premium	Proposed Monthly Premium on your 2015 Effective Date (pending DFS approval)	% of Change
Premium Rate			

2015 Approved Premium Rates Notice – Individual Plan Subscriber
DATE Subscriber Number:

SUBSCRIBER NAME
ADDRESS 1
ADDRESS 2
CITY, ST ZIP

Re: Notice of 2015 Approved Premium Rates

Dear Subscriber:

Independent Health is writing to let you know that the New York State Department of Financial Services has reviewed our proposed 2015 monthly premium rates. The final approved premium amounts for the Independent Health plan you are currently enrolled in are listed in the chart on the back of this letter.

Please note: The 2015 approved rates will go into effect for this plan on your renewal date of [MONTH] 1, 2015.

If you have any questions, please contact our Member Services Department at (716) 631-8701 or 1-800-501-3439, Monday through Friday from 8 a.m. to 8 p.m. You may also call our Telecommunications Device for the Deaf at (716) 631-3108.

Thank you for choosing Independent Health.

Sincerely,

Verbal translation, alternate formats of written materials, and/or assistance for those with special needs, may be available upon request. (Traducción verbal, formatos alternativos de materiales escritos y/o asistencia para quienes tienen necesidades especiales, disponibles a solicitud.)

Premium Rate Comparison

This chart compares your current plan's 2014 monthly premium rate and approved 2015 monthly premium rate.

[PLAN NAME]

	2014 Monthly Premium	2015 Monthly Premium
Single		
Subscriber & Child		
Subscriber & Spouse		
Family		

EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE FILING

Company Name: Independent Health Benefits Corporation
NAIC Code: 47034
SERFF Tracking #: NDPD-129588074
Market Segment: Individuals Off Exchange

A. Insurer Information:

Independent Health Benefits Corporation	Not-For-Profit - 43	Not-for-Profit	47034
Company submitting the rate filing request	Company Type	Org. Type	Company NAIC Code

[redacted]
Company mailing address

B. Contact Person:

[redacted]	[redacted]	[redacted]
Rate filing contact person name, title	Contact phone number	Contact Email address

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information:

1/1/2015 - 12/31/2015	1/1/2015	NDPD-129588074
New rate applicability period	New rate effective date	SERFF Tracking Number

E. Market segment included in filing (e.g., Small Group (including Healthy NY Small Group), Individual - only one market segment per rate adjustment filing): Individual

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (1). If yes, provide a brief description of the contract language changes included in this filing.	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing? If yes, mention these filings on Exhibit 16.	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (2).	Yes, All required notices were mailed prior to this application's submission. Notices for Subscribers were mailed on 6/13/2014.
4. Have all the required exhibits been submitted with this rate filing? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary and numerical summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefiling.	Yes, NDPD-129574328

Notes:

(1) As mentioned in the checklist, this combined non-grandfathered product rate adjustment and form/rate filing can only include minor contract revisions, such as due to changes in the model language, changes to the catastrophic plan due to change in out of pocket maximum, changes to the standard plan designs. Substantial changes need to be submitted as a separate rate and form filing (e.g., a new plan design not replacing an existing plan design, contract language changes not just due to changes in the model language).

(2) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment filing is submitted to the Department of Financial Services.

Independent Health Benefits Corporation

Individual Off-Exchange Plans

2015

June 9, 2014

Development of Index Rate and Premium Rates: Overview

The purpose of this memorandum to present and provide support for key assumptions in the development of the proposed rates for Independent Health Benefits Corporation's (IHBC's) individual plans to be offered for sale off of the New York State Individual Health Insurance Exchange.

IHBC is the Article 43 licensee of Independent Health, and all of Independent Health's 2015 individual plans will be sold under this entity. All plans on and off the exchange are part of the same risk pool and were developed using Independent Health's current small-group book of business (adjusted for morbidity), following the methodology outlined below.

- ***Experience Period / Risk Pool Merging***
  2015 rate projections were developed based on small-group incurred claims from the 12-month experience period from January 1, 2013 through December 31, 2013, with completion factors based on claims runout through March 31, 2014. No Regulation 146 or Stop-Loss Reimbursement Pool monies were included in the experience data. A morbidity factor was applied later in the process to convert this data to expected individual experience.

  Because Independent Health's current small-group book of business is split between IHBC and its Article 44 licensee, Independent Health Association (IHA), the 2013 claims data was adjusted to include IHA experience, with adjustments for differences in provider reimbursement rates between IHA and IHBC. In doing so, any claim experience from Healthy New York Individual and Sole Proprietor business was specifically excluded, given that these segments have transitioned to the Individual Exchange market in 2014.

  Adjustments to the experience period were made for essential health benefits. These adjustments included inpatient and outpatient psychiatric and substance abuse, skilled nursing facility, and DME/PA.

- ***Trend***
  Utilization and unit cost trends were applied to project experience forward from the base period of calendar year 2013 to the rate period.

- ***Reinsurance***

  The projected 2015 claims experience was adjusted to reflect the anticipated impact of the Federal Transitional Reinsurance Program.

- ***Risk Adjustment***
  The projected 2015 claims experience was adjusted to reflect the anticipated impact of the Federal Risk Adjustment Transfer Formula, using results modeled from the Deloitte/Department of Financial Services (DFS) study carried out on New York plans' data earlier this year.

- ***Morbidity Adjustment***
  Because Independent Health's individual book of business in 2014 is new and immature, Independent Health applied a morbidity adjustment to its small-group experience in order to develop the individual rates. The morbidity factor was derived by comparing demographic and, where available, claim-based risk characteristics to assess the expected utilization of healthcare services in the individual market relative to small group. Examination of patterns in enrollment trends in Independent Health's 2014 individual products over the course of the annual open enrollment period was also considered.

- ***Benefit Adjustment***
  Product-specific pricing was carried out using the ratio of each product's Pricing Actuarial Value (AV) to the average Pricing AV inherent in the experience period data. The ratio includes the relative impact of induced demand.

- ***Regulation 146 / SMC Adjustment***
  Plan level adjustments were made to credit rates with refunds applicable to market stabilization and specified medical condition pools from the years 1999 – 2013.

- ***Administrative Expenses and Profit Margin***
  An 87% medical loss ratio (prior to additional taxes and fees) was used in the development of the premium rates. The additional taxes and fees related to the Affordable Care Act (ACA) that were built into the rates included the Health Insurance Tax (HIT), provision for contributions to the Federal Transitional Reinsurance Program, the Patient-Centered Outcomes Research Initiative fee (PCORI), and the Risk Adjustment User Fee. Even with the addition of the above-noted taxes and fees, all products are expected to be above the minimum 82% loss ratio in New York State.

- ***Conversion / Step-Up Factor***
  A conversion factor to step up the projected PMPM revenue requirement to the Single/Individual rate was developed based on observed contract distributions and sizes from Independent Health's individual block, recalculated to reflect the four-tier structure required in 2015. Census tier relativities as prescribed by DFS were also used in the development of this factor, as well as in setting the premium rates for each tier.

- ***Area Factors***
  All of Independent Health's products fall under the Buffalo rating region (Region 2).

Supporting Details for Key Assumptions

- **Claim Trend Rates**

  As described in more detail below, Independent Health utilizes a cost-model approach to premium rating, with claim costs mapped to over 60 types of medical benefit categories, primarily using Milliman's Health Cost Guidelines algorithm.

  For each of these categories, utilization trend assumptions were generally estimated using the least-squares-based techniques, using the prior three years' utilization experience for IHA and IHBC combined. Some manual overrides were employed where the least-squares-based results appeared to be unreasonable (for example, due to low credibility of the type of service category) or where additional relevant information about utilization patterns in a service category was known.

  Average charge trends were developed based on anticipated (or, where available, already contracted) provider fee increases.

  To estimate prescription drug trends, prescription drug data for IHA and IHBC small group combined from January 2010 through December 2013 were analyzed to determine recent prescription drug trends and to project future trends into 2015. Drugs were first re-mapped to reflect 2015 formulary changes; where applicable, drugs that are no longer on the formulary were allocated the to the most likely on-formulary substitute drug.

  The resulting average "first dollar" or "allowed" trend assumptions by type of service category are summarized below.

Independent Health Benefits Corporation
Annualized Allowed Claim Trends by Type of Service

Type of Service	Utilization	Unit Cost	PMPM
Inpatient Hospital	-0.5%	6.8%	6.6%
Outpatient Hospital	1.0%	4.8%	5.9%
Professional	1.4%	2.6%	4.1%
Other	2.2%	9.4%	11.8%
Pharmacy	3.1%	6.9%	10.2%
Total Trend			7.0%

- ***Administrative Expense / Contribution to Surplus***
  Consistent with recent filings, IHBC is using a 13% administrative expense load (before ACA taxes and fees), which includes a 0.7% component for risk margin / contribution to surplus. Allocations of administrative expense by component are detailed on Exhibit 19, and were done in a manner consistent with IHBC's most recent audited financial statements.

  Premium rates also reflect provisions for various ACA taxes and fees, as follows:
  - Health Insurer Tax: 2.90% (of premium)
  - Contribution to Federal Transitional Reinsurance Program: $3.67 PMPM
  - Patient-Centered Outcomes Research Initiative: $0.18 PMPM
  - Risk Adjustment User Fee: $0.08 PMPM

- ***Adjustments to Actuarial Values***
  AV Metal Values were determined by entering product benefit configurations into the AV Calculator developed by the Department of Health and Human Services (HHS).
  Because the HHS AV Calculator does not specifically address wellness benefits, which are included in each of Independent Health's non-standard product offerings, we adjusted the results from the calculator by adding the PMPM value of the benefit to both the numerator and denominator of the output from the calculator's continuance tables. The adjustment varied by plan, but on average increased the HHS AV in the range of 0.2 to 0.3%.

- ***Conversion Factors***
  IHBC's individual conversion factor is 1.0589. The following table outlines the derivation of this factor, based on individual enrollees in Q1 2014. The tier factors used in the calculation are the standardized values required by DFS. Small-group conversion factors have been relatively stable over time, and Independent Health does not anticipate any significant changes in 2015.

Independent Health Benefits Corporation
Development of 2015 Individual Conversion Factor

Census Tier	% of Total Contracts	Average Contract Size	Tier Ratio (per DFS)
Single	73.9%	1.00	1.000
Single + Spouse	18.1%	2.00	2.000
Single + Child(ren)	2.3%	2.67	1.700
Single + Spouse + Child(ren)	4.8%	3.85	2.850
Child Only	1.0%	1.00	0.412
	100.0%	1.35	1.28
Conversion Factor (Average Contract Size / Average Tier Ratio):			1.0589

- ***Standardized Rating Regions***
  IHBC is filing these rates solely for the Buffalo rating region (Region 2).

- ***Determination of AV Pricing Values***
  Independent Health utilizes a cost-model approach in developing its premium rating. The basis for the cost models is Milliman's Health Cost Guidelines algorithm, which uses claims data to report utilization and unit cost statistics for over 60 benefit categories, such as Inpatient Medical, Emergency Room, and Radiology. Independent Health subsequently performs claim-based analyses to refine a small number of these categories further; for example, the "Radiology" category is split into "Hi-Tech Imaging" (e.g. MRIs, PET scans) and "Routine Radiology" (e.g. X-Rays).

  Once utilization and unit cost statistics by benefit category are established, impacts of member cost-sharing in the form of copays and coinsurance can be modeled by entering these parameters and observing the impact on unit costs. *Note that no "induced demand" or "utilization deterrent" impacts are built in at the benefit category level.* For example, a benefit category with a utilization rate of 200 visits per 1,000, having an average cost of $800 per visit, will see an expected PMPM cost of $13.33 (200 x 800 / 12000). If a $50 copay is introduced, the impact will be modeled by reducing the unit cost from $800 to $750 and leaving utilization unchanged, yielding a new expected PMPM cost of $12.50.

  Rather than benefit-level application, induced demand is built in globally, using the scale of induced demand factors by metal level as published in the *HHS Notice of Benefit and Payment Parameters for 2015*. These demand factors were first renormalized to reflect the average

metal tier inherent in the experience data (Gold) and then applied uniformly across all cost models falling under a given metal tier.

Impacts of other plan features such as deductibles and out-of-pocket maximums were modeled using continuance tables constructed from Independent Health's own small-group experience. These continuance tables were built according to the "single risk pool" dictum, and were calibrated to each product based on the expected allowed costs of that product.

- ***Wellness***
  We estimated the claims costs for the wellness benefit as follows:
  - New York Standard Wellness Benefit: this benefit reimburses $200 to the subscriber and $100 to the spouse every six months (maximum of $300), provided that eligibility has been proven by documenting 50 gym visits during the period. We assumed a 27.5% utilization rate for this benefit, in conjunction with the projected contract distribution.
  - Exercise / Nutrition Point of Enrollment Benefit: non-standard plans allow for selection at point of enrollment between an exercise benefit that provides up to $250 reimbursement per contract towards gym benefits, or a nutrition benefit that loads a grocery debit card with $1 for each $2 spent on produce, up to a maximum of $500 for single, and $1000 for family contracts. We estimated the gym portion of the benefit using historical data from Independent Health's Flex-Fit cards, and estimated the nutrition portion using a combination of vendor and census data on produce consumption by household.

- ***Federal Reinsurance Adjustment***
  As described in the section above, continuance tables were used in modeling impacts of deductibles and out-of-pocket maximums. These same continuance tables were also used to estimate the impact of the transitional reinsurance program.

- ***Federal Risk Adjustment***
  In determining the expected impact of the Federal Risk Adjustment Transfer Payment, we relied on the study of 2013 New York state plan data performed by Deloitte in conjunction with DFS, as well as Exhibit 23, which all plans completed and submitted to DFS and whose results were communicated back to plans in April of this year.

  Independent Health used the relative risk and geographic cost factors (GCF) from the risk adjustment study in conjunction with the membership distributions by tier and Cost-Sharing Reduction (CSR) subsidy level as inputs to the Federal Risk Adjustment Formula. A comparison of demographics in the risk adjustment study versus Exhibit 23 seems to indicate that the risk profile of Independent Health's individual pool has deteriorated relative to the overall statewide individual pool, so a further adjustment of 2.5% was applied to reflect this increased risk.

The resulting transfer formula adjustment of 7.5% (expected distribution from the pool, as a percent of premium) was applied in the rate development.

- ***Morbidity***

  Independent Health used a morbidity factor to modify its small-group experience for applicability in the individual market. The morbidity factor was developed by considering the relative risk of the two populations as measured in two ways:

  1) Using commercially-available predictive modeling algorithms on the subset of 2014 individual market membership who had previous group or direct-pay experience with Independent Health. 2013 member-months for this cohort were just shy of 16,000, indicating a reasonable amount of credibility
  2) Using Independent Health's standard demographic factors on the full set of individual and small group membership enrolled as of April 2014.

  Predictive modeling results from the individual cohort described above indicated that they were expected to cost 78% more than the corresponding small-group cohort, while the demographic factor analysis predicted 40% higher costs. Independent Health weighted these results together at 40% on demographics and 60% on risk, but then applied a further 5% reduction to the overall result. This 5% reduction was applied in recognition of the changing composition of individual enrollees observed over the course of the open enrollment period; the general pattern was of older and sicker members signing up at the beginning of the period, followed by a decline in age over the course of the period, with the demographics of those enrolled in the weeks at the end of the period being approximately 5% better than those of the full cohort.

- ***Cost-Sharing Reduction (CSR) Adjustment***

  Individuals with incomes at or below 250% of the Federal Poverty Level (FPL) may enroll in Silver level plans with reduced cost-sharing, in which a portion of the member's normal cost-share amount is covered by a Federal government subsidy. Depending on income level, an enrollee may choose 73%, 87%, or 94% Actuarial Value variants of the base Silver plan. For premium rating purposes, all of these plans are classified as Silver plans and, in particular, receive an induced demand adjustment that is appropriate to that metal level. However, from a member's perspective, the 87% and 94% variants "feel" like Platinum plans, because of the reduced cost-shares. As such, they are liable to see induced demand increases corresponding to those metal levels.

  Because the federal subsidy only covers the change in cost-share, and not the change in induced demand, Independent Health made an additional adjustment in the pricing. The base Silver plan allowed PMPM was multiplied by the change in induced demand (Platinum-level for the 87% and 94% variants, and no change for the 73% variant) and the results weighted by projected membership in these plans. As a last step, the prior result was divided by total projected member-months to yield an expected CSR adjustment of $10.76 PMPM.

- ***Reg 146 / SMC Adjustment***

  Based on exhibits provided to DFS in late 2013 and subsequent communications related to these exhibits, it was determined that Independent Health has $6,534,866 in refunds from the Individual Market Stabilization Pool ("Reg 146") from the period covering the years 2007 through 2013 which can be applied to reduce Individual premium rates in 2015 and 2016. Subsequent communications from DFS on May 30th of this year indicated that a further $1,312,838, stemming from the discontinued Specified Medical Conditions pool for the years 1999 through 2004, was also available for the same purpose.

  Independent Health is proposing to use 30% of these total funds, amounting to $2,354,311 (0.3 x $7,847,704) to be applied as a credit against 2015 premium rates. The remaining 70% will be used similarly in 2016, and will help smooth increases that might otherwise result – for example, from reductions in the Transitional Reinsurance program. Deferring a larger portion of the money to 2015 will also help to preserve the impact of the credits against expected future increases in membership.

  When applied against projected 2015 membership, this yields a rate credit of $29.75 PMPM.

- ***Catastrophic Plan***
  The same cost model template used in pricing all of the other Individual market plans was used in pricing the catastrophic plans. The only difference was that pricing for the catastrophic plan specifically reflected the unique demographic characteristics of the expected enrollees in that plan.

- ***Out-of-Network Benefits***
  Adjustment factors used in pricing different out-of-network benefit levels among the various products were developed based on data from Independent Health's small-group book of business. These data were analyzed for establishing relativities between in-network and. out-of-network utilization and unit costs, as well as in building out-of-network continuance tables.

- **Significant Premium Differences between Plans in the Same Metal Tier**
  Additional adjustments to utilization and unit cost have been made to Independent Health's Choice Plus products, which utilize a network built around Catholic Hospital Systems (CHS) and Catholic Medical Partners. These adjustments reflect several unique characteristics of this network:
  - CHS made available significant discounts for inpatient and outpatient rates at CHS facilities for this product
  - CMP/CHS has been in risk-sharing models for all insured populations with IH for many years with very positive results versus plan average. These results were incorporated into the pricing for this product.
  - Concurrent review at all CHS facilities that begins when the member presents at the Emergency Room

- Integrated Care between PCP and Specialists
- CMP employs hundreds of care managers embedded in the physician offices to help coordinate appropriate care

ACTUARIAL CERTIFICATION

I, [redacted], Director of Actuarial Services for Independent Health, am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification under 11NYCRR 52.40(a)(1) of New York Laws.

I certify that to the best of my knowledge:

- This filing is in compliance with applicable laws and regulations of State of New York;
- This filing complies with Actuarial Standard of Practice No. 8 "Regulatory Filings for Health Plan Entities";
- The expected loss ratios incorporated into the proposed rate tables meet the minimum requirements of the State of New York.
- The benefits are reasonable in relation to the premiums charged and the rates are not unfairly discriminatory.
- The Index Rates in the Unified Rate Review Template and Exhibit 18 which accompany this filing were developed in accordance with federal regulations
- Actuarial Values were determined using the Federal Actuarial Value Calculator and were adjusted appropriately where plan designs deviated significantly from the Calculator's parameters.
- The percent of premium representing Essential Health Benefits, and upon which Advance Premium Tax Credits are based, was calculated in accordance with Actuarial Standards of Practice.

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

[redacted]

_____

[redacted], ASA, MAAA
Director, Actuarial Services
Independent Health Benefits Corporation

June 9, 2014

Attachment A: Quality Improvement / Cost Containment Programs

Expense Type (per Supplemental Health Care Exhibit)

Improve Health Outcomes

- Health A to Z: provides members with access to health solutions
- PCIP: Primary Care Coordination
- NIA Cardiac: connects patients with the most appropriate cardiac diagnostic exams

Activities to Prevent Hospital Readmissions

- Case management: coordination of patient services
  - Care Transitions: program to prepare members with the knowledge and skills to avoid readmissions to hospitals

Improve Patient Safety and Reduce Medical Errors

- SIU (Special Investigations Unit): recoveries through claims investigations

Wellness & Health Promotion Activities

- P4Pathways: Oncology management services
- Smoking Cessation: programs to help members quit smoking

HIT Expenses for Health Care Quality Improvements

- WNY QMC: P2/QMC data aggregation
- WNYCIE: Clinical Information Exchange
- HEALTHeNET: optimizes delivery patient information to the healthcare community by leveraging shared infrastructure, technology and intellectual capital.

Note that the above items are considered part of claims expense for Federal MLR purposes; however, certain of these activities, such as case management and SIU, are considered part of administrative expense under New York State regulations.

User Inputs for Plan Parameters

Platinum

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

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

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Platinum

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$1,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%			60.00%
OOP Maximum ($)			$5,000.00			$6,450.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00	☐	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	94.42%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	98.13%		☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☑	50%		☐	☑	50%	
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Platinum

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐		
Specialist Visit	☐	☐		$30.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐		
X-rays and Diagnostic Imaging	☐	☐		$30.00	☐	☐		
Skilled Nursing Facility	☐	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	94.42%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☐	☑	98.13%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.0%
Metal Tier:	Platinum

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Gold

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☐	☐		
Specialist Visit	☑	☐		$40.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$25.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.28%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☐	☐		$70.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.3%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Gold

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☐	☐		
Specialist Visit	☑	☐		$45.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$45.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$45.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$45.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$45.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94.18%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96.98%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.5%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Gold

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00		$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		50.00%	100.00%	
OOP Maximum ($)	$5,450.00			$6,450.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☑	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$40.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94.18%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	97.31%		☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☑	50%		☐	☑	50%	
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Silver

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☐	☐		
Specialist Visit	☑	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	93.36%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96.21%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☑	☐		$45.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.43%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☐	☐		$70.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Silver

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%			50.00%
OOP Maximum ($)			$5,900.00			$6,450.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☑	☑	80%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☐		$4.00	☑	☐		$4.00
Preferred Brand Drugs	☑	☐		$30.00	☑	☐		$30.00
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 67.9%
Metal Tier:

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

Silver

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Bronze

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Bronze

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

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,750.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.6%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			$5,000.00
Coinsurance (%, Insurer's Cost Share)			30.00%			50.00%
OOP Maximum ($)			$6,350.00			$6,450.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☑	☑	30%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☑	30%		☑	☑	50%	
Preferred Brand Drugs	☑	☑	30%		☑	☑	50%	
Non-Preferred Brand Drugs	☑	☑	30%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	30%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.8%
Metal Tier:	Bronze

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Catastrophic

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):		3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.8%
Metal Tier:	Bronze

Unified Rate Review v2.0.2

Company Legal Name: **Independent Health Benefits** State: **NY**
HIOS Issuer ID: **18029** Market: **Individual**
Effective Date of Rate Change(s):

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2013 to 12/31/2013

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$1	$1.00	100.00%
Incurred Claims in Experience Period	$1	1.00	100.00%
Allowed Claims:	$1	1.00	100.00%
Index Rate of Experience Period		$1.00	
Experience Period Member Months	1		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/0/1900 to 12/30/1900 Mid-point to Mid-point, Experience to Projection: -1357 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	1.00	$2,000.00	$0.17	1.000	1.000	1.000	1.000	1.00	$2,000.00	$0.17	87.46	$18,518.06	$134.96
Outpatient Hospital	Services	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	11937.21	113.41	112.81
Professional	Services	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	20475.45	115.66	197.35
Other Medical	Services	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	1358.69	184.50	20.89
Capitation	Benefit Period	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	12000.00	1.72	1.72
Prescription Drug	Prescriptions	1.00	2,000.00	0.17	1.000	1.000	1.000	1.000	1.00	2,000.00	0.17	15692.42	95.62	125.04
Total				$1.00							$1.00			$592.77

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$592.77	$4,640,829
Paid to Allowed Average Factor in Projection Period			0.817	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$484.31	$3,791,651
Projected Risk Adjustments PMPM			37.37	292,606
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$446.93	$3,499,044
Projected ACA reinsurance recoveries, net of rein prem, PMPM			31.25	244,683
Projected Incurred Claims			$415.68	$3,254,361
Administrative Expense Load		11.48%	56.93	445,715
Profit & Risk Load		0.68%	3.38	26,485
Taxes & Fees		4.00%	19.85	155,419
Single Risk Pool Gross Premium Avg. Rate, PMPM			$495.85	$3,881,980
Index Rate for Projection Period			$589.87	
% increase over Experience Period			49484.63%	
% Increase, annualized:			-5.34%	
Projected Member Months				7,829

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Product-Plan Data Collection

Company Legal Name: **Independent Health Benefits Corporation** State: **NY**
HIOS Issuer ID: **18029** Market: **Individual**
Effective Date of Rate Change(s):

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Product	Platinum										Gold									
Product ID:	18029NY999	18029NY118										18029NY122									
Metal:	Catastrophic	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
AV Metal Value	0.000	0.883	0.883	0.883	0.883	0.883	0.883	0.882	0.882	0.882	0.882	0.785	0.785	0.788	0.788	0.796	0.796	0.796	0.796	0.796	0.796
AV Pricing Value	0.000	0.948	0.948	0.948	0.948	0.948	0.948	0.901	0.901	0.911	0.911	0.829	0.829	0.843	0.843	0.877	0.877	0.877	0.877	0.877	0.877
Plan Type:	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS	POS
Plan Name	Terminated Products	Standard Platinum	Standard Platinum	Standard Platinum	Standard Platinum	Standard Platinum	Standard Platinum	Choice Plus Platinum	Choice Plus Platinum	FlexFit Platinum	FlexFit Platinum	Choice Plus Gold	Choice Plus Gold	iDirect Gold	iDirect Gold	Standard Gold	Standard Gold	Standard Gold	Standard Gold	Standard Gold	Standard Gold
Plan ID (Standard Component ID):	18029NY9999999	18029NY1180001	18029NY1180009	18029NY1180002	18029NY1180008	18029NY1180012	18029NY1180010	18029NY1180077	18029NY1180078	18029NY1180021	18029NY1180022	18029NY1220025	18029NY1220026	18029NY1220021	18029NY1220022	18029NY1220001	18029NY1220009	18029NY1220002	18029NY1220005	18029NY1220007	18029NY1220006
Exchange Plan?	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2	0.00%	0.00%										0.00%									
Historical Rate Increase - Calendar Year - 1	0.00%	0.00%										0.00%									
Historical Rate Increase - Calendar Year 0	0.00%	0.00%										0.00%									
Effective Date of Proposed Rates	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)	0.00%	5.45%	5.45%	6.07%	5.45%	5.45%	6.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.13%	5.13%	5.75%	5.13%	5.13%	5.75%
Cum'tive Rate Change % (over 12 mos prior)	-999.00%	5.45%	5.45%	6.07%	5.45%	5.45%	6.07%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	5.13%	5.13%	5.75%	5.13%	5.13%	5.75%
Proj'd Per Rate Change % (over Exper. Period)	-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%	5.60%										5.40%									

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

Plan ID (Standard Component ID):	Total	18029NY9999999	18029NY1180001	18029NY1180009	18029NY1180002	18029NY1180008	18029NY1180012	18029NY1180010	18029NY1180077	18029NY1180078	18029NY1180021	18029NY1180022	18029NY1220025	18029NY1220026	18029NY1220021	18029NY1220022	18029NY1220001	18029NY1220009	18029NY1220002	18029NY1220005	18029NY1220007	18029NY1220006
Inpatient	$0.00	$0.00	$6.80	$6.80	$7.55	$6.80	$6.80	$7.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.58	$5.58	$6.23	$5.58	$5.58	$6.23
Outpatient	$0.00	$0.00	$5.68	$5.68	$6.31	$5.68	$5.68	$6.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.66	$4.66	$5.21	$4.66	$4.66	$5.21
Professional	$0.00	$0.00	$9.94	$9.94	$11.03	$9.94	$9.94	$11.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.16	$8.16	$9.11	$8.16	$8.16	$9.11
Prescription Drug	$0.00	$0.00	$1.05	$1.05	$1.17	$1.05	$1.05	$1.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.86	$0.86	$0.96	$0.86	$0.86	$0.96
Other	$0.00	$0.00	$0.09	$0.09	$0.10	$0.09	$0.09	$0.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.07	$0.07	$0.08	$0.07	$0.07	$0.08
Capitation	$0.00	$0.00	$6.30	$6.30	$6.99	$6.30	$6.30	$6.99	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.17	$5.17	$5.77	$5.17	$5.17	$5.77
Administration	$0.00	$0.00	-$11.29	-$11.29	-$10.89	-$11.29	-$11.29	-$10.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$10.01	-$10.01	-$9.67	-$10.01	-$10.01	-$9.67
Taxes & Fees	$0.00	$0.00	$6.71	$6.71	$6.89	$6.71	$6.71	$6.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.76	$5.76	$5.92	$5.76	$5.76	$5.92
Risk & Profit Charge	$0.00	$0.00	$8.01	$8.01	$8.07	$8.01	$8.01	$8.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.95	$6.95	$7.00	$6.95	$6.95	$7.00
Total Rate Increase	$0.00	$0.00	$33.29	$33.29	$37.22	$33.29	$33.29	$37.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.20	$27.20	$30.61	$27.20	$27.20	$30.61
Member Cost Share Increase	$0.00	$0.00	-$3.84	-$3.84	-$3.84	-$3.84	-$3.84	-$3.84	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.83	$6.83	$6.83	$6.83	$6.83	$6.83
Average Current Rate PMPM	$490.26	$1.00	$525.53	$525.53	$527.46	$525.53	$525.53	$527.46	$518.99	$523.97	$583.85	$589.44	$445.77	$450.02	$506.08	$510.92	$456.80	$456.80	$458.46	$456.80	$456.80	$458.46
Projected Member Months	7,829	0	3	6	3	3	6	3	72	72	2,156	2,156	90	90	30	30	30	6	30	30	6	30

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	18029NY9999999	18029NY1180001	18029NY1180009	18029NY1180002	18029NY1180008	18029NY1180012	18029NY1180010	18029NY1180077	18029NY1180078	18029NY1180021	18029NY1180022	18029NY1220025	18029NY1220026	18029NY1220021	18029NY1220022	18029NY1220001	18029NY1220009	18029NY1220002	18029NY1220005	18029NY1220007	18029NY1220006
Average Rate PMPM	$1.00	$1.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Months	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Premium (TP)	$1	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB Percent of TP, [see instructions]	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	$1	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB Percent of TAC, [see instructions]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Incurred claims, payable with issuer funds	$1	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	$1.00	$1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	$1.00	$1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	$0.00	$0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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

Plan ID (Standard Component ID):	Total	18029NY9999999	18029NY1180001	18029NY1180009	18029NY1180002	18029NY1180008	18029NY1180012	18029NY1180010	18029NY1180077	18029NY1180078	18029NY1180021	18029NY1180022	18029NY1220025	18029NY1220026	18029NY1220021	18029NY1220022	18029NY1220001	18029NY1220009	18029NY1220002	18029NY1220005	18029NY1220007	18029NY1220006
Plan Adjusted Index Rate	$495.85	$0.00	$608.12	$608.12	$613.95	$608.12	$608.12	$613.95	$518.99	$523.97	$583.85	$589.44	$445.77	$450.02	$506.08	$510.92	$526.96	$526.96	$532.00	$526.96	$526.96	$532.00
Member Months	7,829	-	3	6	3	3	6	3	72	72	2,156	2,156	90	90	30	30	30	6	30	30	6	30
Total Premium (TP)	$3,881,980	$0	$1,824	$3,649	$1,842	$1,824	$3,649	$1,842	$37,367	$37,726	$1,258,781	$1,270,833	$40,119	$40,502	$15,182	$15,328	$15,941	$3,162	$16,093	$15,941	$3,162	$16,093
EHB Percent of TP, [see instructions]	99.51%	100.00%	99.98%	99.98%	99.03%	99.98%	99.98%	99.03%	99.98%	99.03%	99.98%	99.03%	99.98%	99.03%	99.98%	99.03%	99.98%	99.98%	99.03%	99.98%	99.98%	99.03%
state mandated benefits portion of TP that are other than EHB	0.49%	0.00%	0.02%	0.02%	0.97%	0.02%	0.02%	0.97%	0.02%	0.97%	0.02%	0.97%	0.02%	0.97%	0.02%	0.97%	0.02%	0.02%	0.97%	0.02%	0.02%	0.97%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$4,640,829	$0	$1,914	$3,828	$1,932	$1,914	$3,828	$1,932	$41,606	$42,007	$1,376,340	$1,389,599	$49,085	$49,557	$18,004	$18,178	$18,145	$3,599	$18,320	$18,145	$3,599	$18,320
EHB Percent of TAC, [see instructions]	99.51%	100.00%	99.98%	99.98%	99.03%	99.98%	99.98%	99.03%	99.98%	99.03%	99.98%	99.03%	99.98%	99.03%	99.98%	99.03%	99.98%	99.98%	99.03%	99.98%	99.98%	99.03%
state mandated benefits portion of TAC that are other than EHB	0.49%	0.00%	0.02%	0.02%	0.97%	0.02%	0.02%	0.97%	0.02%	0.97%	0.02%	0.97%	0.02%	0.97%	0.02%	0.97%	0.02%	0.02%	0.97%	0.02%	0.02%	0.97%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Allowed Claims which are not the issuer's obligation	$1,399,256	$0	$383	$2,578	$387	$383	$2,578	$387	$10,278	$10,377	$320,115	$323,198	$15,492	$15,641	$5,278	$5,329	$4,779	$2,518	$4,825	$4,779	$2,518	$4,825
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$84,240		$32	$65	$32	$32	$65	$32	$775	$775	$23,199	$23,199	$968	$968	$323	$323	$325	$65	$325	$325	$65	$325
Portion of above payable by HHS on behalf of insured person, as %	6.02%		8.43%	2.50%	8.35%	8.43%	2.50%	8.35%	7.54%	7.47%	7.25%	7.18%	6.25%	6.19%	6.12%	6.06%	6.81%	2.56%	6.75%	6.81%	2.56%	6.75%
Total Incurred claims, payable with issuer funds	$3,241,573	$0	$1,531	$1,250	$1,546	$1,531	$1,250	$1,546	$31,328	$31,630	$1,056,224	$1,066,401	$33,593	$33,917	$12,726	$12,849	$13,366	$1,081	$13,495	$13,366	$1,081	$13,495
Net Amt of Rein	$244,683	$0	$112	$224	$112	$112	$224	$112	$2,301	$2,301	$76,896	$76,896	$2,547	$2,547	$936	$936	$978	$194	$978	$978	$194	$978
Net Amt of Risk Adj	-$292,606	$0	-$137	-$273	-$138	-$137	-$273	-$138	-$2,811	-$2,838	-$94,388	-$95,298	-$3,035	-$3,064	-$1,143	-$1,154	-$1,198	-$238	-$1,210	-$1,198	-$238	-$1,210

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/12/2014		Rate	Rate Material	06/16/2014	A43_Ind_offEx_Manual_2015_6_10_2014.pdf (Superceded)
06/11/2014		Supporting Document	Redacted Documents for Web Posting	06/17/2014	Exhibit 11 - IHBC Ind Off_Redacted.pdf Actuarial Memorandum - Individual IHBC Off_Redacted.pdf (Superceded)

Independent Health Benefits Corporation

Independent Health's Individual Rate Manual

For Plans offered off New York State's Health Insurance Exchange

Effective January 1, 2015

Independent Health Benefits Corporation
511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange

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Independent Health Benefits Corporation
Individual Off Exchange Premium Rates Effective January 1, 2015

HIOS Plan ID	Form Numbers			Marketing Name	Product Description	Single	Double	Employee / Child(ren)	Family
Platinum Plans					**OF = Off Exchange SG = Small Group DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1180077-00	IHBC-C1035	IHBC-SBP014-4		Choice Plus Platinum	OFIN.DEP25.SNF365.DPY.FPY	$549.57	$1,099.14	$934.27	$1,566.27
18029NY1180078-00	IHBC-C1035	IHBC-SBP014-4	IHBC-R1064	Choice Plus Platinum	OFIN.DEP29.SNF365.DPY.FPY	$554.84	$1,109.68	$943.23	$1,581.29
18029NY1180021-00	IHBC-C1024	IHBC-SBP005-4		FlexFit Platinum	OFIN.DEP25.SNF365.DPY.FPY	$618.25	$1,236.50	$1,051.03	$1,762.01
18029NY1180022-00	IHBC-C1024	IHBC-SBP005-4	IHBC-R1064	FlexFit Platinum	OFIN.DEP29.SNF365.DPY.FPY	$624.17	$1,248.34	$1,061.09	$1,778.88
18029NY1180001-00	IHBC-C1024	IHBC-SBP001-4		Standard Platinum	OFIN.DEP25.SNF200.DPY.FPY	$643.95	$1,287.90	$1,094.72	$1,835.26
18029NY1180008-00	IHBC-C1024	IHBC-SBP001-4		Standard Platinum	OFIN.DEP25.SNF365.DPY.FPY	$643.95	$1,287.90	$1,094.72	$1,835.26
18029NY1180002-00	IHBC-C1024	IHBC-SBP001-4	IHBC-R1064	Standard Platinum	OFIN.DEP29.SNF200.DPY.FPY	$650.12	$1,300.24	$1,105.20	$1,852.84
18029NY1180010-00	IHBC-C1024	IHBC-SBP001-4	IHBC-R1064	Standard Platinum	OFIN.DEP29.SNF365.DPY.FPY	$650.12	$1,300.24	$1,105.20	$1,852.84
18029NY1180009-00	IHBC-C1025	IHBC-SBP003-4		Standard Platinum(CO)	OFIN.DEP25.SNF200.DPY.FPY	$265.30	N/A	N/A	N/A
18029NY1180012-00	IHBC-C1025	IHBC-SBP003-4		Standard Platinum(CO)	OFIN.DEP25.SNF365.DPY.FPY	$265.30	N/A	N/A	N/A
Gold Plans					**OF = Off Exchange SG = Small Group DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1220025-00	IHBC-C1035	IHBC-SBG009-4		Choice Plus Gold	OFIN.DEP25.SNF365.DPY.FPY	$472.03	$944.06	$802.45	$1,345.29
18029NY1220026-00	IHBC-C1035	IHBC-SBG009-4	IHBC-R1064	Choice Plus Gold	OFIN.DEP29.SNF365.DPY.FPY	$476.54	$953.08	$810.12	$1,358.14
18029NY1220021-00	IHBC-C1024	IHBC-SBG005-4		iDirect Gold	OFIN.DEP25.SNF365.DPY.FPY	$535.90	$1,071.80	$911.03	$1,527.32
18029NY1220022-00	IHBC-C1024	IHBC-SBG005-4	IHBC-R1064	iDirect Gold	OFIN.DEP29.SNF365.DPY.FPY	$541.02	$1,082.04	$919.73	$1,541.91
18029NY1220001-00	IHBC-C1024	IHBC-SBG001-4		Standard Gold	OFIN.DEP25.SNF200.DPY.FPY	$558.01	$1,116.02	$948.62	$1,590.33
18029NY1220005-00	IHBC-C1024	IHBC-SBG001-4		Standard Gold	OFIN.DEP25.SNF365.DPY.FPY	$558.01	$1,116.02	$948.62	$1,590.33
18029NY1220002-00	IHBC-C1024	IHBC-SBG001-4	IHBC-R1064	Standard Gold	OFIN.DEP29.SNF200.DPY.FPY	$563.35	$1,126.70	$957.70	$1,605.55
18029NY1220006-00	IHBC-C1024	IHBC-SBG001-4	IHBC-R1064	Standard Gold	OFIN.DEP29.SNF365.DPY.FPY	$563.35	$1,126.70	$957.70	$1,605.55
18029NY1220009-00	IHBC-C1025	IHBC-SBG002-4		Standard Gold(CO)	OFIN.DEP25.SNF200.DPY.FPY	$229.90	N/A	N/A	N/A
18029NY1220007-00	IHBC-C1025	IHBC-SBG002-4		Standard Gold(CO)	OFIN.DEP25.SNF365.DPY.FPY	$229.90	N/A	N/A	N/A
Silver Plans					**OF = Off Exchange SG = Small Group DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1260127-00	IHBC-C1035	IHBC-SBS015-4		Choice Plus Silver	OFIN.DEP25.SNF365.DPY.FPY	$406.79	$813.58	$691.54	$1,159.35
18029NY1260128-00	IHBC-C1035	IHBC-SBS015-4	IHBC-R1064	Choice Plus Silver	OFIN.DEP29.SNF365.DPY.FPY	$410.66	$821.32	$698.12	$1,170.38
18029NY1260037-00	IHBC-C1024	IHBC-SBS009-4		iDirect Silver Coinsurance	OFIN.DEP25.SNF365.DPY.FPY	$460.31	$920.62	$782.53	$1,311.88
18029NY1260038-00	IHBC-C1024	IHBC-SBS009-4	IHBC-R1064	iDirect Silver Coinsurance	OFIN.DEP29.SNF365.DPY.FPY	$464.71	$929.42	$790.01	$1,324.42
18029NY1350067-00	IHBC-C1038	IHBC-SBS029-4		Max Silver	OFIN.DEP25.SNF365.DPY.FPY	$474.91	$949.82	$807.35	$1,353.49
18029NY1350068-00	IHBC-C1038	IHBC-SBS029-4	IHBC-R1064	Max Silver	OFIN.DEP29.SNF365.DPY.FPY	$479.45	$958.90	$815.07	$1,366.43
18029NY1260001-00	IHBC-C1024	IHBC-SBS001-4		Standard Silver	OFIN.DEP25.SNF200.DPY.FPY	$482.16	$964.32	$819.67	$1,374.16
18029NY1260005-00	IHBC-C1024	IHBC-SBS001-4		Standard Silver	OFIN.DEP25.SNF365.DPY.FPY	$482.16	$964.32	$819.67	$1,374.16
18029NY1260002-00	IHBC-C1024	IHBC-SBS001-4	IHBC-R1064	Standard Silver	OFIN.DEP29.SNF200.DPY.FPY	$486.76	$973.52	$827.49	$1,387.27
18029NY1260006-00	IHBC-C1024	IHBC-SBS001-4	IHBC-R1064	Standard Silver	OFIN.DEP29.SNF365.DPY.FPY	$486.76	$973.52	$827.49	$1,387.27
18029NY1260009-00	IHBC-C1025	IHBC-SBS002-4		Standard Silver(CO)	OFIN.DEP25.SNF200.DPY.FPY	$198.65	N/A	N/A	N/A
18029NY1260007-00	IHBC-C1025	IHBC-SBS002-4		Standard Silver(CO)	OFIN.DEP25.SNF365.DPY.FPY	$198.65	N/A	N/A	N/A
Bronze Plans					**OF = Off Exchange SG = Small Group DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1310025-00	IHBC-C1035	IHBC-SBB005-4		Choice Plus Bronze	OFIN.DEP25.SNF365.DPY.FPY	$355.78	$711.56	$604.83	$1,013.97
18029NY1310026-00	IHBC-C1035	IHBC-SBB005-4	IHBC-R1064	Choice Plus Bronze	OFIN.DEP29.SNF365.DPY.FPY	$359.17	$718.34	$610.59	$1,023.63
18029NY1310033-00	IHBC-C1024	IHBC-SBB007-4		iDirect Bronze	OFIN.DEP25.SNF365.DPY.FPY	$387.34	$774.68	$658.48	$1,103.92
18029NY1310034-00	IHBC-C1024	IHBC-SBB007-4	IHBC-R1064	iDirect Bronze	OFIN.DEP29.SNF365.DPY.FPY	$391.03	$782.06	$664.75	$1,114.44
18029NY1360069-00	IHBC-C1038	IHBC-SBB014-4		Max Bronze	OFIN.DEP25.SNF365.DPY.FPY	$408.27	$816.54	$694.06	$1,163.57
18029NY1360070-00	IHBC-C1038	IHBC-SBB014-4	IHBC-R1064	Max Bronze	OFIN.DEP29.SNF365.DPY.FPY	$412.16	$824.32	$700.67	$1,174.66
18029NY1310009-00	IHBC-C1024	IHBC-SBB001-4		Standard Bronze	OFIN.DEP25.SNF200.DPY.FPY	$414.14	$828.28	$704.04	$1,180.30
18029NY1310001-00	IHBC-C1024	IHBC-SBB001-4		Standard Bronze	OFIN.DEP25.SNF365.DPY.FPY	$414.14	$828.28	$704.04	$1,180.30
18029NY1310010-00	IHBC-C1024	IHBC-SBB001-4	IHBC-R1064	Standard Bronze	OFIN.DEP29.SNF200.DPY.FPY	$418.09	$836.18	$710.75	$1,191.56
18029NY1310002-00	IHBC-C1024	IHBC-SBB001-4	IHBC-R1064	Standard Bronze	OFIN.DEP29.SNF365.DPY.FPY	$418.09	$836.18	$710.75	$1,191.56
18029NY1310013-00	IHBC-C1025	IHBC-SBB002-4		Standard Bronze(CO)	OFIN.DEP25.SNF200.DPY.FPY	$170.63	N/A	N/A	N/A
18029NY1310003-00	IHBC-C1025	IHBC-SBB002-4		Standard Bronze(CO)	OFIN.DEP25.SNF365.DPY.FPY	$170.63	N/A	N/A	N/A
Catastrophic Plans					**OF = Off Exchange SG = Small Group DEP25 = Dependents to 25 DEP29 = Dependents to 29 SNF200 = Skilled Nursing Facility 200 days max SNF365 = Unlimited Skilled Nursing Facility DPY = Domestic Partner FPY = Family Planning**				
18029NY1290001-00	IHBC-C1026	IHBC-SBC001-4		Catastrophic	OFIN.DEP25.SNF200.DPY.FPY	$220.95	$441.90	$375.62	$629.71

	Choice Plus Platinum	FlexFit Platinum	Standard Platinum
In-Network Deductible	A: $0 B:$1000	$0 $0	
Integrated Medical and Drug Deductible	Yes	Yes	No
In-Network Coinsurance	A: 0% B: 40%	N/A	N/A
In-Network OOP Maximum	A: $5000 B: $6450	$5,000 $2,000	
Emergency Room Services	A: $150 ND B: $150 ND	$150 ND	$100 ND
All Inpatient Hospital Services (inc. MHSA)	A: $500 ND B: 40%	$500 ND	$500 ND
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: $10 ND B: 40%	$10 ND	$15 ND
Specialist Visit	A: $30 ND B: 40%	$30 ND	$35 ND
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: $30 ND B: 40%	$30 ND	$15 ND
Imaging (CT/PET Scans, MRIs)	A: $75 ND B: 40%	$75 ND	$35 ND
Rehabilitative Speech Therapy	A: $30 ND B: 40%	$30 ND	$25 ND
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: $30 ND B: 40%	$30 ND	$25 ND
Laboratory Outpatient and Professional Services	A: $0 ND B: 40%	$10 ND	$35 ND
X-ray and Diagnostic Imaging	A: $30 ND B: 40%	$30 ND	$35 ND
Skilled Nursing Facility	A: $500 ND B: 40%	$500 ND	$500 ND
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: $150 ND B: 40%	$150 ND	$100 ND
Outpatient Surgery Physician/Surgical Services	A: $30 ND B: 40%	$30 ND	$100 ND
Generics	A: $4 ND B: $4 ND	$4 ND	$10 ND
Preferred Brand Drugs	A: $30 ND B: $30 ND	$30 ND	$30 ND
Non-Preferred Brand Drugs	A: 50% ND B: 50% ND	50% ND	$60 ND
Specialty Drugs (i.e., high cost)	A: 50% ND B: 50% ND	50% ND	$60 ND
Out-of-Network Deductible	2000	2000	2000
Out-of-Network Coinsurance	0.4	0.4	0.4
OON OOP Maximum	Unlimited	Unlimited	Unlimited

	Choice Plus Gold	iDirect Gold	Standard Gold
In-Network Deductible	A: $1000 B: $2000	$750 $600	
Integrated Medical and Drug Deductible	No	No	No
In-Network Coinsurance	A: 0% B: 50%	N/A	N/A
In-Network OOP Maximum	A: $5450 B: $6450	$6,350 $4,000	
Emergency Room Services	A: $150 B: $150	$150 $150	
All Inpatient Hospital Services (inc. MHSA)	A: $500 B: 50%	$1,000 $1,000	
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: $20 ND B: 50%	$15 ND	$25
Specialist Visit	A: $40 B: 50%	$45 $40	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: $40 B: 50%	$45 $25	
Imaging (CT/PET Scans, MRIs)	A: $75 B:50%	$100 $40	
Rehabilitative Speech Therapy	A: $40 B: 50%	$45 $30	
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: $40 B: 50%	$45 $30	
Laboratory Outpatient and Professional Services	A: $20 B: 50%	$25 $40	
X-ray and Diagnostic Imaging	A: $40 B: 50%	$45 $25	
Skilled Nursing Facility	A: $500 B: 50%	$1,000 $1,000	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: $150 B:50%	$150 $100	
Outpatient Surgery Physician/Surgical Services	A: $40 B: 50%	$45 $100	
Generics	A: $4 ND B: $4 ND	$4 ND	$10 ND
Preferred Brand Drugs	A: $30 ND B: $30 ND	$30 ND	$35 ND
Non-Preferred Brand Drugs	A: 50% ND B: 50% ND	50% ND	$70 ND
Specialty Drugs (i.e., high cost)	A: 50% ND B: 50% ND	50% ND	$70 ND
Out-of-Network Deductible	2500	2500	2500
Out-of-Network Coinsurance	0.5	0.4	0.4
OON OOP Maximum	Unlimited	Unlimited	Unlimited

	Choice Plus Silver	iDirect Silver Coinsurance	Max Silver	Standard Silver
In-Network Deductible	A: $2000 B: $4000	$2000	$2000	$2,000
Integrated Medical and Drug Deductible	Yes	Yes	Yes	No
In-Network Coinsurance	A: 20% B: 50%	20%	N/A	N/A
In-Network OOP Maximum	A: $5900 B: $6450	$6000	$6000	$5,500
Emergency Room Services	A:20% B:20%	20%	$200	$150
All Inpatient Hospital Services (inc. MHSA)	A: 20% B: 50%	20%	$1000	$1500
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: 20% B: 50%	20%	$35 ND	$30
Specialist Visit	A: 20% B: 50%	20%	$50	$50
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: 20% B: 50%	20%	$50	$30
Imaging (CT/PET Scans, MRIs)	A: 20% B: 50%	20%	$100	$50
Rehabilitative Speech Therapy	A: 20% B: 50%	20%	$50	$30
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: 20% B: 50%	20%	$50	$30
Laboratory Outpatient and Professional Services	A: 20% B: 50%	20%	$30	$50
X-ray and Diagnostic Imaging	A: 20% B: 50%	20%	$50	$50
Skilled Nursing Facility	A: 20% B: 50%	20%	$1000	$1500
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: 20% B: 50%	20%	$150	$100
Outpatient Surgery Physician/Surgical Services	A: 20% B: 50%	20%	$50	$100
Generics	A: $4 B: $4	$4	$10 ND	$10 ND
Preferred Brand Drugs	A: $30 B: $30	$30 $45		$35 ND
Non-Preferred Brand Drugs	A: 50% B: 50%	50%	50%	$70 ND
Specialty Drugs (i.e., high cost)	A: 50% B: 50%	50%	50%	$70 ND
Out-of-Network Deductible	5000	3000	Not Applicable	3000
Out-of-Network Coinsurance	0.5	0.4	100%	0.4
OON OOP Maximum	Unlimited	Unlimited	Not Applicable	Unlimited

	Choice Plus Bronze	iDirect Bronze	Max Bronze	Standard Bronze
In-Network Deductible	A: $3500 B: $5000	$4,750 $5,500		$3,000
Integrated Medical and Drug Deductible	Yes	Yes	Yes	Yes
In-Network Coinsurance	A: .3 B: .5	0.40	0.25	0.5
In-Network OOP Maximum	A: $6350 B: $6450	$6,350 $6,600		$6,350
Emergency Room Services	A: .3 B: .3	0.40	$0 0.5	
All Inpatient Hospital Services (inc. MHSA)	A: .3 B: .5	0.40	0.25	0.5
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	A: .3 B: .5	0.40	$40 ND	0.5
Specialist Visit	A: .3 B: .5	0.40	0.25	0.5
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	A: .3 B: .5	0.40	0.25	0.5
Imaging (CT/PET Scans, MRIs)	A: .3 B: .5	0.40	0.25	0.5
Rehabilitative Speech Therapy	A: .3 B: .5	0.40	0.25	0.5
Rehabilitative Occupational and Rehabilitative Physician Therapy	A: .3 B: .5	0.40	0.25	0.5
Laboratory Outpatient and Professional Services	A: .3 B: .5	0.40	0.25	0.5
X-ray and Diagnostic Imaging	A: .3 B: .5	0.40	0.25	0.5
Skilled Nursing Facility	A: .3 B: .5	0.40	0.25	0.5
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	A: .3 B: .5	0.40	0.25	0.5
Outpatient Surgery Physician/Surgical Services	A: .3 B: .5	0.40	0.25	0.5
Generics	A: .5 B: .5	0.50	$10 ND	$10
Preferred Brand Drugs	A: .5 B: .5	0.50	0.5	$35
Non-Preferred Brand Drugs	A: .5 B: .5	0.50	0.5	$70
Specialty Drugs (i.e., high cost)	A: .5 B: .5	0.50	0.5	$70
Out-of-Network Deductible	5000	5000	Not Applicable	5000
Out-of-Network Coinsurance	0.5	0.5	1	0.5
OON OOP Maximum	Unlimited	Unlimited	Not Applicable	Unlimited

	Catastrophic
In-Network Deductible	$6,600
Integrated Medical and Drug Deductible	Yes
In-Network Coinsurance	0%
In-Network OOP Maximum	$6,600
Emergency Room Services	0%
All Inpatient Hospital Services (inc. MHSA)	0%
Primary Care Visit to Treat an injury or Illness (exc. Preventive, and X-ray)	0% 3 Visits ND
Specialist Visit	0%
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0%
Imaging (CT/PET Scans, MRIs)	0%
Rehabilitative Speech Therapy	0%
Rehabilitative Occupational and Rehabilitative Physician Therapy	0%
Laboratory Outpatient and Professional Services	0%
X-ray and Diagnostic Imaging	0%
Skilled Nursing Facility	0%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0%
Outpatient Surgery Physician/Surgical Services	0%
Generics	0%
Preferred Brand Drugs	0%
Non-Preferred Brand Drugs	0%
Specialty Drugs (i.e., high cost)	0%
Out-of-Network Deductible	Not Applicable
Out-of-Network Coinsurance	100%
OON OOP Maximum	Not Applicable

Independent Health Benefits Corporation

511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange

Rating Regions

The rating region for this rate manual is the Western New York service area including Erie, Chautauqua, Cattaraugus, Genesee, Niagara, Wyoming, Allegany, and Orleans Counties.

Expected Loss Ratio

The Expected Loss Ratio for all products in this manual is 87%

Since this rate manual applies to individual business only, broker commissions do not apply. However, IHBC has filed it's broker commissions on SERFF under state tracking number 2013030147.

Independent Health Benefits Corporation
511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health's Individual Rate Manual
For Plans Offered Off the NYS Health Insurance Exchange

Underwriting Guidelines

Eligible Individual –

Means an individual, who is seeking to enroll in a qualified health plan in the individual market, but not offered through the Exchange, and lawfully resides in the eight counties of WNY. Incarcerated individuals are excluded, except for individuals pending the disposition of charges.

Rating arrangement –

Community rated, meaning a rate methodology in which the premium for all persons covered is the same and based on the experience of the entire pool without regard to age, sex, health status or occupation.

Out of area Individuals –

IHBC products are limited to individuals who reside within the WNY service area.

Off cycle plan changes –

All product changes must occur on the anniversary date.

Pre-existing conditions limitations –

Per Section 1501 of PPACA, pre-existing conditions limitations are waived for all enrollees.

Independent Health Benefits Corporation

Individual Off-Exchange Plans

2015

June 9, 2014

Development of Index Rate and Premium Rates: Overview

The purpose of this memorandum to present and provide support for key assumptions in the development of the proposed rates for Independent Health Benefits Corporation's (IHBC's) individual plans to be offered for sale off of the New York State Individual Health Insurance Exchange.

IHBC is the Article 43 licensee of Independent Health, and all of Independent Health's 2015 individual plans will be sold under this entity. All plans on and off the exchange are part of the same risk pool and were developed using Independent Health's current small-group book of business (adjusted for morbidity), following the methodology outlined below.

- ***Experience Period / Risk Pool Merging***

  2015 rate projections were developed based on small-group incurred claims from the 12-month experience period from January 1, 2013 through December 31, 2013, with completion factors based on claims runout through March 31, 2014. No Regulation 146 or Stop-Loss Reimbursement Pool monies were included in the experience data. A morbidity factor was applied later in the process to convert this data to expected individual experience.

  Because Independent Health's current small-group book of business is split between IHBC and its Article 44 licensee, Independent Health Association (IHA), the 2013 claims data was adjusted to include IHA experience, with adjustments for differences in provider reimbursement rates between IHA and IHBC. In doing so, any claim experience from Healthy New York Individual and Sole Proprietor business was specifically excluded, given that these segments have transitioned to the Individual Exchange market in 2014.

  Adjustments to the experience period were made for essential health benefits. These adjustments included inpatient and outpatient psychiatric and substance abuse, skilled nursing facility, and DME/PA.

- ***Trend***

  Utilization and unit cost trends were applied to project experience forward from the base period of calendar year 2013 to the rate period.

- ***Reinsurance***

  The projected 2015 claims experience was adjusted to reflect the anticipated impact of the Federal Transitional Reinsurance Program.

- ***Risk Adjustment***

  The projected 2015 claims experience was adjusted to reflect the anticipated impact of the Federal Risk Adjustment Transfer Formula, using results modeled from the Deloitte/Department of Financial Services (DFS) study carried out on New York plans' data earlier this year.

- ***Morbidity Adjustment***
  Because Independent Health's individual book of business in 2014 is new and immature, Independent Health applied a morbidity adjustment to its small-group experience in order to develop the individual rates. The morbidity factor was derived by comparing demographic and, where available, claim-based risk characteristics to assess the expected utilization of healthcare services in the individual market relative to small group. Examination of patterns in enrollment trends in Independent Health's 2014 individual products over the course of the annual open enrollment period was also considered.

- ***Benefit Adjustment***
  Product-specific pricing was carried out using the ratio of each product's Pricing Actuarial Value (AV) to the average Pricing AV inherent in the experience period data. The ratio includes the relative impact of induced demand.

- ***Regulation 146 / SMC Adjustment***
  Plan level adjustments were made to credit rates with refunds applicable to market stabilization and specified medical condition pools from the years 1999 – 2013.

- ***Administrative Expenses and Profit Margin***
  An 87% medical loss ratio (prior to additional taxes and fees) was used in the development of the premium rates. The additional taxes and fees related to the Affordable Care Act (ACA) that were built into the rates included the Health Insurance Tax (HIT), provision for contributions to the Federal Transitional Reinsurance Program, the Patient-Centered Outcomes Research Initiative fee (PCORI), and the Risk Adjustment User Fee. Even with the addition of the above-noted taxes and fees, all products are expected to be above the minimum 82% loss ratio in New York State.

- ***Conversion / Step-Up Factor***
  A conversion factor to step up the projected PMPM revenue requirement to the Single/Individual rate was developed based on observed contract distributions and sizes from Independent Health's individual block, recalculated to reflect the four-tier structure required in 2015. Census tier relativities as prescribed by DFS were also used in the development of this factor, as well as in setting the premium rates for each tier.

- ***Area Factors***
  All of Independent Health's products fall under the Buffalo rating region (Region 2).

Supporting Details for Key Assumptions

- **Claim Trend Rates**

  As described in more detail below, Independent Health utilizes a cost-model approach to premium rating, with claim costs mapped to over 60 types of medical benefit categories, primarily using Milliman's Health Cost Guidelines algorithm.

  For each of these categories, utilization trend assumptions were generally estimated using the least-squares-based techniques, using the prior three years' utilization experience for IHA and IHBC combined. Some manual overrides were employed where the least-squares-based results appeared to be unreasonable (for example, due to low credibility of the type of service category) or where additional relevant information about utilization patterns in a service category was known.

  Average charge trends were developed based on anticipated (or, where available, already contracted) provider fee increases.

  To estimate prescription drug trends, prescription drug data for IHA and IHBC small group combined from January 2010 through December 2013 were analyzed to determine recent prescription drug trends and to project future trends into 2015. Drugs were first re-mapped to reflect 2015 formulary changes; where applicable, drugs that are no longer on the formulary were allocated the to the most likely on-formulary substitute drug.

  The resulting average "first dollar" or "allowed" trend assumptions by type of service category are summarized below.

Independent Health Benefits Corporation
Annualized Allowed Claim Trends by Type of Service

Type of Service	Utilization	Unit Cost	PMPM
Inpatient Hospital	-0.5%	6.8%	6.6%
Outpatient Hospital	1.0%	4.8%	5.9%
Professional	1.4%	2.6%	4.1%
Other	2.2%	9.4%	11.8%
Pharmacy	3.1%	6.9%	10.2%
Total Trend			7.0%

- ***Administrative Expense / Contribution to Surplus***
  Consistent with recent filings, IHBC is using a 13% administrative expense load (before ACA taxes and fees), which includes a 0.7% component for risk margin / contribution to surplus. Allocations of administrative expense by component are detailed on Exhibit 19, and were done in a manner consistent with IHBC's most recent audited financial statements.

  Premium rates also reflect provisions for various ACA taxes and fees, as follows:
  - Health Insurer Tax: 2.90% (of premium)
  - Contribution to Federal Transitional Reinsurance Program: $3.67 PMPM
  - Patient-Centered Outcomes Research Initiative: $0.18 PMPM
  - Risk Adjustment User Fee: $0.08 PMPM

- ***Adjustments to Actuarial Values***
  AV Metal Values were determined by entering product benefit configurations into the AV Calculator developed by the Department of Health and Human Services (HHS).
  Because the HHS AV Calculator does not specifically address wellness benefits, which are included in each of Independent Health's non-standard product offerings, we adjusted the results from the calculator by adding the PMPM value of the benefit to both the numerator and denominator of the output from the calculator's continuance tables. The adjustment varied by plan, but on average increased the HHS AV in the range of 0.2 to 0.3%.

- ***Conversion Factors***
  IHBC's individual conversion factor is 1.0589. The following table outlines the derivation of this factor, based on individual enrollees in Q1 2014. The tier factors used in the calculation are the standardized values required by DFS. Small-group conversion factors have been relatively stable over time, and Independent Health does not anticipate any significant changes in 2015.

Independent Health Benefits Corporation
Development of 2015 Individual Conversion Factor

Census Tier	% of Total Contracts	Average Contract Size	Tier Ratio (per DFS)
Single	73.9%	1.00	1.000
Single + Spouse	18.1%	2.00	2.000
Single + Child(ren)	2.3%	2.67	1.700
Single + Spouse + Child(ren)	4.8%	3.85	2.850
Child Only	1.0%	1.00	0.412
	100.0%	1.35	1.28
Conversion Factor (Average Contract Size / Average Tier Ratio):			1.0589

- ***Standardized Rating Regions***
  IHBC is filing these rates solely for the Buffalo rating region (Region 2).

- ***Determination of AV Pricing Values***
  Independent Health utilizes a cost-model approach in developing its premium rating. The basis for the cost models is Milliman's Health Cost Guidelines algorithm, which uses claims data to report utilization and unit cost statistics for over 60 benefit categories, such as Inpatient Medical, Emergency Room, and Radiology. Independent Health subsequently performs claim-based analyses to refine a small number of these categories further; for example, the "Radiology" category is split into "Hi-Tech Imaging" (e.g. MRIs, PET scans) and "Routine Radiology" (e.g. X-Rays).

  Once utilization and unit cost statistics by benefit category are established, impacts of member cost-sharing in the form of copays and coinsurance can be modeled by entering these parameters and observing the impact on unit costs. *Note that no "induced demand" or "utilization deterrent" impacts are built in at the benefit category level.* For example, a benefit category with a utilization rate of 200 visits per 1,000, having an average cost of $800 per visit, will see an expected PMPM cost of $13.33 (200 x 800 / 12000). If a $50 copay is introduced, the impact will be modeled by reducing the unit cost from $800 to $750 and leaving utilization unchanged, yielding a new expected PMPM cost of $12.50.

  Rather than benefit-level application, induced demand is built in globally, using the scale of induced demand factors by metal level as published in the *HHS Notice of Benefit and Payment Parameters for 2015*. These demand factors were first renormalized to reflect the average

metal tier inherent in the experience data (Gold) and then applied uniformly across all cost models falling under a given metal tier.

Impacts of other plan features such as deductibles and out-of-pocket maximums were modeled using continuance tables constructed from Independent Health's own small-group experience. These continuance tables were built according to the "single risk pool" dictum, and were calibrated to each product based on the expected allowed costs of that product.

- ***Federal Reinsurance Adjustment***
  As described in the section above, continuance tables were used in modeling impacts of deductibles and out-of-pocket maximums. These same continuance tables were also used to estimate the impact of the transitional reinsurance program.

- ***Federal Risk Adjustment***
  In determining the expected impact of the Federal Risk Adjustment Transfer Payment, we relied on the study of 2013 New York state plan data performed by Deloitte in conjunction with DFS, as well as Exhibit 23, which all plans completed and submitted to DFS and whose results were communicated back to plans in April of this year.

  Independent Health used the relative risk and geographic cost factors (GCF) from the risk adjustment study in conjunction with the membership distributions by tier and Cost-Sharing Reduction (CSR) subsidy level as inputs to the Federal Risk Adjustment Formula. A comparison of demographics in the risk adjustment study versus Exhibit 23 seems to indicate that the risk profile of Independent Health's individual pool has deteriorated relative to the overall statewide individual pool, so a further adjustment of 2.5% was applied to reflect this increased risk.

  The resulting transfer formula adjustment of 7.5% (expected distribution from the pool, as a percent of premium) was applied in the rate development.

- ***Morbidity***
  Independent Health used a morbidity factor to modify its small-group experience for applicability in the individual market. The morbidity factor was developed by considering the relative risk of the two populations as measured in two ways:
  1) Using commercially-available predictive modeling algorithms on the subset of 2014 individual market membership who had previous group or direct-pay experience with Independent Health. 2013 member-months for this cohort were just shy of 16,000, indicating a reasonable amount of credibility
  2) Using Independent Health's standard demographic factors on the full set of individual and small group membership enrolled as of April 2014.

  Predictive modeling results from the individual cohort described above indicated that they were expected to cost 78% more than the corresponding small-group cohort, while the demographic

factor analysis predicted 40% higher costs. Independent Health weighted these results together at 40% on demographics and 60% on risk, but then applied a further 5% reduction to the overall result. This 5% reduction was applied in recognition of the changing composition of individual enrollees observed over the course of the open enrollment period; the general pattern was of older and sicker members signing up at the beginning of the period, followed by a decline in age over the course of the period, with the demographics of those enrolled in the weeks at the end of the period being approximately 5% better than those of the full cohort.

- ***Cost-Sharing Reduction (CSR) Adjustment***

  Individuals with incomes at or below 250% of the Federal Poverty Level (FPL) may enroll in Silver level plans with reduced cost-sharing, in which a portion of the member's normal cost-share amount is covered by a Federal government subsidy. Depending on income level, an enrollee may choose 73%, 87%, or 94% Actuarial Value variants of the base Silver plan. For premium rating purposes, all of these plans are classified as Silver plans and, in particular, receive an induced demand adjustment that is appropriate to that metal level. However, from a member's perspective, the 87% and 94% variants "feel" like Gold and Platinum plans, respectively, because of the reduced cost-shares. As such, they are liable to see induced demand increases corresponding to those metal levels.

  Because the federal subsidy only covers the change in cost-share, and not the change in induced demand, Independent Health made an additional adjustment in the pricing. The base Silver plan allowed PMPM was multiplied by the change in induced demand (Gold-level for the 87% variant, Platinum-level for the 94% variant, and no change for the 73% variant) and the results weighted by projected membership in these plans. As a last step, the prior result was divided by total projected member-months to yield an expected CSR adjustment of $10.76 PMPM.

- ***Reg 146 / SMC Adjustment***

  Based on exhibits provided to DFS in late 2013 and subsequent communications related to these exhibits, it was determined that Independent Health has $6,534,866 in refunds from the Individual Market Stabilization Pool ("Reg 146") from the period covering the years 2007 through 2013 which can be applied to reduce Individual premium rates in 2015 and 2016. Subsequent communications from DFS on May 30th of this year indicated that a further $1,312,838, stemming from the discontinued Specified Medical Conditions pool for the years 1999 through 2004, was also available for the same purpose.

  Independent Health is proposing to use 30% of these total funds, amounting to $2,354,311 (0.3 x $7,847,704) to be applied as a credit against 2015 premium rates. The remaining 70% will be used similarly in 2016, and will help smooth increases that might otherwise result – for example, from reductions in the Transitional Reinsurance program. Deferring a larger portion of the money to 2015 will also help to preserve the impact of the credits against expected future increases in membership.

When applied against projected 2015 membership, this yields a rate credit of $29.75 PMPM.

- ***Catastrophic Plan***
  The same cost model template used in pricing all of the other Individual market plans was used in pricing the catastrophic plans. The only difference was that pricing for the catastrophic plan specifically reflected the unique demographic characteristics of the expected enrollees in that plan.

- ***Out-of-Network Benefits***
  Adjustment factors used in pricing different out-of-network benefit levels among the various products were developed based on data from Independent Health's small-group book of business. These data were analyzed for establishing relativities between in-network and. out-of-network utilization and unit costs, as well as in building out-of-network continuance tables.

- **Significant Premium Differences between Plans in the Same Metal Tier**
  Additional adjustments to utilization and unit cost have been made to Independent Health's Choice Plus products, which utilize a network built around Catholic Hospital Systems (CHS) and Catholic Medical Partners. These adjustments reflect several unique characteristics of this network:
  - CHS made available significant discounts for inpatient and outpatient rates at CHS facilities for this product
  - CMP/CHS has been in risk-sharing models for all insured populations with IH for many years with very positive results versus plan average. These results were incorporated into the pricing for this product.
  - Concurrent review at all CHS facilities that begins when the member presents at the Emergency Room
  - Integrated Care between PCP and Specialists
  - CMP employs hundreds of care managers embedded in the physician offices to help coordinate appropriate care

ACTUARIAL CERTIFICATION

I, [redacted], Director of Actuarial Services for Independent Health, am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification under 11NYCRR 52.40(a)(1) of New York Laws.

I certify that to the best of my knowledge:

- This filing is in compliance with applicable laws and regulations of State of New York;
- This filing complies with Actuarial Standard of Practice No. 8 "Regulatory Filings for Health Plan Entities";
- The expected loss ratios incorporated into the proposed rate tables meet the minimum requirements of the State of New York.
- The benefits are reasonable in relation to the premiums charged and the rates are not unfairly discriminatory.
- The Index Rates in the Unified Rate Review Template and Exhibit 18 which accompany this filing were developed in accordance with federal regulations
- Actuarial Values were determined using the Federal Actuarial Value Calculator and were adjusted appropriately where plan designs deviated significantly from the Calculator's parameters.
- The percent of premium representing Essential Health Benefits, and upon which Advance Premium Tax Credits are based, was calculated in accordance with Actuarial Standards of Practice.

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

[redacted]

[redacted], ASA, MAAA
Director, Actuarial Services
Independent Health Benefits Corporation

Attachment A: Quality Improvement / Cost Containment Programs

Expense Type (per Supplemental Health Care Exhibit)

Improve Health Outcomes

- Health A to Z: provides members with access to health solutions
- PCIP: Primary Care Coordination
- NIA Cardiac: connects patients with the most appropriate cardiac diagnostic exams

Activities to Prevent Hospital Readmissions

- Case management: coordination of patient services
  - Care Transitions: program to prepare members with the knowledge and skills to avoid readmissions to hospitals

Improve Patient Safety and Reduce Medical Errors

- SIU (Special Investigations Unit): recoveries through claims investigations

Wellness & Health Promotion Activities

- P4Pathways: Oncology management services
- Smoking Cessation: programs to help members quit smoking

HIT Expenses for Health Care Quality Improvements

- WNY QMC: P2/QMC data aggregation
- WNYCIE: Clinical Information Exchange
- HEALTHeNET: optimizes delivery patient information to the healthcare community by leveraging shared infrastructure, technology and intellectual capital.

Note that the above items are considered part of claims expense for Federal MLR purposes; however, certain of these activities, such as case management and SIU, are considered part of administrative expense under New York State regulations.

User Inputs for Plan Parameters

Platinum

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

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

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Platinum

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$1,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%			60.00%
OOP Maximum ($)			$5,000.00			$6,450.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00	☐	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	94.42%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	98.13%		☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☑	50%		☐	☑	50%	
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Platinum

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐		
Specialist Visit	☐	☐		$30.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐		
X-rays and Diagnostic Imaging	☐	☐		$30.00	☐	☐		
Skilled Nursing Facility	☐	☐		$500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	94.42%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☐	☑	98.13%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.0%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Gold

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☐	☐		
Specialist Visit	☑	☐		$40.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$25.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.28%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☐	☐		$70.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.3%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☐	☐		
Specialist Visit	☑	☐		$45.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$45.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$45.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$45.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$45.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94.18%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96.98%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☐	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.5%
Metal Tier:	Gold

User Inputs for Plan Parameters

Gold

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00		$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		50.00%	100.00%	
OOP Maximum ($)	$5,450.00			$6,450.00		
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☑	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$40.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94.18%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	97.31%		☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☑	50%		☐	☑	50%	
Specialty Drugs (i.e. high-cost)	☐	☑	50%		☐	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Silver

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☐	☐		
Specialist Visit	☑	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$50.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,000.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	93.36%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	96.21%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☑	☐		$45.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

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

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$150.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐		
Specialist Visit	☑	☐		$50.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☐	☐		
Rehabilitative Speech Therapy	☑	☐		$30.00	☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☐	☐		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐		
Skilled Nursing Facility	☑	☐		$1,500.00	☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.43%		☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☐	☐		$70.00	☐	☐		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver

User Inputs for Plan Parameters

Silver

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%			50.00%
OOP Maximum ($)			$5,900.00			$6,450.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☑	☑	80%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☐		$4.00	☑	☐		$4.00
Preferred Brand Drugs	☑	☐		$30.00	☑	☐		$30.00
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	67.9%
Metal Tier:	

User Inputs for Plan Parameters

Silver

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☐		$4.00	☐	☐		
Preferred Brand Drugs	☑	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

User Inputs for Plan Parameters

Bronze

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

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

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	95%
		2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,750.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☑	50%		☐	☐		
Preferred Brand Drugs	☑	☑	50%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.6%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Bronze

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

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

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			$5,000.00
Coinsurance (%, Insurer's Cost Share)			30.00%			50.00%
OOP Maximum ($)			$6,350.00			$6,450.00
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☑			☑	☑	30%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☑	☑	30%		☑	☑	50%	
Preferred Brand Drugs	☑	☑	30%		☑	☑	50%	
Non-Preferred Brand Drugs	☑	☑	30%		☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	30%		☑	☑	50%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.8%
Metal Tier:	Bronze

User Inputs for Plan Parameters

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

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

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	95%
2nd Tier Utilization:	5%

Catastrophic

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.8%
Metal Tier:	Bronze