

**State:** District of Columbia **Filing Company:** Aetna Health Inc. PA AZ DC DE IN KY MA MD NV  
 NC OK TN VA WV  
**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only  
 - HMO  
**Product Name:** DC AHI SG HMO 2015  
**Project Name/Number:** 2015 Exchange - Aetna/HMO

**Filing at a Glance**

Company: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV  
 Product Name: DC AHI SG HMO 2015  
 State: District of Columbia  
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)  
 Sub-TOI: HOrg02G.004F Small Group Only - HMO  
 Filing Type: Rate  
 Date Submitted: 06/13/2014  
 SERFF Tr Num: AETN-129582439  
 SERFF Status: Assigned  
 State Tr Num:  
 State Status:  
 Co Tr Num: AETN-129582439  
 Implementation 01/01/2015  
 Date Requested:  
 Author(s): Andrew Owen, Bruce Campbell, Barbara Hill, Nhu Nguyen, David Walker, Cynthia Parenteau,  
 Brenda Dinnald, Robert Jackson, Amit Ghambir, Caitlin Bollbach, Amy Ovuka  
 Reviewer(s): Efren Tanhehco (primary), Alula Selassie  
 Disposition Date:  
 Disposition Status:  
 Implementation Date:  
 State Filing Description:

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**General Information**

Project Name: 2015 Exchange - Aetna	Status of Filing in Domicile:
Project Number: HMO	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 06/16/2014	
State Status Changed:	Deemer Date:
Created By: Barbara Hill	Submitted By: David Walker
Corresponding Filing Tracking Number:	
PPACA: Non-Grandfathered Immed Mkt Reforms	
PPACA Notes: null	
Exchange Intentions:	Includes forms for products to be offered to Small Groups on the DC Health Benefits Exchange.

Filing Description:  
 Aetna Health, Inc. 1Q15 Small Group HMO rate filing for DC.  
 The corresponding forms filing was submitted separately. The SERFF ID Number is AETN-129570338.

**Company and Contact**

**Filing Contact Information**

Cynthia Parenteau, P&RA Consultant	ParenteauC@Aetna.com
151 Farmington Ave	860-267-2217 [Phone]
Hartford, CT 06156	

**Filing Company Information**

Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV	CoCode: 95109	State of Domicile: Pennsylvania
980 Jolly Road	Group Code: 1	Company Type:
Blue Bell, PA 19422	Group Name:	State ID Number:
(999) 999-9999 ext. [Phone]	FEIN Number: 23-2169745	

**Filing Fees**

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:

SERFF Tracking #:

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### Rate Information

Rate data applies to filing.

Filing Method: Review & Approval

Rate Change Type: Increase

Overall Percentage of Last Rate Revision: 0.000%

Effective Date of Last Rate Revision: 01/01/2014

Filing Method of Last Filing: Review & Approval

### 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):
Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV	Increase	1.300%	1.300%	\$25,175	475	\$1,904,275	9.500%	-5.000%

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**Rate Review Detail**

**COMPANY:**

Company Name: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV  
 HHS Issuer Id: 73987

**PRODUCTS:**

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
DC AHI SG HMO 2015	73987DC004		475

Trend Factors:

**FORMS:**

New Policy Forms: HI SGHIXSched-5248 02, HI SGHIXSchedAOA-5249 02, HI SGHIXSched-5251 02, HI SGHIXSchedAOA-5252 02, HI SGHIXSched-5254 02, HI SGHIXSched-5256 02, HI SGHIXSchedAOA-5258 02, HI SGHIXSched-5260 02, HI SGHIXSched-5262 02, HI SGHIXSched-5264 02

Affected Forms:

Other Affected Forms:

**REQUESTED RATE CHANGE INFORMATION:**

Change Period: Quarterly  
 Member Months: 171,517  
 Benefit Change: None  
 Percent Change Requested: Min: -5.0 Max: 9.5 Avg: 1.3

**PRIOR RATE:**

Total Earned Premium: 2,125,000.00  
 Total Incurred Claims: 1,636,000.00  
 Annual \$: Min: 1,723.00 Max: 11,301.00 Avg: 3,379.00

**REQUESTED RATE:**

Projected Earned Premium: 1,904,275.00  
 Projected Incurred Claims: 1,438,203.00  
 Annual \$: Min: 2,090.00 Max: 11,363.00 Avg: 4,009.00

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## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		DC AHI SG HMO 2015	HI SGHIXSched-5248 02, HI SGHIXSchedAOA-5249 02, HI SGHIXSched-5251 02, HI SGHIXSchedAOA-5252 02, HI SGHIXSched-5254 02, HI SGHIXSched-5256 02, HI SGHIXSchedAOA-5258 02, HI SGHIXSched-5260 02, HI SGHIXSched-5262 02, HI SGHIXSched-5264 02	Revised	Previous State Filing Number: AETN-128968538 Percent Rate Change Request:	AE_DC_SG_73987_Rates_ON_v1.xlsm, DC SG Rate Manual - 1Q15 SHOP AHI.pdf,

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State:

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Filing Company:

Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA  
WV

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

DC AHI SG HMO 2015

Project Name/Number:

2015 Exchange - Aetna/HMO

**Attachment AE\_DC\_SG\_73987\_Rates\_ON\_v1.xlsm is not a PDF document and cannot be reproduced here.**

## 2015 District of Columbia Small Group Premium Rate Manual

The following steps are used to calculate premium rates. Rates are determined using the prescribed member build-up approach, with a cap of 3 dependent children. For each member, including only the 3 oldest dependent children under age 21, calculate the Member Rate as follows:

1. **Market Index Rate** – Starting premium rate.
2. **Member Age Factor** – Rate factor for each member Age.
3. **Plan Relativity Factor** – Rate factor for each unique plan design.

The product identifier will identify the plan. For each product identifier, there will be a plan relativity factor.

4. **Area Factor** - Rate factor to reflect differences in cost by geographic area.  
DC has only one area, therefore the area factor is 1.000.
5. **Effective Date Factor** – Premium rate level adjustment factor to reflect differences in cost by effective date.
6. **Final Member Premium** (1 x 2 x 3 x 4 x 5 steps above)  
Format will be the same as base rate table.

Add up the Member Rate for each covered member, subject to the dependent child cap, to determine the total premium for the policy.

# 2015 District of Columbia Small Group Premium Rate Manual

## Rating Tables Effective 1/1/2015

<b>Market Index Rate</b>	342.27
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### Area Factor Table

<b>Name</b>	<b>Area Factors</b>
Washington	1.0000

### Effective Date Factor Table

<b>Effective Date</b>	<b>Factor</b>
01/01/2015 - 3/31/2015	1.0000
04/01/2015 - 6/30/2015	1.0220
07/01/2015 - 9/30/2015	1.0445
10/01/2015 - 12/31/2015	1.0675

## 2015 District of Columbia Small Group Premium Rate Manual

<u>Age</u>	<u>Factor</u>
<21	0.6540
21	0.7270
22	0.7270
23	0.7270
24	0.7270
25	0.7270
26	0.7270
27	0.7270
28	0.7440
29	0.7600
30	0.7790
31	0.7990
32	0.8170
33	0.8360
34	0.8560
35	0.8760
36	0.8960
37	0.9160
38	0.9270
39	0.9380
40	0.9750
41	1.0130
42	1.0530
43	1.0940
44	1.1370
45	1.1810
46	1.2270
47	1.2750
48	1.3250
49	1.3770
50	1.4310
51	1.4870
52	1.5450
53	1.6050
54	1.6680
55	1.7330
56	1.8010
57	1.8710
58	1.9440
59	2.0200
60	2.0990
61	2.1803
62	2.1803
63	2.1803
64	2.1803
65+	2.1803

## 2015 District of Columbia Small Group Premium Rate Manual

<b>HMO Plans</b>				
<b>Actively Marketed Plans 01/01/15</b>				
<b>HIOS Plan ID</b>	<b>Metal Tier</b>	<b>PLAN NAME</b>	<b>Plan Relativity Factor</b>	<b>AV Factor</b>
73987DC0040013	Gold	DC Gold HMO 90%	1.21562	0.813
73987DC0040021	Gold	DC Gold HNOOnly 90%	1.26845	0.813
73987DC0040034	Gold	DC Gold HMO SJ 1500	1.08240	0.787
73987DC0040033	Gold	DC Gold HMO 70%	1.13896	0.784
73987DC0040017	Gold	DC Gold HNOOnly 70%	1.18835	0.784
73987DC0040005	Gold	DC Gold HMO 2000 70%	1.02867	0.781
73987DC0040029	Silver	DC Silver HNOOnly 2000 90% HSA	1.00000	0.693
73987DC0040035	Silver	DC Select Silver HMO SJ 2500	0.97882	0.695
73987DC0040025	Silver	DC Silver HMO 5000 70%	0.84978	0.682
73987DC0040001	Bronze	DC Bronze HMO 5400	0.77798	0.582

**Note:**

Rates will be reduced where necessary to ensure compliance with regulatory requirements, including the 3:1 federal requirement and the DC 4% incremental limit.

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TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

DC AHI SG HMO 2015

Project Name/Number:

2015 Exchange - Aetna/HMO

## Supporting Document Schedules

<b>Bypassed - Item:</b>	Actuarial Justification
<b>Bypass Reason:</b>	This is not a new form filing.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Actuarial Memorandum
<b>Comments:</b>	
<b>Attachment(s):</b>	AHI DC SG 2015 Memo and Cert.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Actuarial Memorandum and Certifications
<b>Comments:</b>	
<b>Attachment(s):</b>	AHI DC SG 2015 Memo and Cert.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Certificate of Authority to File
<b>Bypass Reason:</b>	The filing is being made by Aetna.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Consumer Disclosure Form
<b>Bypass Reason:</b>	This is the initial submission for the rate revision.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Cover Letter All Filings
<b>Comments:</b>	
<b>Attachment(s):</b>	AETNA 2015 DC Small Group RateFilingCoverLetter.pdf DC SG SHOP Cover Letter - AHI 1Q15.pdf
<b>Item Status:</b>	

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AETN-129582439

**State:** District of Columbia **Filing Company:** Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

**Product Name:** DC AHI SG HMO 2015

**Project Name/Number:** 2015 Exchange - Aetna/HMO

<b>Status Date:</b>	
<b>Satisfied - Item:</b>	DISB Actuarial Memorandum Dataset
<b>Comments:</b>	
<b>Attachment(s):</b>	Additional Actuarial Data Template - DC SG HMO VALUES.xlsx
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
<b>Bypass Reason:</b>	This is not a P & C Filing.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
<b>Bypass Reason:</b>	This is not a P & C Filing.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Unified Rate Review Template
<b>Comments:</b>	
<b>Attachment(s):</b>	AE_DC_SG_73987_URRT_BOTH_2015_v1.xlsm
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Additional Supporting Documentation
<b>Comments:</b>	

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**State Tracking #:****Company Tracking #:**

AETN-129582439

**State:**

District of Columbia

**Filing Company:**Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA  
WV**TOI/Sub-TOI:**

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

**Product Name:**

DC AHI SG HMO 2015

**Project Name/Number:**

2015 Exchange - Aetna/HMO

<b>Attachment(s):</b>	DC_SG_HMO Exhibit A-2 Plan Designs and Screenshots.pdf DC SG AHI 2015Aetna AVCCert.pdf AHI SG Consumer Summary.pdf Exhibit A-1 Product Portfolio.pdf Exhibit B - Projected Membership Distribution by Plan.pdf Exhibit C - Calculation of Plan Base Rates from Projected Index Rate.pdf Exhibit D - Projected Membership Distribution by County.pdf Exhibit E - Demographic Changes.pdf Exhibit J - Projected MLR.pdf Exhibit K - Additional Plan Base Rate Calculations.pdf Part II Justification (Plain Language Summary) AHI SG.pdf Exhibit F - Projected Age Gender Distribution.pdf Exhibit G - Projected Area Distribution.pdf Exhibit H - Projected Tobacco Usage.pdf DC SG HMO rate filing check list.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	FOIA Letter
<b>Comments:</b>	
<b>Attachment(s):</b>	FOIA 2015 Request DC AHI SG ON.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

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Product Name:

DC AHI SG HMO 2015

Project Name/Number:

2015 Exchange - Aetna/HMO

***Attachment Additional Actuarial Data Template - DC SG HMO VALUES.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment AE\_DC\_SG\_73987\_URRT\_BOTH\_2015\_v1.xlsm is not a PDF document and cannot be reproduced here.***

# Actuarial Memorandum and Certification

## General Information

### *Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** District of Columbia  
**HIOS Issuer ID:** 73987  
**Market:** Small Group  
**Policy Form:**  
**Effective Date:** 01/01/2015  
**Filing Reference Number:** AETN-129582439

### *Company Contact Information:*

**Name:** David M. Walker  
**Telephone Number:** (215) 775-0083  
**Email Address:** WalkerD9@Aetna.com

## 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms referenced above;
- 3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
- 4) Provide summaries of the benefit details for the products/plan designs referenced by this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in conjunction with the Aetna Health Inc. in the District of Columbia (DC) beginning January 1, 2015. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available on the Federally Facilitated Exchange in DC.

## 2. Proposed Rate Increase

Monthly premium rates for all Small Group Market products in DC are being revised for effective dates January 1, 2015 through December 31, 2015. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Aetna is proposing a total average increase of 1.4%. This change reflects the premium and member weighted average increase by plan based on Worksheet 2 of the URRT. The actual increase by plan ranges from -5.0% to 9.5% as seen in the table below.

HIOS Plan-ID	Plan	Metallic Tier	Rate Increase
--------------	------	---------------	---------------

73987DC0040013	DC Gold HMO 90%	Gold	-5.0%
73987DC0040021	DC Gold HNOly 90%	Gold	-4.5%
73987DC0040034	DC Gold HMO SJ 1500	Gold	N/A
73987DC0040033	DC Gold HMO 70%	Gold	-4.9%
73987DC0040017	DC Gold HNOly 70%	Gold	-4.4%
73987DC0040005	DC Gold HMO 2000 70%	Gold	0.4%
73987DC0040029	DC Silver HNOly 2000 90% HSA	Silver	-0.1%
73987DC0040035	DC Select Silver HMO SJ 2500	Silver	N/A
73987DC0040025	DC Silver HMO 5000 70%	Silver	0.9%
73987DC0040001	DC Bronze HMO 5400	Bronze	9.5%

A. Reason for Rate Change(s):

Rates for these products are updated to reflect the following:

- Impact of medical claim trend (including increases in provider unit costs and increased utilization of medical cost services);
- Revisions to our assumptions about population morbidity and the projected population distribution;
- Changes in cost sharing levels to ensure that plans comply with Actuarial Value requirements; and
- Changes in provider networks and contracts.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2013 through December 31, 2013 and paid through February 28, 2014.

B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for small group business in DC and Virginia. Internal modeling of MLR Rebates for the DC Small Group MLR Pool for 2013 estimates no rebate liability. As such, no MLR rebates are adjusted out of the premiums earned in 2013 and reported on Worksheet 1 of the Part I URRT.DC

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level details and allow us to distinguish between Grandfathered and Non-Grandfathered blocks of business.

Incurred claims are developed through the process of estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off to reduce the impact of IBNP estimates in the most recent incurred month. As a result, the IBNP reserves account for approximately 4.4% of the experience period incurred claims.

#### 4. Benefit Categories

The benefit categories used generally align with the Federal instructions dated March 20, 2014. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, while Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses. Other includes home health care, mental health care, medical pharmacy expenses, as well as laboratory and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

#### 5. Projection Factors

##### A. Changes in the Morbidity of the Population Insured:

The projected change in the morbidity of the population is based on modeling for the projected impact on the small group market of:

- Guaranteed Issue (based on a market migration model)
- Pent-Up Demand for the current uninsured population that will enter the small group market

We also adjust the experience period claims to account for estimated differences between the morbidity of our current business and the overall and small group market in DC.

##### B. Changes in Benefits:

These products include additional benefits to bring them into compliance with DC Essential Health Benefits (EHBs). The benefit changes determined to have an impact on rates from the experience period include the following:

- Expansion of DME benefits
- Coverage for nutritional formula
- Expansion of infertility coverage
- Coverage for eye glasses for children
- Home health care and private duty nursing

The estimated net allowed impact of these changes relative to the current small group base period experience is approximately 1.2% of claims cost.

##### C. Changes in Demographics:

Experience data was normalized for projected changes in the 2015 age gender mix using Aetna demographic factors. The projected enrollment by age was based on Small Group experience from 2013. While this increases the average rate, this does not cause an increase to age specific rates.

##### D. Other Adjustments:

The expected mix of business for 2015 was projected and used to determine a projected market average rate. The effect of the change in mix of business due to differences in benefits, demographics, and area is shown in the “Other” adjustment column.

E. Trend Factors (Cost/Utilization):

Anticipated annual trend from the experience period to the rating period for the product line is as follows:

<b>Component</b>	<b>Unit Cost</b>	<b>Utilization</b>	<b>Benefit Changes Utilization</b>	<b>Total Trend</b>
Total	5.4%	3.5%	2.1%	<b>11.4%</b>

a. **Medical and Pharmacy Trend**

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that will start in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived from the federal risk adjustment program factors. The amount shown above is the annualized impact.

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. The trends noted in the table above are for our current pharmacy network and current formulary. Changes to the current network and formulary are included in the Other Trend as noted above.

6. Credibility Manual Rate Development

We did not rely on our market single risk pool experience data reported in Section 1, Worksheet 1 of the URRT.

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the experience incurred from January 2013 to December 2013 and paid through February 2014 for Aetna Health Inc. in the DC and Virginia Small Group market. Aetna does not consider the District of Columbia experience alone to be credible. In order to obtain sufficient credibility, the State of Virginia and District of Columbia experience combine was considered in developing the index rate.

B. Adjustments Made to the Data:

The data is adjusted for the projected changes in network, provider contracts, and claims adjudication.

**C. Inclusion of Capitation Payments:**

No services provided in 2015 are expected to be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

**7. Credibility of Experience**

No credibility is assigned to the experience data. This is due to the use of alternate experience data.

**8. Paid-to-Allowed Ratio**

We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 68.4% demonstrated below from Worksheet II of the URRT.

Total Incurred claims, payable with issuer funds	\$1,524,337
Total Allowed Claims (TAC)	\$2,227,252
Paid to Allowed Ratio	0.684

The projected average premium is based on a 1.0 rating area, average age 40, and member distribution by plan as shown in Exhibit B.

Tier	Projected Membership Distribution	Projected Average Premium	Actuarial Value
Bronze	18%	\$266	58%
Silver	70%	\$323	69%
Gold	12%	\$395	79%
Total	100.0%	\$321	69%

**9. Risk Adjustment and Reinsurance**

We developed a market base rate that represents the average market morbidity expected in 2015. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level.

There will be no reinsurance recoveries, as the reinsurance program only applies to individual products. This filing is for a small group product.

**10. Non-Benefit Expenses and Profit & Risk**

The Retention Portion of the Market Base Rate is 24.82%. This was developed from the following items and approximated as shown:

1. Taxes and Fees 6.70% comprised of:
  - a. Premium Taxes of 1.55%

- b. Patient Centered Outcomes Research Fund of \$0.17 per member per month, converted to 0.05%
  - c. d. Health Insurer Fee of 3.0%
    - i. 1.95% paid post-tax as the Health Insurer Fee
    - ii. 1.05%, charged as a corporate tax of 35% on the 1.95% pre-tax charge
  - e. No exchange user fee for SHOP participation.
  - f. Federal Income Tax of 2.1%, assuming 35% tax rate
  - 2. Commissions of 5.34% of premium
  - 3. General Administrative Expenses of \$29.79, converted to 8.88% of premium based upon an expected average premium level
- Of the above total general administration expenses,
- a. 0.60 % is classified as Quality Improvement Activities under 45 CFR Part 158.
- 4. Risk Charge of 3.90%

These prospective expenses are based on historical expense levels and the changes expected with the requirements of PPACA and the Exchange.

The Risk Charge of 3.90% is in line with the amount allowed in the Risk Corridor calculation.

#### 11. Projected Loss Ratio

The expected loss ratio for these products is 75.18%. This is consistent with the effective retention target of 24.84% of premium. As noted below, Aetna projects an MLR in excess of the minimum regulatory requirement.

A projection of the MLR for this product is provided in Exhibit J. This projection includes anticipated experience for this product for the 12 months in 2015 and does not include a credibility adjustment. We expect this to be equivalent to a Loss Ratio with Federal Adjustments of 81.22% as illustrated in Exhibit J.

#### 12. Average Annual Premium

Based on the plan adjusted index rate of \$334.05 as shown in Worksheet 2 of the URRT, the average annual premium for this product is \$4,009.

#### 13. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in DC through Aetna Health Inc.. Rates for plans that may be renewed outside the single risk pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing and will be submitted in a separate filing as necessary.

The experience reported on Worksheet 1 includes all Aetna Health Inc. experience that is part of the Small Group market in DC.

#### 14. Index Rate

The index rate for the projection period is set equal to the projected allowed claims. The 2015 plans do not cover any non-EHBs.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, the impact of induced utilization, and the plan's provider network, delivery system characteristics, and utilization management practices. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR Part 156, §156.80(d)(2).

### 15. Market-Adjusted Index Rate

Exhibit K illustrates the development of the Market Adjusted Index Rate. The three adjustments (Transitional Reinsurance, Risk Adjustment, and Exchange User Fees) were discussed previously. They are developed as multiplicative adjustments to paid claims for the Essential Health Benefits, and are applied as multiplicative adjustments to the index rate, which differs from the basis on which the adjustments were developed by the paid to allowed ratio.

### 16. Plan-Adjusted Index Rates

Exhibit K illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The Plan Adjusted Index Rates are displayed in Column 15. The following briefly describes how each set of adjustments was determined.

#### A. Actuarial Value and Cost Sharing:

We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The result of these analyses is the cost sharing adjustment (1.0 indicates full coverage of allowed claims) in Column 8. In Column 9, we applied an adjustment to reflect the impact of the different levels of cost sharing on the use of medical services. These adjustments are based on the induced utilization factors used in the Risk Adjustment program, and have been normalized to result in an aggregate factor of 1.0 when applied to the projected 2015 membership.

#### B. Provider Network, Delivery System, and Utilization Management:

The network adjustment (Column 6) reflects the estimated impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences, and estimated the expected impact on allowed claims.

#### C. Benefits in addition to EHBs:

The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). These products do not provide coverage for non-EHBs.

#### D. Non-Tobacco Adjustment:

Per DISB instructions, we applied no load for tobacco usage.

#### E. Catastrophic Plan Eligibility:

We are not filing any catastrophic plans in the small group market.

#### F. Distribution and Administrative Costs:

We applied an adjustment to load the rate for the expected cost impact of limiting billable members to three dependents younger than age 21. This adjustment is reflected in Column 13. Columns 14a and 14b reflect the projected administrative costs and profit margin. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Reinsurance Contribution, Risk Adjustment User Fee, and Exchange User Fee, which are reflected elsewhere. These expense and profit assumptions do not vary by plan.

### 17. Calibration

#### A. Age Curve Calibration:

The age factors are based on the DC specific age scale. The factors are shown in Exhibit F.

We projected an average age factor for the 2015 membership of 1.0406. We determined a calibration factor of .961 by determining the average age factor (using the DC specific age curve) for the projected

enrollment by age and taking its reciprocal. The average age factor is a member-weighted average; the projected age distribution is based on the Aetna Health Inc. Small Group experience from 2013.

Based on Aetna’s Small Group experience, we estimated that billing for no more than three dependents under age 21 requires a 0.50% increase to the base rate.

**B. Geographic Factor Calibration:**

Exhibit D summarizes the rating area definitions and factors. DC only has one rating area and an area factor of 1.0. Exhibit G displays the projected membership by area and the projected average area factor of 1.0.

**18. Consumer-Adjusted Premium Rate Development**

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three dependents under age 21, only the three oldest dependents will be considered in determining the family’s premium. Additional dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

$$\text{Market Base Rate} * \text{Age Factor} * \text{Area Factor} * \text{Plan Factor}$$

As an example of this calculation, consider a family living in DC that enrolls in the DC Silver HN Only 2000 90% HSA plan. Assume that the parents are ages 42 and 40 and have children ages 13, 11, 8, and 6. The rate for this family is calculated as:

Member Age	42	40	13	11	8	6
Market Base Rate	\$470.03	\$470.03	\$470.03	\$470.03	\$470.03	\$470.03
Age Factor	1.053	0.975	0.654	0.654	0.654	0.654
Area Factor	1	1	1	1	1	1
Tobacco Factor	N/A	N/A	N/A	N/A	N/A	N/A
Plan Factor	0.728	0.728	0.728	0.728	0.728	0.728
Final Rate	\$360.32	\$333.63	\$223.79	\$223.79	\$223.79	N/A

The family’s final monthly rate is the sum of the member rates, or \$1,365.31. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example. Since we apply no tobacco load in DC, we did include a tobacco factor in the above calculation.

**19. AV Metal Values**

The AV Metal Values on Worksheet 2 were based on the AV Calculator. Adjustments were made to account for plan design features that could not be entered into the AV Calculator and have a material impact on the AV. These adjustments were developed using an acceptable alternative method as outlined in 45 CFR Part 156, §156.135 and as discussed in the accompanying certification regarding the development of the AV metal values. Exhibit A-2 provides a summary of the plan designs as well as AV screenshots from the calculator.

**20. AV Pricing Values**

The fixed reference plan is 73987DC0040029 (DC Silver HN Only 2000 90% HSA plan). Benefit factors were developed taking into account the allowable rating characteristics and discussed above and

illustrated in Exhibit K. The resulting plan factors are displayed in Column 20 of Exhibit K. We have not adjusted the benefit factors based on morbidity differences or benefit selection.

A plan factor to adjust the market base rate for differences in plan-specific expected claims was calculated. These factors account for differences in benefits, cost sharing, and network design (where applicable). The benchmark Silver plan is assigned a factor of 1.0. The factors were developed using a proprietary pricing model which relies on:

- a) State- and product-specific service category weights;
- b) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and copays
- c) Utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier.

#### 21. Membership Projections

The model discussed in the “Claims Development and Morbidity Adjustments” section below contains detail on current and projected membership by age band and benefit level. It is used to form a basis for projecting the membership distribution in these plans.

Exhibit K summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience, enrollment in ACA-compliant plans through February 2014, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans. We assumed that total enrollment will be similar to our current enrollment.

#### 22. Terminated Products

The following products will be closed to new sales prior to January 1, 2015, and are included in the Terminated Products reporting column in Worksheet 2:

- 73987DC0040003 (Aetna Bronze HMO 6350 RE)
- 73987DC0040007 (Aetna Gold HMO 2000 70% RE)
- 73987DC0040011 (Aetna Gold HMO 70% RE)
- 73987DC0040015 (Aetna Gold HMO 90% RE)
- 73987DC0040019 (Aetna Gold HNOOnly 70% RE)
- 73987DC0040023 (Aetna Gold HNOOnly 90% RE)
- 73987DC0040027 (Aetna Silver HMO 5000 70% RE)
- 73987DC0040031 (Aetna Silver HNOOnly 2000 90% HSA RE)

Consistent with the URRT instructions, experience for all terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

#### 23. Plan Type

All plans are consistent with the plan type indicated in Worksheet 2.

#### 24. Warning Alerts

The URRT as submitted does not include any Warning Alerts.

#### 25. Benefit Design

This filing includes the following standard plans: one Bronze, six Silver, and four Gold. These plans will be offered through the Exchange and will include pediatric dental benefits.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is

summarized in Exhibit A and B. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

#### 26. Marketing

As described above, all of these plans will be made available through the Exchange.

#### 27. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the Exchange as verification of eligibility.

#### 28. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

#### 29. Claims Development and Morbidity Adjustments

A key provision of the PPACA is that all Small Group policies effective on or after January 1, 2014 are offered on a guaranteed issue basis without rating for pre-existing medical conditions, with product-level rate differentiation limited by the actuarial value requirements of the four metallic tiers, and rating variations limited to age, network and rating area.

In the pre-January 1, 2014 Small Group market environment in DC, rates varied by network, rating area, age, gender, and the medically underwritten health-status, and coverage could be denied based on medical underwriting exams. In addition to the elimination of medical underwriting, PPACA-related rating changes including the individual mandate, advanced premium tax credits, and cost sharing subsidies will motivate more people to purchase individual insurance. As a result of the changes in product issuance, rating, and financial assistance available to individuals without group insurance, the morbidity profile of the Small Group insurance market in DC changed in 2014. The adjustment for this change was discussed in section 5 A above.

We are using this projection to set our prices at the anticipated market morbidity levels.

#### 30. Company Financial Condition

As of December 31, 2013, the total adjusted capital (TAC) held by Aetna Health Inc. was approximately \$329 million. This amount is disclosed in the Company's statutory financial statement dated December 31, 2013. The Company issues insurance nationwide for multiple lines of business including, large group medical, Small Group medical, individual medical, and various non-medical products.

#### Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, David M. Walker, am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of DC, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Plan Entities
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 41, Actuarial Communications.
  
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
  
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
  
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
  
5. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments were made to reflect benefit features not handled by the AV Calculator, as outlined in the attached certification required by 45 CFR Part 156, §156.135.



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David M. Walker, ASA, MAAA  
Aetna

June 12, 2014

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Date

# Actuarial Memorandum and Certification

## General Information

### *Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** District of Columbia  
**HIOS Issuer ID:** 73987  
**Market:** Small Group  
**Policy Form:**  
**Effective Date:** 01/01/2015  
**Filing Reference Number:** AETN-129582439

### *Company Contact Information:*

**Name:** David M. Walker  
**Telephone Number:** (215) 775-0083  
**Email Address:** WalkerD9@Aetna.com

## 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms referenced above;
- 3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
- 4) Provide summaries of the benefit details for the products/plan designs referenced by this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in conjunction with the Aetna Health Inc. in the District of Columbia (DC) beginning January 1, 2015. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available on the Federally Facilitated Exchange in DC.

## 2. Proposed Rate Increase

Monthly premium rates for all Small Group Market products in DC are being revised for effective dates January 1, 2015 through December 31, 2015. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Aetna is proposing a total average increase of 1.4%. This change reflects the premium and member weighted average increase by plan based on Worksheet 2 of the URRT. The actual increase by plan ranges from -5.0% to 9.5% as seen in the table below.

HIOS Plan-ID	Plan	Metallic Tier	Rate Increase
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73987DC0040013	DC Gold HMO 90%	Gold	-5.0%
73987DC0040021	DC Gold HNOOnly 90%	Gold	-4.5%
73987DC0040034	DC Gold HMO SJ 1500	Gold	N/A
73987DC0040033	DC Gold HMO 70%	Gold	-4.9%
73987DC0040017	DC Gold HNOOnly 70%	Gold	-4.4%
73987DC0040005	DC Gold HMO 2000 70%	Gold	0.4%
73987DC0040029	DC Silver HNOOnly 2000 90% HSA	Silver	-0.1%
73987DC0040035	DC Select Silver HMO SJ 2500	Silver	N/A
73987DC0040025	DC Silver HMO 5000 70%	Silver	0.9%
73987DC0040001	DC Bronze HMO 5400	Bronze	9.5%

A. Reason for Rate Change(s):

Rates for these products are updated to reflect the following:

- Impact of medical claim trend (including increases in provider unit costs and increased utilization of medical cost services);
- Revisions to our assumptions about population morbidity and the projected population distribution;
- Changes in cost sharing levels to ensure that plans comply with Actuarial Value requirements; and
- Changes in provider networks and contracts.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2013 through December 31, 2013 and paid through February 28, 2014.

B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for small group business in DC and Virginia. Internal modeling of MLR Rebates for the DC Small Group MLR Pool for 2013 estimates no rebate liability. As such, no MLR rebates are adjusted out of the premiums earned in 2013 and reported on Worksheet 1 of the Part I URRT.DC

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level details and allow us to distinguish between Grandfathered and Non-Grandfathered blocks of business.

Incurred claims are developed through the process of estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off to reduce the impact of IBNP estimates in the most recent incurred month. As a result, the IBNP reserves account for approximately 4.4% of the experience period incurred claims.

#### 4. Benefit Categories

The benefit categories used generally align with the Federal instructions dated March 20, 2014. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, while Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses. Other includes home health care, mental health care, medical pharmacy expenses, as well as laboratory and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

#### 5. Projection Factors

##### A. Changes in the Morbidity of the Population Insured:

The projected change in the morbidity of the population is based on modeling for the projected impact on the small group market of:

- Guaranteed Issue (based on a market migration model)
- Pent-Up Demand for the current uninsured population that will enter the small group market

We also adjust the experience period claims to account for estimated differences between the morbidity of our current business and the overall and small group market in DC.

##### B. Changes in Benefits:

These products include additional benefits to bring them into compliance with DC Essential Health Benefits (EHBs). The benefit changes determined to have an impact on rates from the experience period include the following:

- Expansion of DME benefits
- Coverage for nutritional formula
- Expansion of infertility coverage
- Coverage for eye glasses for children
- Home health care and private duty nursing

The estimated net allowed impact of these changes relative to the current small group base period experience is approximately 1.2% of claims cost.

##### C. Changes in Demographics:

Experience data was normalized for projected changes in the 2015 age gender mix using Aetna demographic factors. The projected enrollment by age was based on Small Group experience from 2013. While this increases the average rate, this does not cause an increase to age specific rates.

##### D. Other Adjustments:

The expected mix of business for 2015 was projected and used to determine a projected market average rate. The effect of the change in mix of business due to differences in benefits, demographics, and area is shown in the “Other” adjustment column.

E. Trend Factors (Cost/Utilization):

Anticipated annual trend from the experience period to the rating period for the product line is as follows:

<b>Component</b>	<b>Unit Cost</b>	<b>Utilization</b>	<b>Benefit Changes Utilization</b>	<b>Total Trend</b>
Total	5.4%	3.5%	2.1%	<b>11.4%</b>

a. **Medical and Pharmacy Trend**

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that will start in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived from the federal risk adjustment program factors. The amount shown above is the annualized impact.

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. The trends noted in the table above are for our current pharmacy network and current formulary. Changes to the current network and formulary are included in the Other Trend as noted above.

6. Credibility Manual Rate Development

We did not rely on our market single risk pool experience data reported in Section 1, Worksheet 1 of the URRT.

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the experience incurred from January 2013 to December 2013 and paid through February 2014 for Aetna Health Inc. in the DC and Virginia Small Group market. Aetna does not consider the District of Columbia experience alone to be credible. In order to obtain sufficient credibility, the State of Virginia and District of Columbia experience combine was considered in developing the index rate.

B. Adjustments Made to the Data:

The data is adjusted for the projected changes in network, provider contracts, and claims adjudication.

**C. Inclusion of Capitation Payments:**

No services provided in 2015 are expected to be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

**7. Credibility of Experience**

No credibility is assigned to the experience data. This is due to the use of alternate experience data.

**8. Paid-to-Allowed Ratio**

We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 68.4% demonstrated below from Worksheet II of the URRT.

Total Incurred claims, payable with issuer funds	\$1,524,337
Total Allowed Claims (TAC)	\$2,227,252
Paid to Allowed Ratio	0.684

The projected average premium is based on a 1.0 rating area, average age 40, and member distribution by plan as shown in Exhibit B.

Tier	Projected Membership Distribution	Projected Average Premium	Actuarial Value
Bronze	18%	\$266	58%
Silver	70%	\$323	69%
Gold	12%	\$395	79%
Total	100.0%	\$321	69%

**9. Risk Adjustment and Reinsurance**

We developed a market base rate that represents the average market morbidity expected in 2015. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level.

There will be no reinsurance recoveries, as the reinsurance program only applies to individual products. This filing is for a small group product.

**10. Non-Benefit Expenses and Profit & Risk**

The Retention Portion of the Market Base Rate is 24.82%. This was developed from the following items and approximated as shown:

1. Taxes and Fees 6.70% comprised of:
  - a. Premium Taxes of 1.55%

- b. Patient Centered Outcomes Research Fund of \$0.17 per member per month, converted to 0.05%
  - c. d. Health Insurer Fee of 3.0%
    - i. 1.95% paid post-tax as the Health Insurer Fee
    - ii. 1.05%, charged as a corporate tax of 35% on the 1.95% pre-tax charge
  - e. No exchange user fee for SHOP participation.
  - f. Federal Income Tax of 2.1%, assuming 35% tax rate
  - 2. Commissions of 5.34% of premium
  - 3. General Administrative Expenses of \$29.79, converted to 8.88% of premium based upon an expected average premium level
- Of the above total general administration expenses,
- a. 0.60 % is classified as Quality Improvement Activities under 45 CFR Part 158.
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These prospective expenses are based on historical expense levels and the changes expected with the requirements of PPACA and the Exchange.

The Risk Charge of 3.90% is in line with the amount allowed in the Risk Corridor calculation.

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The expected loss ratio for these products is 75.18%. This is consistent with the effective retention target of 24.84% of premium. As noted below, Aetna projects an MLR in excess of the minimum regulatory requirement.

A projection of the MLR for this product is provided in Exhibit J. This projection includes anticipated experience for this product for the 12 months in 2015 and does not include a credibility adjustment. We expect this to be equivalent to a Loss Ratio with Federal Adjustments of 81.22% as illustrated in Exhibit J.

#### 12. Average Annual Premium

Based on the plan adjusted index rate of \$334.05 as shown in Worksheet 2 of the URRT, the average annual premium for this product is \$4,009.

#### 13. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in DC through Aetna Health Inc.. Rates for plans that may be renewed outside the single risk pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing and will be submitted in a separate filing as necessary.

The experience reported on Worksheet 1 includes all Aetna Health Inc. experience that is part of the Small Group market in DC.

#### 14. Index Rate

The index rate for the projection period is set equal to the projected allowed claims. The 2015 plans do not cover any non-EHBs.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, the impact of induced utilization, and the plan's provider network, delivery system characteristics, and utilization management practices. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR Part 156, §156.80(d)(2).

### 15. Market-Adjusted Index Rate

Exhibit K illustrates the development of the Market Adjusted Index Rate. The three adjustments (Transitional Reinsurance, Risk Adjustment, and Exchange User Fees) were discussed previously. They are developed as multiplicative adjustments to paid claims for the Essential Health Benefits, and are applied as multiplicative adjustments to the index rate, which differs from the basis on which the adjustments were developed by the paid to allowed ratio.

### 16. Plan-Adjusted Index Rates

Exhibit K illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The Plan Adjusted Index Rates are displayed in Column 15. The following briefly describes how each set of adjustments was determined.

#### A. Actuarial Value and Cost Sharing:

We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The result of these analyses is the cost sharing adjustment (1.0 indicates full coverage of allowed claims) in Column 8. In Column 9, we applied an adjustment to reflect the impact of the different levels of cost sharing on the use of medical services. These adjustments are based on the induced utilization factors used in the Risk Adjustment program, and have been normalized to result in an aggregate factor of 1.0 when applied to the projected 2015 membership.

#### B. Provider Network, Delivery System, and Utilization Management:

The network adjustment (Column 6) reflects the estimated impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences, and estimated the expected impact on allowed claims.

#### C. Benefits in addition to EHBs:

The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). These products do not provide coverage for non-EHBs.

#### D. Non-Tobacco Adjustment:

Per DISB instructions, we applied no load for tobacco usage.

#### E. Catastrophic Plan Eligibility:

We are not filing any catastrophic plans in the small group market.

#### F. Distribution and Administrative Costs:

We applied an adjustment to load the rate for the expected cost impact of limiting billable members to three dependents younger than age 21. This adjustment is reflected in Column 13. Columns 14a and 14b reflect the projected administrative costs and profit margin. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Reinsurance Contribution, Risk Adjustment User Fee, and Exchange User Fee, which are reflected elsewhere. These expense and profit assumptions do not vary by plan.

### 17. Calibration

#### A. Age Curve Calibration:

The age factors are based on the DC specific age scale. The factors are shown in Exhibit F.

We projected an average age factor for the 2015 membership of 1.0406. We determined a calibration factor of .961 by determining the average age factor (using the DC specific age curve) for the projected

enrollment by age and taking its reciprocal. The average age factor is a member-weighted average; the projected age distribution is based on the Aetna Health Inc. Small Group experience from 2013.

Based on Aetna’s Small Group experience, we estimated that billing for no more than three dependents under age 21 requires a 0.50% increase to the base rate.

**B. Geographic Factor Calibration:**

Exhibit D summarizes the rating area definitions and factors. DC only has one rating area and an area factor of 1.0. Exhibit G displays the projected membership by area and the projected average area factor of 1.0.

**18. Consumer-Adjusted Premium Rate Development**

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three dependents under age 21, only the three oldest dependents will be considered in determining the family’s premium. Additional dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

$$\text{Market Base Rate} * \text{Age Factor} * \text{Area Factor} * \text{Plan Factor}$$

As an example of this calculation, consider a family living in DC that enrolls in the DC Silver HN Only 2000 90% HSA plan. Assume that the parents are ages 42 and 40 and have children ages 13, 11, 8, and 6. The rate for this family is calculated as:

Member Age	42	40	13	11	8	6
Market Base Rate	\$470.03	\$470.03	\$470.03	\$470.03	\$470.03	\$470.03
Age Factor	1.053	0.975	0.654	0.654	0.654	0.654
Area Factor	1	1	1	1	1	1
Tobacco Factor	N/A	N/A	N/A	N/A	N/A	N/A
Plan Factor	0.728	0.728	0.728	0.728	0.728	0.728
Final Rate	\$360.32	\$333.63	\$223.79	\$223.79	\$223.79	N/A

The family’s final monthly rate is the sum of the member rates, or \$1,365.31. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example. Since we apply no tobacco load in DC, we did include a tobacco factor in the above calculation.

**19. AV Metal Values**

The AV Metal Values on Worksheet 2 were based on the AV Calculator. Adjustments were made to account for plan design features that could not be entered into the AV Calculator and have a material impact on the AV. These adjustments were developed using an acceptable alternative method as outlined in 45 CFR Part 156, §156.135 and as discussed in the accompanying certification regarding the development of the AV metal values. Exhibit A-2 provides a summary of the plan designs as well as AV screenshots from the calculator.

**20. AV Pricing Values**

The fixed reference plan is 73987DC0040029 (DC Silver HN Only 2000 90% HSA plan). Benefit factors were developed taking into account the allowable rating characteristics and discussed above and

illustrated in Exhibit K. The resulting plan factors are displayed in Column 20 of Exhibit K. We have not adjusted the benefit factors based on morbidity differences or benefit selection.

A plan factor to adjust the market base rate for differences in plan-specific expected claims was calculated. These factors account for differences in benefits, cost sharing, and network design (where applicable). The benchmark Silver plan is assigned a factor of 1.0. The factors were developed using a proprietary pricing model which relies on:

- a) State- and product-specific service category weights;
- b) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and copays
- c) Utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier.

#### 21. Membership Projections

The model discussed in the “Claims Development and Morbidity Adjustments” section below contains detail on current and projected membership by age band and benefit level. It is used to form a basis for projecting the membership distribution in these plans.

Exhibit K summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience, enrollment in ACA-compliant plans through February 2014, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans. We assumed that total enrollment will be similar to our current enrollment.

#### 22. Terminated Products

The following products will be closed to new sales prior to January 1, 2015, and are included in the Terminated Products reporting column in Worksheet 2:

- 73987DC0040003 (Aetna Bronze HMO 6350 RE)
- 73987DC0040007 (Aetna Gold HMO 2000 70% RE)
- 73987DC0040011 (Aetna Gold HMO 70% RE)
- 73987DC0040015 (Aetna Gold HMO 90% RE)
- 73987DC0040019 (Aetna Gold HNOnly 70% RE)
- 73987DC0040023 (Aetna Gold HNOnly 90% RE)
- 73987DC0040027 (Aetna Silver HMO 5000 70% RE)
- 73987DC0040031 (Aetna Silver HNOnly 2000 90% HSA RE)

Consistent with the URRT instructions, experience for all terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

#### 23. Plan Type

All plans are consistent with the plan type indicated in Worksheet 2.

#### 24. Warning Alerts

The URRT as submitted does not include any Warning Alerts.

#### 25. Benefit Design

This filing includes the following standard plans: one Bronze, six Silver, and four Gold. These plans will be offered through the Exchange and will include pediatric dental benefits.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is

summarized in Exhibit A and B. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

#### 26. Marketing

As described above, all of these plans will be made available through the Exchange.

#### 27. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the Exchange as verification of eligibility.

#### 28. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

#### 29. Claims Development and Morbidity Adjustments

A key provision of the PPACA is that all Small Group policies effective on or after January 1, 2014 are offered on a guaranteed issue basis without rating for pre-existing medical conditions, with product-level rate differentiation limited by the actuarial value requirements of the four metallic tiers, and rating variations limited to age, network and rating area.

In the pre-January 1, 2014 Small Group market environment in DC, rates varied by network, rating area, age, gender, and the medically underwritten health-status, and coverage could be denied based on medical underwriting exams. In addition to the elimination of medical underwriting, PPACA-related rating changes including the individual mandate, advanced premium tax credits, and cost sharing subsidies will motivate more people to purchase individual insurance. As a result of the changes in product issuance, rating, and financial assistance available to individuals without group insurance, the morbidity profile of the Small Group insurance market in DC changed in 2014. The adjustment for this change was discussed in section 5 A above.

We are using this projection to set our prices at the anticipated market morbidity levels.

#### 30. Company Financial Condition

As of December 31, 2013, the total adjusted capital (TAC) held by Aetna Health Inc. was approximately \$329 million. This amount is disclosed in the Company's statutory financial statement dated December 31, 2013. The Company issues insurance nationwide for multiple lines of business including, large group medical, Small Group medical, individual medical, and various non-medical products.

#### Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, David M. Walker, am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of DC, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Plan Entities
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 41, Actuarial Communications.
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments were made to reflect benefit features not handled by the AV Calculator, as outlined in the attached certification required by 45 CFR Part 156, §156.135.



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David M. Walker, ASA, MAAA  
Aetna

June 12, 2014

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Date



CHESTER A. MCPHERSON  
GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPT. OF INSURANCE, SECURITIES, AND BANKING  
810 FIRST STREET, N. E., SUITE 701  
WASHINGTON, DC 20002

## Re: DC Small Group Rate Filing

DEAR COMMISSIONER MCPHERSON:

### New Marketplace Dynamics

As you know, some of the most significant provisions of the Affordable Care Act (ACA) went into effect on January 1, 2014. These provisions, including guarantee issue, limitations on age rating and minimum benefit requirements, have fundamentally changed the way the Small Group market operates.

As the health care environment continues to evolve, our focus continues to be on delivering competitively priced products and services that deliver value.

We strongly believe the rates we are filing for 2015 will be competitive with, the products offered by other carriers in the market. The submitted rates demonstrate our commitment to offering affordable products and services that meet the needs of consumers in the District of Columbia.

### Factors Impacting Premiums for 2015

A number of factors are represented in the rates we are filing today. These factors include:

- **Medical costs:** Medical costs are the primary driver of the premiums people pay. Medical costs vary by region and include utilization and unit costs for hospital care, outpatient care and doctor services. They also include reimbursement for prescription drugs, lab and X-ray fees.
- **Risk pool changes:** Our rates for 2014 included projections around anticipated experience. This rate filing uses actual experience to date (which is limited) as well as projections based on previous performance in the Small Group market.
- **Critical system and operational investments:** Expenses include investments necessary to implement and comply with the provisions of the ACA. These investments also include improvements to our claims and billing systems, enhancements to our customer service model, and advancements in technology.

All of our submitted rates are inclusive of the ACA-mandated taxes and fees, which now account for, on average, 6% of the full premium that consumers pay.

### Aetna is committed to affordability

Aetna is taking a number of steps to address the underlying cost of health care, such as:

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

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

Our goal is to deliver competitive pricing that allows our customers and members to get the greatest value out of their health benefits. Of course, consumers also benefit from the ACA's medical loss ratio requirement, which provides additional protection in the form of rebates if our medical cost trend predictions are not accurate.

Thank you in advance for your review and consideration.

A handwritten signature in black ink that reads "Thomas J. Grote". The signature is written in a cursive style with a large, stylized initial "T".

Thomas J. Grote  
President, Capitol Market  
Aetna  
thomas.grote@aetna.com  
509 Progress Drive  
Linthicum, MD 21090



980 Jolly Road  
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June 12, 2015

Mr. Efren Tanheco  
Supervising Actuary  
District of Columbia Department of Insurance & Securities Regulation  
810 First Street NE, 6<sup>th</sup> Floor  
Washington, DC 20002

Subject: Aetna Health, Inc. - NAIC Number 95109  
Small Group Premium Rate Filing – DC On Exchange  
Effective dates [January 1, 2015 – December 31, 2015](#)

Dear Mr. Tanheco:

I am writing to request approval of the attached Rate Filing for plans offered to Small Groups by Aetna Health, Inc. sold on the DC Exchange. This filing is for effective dates [January 1, 2015 – December 31, 2015](#). This filing contains the benefit plans and rating methodology. The average rate revision proposed is an increase of 1.4%.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group Market and conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010.

This filing is for Aetna's Small Group HMO Medical Expense coverage.

The following supporting documentation is also included:

- DC Rate Filing Checklist
- An Actuarial Memorandum including supporting exhibits, documentation and Actuarial Certification
- NAIC Transmittal Form

The forms filing has been submitted under separate cover and the SERFF Filing ID # is [AETN-129570338](#).

The purpose of this rate filing is to comply with regulatory rate filing requirements. This filing is not intended to be used for other purposes. . If you need additional information, please contact me by telephone at (215) 775-0083, or via e-mail at [WalkerD9@Aetna.com](mailto:WalkerD9@Aetna.com).

Sincerely,

A handwritten signature in black ink, appearing to read 'David M. Walker', is written in a cursive style.

David M. Walker

**Form Numbers – Small Group HMO**

HI SGHIXSched-5248 02

HI SGHIXSchedAOA-5249 02

HI SGHIXSched-5251 02

HI SGHIXSchedAOA-5252 02

HI SGHIXSched-5254 02

HI SGHIXSched-5256 02

HI SGHIXSchedAOA-5258 02

HI SGHIXSched-5260 02

HI SGHIXSched-5262 02

HI SGHIXSched-5264 02

**District of Columbia Small Group Portfolio | Summary of Benefits**

**Contents**

DC Gold HMO 2000 70% ..... 2  
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DC Gold HMO 90% ..... 6  
DC Gold HMO SJ 1500 ..... 8  
DC Gold HNOOnly 70% ..... 10  
DC Gold HNOOnly 90% ..... 12  
DC Silver HMO 5000 70% ..... 14  
DC Silver HMO SJ 2500 ..... 16  
DC Silver HNOOnly 2000 90% HSA ..... 18  
DC Bronze HMO 5400 ..... 20

*NOTE: This exhibit includes benefit summaries for plans without the “PD” suffix. Plans with the “PD” suffix are identical to plans without the suffix except that they cover pediatric dental benefits.*

**Summary of Benefits Covered**

DC GOLD HMO 2000 70%

District of Columbia

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$2,000
Family	\$4,000
<b>Coinsurance</b> <i>(Member Responsibility)</i>	30%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$4,500
Family	\$9,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$10 per visit
<b>Specialist Visit</b>	\$30 per visit
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	30% after deductible
<b>Emergency Room Services</b>	\$250 per visit
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$30/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	30% after deductible
<b>Rehabilitative Speech Therapy</b>	30% after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	30% after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	0%
<b>X-rays and Diagnostic Imaging</b>	\$10 per visit
<b>Skilled Nursing Facility</b>	30% after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	30% after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	30% after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	No
<b>Generics</b>	\$4, deductible waived
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	50% after deductible
<b>Specialty Drugs (i.e. high-cost)</b>	50% up to \$500

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>	<b>HSA/HRA Options</b>		<b>Narrow Network Options</b>			
Apply Inpatient Copay per Day?	<input type="checkbox"/>	HSA/HRA Employer Contribution? <input type="checkbox"/>		Blended Network/POS Plan? <input type="checkbox"/>			
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>	Annual Contribution Amount:		1st Tier Utilization:			
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>			2nd Tier Utilization:			
Indicate if Plan Meets CSR Standard?	<input type="checkbox"/>						
Desired Metal Tier	Gold	<b>Tier 1 Plan Benefit Design</b>			<b>Tier 2 Plan Benefit Design</b>		
		Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)		\$2,000.00	\$500.00				
Coinsurance (% , Insurer's Cost Share)		75.79%	78.14%				
OOP Maximum (\$)		\$4,500.00					
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
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$4.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

### Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.

Actuarial Value: 77.9%

Metal Tier:

Option 3 DedCopay adj 0.2%

Final AV 78.1%

This product, DC Gold HMO 2000 70%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 78.1%

**Summary of Benefits Covered**

DC GOLD HMO 70%

District of Columbia

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$0
Family	\$0
<b>Coinsurance</b> <i>(Member Responsibility)</i>	30%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$5,000
Family	\$10,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$30 per visit
<b>Specialist Visit</b>	\$50 per visit
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	30%
<b>Emergency Room Services</b>	\$300 per visit
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	\$300 per visit
<b>Rehabilitative Speech Therapy</b>	\$50 per visit
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$50 per visit
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$15 per visit
<b>X-rays and Diagnostic Imaging</b>	\$50 per visit
<b>Skilled Nursing Facility</b>	30%
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	30%
<b>Outpatient Surgery Physician/Surgical Services</b>	30%

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	\$100
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>	<b>HSA/HRA Options</b>		<b>Narrow Network Options</b>			
Apply Inpatient Copay per Day?	<input type="checkbox"/>	HSA/HRA Employer Contribution? <input type="checkbox"/>		Blended Network/POS Plan? <input type="checkbox"/>			
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>	Annual Contribution Amount:		1st Tier Utilization:			
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>			2nd Tier Utilization:			
Indicate if Plan Meets CSR Standard?	<input type="checkbox"/>						
Desired Metal Tier	Gold	<b>Tier 1 Plan Benefit Design</b>			<b>Tier 2 Plan Benefit Design</b>		
		Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)		\$0.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)		67.41%	71.04%				
OOP Maximum (\$)		\$5,000.00					
OOP Maximum if Separate (\$)							

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### Options for Additional Benefit Design Limits:

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

### Output

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 78.2%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 78.4%

This product, DC Gold HMO 70%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 78.4%

## Summary of Benefits Covered

DC GOLD HMO 90%

District of Columbia

Gold Plan

### Summary of Features

In-Network

<b>Deductible</b>	
Individual	\$0
Family	\$0
<b>Coinsurance</b> (Member Responsibility)	10%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$5,000
Family	\$10,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> (excludes Preventative and X-rays)	\$30 per visit
<b>Specialist Visit</b>	\$50 per visit
<b>All Inpatient Hospital Services</b> (includes Mental/Behavioral Health and Substance Abuse)	10%
<b>Emergency Room Services</b>	\$300 per visit
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	\$300 per visit
<b>Rehabilitative Speech Therapy</b>	\$50 per visit
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$50 per visit
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$15 per visit
<b>X-rays and Diagnostic Imaging</b>	\$50 per visit
<b>Skilled Nursing Facility</b>	10%
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	10%
<b>Outpatient Surgery Physician/Surgical Services</b>	10%

### Pharmacy

In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	\$100
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

**User Inputs for Plan Parameters**

Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>	<b>HSA/HRA Options</b>		<b>Narrow Network Options</b>			
Apply Inpatient Copay per Day?	<input type="checkbox"/>	HSA/HRA Employer Contribution? <input type="checkbox"/>		Blended Network/POS Plan? <input type="checkbox"/>			
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>	Annual Contribution Amount:		1st Tier Utilization:			
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>			2nd Tier Utilization:			
Indicate if Plan Meets CSR Standard?	<input type="checkbox"/>						
Desired Metal Tier	Gold	<b>Tier 1 Plan Benefit Design</b>			<b>Tier 2 Plan Benefit Design</b>		
		Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)		\$0.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)		79.59%	71.04%				
OOP Maximum (\$)		\$5,000.00					
OOP Maximum if Separate (\$)							

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

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

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 81.1%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 81.3%

This product, DC Gold HMO 90%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 81.3%

**Summary of Benefits Covered**

DC GOLD HMO SJ 1500

District of Columbia

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$1,500
Family	\$3,500
<b>Coinsurance</b> <i>(Member Responsibility)</i>	0%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$3,500
Family	\$7,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$10 per visit
<b>Specialist Visit</b>	\$40 per visit after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	0% after deductible
<b>Emergency Room Services</b>	\$200 per visit after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	\$40 per visit after deductible
<b>Rehabilitative Speech Therapy</b>	\$40 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$40 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	0%
<b>X-rays and Diagnostic Imaging</b>	0% after deductible
<b>Skilled Nursing Facility</b>	0% after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	0% after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	0% after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$3; T1: \$5
<b>Preferred Brand Drugs</b>	\$30
<b>Non-Preferred Brand Drugs</b>	\$60
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

**User Inputs for Plan Parameters**

Use Integrated Medical and Drug Deductible?	<input checked="" type="checkbox"/>	<b>HSA/HRA Options</b>		<b>Narrow Network Options</b>	
Apply Inpatient Copay per Day?	<input type="checkbox"/>	HSA/HRA Employer Contribution? <input type="checkbox"/>		Blended Network/POS Plan? <input type="checkbox"/>	
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>	Annual Contribution Amount:		1st Tier Utilization:	
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>			2nd Tier Utilization:	
Indicate if Plan Meets CSR Standard?	<input type="checkbox"/>				
Desired Metal Tier	Gold	<b>Tier 1 Plan Benefit Design</b>		<b>Tier 2 Plan Benefit Design</b>	
		<b>Medical</b>	<b>Drug</b>	<b>Combined</b>	<b>Medical</b>
Deductible (\$)				\$1,500.00	
Coinsurance (% , Insurer's Cost Share)				91.26%	
OOP Maximum (\$)				\$3,500.00	
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
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$4.04	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

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

**Output**

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 78.5%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 78.7%

This product, DC Gold HMO SJ 1500, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 78.7%

**Summary of Benefits Covered**

DC GOLD HNONLY 70%

District of Columbia

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$0
Family	\$0
<b>Coinsurance</b> <i>(Member Responsibility)</i>	30%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$5,000
Family	\$10,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$30 per visit
<b>Specialist Visit</b>	\$50 per visit
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	30%
<b>Emergency Room Services</b>	\$300 per visit
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	\$300 per visit
<b>Rehabilitative Speech Therapy</b>	\$50 per visit
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$50 per visit
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$15 per visit
<b>X-rays and Diagnostic Imaging</b>	\$50 per visit
<b>Skilled Nursing Facility</b>	30%
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	30%
<b>Outpatient Surgery Physician/Surgical Services</b>	30%

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	\$100
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>	<b>HSA/HRA Options</b>		<b>Narrow Network Options</b>			
Apply Inpatient Copay per Day?	<input type="checkbox"/>	HSA/HRA Employer Contribution? <input type="checkbox"/>		Blended Network/POS Plan? <input type="checkbox"/>			
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>	Annual Contribution Amount:		1st Tier Utilization:			
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>			2nd Tier Utilization:			
Indicate if Plan Meets CSR Standard?	<input type="checkbox"/>						
Desired Metal Tier	Gold	<b>Tier 1 Plan Benefit Design</b>			<b>Tier 2 Plan Benefit Design</b>		
		Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)		\$0.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)		67.41%	71.04%				
OOP Maximum (\$)		\$5,000.00					
OOP Maximum if Separate (\$)							

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### Options for Additional Benefit Design Limits:

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

### Output

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 78.2%  
 Metal Tier: Gold  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 78.4%

This product, DC Gold HNOOnly 70%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 78.4%

**Summary of Benefits Covered**

DC GOLD HNONLY 90%

District of Columbia

Gold Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$0
Family	\$0
<b>Coinsurance</b> <i>(Member Responsibility)</i>	10%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$5,000
Family	\$10,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$30 per visit
<b>Specialist Visit</b>	\$50 per visit
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	10%
<b>Emergency Room Services</b>	\$300 per visit
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	\$300 per visit
<b>Rehabilitative Speech Therapy</b>	\$50 per visit
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$50 per visit
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$15 per visit
<b>X-rays and Diagnostic Imaging</b>	\$50 per visit
<b>Skilled Nursing Facility</b>	10%
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	10%
<b>Outpatient Surgery Physician/Surgical Services</b>	10%

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	\$100
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by 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: Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	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)	79.59%	71.04%				
OOP Maximum (\$)	\$5,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### 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: 81.1%

Metal Tier: Gold

Option 3 DedCopay adj: 0.2%

Final AV: 81.3%

This product, DC Gold HNOOnly 90%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 81.3%

**Summary of Benefits Covered**

DC SILVER HMO 5000 70%

District of Columbia

Silver Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$5,000
Family	\$10,000
<b>Coinsurance</b> <i>(Member Responsibility)</i>	30%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$6,350
Family	\$12,700
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$30 per visit
<b>Specialist Visit</b>	\$60 per visit
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	30% after deductible
<b>Emergency Room Services</b>	\$400 per visit
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	30% after deductible
<b>Rehabilitative Speech Therapy</b>	\$30 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$30 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	\$30 per visit
<b>X-rays and Diagnostic Imaging</b>	\$60 per visit
<b>Skilled Nursing Facility</b>	30% after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	30% after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	30% after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	No
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	\$100
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by 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?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

  

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$5,000.00	\$500.00				
Coinsurance (% , Insurer's Cost Share)	66.80%	64.90%				
OOP Maximum (\$)	\$6,350.00					
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
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$400.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

Set a Maximum on Specialty Rx Coinsurance Payments?  
 Specialty Rx Coinsurance Maximum: \$500  
 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: 68.0%  
 Metal Tier: Silver  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 68.2%

This product, DC Silver HMO 5000 70%, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.2%

**Summary of Benefits Covered**

DC SILVER HMO SJ 2500

District of Columbia

Silver Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$2,500
Family	\$5,000
<b>Coinsurance</b> <i>(Member Responsibility)</i>	0% varies; see below <i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$6,600
Family	\$13,200
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$20 per visit
<b>Specialist Visit</b>	\$40 per visit after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	0% after deductible
<b>Emergency Room Services</b>	\$200 per visit after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	\$25/visits 1-40; \$40/visits 41+
<b>Imaging (CT/PET Scans, MRIs)</b>	\$40 per visit after deductible
<b>Rehabilitative Speech Therapy</b>	\$40 per visit after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	\$40 per visit after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	0% after deductible
<b>X-rays and Diagnostic Imaging</b>	0% after deductible
<b>Skilled Nursing Facility</b>	0% after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	0% after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	0% after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$45
<b>Non-Preferred Brand Drugs</b>	\$75
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

**User Inputs for Plan Parameters**

Use Integrated Medical and Drug Deductible?	<input checked="" type="checkbox"/>	<b>HSA/HRA Options</b>		<b>Narrow Network Options</b>	
Apply Inpatient Copay per Day?	<input type="checkbox"/>	HSA/HRA Employer Contribution? <input type="checkbox"/>		Blended Network/POS Plan? <input type="checkbox"/>	
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>	Annual Contribution Amount:		1st Tier Utilization:	
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>			2nd Tier Utilization:	
Indicate if Plan Meets CSR Standard?	<input type="checkbox"/>				
Desired Metal Tier	Silver				

  

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$2,500.00			
Coinsurance (% , Insurer's Cost Share)			88.65%			
OOP Maximum (\$)			\$6,600.00			
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
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$200.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$45.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

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

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 69.3%  
 Metal Tier: Silver  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 69.5%

This product, DC Silver HMO SJ 2500, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 69.5%

**Summary of Benefits Covered**

DC SILVER HNONLY 2000 90% HSA

District of Columbia

Silver Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$2,000
Family	\$4,000
<b>Coinsurance</b> <i>(Member Responsibility)</i>	10%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$6,250
Family	\$12,500
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	10% after deductible
<b>Specialist Visit</b>	10% after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	10% after deductible
<b>Emergency Room Services</b>	10% after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	10% after deductible
<b>Imaging (CT/PET Scans, MRIs)</b>	10% after deductible
<b>Rehabilitative Speech Therapy</b>	10% after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	10% after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	10% after deductible
<b>X-rays and Diagnostic Imaging</b>	10% after deductible
<b>Skilled Nursing Facility</b>	10% after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	10% after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	10% after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	T1A: \$5; T1: \$15
<b>Preferred Brand Drugs</b>	\$50
<b>Non-Preferred Brand Drugs</b>	\$100
<b>Specialty Drugs (i.e. high-cost)</b>	\$300

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by 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?	<input checked="" type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

  

	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)			85.60%			
OOP Maximum (\$)			\$6,250.00			
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
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.07	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

### 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: 69.1%  
 Metal Tier: Silver  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 69.3%

This product, DC Silver HNONly 2000 90% HSA, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 69.3%

**Summary of Benefits Covered**

DC BRONZE HMO 5400

District of Columbia

Bronze Plan

**Summary of Features** In-Network

<b>Deductible</b>	
Individual	\$5,400
Family	\$10,800
<b>Coinsurance</b> <i>(Member Responsibility)</i>	0%
	varies; see below
	<i>\$0 once out-of-pocket max. is satisfied</i>
<b>Out-of-Pocket Maximum</b>	
Individual	\$5,400
Family	\$10,800
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
<b>Primary Care Visit to Treat an Injury or Illness</b> <i>(excludes Preventative and X-rays)</i>	\$20 ded waived/visits 1-3
<b>Specialist Visit</b>	0% after deductible
<b>All Inpatient Hospital Services</b> <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	0% after deductible
<b>Emergency Room Services</b>	0% after deductible
<b>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</b>	0% after deductible
<b>Imaging (CT/PET Scans, MRIs)</b>	0% after deductible
<b>Rehabilitative Speech Therapy</b>	0% after deductible
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	0% after deductible
<b>Preventive Care/Screening/Immunization</b>	0%
<b>Laboratory Outpatient and Professional Services</b>	0% after deductible
<b>X-rays and Diagnostic Imaging</b>	0% after deductible
<b>Skilled Nursing Facility</b>	0% after deductible
<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	0% after deductible
<b>Outpatient Surgery Physician/Surgical Services</b>	0% after deductible

**Pharmacy** In-Network

<b>Pharmacy Deductible</b>	
Individual	N/A
Family	N/A
<b>Generics</b>	0% after deductible
<b>Preferred Brand Drugs</b>	0% after deductible
<b>Non-Preferred Brand Drugs</b>	0% after deductible
<b>Specialty Drugs (i.e. high-cost)</b>	0% after deductible

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by 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: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? <input type="checkbox"/>	Blended Network/POS Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$5,400.00			
Coinsurance (% , Insurer's Cost Share)			82.63%			
OOP Maximum (\$)			\$5,400.00			
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
<b>Medical</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$20.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Options for Additional Benefit Design Limits:**

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

**Output**

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 58.0%  
 Metal Tier: Bronze  
 Option 3 DedCopay adj: 0.2%  
 Final AV: 58.2%

This product, DC Bronze HMO 5400, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 58.2%

**Unique Plan Design - Issuer AV  
Supporting Documentation and Justification**

**State:** DC  
**HIOS Issuer ID:** 73987  
**HIOS Product Ids:** 73987DC004

**HIOS Plan Ids:** 73987DC0040001  
73987DC0040005  
73987DC0040013  
73987DC0040017  
73987DC0040021  
73987DC0040025  
73987DC0040029  
73987DC0040033  
73987DC0040034  
73987DC0040035

**1) Justification for use of Issuer AV:**

Per 156.135, the AV must be certified by member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

- (1) Option 1 - Certify that the plan was entered correctly and not vary materially from standard options entered
- (2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

Aetna benefit plans were analyzed vs the AVC to determined when Option 2 vs Option 1 certification was necessary. Five underlying calculators were built to support population of the OP facility, S, ER, Rx generic rows in the AVC and average coinsurance cells. These all support Option 2 certifications. In addition, all Aetna plans were run with coinsurance entered on each row where applicable. This was done even if the unique coinsurance on the row was the same as the average coinsurance in row 11. This methodology prevents the OP facility/physician splitting methodology from being invoked which we do not believe is appropriate for our benefit plans. The output from this consistently applied process reflects our certified Actuarial Values.

**2) Regulatory permitted alternate method used:**

- (2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

**3) Confirmation that only in-network cost sharing including multitier networks, was considered:**

Confirmed. Only in-network cost sharing information was used.

**4) Description of standardized plan population data used:**

Detail of data used for each of the subcalculators is described below in items 5 & 6. All data was based on either the AVC continuance tables, or a national data set which is representative of the S in 2015.

**5) If the method described in 156.135.(b).(2) was used, description of how the benefits were modified to fit the parameters of the AV calculator:**

#### Average Coinsurance

The 2014/2015 AVC does not appropriately calculate an average coinsurance. Therefore, we calculate an effective average coinsurance across copay and coinsurance rows using the AVC continuance table weights and unit costs. This methodology is similar to that embedded in the 2015 preliminary AVC.

#### OP Facility Benefit Plan Fit Process

OP facility has two subcategories of OP surg - hospital and OP surg- freestanding. The equivalent coinsurance for each was set as the plan copay divided by the unit cost. The adjusted equivalent was then calculated for each copay/deduct combination. It was adjusted to account for the portion of cost less than the deduct that was at 0% coinsurance in the model as compared to the portion of cost less than the deduct that was at 0% coinsurance in the model. It was validated that these adjusted equivalence factors did not vary materially based on the underlying continuance table used. The average coinsurance of the row was calculated based on the weights of the internal subcategories.

#### Rx Generic Tier1a

Using internal cost data, the distribution of Rx generic costs between Tier1a and Tier1 was determined. An weighted average adjusted copay/coins was then calculated based on this distribution and adjusted for the relative drug cost level between the tiers.

#### **6) If the method described in 156.135.(b).(3) was used, description of the data and method used to develop the adjustments:**

For deduct and then copay plans, an adjustment was made for the underlying assumption in the model that plans are copay then deduct. Adjustment was determined based on methodology in the 2015 preliminary AVC.

#### **Certification Language:**

The development of the actuarial value is based on one of the acceptable alternative methods outlines in 156.135.(b).(2) or 156.135.(b).(3) for those benefits that deviate from parameters of the AV calculator and have a material impact on the AV.

The analysis was

- (i) conducted by a member of the American Academy of Actuaries
- (ii) performed in accordance with generally accepted actuarial principles and methodologies

Actuary Signature: *David Walker*  
Actuary Printed name: David Walker, ASA MAAA  
Date: 06/11/2014

Aetna Health, Inc.

Consumer Summary

Small Group HMO Medical Expense Benefit Plans

Renewal Period for which Rates are Effective: January 1, 2015 – December 31, 2015

Proposed Rate Increase/Decrease: 1.3%

5 Year History of Rate Increases/Decreases for this Product: No prior changes; first issued January 2014

Justification for Rate Increase/Decrease in Plain Language

Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts. Additional information is shown in the Rate Filing Justification Part II.

Aetna Health Inc.  
HIOS ISSUER ID: 73987

Exhibit A  
Product Portfolio

HIOS Plan-ID	Network	Plan	Metallic Tier	Actuarial Value	Exchange Offering
73987DC0040013	Full Network	DC Gold HMO 90%	Gold	81.31%	Yes
73987DC0040021	Full Network	DC Gold HNOOnly 90%	Gold	81.31%	Yes
73987DC0040034	Full Network	DC Gold HMO SJ 1500	Gold	78.73%	Yes
73987DC0040033	Full Network	DC Gold HMO 70%	Gold	78.36%	Yes
73987DC0040017	Full Network	DC Gold HNOOnly 70%	Gold	78.36%	Yes
73987DC0040005	Full Network	DC Gold HMO 2000 70%	Gold	78.12%	Yes
73987DC0040029	Full Network	DC Silver HNOOnly 2000 90% HSA	Silver	69.33%	Yes
73987DC0040035	Full Network	DC Select Silver HMO SJ 2500	Silver	69.50%	Yes
73987DC0040025	Full Network	DC Silver HMO 5000 70%	Silver	68.23%	Yes
73987DC0040001	Full Network	DC Bronze HMO 5400	Bronze	58.22%	Yes

**Aetna Health Inc.**  
**HIOS ISSUER ID: 73987**

**Exhibit B**  
**Projected Membership Distribution by Plan**

<b>HIOS Plan-ID</b>	<b>Plan</b>	<b>Metallic Tier</b>	<b>Projected Membership Distribution</b>
73987DC0040013	DC Gold HMO 90%	Gold	1.99%
73987DC0040021	DC Gold HNOOnly 90%	Gold	1.99%
73987DC0040034	DC Gold HMO SJ 1500	Gold	1.99%
73987DC0040033	DC Gold HMO 70%	Gold	1.99%
73987DC0040017	DC Gold HNOOnly 70%	Gold	1.99%
73987DC0040005	DC Gold HMO 2000 70%	Gold	1.99%
73987DC0040029	DC Silver HNOOnly 2000 90% HSA	Silver	23.25%
73987DC0040035	DC Select Silver HMO SJ 2500	Silver	23.25%
73987DC0040025	DC Silver HMO 5000 70%	Silver	23.25%
73987DC0040001	DC Bronze HMO 5400	Bronze	18.28%

<b>Metallic Tier</b>	<b>Projected Membership Distribution</b>
Platinum	0%
Gold	12%
Silver	70%
Bronze	18%
Catastrophic	0%



(13) (15) (16) (17) (18) (19)

= (12)\*(13)/(1-(15))

= (16)\*(17)/(18)

Tier Adjustment	Admin Costs	Plan Adjusted Index Rate	Age	Area	Consumer Adjusted Index Rate	AV Pricing Value	Projected Member Months
0.995	24.8%	\$432.95	0.961	1.000	\$416.07	0.885	122
0.995	24.8%	\$451.77	0.961	1.000	\$434.16	0.924	122
0.995	24.8%	\$385.50	0.961	1.000	\$370.48	0.788	122
0.995	24.8%	\$405.65	0.961	1.000	\$389.84	0.829	122
0.995	24.8%	\$423.24	0.961	1.000	\$406.74	0.865	122
0.995	24.8%	\$366.37	0.961	1.000	\$352.09	0.749	122
0.995	24.8%	\$356.16	0.961	1.000	\$342.27	0.728	1,423
0.995	24.8%	\$348.61	0.961	1.000	\$335.02	0.713	1,423
0.995	24.8%	\$302.66	0.961	1.000	\$290.86	0.619	1,423
0.995	24.8%	\$277.08	0.961	1.000	\$266.28	0.567	1,119

Exhibit D  
Projected Membership Distribution by County

Rating Area	Counties	Current Membership Distribution	Current Area Factor	Projected Membership Distribution	Projection Area Factor	Pricing Area Factor
1	District of Columbia	100.0%	1.0000	100.0%	1.0000	1.0000

<b>Current Area Normalization Factor</b>	1.0000
--	--------

**Note:**  
Current Area Normalization Factor computed as the weighted average of Current Area Factors by current membership distribution.

<b>Projected Area Normalization Factor</b>	1.0000
--	--------

**Note:**  
Projected Area Normalization Factor computed as the weighted average of Current Area Factors by projected membership distribution.

<b>Area Shift Factor</b>	1.0000
--------------------------	--------

**Note:**  
Area Shift Factor computed as the ratio of the Projected Area Normalization Factor over the Current Area Normalization Factor. Factor represents the impact due to the shift of the population distribution across areas.

<b>Projected Network Factor</b>	1.0000
---------------------------------	--------

**Note:**  
Projected Network Factor computed as the weighted average of Projected Area Factors by projected membership distribution.

<b>Network Shift Factor</b>	1.0000
-----------------------------	--------

**Note:**  
Network Shift Factor computed as the ratio of the Projected Network Factor over the Projected Area Normalization Factor. Factor represents the impact due to network changes from the experience period to rating period.

Aetna Health Inc.  
HIOS ISSUER ID: 73987

Exhibit E  
Claim Impact due to Demographic Changes

Age	Current Distribution		Projected Distribution		Demographic Factor	
	Male	Female	Male	Female	Male	Female
0	0.32%	0.32%	0.49%	0.52%	1.050	0.939
1	0.64%	0.32%	0.54%	0.63%	1.050	0.939
2	0.75%	0.11%	0.61%	0.50%	0.601	0.596
3	0.43%	0.43%	0.65%	0.58%	0.601	0.596
4	0.43%	0.96%	0.62%	0.63%	0.601	0.596
5	0.21%	0.54%	0.57%	0.71%	0.570	0.565
6	0.43%	0.32%	0.69%	0.63%	0.570	0.565
7	0.21%	0.43%	0.72%	0.76%	0.570	0.565
8	0.64%	0.64%	0.68%	0.74%	0.570	0.565
9	0.32%	0.32%	0.71%	0.61%	0.570	0.565
10	0.64%	0.32%	0.71%	0.66%	0.578	0.565
11	0.54%	0.21%	0.76%	0.64%	0.578	0.565
12	0.32%	0.32%	0.69%	0.67%	0.578	0.565
13	0.32%	0.43%	0.69%	0.69%	0.578	0.565
14	0.21%	0.21%	0.64%	0.78%	0.578	0.565
15	0.21%	0.43%	0.72%	0.72%	0.606	0.615
16	0.43%	0.32%	0.71%	0.60%	0.606	0.615
17	0.32%	0.00%	0.72%	0.58%	0.606	0.615
18	0.54%	0.54%	0.76%	0.68%	0.606	0.615
19	0.21%	0.54%	0.62%	0.58%	0.606	0.615
20	0.54%	0.43%	0.58%	0.57%	0.451	0.741
21	0.32%	0.54%	0.70%	0.59%	0.451	0.741
22	1.07%	0.32%	0.65%	0.59%	0.451	0.741
23	1.18%	0.64%	0.73%	0.71%	0.451	0.741
24	1.07%	0.96%	0.72%	0.83%	0.451	0.741
25	0.64%	1.07%	0.80%	0.93%	0.460	1.106
26	0.64%	0.96%	0.82%	0.83%	0.460	1.106
27	0.96%	1.28%	0.93%	0.86%	0.460	1.106
28	1.18%	1.82%	0.80%	0.92%	0.460	1.106
29	0.75%	1.71%	0.88%	0.90%	0.460	1.106
30	1.50%	1.61%	0.95%	0.96%	0.519	1.197
31	0.96%	1.28%	1.03%	0.98%	0.519	1.197
32	1.07%	1.28%	1.14%	0.92%	0.519	1.197
33	1.93%	1.07%	1.03%	0.89%	0.519	1.197
34	0.75%	1.39%	0.91%	0.93%	0.519	1.197
35	0.96%	0.43%	0.86%	0.86%	0.630	1.197
36	1.07%	0.96%	0.94%	0.87%	0.630	1.197
37	1.07%	0.54%	0.92%	0.84%	0.630	1.197
38	0.43%	1.28%	0.94%	0.86%	0.630	1.197
39	1.18%	0.54%	0.90%	0.76%	0.630	1.197
40	1.39%	0.96%	0.93%	0.91%	0.790	1.197
41	1.18%	0.75%	1.08%	1.01%	0.790	1.197
42	1.18%	0.64%	1.11%	0.91%	0.790	1.197
43	0.86%	0.75%	1.03%	0.95%	0.790	1.197
44	0.54%	0.54%	1.03%	0.99%	0.790	1.197
45	0.96%	0.75%	1.00%	0.81%	1.000	1.269
46	1.18%	0.43%	1.13%	0.85%	1.000	1.269
47	0.75%	0.32%	0.96%	0.90%	1.000	1.269
48	0.86%	0.64%	1.01%	0.81%	1.000	1.269
49	0.64%	0.75%	1.05%	0.88%	1.000	1.269
50	1.18%	1.39%	1.06%	0.82%	1.370	1.460
51	1.07%	0.75%	0.93%	0.83%	1.370	1.460
52	1.18%	0.96%	0.89%	0.73%	1.370	1.460
53	0.75%	0.64%	0.86%	0.73%	1.370	1.460
54	0.96%	1.07%	0.84%	0.66%	1.370	1.460
55	1.07%	0.86%	0.76%	0.69%	1.757	1.745
56	1.07%	1.07%	0.90%	0.68%	1.757	1.745
57	0.75%	0.86%	0.78%	0.65%	1.757	1.745
58	0.86%	0.64%	0.71%	0.61%	1.757	1.745
59	0.64%	0.75%	0.63%	0.53%	1.757	1.745
60	0.75%	0.54%	0.56%	0.50%	2.218	2.128
61	0.54%	0.75%	0.51%	0.47%	2.218	2.128
62	0.96%	0.43%	0.38%	0.42%	2.218	2.128
63	0.96%	0.54%	0.41%	0.33%	2.218	2.128
64	0.96%	0.75%	0.36%	0.24%	2.218	2.128
65+	1.82%	1.18%	0.64%	0.50%	3.200	2.700

<b>Current Demographic Factor</b>	1.1230
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**Note:**  
Current Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

<b>Projected Demographic Factor</b>	0.9993
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**Note:**  
Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

<b>Claim Impact due to Demographic Changes</b>	0.8898
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**Note:**  
Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Current Demographic Factor

**Aetna Health Inc.**  
**SERFF Filing # AETN-129582439**  
**HIOS Product ID: 73987DC004**  
**Exhibit J**  
**Projected MLR**

			Formula
(a)	Projected 2015 Claims (pmpm)	\$252.32	
(b)	Required Premium (pmpm)	\$335.62	
(c)	2015 Projected MBR	75.18%	= (a)/(b)
(d)	QIA	\$2.01	= (b)* 0.60%
(e)	HIF Tax	\$10.07	= (b)* 3.00%
(f)	State Premium Tax	\$5.20	= (b)* 1.55%
(g)	PCORF	\$0.17	= (b)* 0.05%
(h)	FIT	\$7.05	= (b)* 2.10%
(i)	Exchange User Fee	\$0.00	= (b)* 0.00%
(j)	Total Taxes & Fees	\$22.49	= (e) + (f) + (g) + (h) + (i)
(k)	Adjusted Premium	\$313.13	= (b) - (j)
(l)	Adjusted Claims	\$254.33	= (a) + (d)
(m)	Projected MLR	81.22%	= (l) / (k)

Aetna Health Inc.  
 HIOS ISSUER ID: 73987

Exhibit K  
 Additional Plan Base Rate Calculations

(1) (2) (3) (4) (5) (6) (7a) (7b) (8) (9) (10) (11) (12)

= (1)\*(2)\*(3)\* (4)

=  
 [(5)+(7a)]\*(6)\*(7b)  
 \*(8)\*(9)\*(10)\*(11)

Plan ID	Plan Name	Index Rate	Risk Adjustment	Reinsurance	Exchange User Fees	Market Adjusted Index Rate	Network Adjustment	Benefits Other than EHBs		Cost Sharing	Utilization Adjustment	Non-Tobacco Adjustment	Catastrophic Eligibility	Incurred Claims
73987DC0040013	DC Gold HMO 90%	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.813	1.088	1.000	1.000	326.94
73987DC0040021	DC Gold HNOOnly 90%	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.813	1.136	1.000	1.000	341.15
73987DC0040034	DC Gold HMO SJ 1500	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.787	1.001	1.000	1.000	291.11
73987DC0040033	DC Gold HMO 70%	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.784	1.058	1.000	1.000	306.32
73987DC0040017	DC Gold HNOOnly 70%	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.784	1.104	1.000	1.000	319.60
73987DC0040005	DC Gold HMO 2000 70%	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.781	0.959	1.000	1.000	276.66
73987DC0040029	DC Silver HNOOnly 2000 90% HSA	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.693	1.050	1.000	1.000	268.95
73987DC0040035	DC Select Silver HMO SJ 2500	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.695	1.025	1.000	1.000	263.25
73987DC0040025	DC Silver HMO 5000 70%	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.682	0.907	1.000	1.000	228.55
73987DC0040001	DC Bronze HMO 5400	\$363.93	1.000	1.015	1.000	\$369.42	1.000	-	1.000	0.582	0.973	1.000	1.000	209.24

(13)            (14a)            (14b)            (15)            (16)            (17)            (18)            (19)            (20)

$$= \frac{(12) \times (13) + (14a)}{1 - (14b)}$$

$$= \frac{(15) \times (16) \times (17) \times (18) \times (19)}{(17) \times (18) \times (19)}$$

**Calibration Adjustments**

Dependent Cap Adjustment	Admin Costs		Plan Adjusted Index Rate	Age	Area	Average Trend Factor	Plan Base Rate	Plan Relativity Factor
0.995	-	24.8%	\$432.95	0.961	1.000	1.000	\$416.07	1.2156
0.995	-	24.8%	\$451.77	0.961	1.000	1.000	\$434.16	1.2685
0.995	-	24.8%	\$385.50	0.961	1.000	1.000	\$370.48	1.0824
0.995	-	24.8%	\$405.65	0.961	1.000	1.000	\$389.84	1.139
0.995	-	24.8%	\$423.24	0.961	1.000	1.000	\$406.74	1.1884
0.995	-	24.8%	\$366.37	0.961	1.000	1.000	\$352.09	1.0287
0.995	-	24.8%	\$356.16	0.961	1.000	1.000	\$342.27	1
0.995	-	24.8%	\$348.61	0.961	1.000	1.000	\$335.02	0.9788
0.995	-	24.8%	\$302.66	0.961	1.000	1.000	\$290.86	0.8498
0.995	-	24.8%	\$277.08	0.961	1.000	1.000	\$266.28	0.778

**Projected Member Months**

122
122
122
122
122
122
1,423
1,423
1,423
1,119

## Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF or Microsoft Word file under the Consumer Disclosure Form section of the Supporting Documentation tab.

---

Name of Company Aetna Health, Inc.

SERFF tracking number AETN-129582439

Submission Date June 11, 2014

Product Name DC AHI HMO SG 2015

Market Type (Individual/Small Group) Small Group

Rate Filing Type (Rate Increase / New Filing) Rate Increase

### Scope and Range of the Increase:

The 1.3 % increase is requested because: Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts.

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This filing will impact:

# of DC policyholders \_\_\_\_\_ # of DC covered lives \_\_\_\_\_

The average, minimum, and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 1.3 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved -5.0 (decrease) %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 9.4 %

Individuals within the group may vary from the aggregate of the above increase components as a result

of: N/A

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### Financial Experience of Product

The overall financial experience of the product includes:

These plans were first sold in 2014 and financial experience has not yet developed.

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The rate increase will affect the projected financial experience of the product by:

The rate revision is not expected to impact the profitability of the product.

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### Components of Increase

The request is made up of the following components:

*Trend Increases* – 9.1 % of the 1.3 % total filed increase

1. Medical Utilization Changes – Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 3.5 % of the 1.3 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is 5.41 % of the 1.3 % total filed increase.

*Other Increases* – -7.1 % of the 1.3 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is 0 % of the 1.3 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is -4.5 % of the 1.3 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is 4.9 % of the 1.3 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is -0.1 % of the 1.3 % total filed increase.

5. Other – Defined as:

Changes in other retention such as commissions, changes in claim costs from benefit slope changes and morbidity assumptions.

This component is -7.2 % of the 1.3 % total filed increase.

**Aetna Health Inc.**  
**HIOS ISSUER ID: 73987**

**Exhibit F**  
**Projected Age/Gender Distribution**

Age	Male	Female	DC Age Factor
0-20	13.89%	13.48%	0.654
21	0.70%	0.59%	0.727
22	0.65%	0.59%	0.727
23	0.73%	0.71%	0.727
24	0.72%	0.83%	0.727
25	0.80%	0.93%	0.727
26	0.82%	0.83%	0.727
27	0.93%	0.86%	0.727
28	0.80%	0.92%	0.744
29	0.88%	0.90%	0.760
30	0.95%	0.96%	0.779
31	1.03%	0.98%	0.799
32	1.14%	0.92%	0.817
33	1.03%	0.89%	0.836
34	0.91%	0.93%	0.856
35	0.86%	0.86%	0.876
36	0.94%	0.87%	0.896
37	0.92%	0.84%	0.916
38	0.94%	0.86%	0.927
39	0.90%	0.76%	0.938
40	0.93%	0.91%	0.975
41	1.08%	1.01%	1.013
42	1.11%	0.91%	1.053
43	1.03%	0.95%	1.094
44	1.03%	0.99%	1.137
45	1.00%	0.81%	1.181
46	1.13%	0.85%	1.227
47	0.96%	0.90%	1.275
48	1.01%	0.81%	1.325
49	1.05%	0.88%	1.377
50	1.06%	0.82%	1.431
51	0.93%	0.83%	1.487
52	0.89%	0.73%	1.545
53	0.86%	0.73%	1.605
54	0.84%	0.66%	1.668
55	0.76%	0.69%	1.733
56	0.90%	0.68%	1.801
57	0.78%	0.65%	1.871
58	0.71%	0.61%	1.944
59	0.63%	0.53%	2.020
60	0.56%	0.50%	2.099
61	0.51%	0.47%	2.181
62	0.38%	0.42%	2.181
63	0.41%	0.33%	2.181
64	0.36%	0.24%	2.181
65+	0.64%	0.50%	2.181

<b>Projected Age Premium Impact Factor</b>	1.0406
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**Note:**  
Projected Age Premium Impact Factor computed as the weighted average of DC Age Factor by projected membership distribution.

<b>Dependent Age Cap Factor</b>	1.0050
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**Note:**  
The expected shortfall in premium collected due to limiting the number of ratable dependents on a policy; computed as the estimated premium for all projected enrolled members less the premium for un-ratable dependents.

<b>Age Calibration Factor</b>	1.0458
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**Note:**  
Age Calibration Factor computed as the product of the Projected Age Premium Impact Factor and the Dependent Age Cap Factor.

**Note:**  
Rates will be reduced where necessary to ensure compliance with regulatory requirements, including the 3:1 federal requirement and the DC 4% incremental limit.

**Aetna Health Inc.**  
**HIOS ISSUER ID: 73987**

**Exhibit G**  
**Projected Area Distribution**

<b>Rating Area</b>	<b>Projected Membership Distribution</b>	<b>Area Factor</b>
1	100.0%	1.000

<b>Projected Area Calibration Factor</b>	1.0000
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**Note:**

Projected Area Calibration Factor computed as the weighted average of Area Factors by Projected Membership Distribution.

Aetna Health Inc.  
HIOS ISSUER ID: 73987

Exhibit H  
Projected Tobacco Usage

Age Bracket	Projected Membership Distribution	Premium Load	Projected Tobacco Usage
< 20	27%	0%	10%
20 - 24	6%	0%	10%
25 - 29	9%	0%	10%
30 - 34	10%	0%	10%
35 - 39	9%	0%	10%
40 - 44	10%	0%	10%
45 - 49	9%	0%	10%
50 - 54	8%	0%	10%
55 - 59	7%	0%	10%
60 - 64	4%	0%	10%
65	1%	0%	10%

Tobacco Calibration Factor	1.0000
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**Note:**  
The Tobacco Calibration Factor computed as the weighted average of the product of the Premium Load and Projected Tobacco Usage by the projected member distribution of age bracket.

Aetna Health, Inc.

**Rate Filing Check List**

Filing # AETN- 129582439

HIOS Product ID: 73987DC004

Policy Forms: HI SGHIXSched-5248 02 et al.

Small Group HMO Medical Expense Benefit Plans

Based on the DC Health Benefit Exchange Authority, Health Insurance Rate Filing Requirements, below is the check list for our rate filing.

**1. Cover Letter**

Please see attached Cover Letter.

**2. For Renewal Filings, One Page Consumer Summary**

The Rate Justification Part II (Plain Language Summary) is found in the Supplementary Documentation along with the additional Consumer Summary information.

**3. Actuarial Memorandum**

**A. Description of Benefits**

This filing covers HMO group medical benefit coverage. The range of coverage includes inpatient, outpatient, primary care, specialist services, pharmacy, DME and vision. All benefits are compliant with state mandates and the requirements of the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010, including preventive care benefits, deductible limits, and Actuarial Value requirements. Please refer to the referenced policy forms for detailed benefit language.

The rate filing contains worksheets and instructions for calculating the premium rates for the benefit plans available from Aetna Health, Inc. (AHI). The metal level and actuarial value for each plan design was determined using the AV calculator developed and made available by HHS.

The age curve used in DC is the age curve from Appendix A of the DC Exchange Carrier Reference Manual. Aetna does not consider the District of Columbia experience alone to be credible. In order to obtain sufficient credibility, the State of Virginia and District of Columbia experience combine was considered in developing the index rate. As further guidance and information is received, we reserve the right to submit revisions to these assumptions.

**B. Issue Age Range**

Policies will be issued to all ages.

### **C. Marketing Method**

These plans will be made available through the District of Columbia Health Benefit Exchange.

### **D. Premium Basis**

Member level rating will be used, with a cap of 3 dependent children under age 21.

### **E. Nature of Rate Change and Proposed Rate/Methodology Change**

The proposed rate revision averages 1.4%. Additional details are shown in the Actuarial memorandum and Supporting Documentation.

### **F. For Each Change, Indication if New or Modified**

The changes are shown on a by-plan basis in the Supporting Documentation.

### **G. For Each Change Comparison to Status Quo**

The changes are shown on a by-plan basis in the Supporting Documentation.

### **H. Summary of How Each Proposed Modification Differs from Corresponding Current/Approved Rate/Methodology**

The changes are shown on a by-plan basis in the Supporting Documentation.

### **I. Annual Rate Change for DC Policyholders**

The proposed annual rate change is 6.7%.

### **J. Base Period Experience**

- i. The base experience period used is from 1/1/2013 to 12/31/2013 and paid through 2/28/2014.
- ii. In order to obtain sufficient credibility, and due to the merge of the individual and small group pool, the base period experience used is the grandfathered and non-grandfathered AHI Individual business and the non-grandfathered small group business in the District of Columbia and State of Virginia markets of Aetna Health, Inc. (AHI). We have no grandfathered experience for AHI small group.
- iii. IBNR reserves represent 4.4% of the experience period claims.
- iv. No adjustments were made for large claims.

### **K. Projected Base Period Experience**

- i. Demonstrate and support each adjustment made to the base period experience for removal of claims for services covered during the base period that are not an essential health benefit; addition of cost for services not covered during the base period, that represent essential health benefits required to be covered during the projection period.**

No adjustment was made.

- ii. Describe and provide support for the development of each of the following projection factors applied to the base period:**

- 1. Medical and prescription drug trends including a description of the methodology used for calculating, data relied upon, and all adjustments made to the data and quantitative support.**

Trends are shown in Worksheet I of the URRT. Additional background is provided in Section 5.E. of the Actuarial Memorandum.

- 2. Projected changes in the underlying demographics of the population anticipated to be insured in the merged individual and small group pool, including a description of the factors used to adjust the base period experience.**

Please see Exhibit E, "Demographic Changes" in the Supporting Documentation. There is no individual coverage for AHL.

- 3. Projected changes in the average morbidity of the population anticipated to be insured in the merged individual and small group pool, including but not limited to the separately identifying the impact of guaranteed issue, premium and cost sharing subsidies, a mandate that most individuals obtain coverage, pent-up demand, and termination of current high risk pools.**

The change in morbidity is shown in Worksheet I of the URRT and discussed in Section 5 of the Actuarial Memorandum. There is no individual coverage for AHL.

- 4. The impact on the utilization due to projected changes in average cost sharing in force across the merged individual and small group pool.**

No adjustment is made on the impact on the utilization.

## **L. Manual Rate Development**

Please see Exhibit K in the Supporting Documentation. The Actuarial Memorandum provides additional support.

#### **M. Credibility**

DC experience was combined with State of Virginia experience, which we used with 100% credibility.

#### **N. Projected Index Rate**

- i. The index rate represents the average allowed claim cost per member per month for coverage of essential health benefits for the market, prior to adjustment for payments and charges under the risk adjustment and transitional reinsurance programs, as defined by 45 CFR 156.80(d).
- ii. Allowed claims were used as the basis for developing the index rate.
- iii. We assumed 100% credibility for the combined DC/Virginia data.
- iv. There was no blending; there is only Small Group business in AHL.

#### **O. Market-wide Adjustments to the Index Rate**

##### **i. Support for the market-wide risk transfer payment/charge assumed.**

We have assumed a neutral position for the risk program with zero payments and receipts.

##### **ii. Support for the market-wide adjustment for assessments and recoveries under the transitional reinsurance program.**

For the small group market, we assume that there will be no benefits to Aetna from the transitional reinsurance program.

##### **iii. The amount of any federal or District of Columbia Exchange user fees PMPM.**

No Exchange user fees have been included to develop the index rate.

#### **P. Plan Level Adjustments to the Index Rate**

##### **i. Adjustments to reflect the actuarial value and cost sharing design of each plan.**

Please see Exhibits A-1, A-2, and K included in Supplementary Documentation.

##### **ii. Support for any differences at the plan level due to provider network, delivery system characteristics, and utilization management practices.**

The estimated claim impact associated with the restructuring of our network arrangements was determined by repricing state-specific claims experience for the commercial medical products issued by Aetna Health, Inc. for all fully insured market segments using the revised/renegotiated fee schedules applicable to participating facilities and providers. Claim repricing also considered changes to network composition including such changes as tiering of participating facilities and providers. Additionally, the estimated impact on voluntary claims incurred through non-participating facilities and providers is based on reduced reimbursement levels, as allowable by state regulations. For purposes of determining the projected savings amount, the distribution of paid claims is based on Aetna Health, Inc. state-specific Small Group experience. The final claim impact assumption was developed as the weighted average expected savings by category.

**iii. Support for additional costs added for benefits provided that are in addition to essential health benefits.**

The EHB adjustment was developed by applying the state-specific medical/Rx claim distribution to the total medical impact and total Rx impact.

**iv. The expected impact of the specific eligibility categories for a catastrophic plan offered in the individual market.**

Not applicable

**Q. Non-Benefit Expenses**

Please see the “Non-Benefit Expenses and Profit & Risk” section in the Actuarial Memorandum.

**R. Filed Loss Ratio**

Please see Exhibit J in the Supplementary Documentation. A target medical loss ratio (claims divided by premium) of 75.18% was used to price the rates in the filing. This is expected to produce a Loss Ratio with Federal adjustments of 81.22%, excluding any credibility adjustments.

**S. Actuarial Certification**

The Actuarial Certification is included in the Actuarial Memorandum.

**T. District of Columbia Loss Ratio Analysis**

- i. Evaluation Period**
- ii. Earned Premium**

- iii. Claims**
- iv. Number of Claims**

Please see the Additional Data Template in Supporting Documentation.

- v. Loss Development Factors**

Please see the Additional Data Template in Supporting Documentation.

- vi. Loss Ratio Demonstration**

Please see the “Projected Loss Ratio” section in the Actuarial Memorandum.

- vii. Permissible Loss Ratio**

Please see the “Projected Loss Ratio” section in the Actuarial Memorandum.

- viii. Credibility Analysis**

We considered the experience for DC and Virginia combined to be 100% credible.

- ix. Determination of Overall Annual Rate Change**

The overall annual rate change was determined by weighting the plans by membership.

#### **U. District of Columbia and Countrywide Experience**

- i. Earned Premium**
- ii. Number of Contracts/Policyholders**
- iii. History of Past Rate Changes**

Please see the “Projected Loss Ratio” section in the Actuarial Memorandum.

#### **4. Rate Table**

Please see attached District of Columbia Small Group rate table.

June 6, 2014

District of Columbia, Department of Insurance  
810 First St. NE, Suite 701  
Washington, DC 20002  
Attention: Freedom of Information Officer

Re: FOIA Confidential Treatment Request  
QHP Application Submission

Aetna Health Inc.

Dear Sir or Madam:

Aetna Health Inc. has recently submitted or will shortly be submitting documentation required in connection with the 2015 Qualified Health Plan (QHP) Certification for the District of Columbia Health Insurance SHOP.

Aetna hereby requests that the following information contained in the filing referenced above be treated as confidential and protected from disclosure under the District of Columbia, Freedom of Information Act - Exemptions From Disclosure, pursuant to DC ST § 2-534.

- Business Rules Template: all fields
- Prescription Drug Formulary Template: all fields
- Rate Template: all fields
- Service Area Template: all fields
- Uniform Rate Review (Data Collection) Template: all fields
- URRT Part 3 Actuarial Memorandum and Certification

Disclosure of this confidential trade secret, commercial, and/or financial information pursuant to the FOIA or otherwise would substantially harm the competitive position of Aetna in the marketplace, and would negatively impact the overall health of the health insurance marketplace and ultimately the consumer. The information is held in strict confidence by Aetna and is not disclosed publicly. It is not known or otherwise generally available in the public. The information would be of tremendous value to Aetna's competitors because it reveals confidential and proprietary strategic information.

We respectfully ask that this information not be disclosed to any member of the public prior to release of similar information with respect to all other carriers which submit requests for 2015 Qualified Health Plan (QHP) Certification.

If for whatever reason public disclosure of the reference filing is scheduled to occur earlier than we have requested, we respectfully request to be notified so that, if deemed appropriate, we can take steps to protect our interests.

We appreciate your attention to this designation and request.

Sincerely,

James E. Brown