

## 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 file under the Consumer Disclosure Form section of the Supporting Documentation tab.

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Name of Company

SERFF tracking number

Submission Date

Product Name

Market Type                      Individual                      Small Group

Rate Filing Type                      Rate Increase                      New Filing

### Scope and Range of the Increase:

The        % increase is requested because:

This filing will impact:

# of policyholder's

# of 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        %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved        %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved        %

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

### Financial Experience of Product

The overall financial experience of the product includes:

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

### Components of Increase

The request is made up of the following components:

*Trend Increases* –           % of the           % 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           % of the           % 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           % of the           % total filed increase.

*Other Increases* –           % of the           % 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           % of the           % 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           % of the           % 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           % of the           % 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           % of the           % total filed increase.

5. Other – Defined as:

This component is           % of the           % total filed increase.