

SERFF Tracking Number: CFAP-125789509 State: District of Columbia
 Filing Company: Group Hospitalization and Medical Services, Inc.State Tracking Number:
 Company Tracking Number: 1145
 TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: Filing #1145 GHMSI DC Ind65+
 Project Name/Number: DC GHMSI Ind65+/1145

Filing at a Glance

Company: Group Hospitalization and Medical Services, Inc.
 Product Name: Filing #1145 GHMSI DC Ind65+ SERFF Tr Num: CFAP-125789509 State: District of Columbia
 TOI: H15I Individual Health - SERFF Status: Closed-APPROVEDState Tr Num:
 Hospital/Surgical/Medical Expense
 Sub-TOI: H15I.001 Health - Co Tr Num: 1145 State Status:
 Hospital/Surgical/Medical Expense
 Filing Type: Rate Reviewer(s): Laszlo Pentek
 Author: Brad Boban Disposition Date: 10/02/2008
 Date Submitted: 08/25/2008 Disposition Status: APPROVED
 Implementation Date Requested: 01/01/2009 Implementation Date:

General Information

Project Name: DC GHMSI Ind65+ Status of Filing in Domicile: Not Filed
 Project Number: 1145 Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: 7.5% Group Market Type:
 Filing Status Changed: 10/02/2008 Explanation for Other Group Market Type:
 State Status Changed:
 Deemer Date: Created By: Brad Boban
 Submitted By: Brad Boban Corresponding Filing Tracking Number:
 Filing Description:
 This filing contains the rate proposal for Group Hospitalization and Medical Services, Inc (GHMSI) dba CareFirst BlueCross BlueShield's Individual, Medigap medical coverage, with an effective date of January 1, 2009. Please refer to the Cover Letter (Supporting Documentation) and the Actuarial Memorandum (Rates/Rules Schedule) for more details.

Company and Contact

Filing Contact Information

Brad Boban, Senior Actuarial Assistant brad.boban@carefirst.com

SERFF Tracking Number: CFAP-125789509 State: District of Columbia
 Filing Company: Group Hospitalization and Medical Services, Inc. State Tracking Number:
 Company Tracking Number: 1145
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: Filing #1145 GHMSI DC Ind65+
 Project Name/Number: DC GHMSI Ind65+/1145

10455 Mill Run Circle 410-998-6230 [Phone]
 Owings Mills, MD 21117 410-998-7704 [FAX]

Filing Company Information

Group Hospitalization and Medical Services, CoCode: 53007 State of Domicile: District of
 Inc. Columbia
 840 First Street NE Group Code: Company Type: Hospital, Medical &
 Washington, DC 20065 Group Name: Dental Service or Indemnity
 (410) 581-3000 ext. [Phone] FEIN Number: 53-0078070
 State ID Number:

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

SERFF Tracking Number: CFAP-125789509 State: District of Columbia
 Filing Company: Group Hospitalization and Medical Services, Inc. State Tracking Number:
 Company Tracking Number: 1145
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: Filing #1145 GHMSI DC Ind65+
 Project Name/Number: DC GHMSI Ind65+/1145

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Actuarial Justification Comments: Attachment: File 1145 - Certification.pdf	APPROVED	10/02/2008

	Item Status:	Status Date:
Satisfied - Item: Cover Letter Comments: Attachment: File 1145 - Letter.pdf	APPROVED	10/02/2008

	Item Status:	Status Date:
Satisfied - Item: NAIC Transmittal Comments: Attachment: NAIC Transmittal Doc.pdf	APPROVED	10/02/2008

ACTUARIAL CERTIFICATION

I, Brett S. Miller, am the Manager in charge of Pricing with CareFirst BlueCross BlueShield (GHMSI) and a member of the American Academy of Actuaries. I have been involved in the development of these rates.

To the best of my knowledge and judgment, this rate filing complies with applicable laws and regulations of the District of Columbia and produces premiums that are reasonable in relation to benefits provided.

Brett S. Miller, FSA, MAAA
Sr. Actuarial Associate, Actuarial Pricing
CareFirst BlueCross BlueShield (GHMSI)
Mail Drop-Point 01-780
Pricing Department
10455 Mill Run Circle
Owings Mills, MD 21117

August 21, 2008

Mr. Laszlo Pentek
Department of Insurance & Securities Regulation
810 1st Street, NE
Suite 701
Washington, DC 20002-8023

Re: Group Hospitalization and Medical Services Inc. trading as CareFirst
BlueCross BlueShield
NAIC 53007
Rate Filing for Individual Medigap (Our Filing #1145)

Dear Mr. Pentek:

Enclosed for your review is the rate filing for the GHMSI Individual Medigap business, effective January 1, 2009. We are requesting no change to our Pre-Standardized rates, a 9.5% increase to our Standardized Non-Underwritten rates and a 14.5% increase to our Underwritten Rates. Duplicate copies of this letter are enclosed for your use.

If you have any questions or concerns, please contact me at (410) 998-7564.

Sincerely,

Brett S Miller, F.S.A., M.A.A.A.
Sr. Actuarial Associate

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	
-----------	----------------------------------	--

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address

5.	Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
-----------	------------------------------	---

6.	Company Tracking Number	
-----------	--------------------------------	--

7.	<input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
-----------	---	-----------------------

8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
		Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9.	Type of Insurance	
-----------	--------------------------	--

10.	Product Coding Matrix Filing Code	
------------	--	--

11.	Submitted Documents	<p><input type="checkbox"/> FORMS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input type="checkbox"/> Application/Enrollment</td> <td><input type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other		
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate										
<input type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising										
<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other											
		<input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____										
		<p>SUPPORTING DOCUMENTATION</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input type="checkbox"/> Statement of Variability</td> <td><input type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications	<input type="checkbox"/> Actuarial Memorandum		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization											
<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements											
<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications											
<input type="checkbox"/> Actuarial Memorandum												
<input type="checkbox"/> Other _____												

12.	Filing Submission Date	
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	
15.	Filing Description:	

16.	Certification (If required)	
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of _____.		
Print Name _____ Title _____		
Signature _____ Date: _____		

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1