Actuarial Memorandum

Issuer #65441

Individual Health Insurance Exchange Premium Rate Filing

August 19th, 2015

Developed By:

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1. EXECUTIVE SUMMARY

This memorandum documents the development of individual rates for Phoenix Health Plans, Inc. (Issuer 65441). These rates will be offered inside and outside of the State of Arizona's health insurance exchange, which is being operated by the federal government. Issuer 65441 will be offering products only in the Maricopa county service area.

Issuer 65441 is a for-profit corporation and a fully licensed HMO. Issuer 65441 is an affiliate of Abrazo Health Care, a part of Tenet Healthcare. Issuer 65441 also has Medicare enrollment and its related company, Phoenix Health Plan, has Medicaid enrollment. Issuer 65441 is offering individual health insurance products in the Catastrophic, Bronze, Silver and Gold metal tiers. Given that Issuer 65441 (through its related company) has a presence in the Medicaid space, Issuer 65441 expects most enrollment to be in the Silver plan, for individuals eligible for premium tax credits and cost sharing reductions. One of the primary reasons that Issuer 65441 entered the individual market within the health insurance exchange is to provide its Medicaid members with a product offering if they lose Medicaid eligibility.

2. GENERAL INFORMATION

Company Legal Name: Phoenix Health Plans, Inc.

State: Arizona

NAIC #: 10160

HIOS Issuer ID: 65441

Market: Individual Market

Effective Date: January 1, 2016

Company Contact Information

Primary Contact Name: Matt Cowley

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Responsible Actuary Information

Responsible Actuary Name: Julie Peper

Company: Wakely Consulting Group

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SERFF Rate Review Detail

Projected Earned Premium: $21,772,255

Projected Incurred Claims: $17,608,320

Annual PMPM: Min: $96.39 Max: $316.62 Weighted Avg: $226.79

Please note that these PMPM's have not been calibrated for age and area.

Other General Information

Type of Filing: New

Type of Plan: HMO; On/Off Exchange; New Business

Months of Rate Guarantee: These rates will be guaranteed until December 31, 2016.

3. PROPOSED RATE INCREASE(S)

The purpose of this filing is to provide premium rates for Issuer 65441's new individual plans for individual and family enrollees with effective dates of January 1, 2016 through December 31, 2016.

This filing reflects the termination of Issuer 65441's existing four plans. This filing also includes the introduction of new plan designs to be offered through the Arizona Exchange as well as in the individual market outside the Exchange. All plans discussed in this filing are compliant with the Affordable Care Act (ACA).

4. MARKET EXPERIENCE

Because there is no 2014 individual market experience, the rate development is based entirely on a manual rate.

5. CREDIBILITY MANUAL RATE DEVELOPMENT

Source and Appropriateness of Experience Data Used

The manual rate was developed utilizing Maricopa MSA large group HMO data pulled from Truven MarketScan's detailed medical and pharmacy claim data (which has over 40 million lives nationwide) for

the calendar year 2013. This starting experience accounts for private reinsurance recoveries, subrogation, and pharmacy rebates. We used the large group experience as our primary data source to develop a manual rate, as is consistent with the methodology used in the 2015 rate filing. Adjustments are made to reflect the unique characteristics of the individual market. We are assuming that the starting data contains a negligible amount of non-essential health benefits.

Adjustments Made to the Data

IBNR

IBNR is not applicable to the analysis. The large group data includes six months of claim run out and is considered complete.

Trend Factors (cost / utilization)

We assumed allowed PMPM medical and pharmacy costs would increase by annual trend to 2016 due to ongoing increases in utilization, unit costs and technology.

The annual allowed PMPM trend assumption was based on an average of the trend assumptions found in Arizona's publicly available individual rate filings of carriers having enrollment in 2014. This assumption takes into account historical data, expectation of future trends, and adjustments for the inherent volatility in trends.

We have assumed published trends which this assumption is based on have been normalized for demographics, benefit changes, and provider contracting changes.

The impact of this assumption can be seen in Appendix A, item (1).

Essential Health Benefits (EHB)

We adjusted the allowed claims in the manual rate development for changes in covered benefits due to EHB requirements. Habilitative services, pediatric vision, and pediatric dental are the benefits expected to have the most significant impact on allowed costs.

Issuer 65441 intends to offer the Arizona Essential Health Benefit plan (Arizona Benefit Options EPO Plan, administered by United Healthcare) with no substitutions. The only variance is Issuer 65441 is not offering pediatric dental in all plans since stand-alone options are available on the exchange and it is assumed off exchange individuals will be able to purchase it elsewhere.

The total adjustments to the large group 2013 experience to reflect the 2016 EHB package for the individual market is 1.2%.

This adjustment is shown in Appendix A, item (3).

Benefit Richness Utilization Adjustment

The starting point of large group plans incorporates lower cost sharing than expected to be purchased in the Arizona individual market. This adjustment normalizes the large group experience to be on the same

benefit richness level as the post ACA individual market. We used the federal induced demand factors to calculate this adjustment. The average large group HMO experience shows an 87% actuarial value which is closest to a Platinum plan under ACA terminology. In the individual market, the predominant plan is the Silver plan. We used the ratio of induced demand factors corresponding to the Platinum and Silver levels to calculate this adjustment.

This adjustment is shown in Appendix A, item (4).

Morbidity Adjustment

To adjust the 2013 large group experience to reflect the morbidity of the 2016 ACA compliant individual market, we used the Society of Actuaries (SOA) impact of the uninsured study (performed by Optum/Lewin), the Wakely National Risk Adjustment Reporting (WNRAR) project, and actuarial judgement to estimate the morbidities of the two markets.

The adjustment was calculated in the following steps:

1.) Pre-ACA Large Group to Pre-ACA Small Group

The morbidity adjustment from the starting data (large group commercial) to the small group individual market before the impact of ACA was calculated using the SOA report that estimated the morbidity of the various markets before and after ACA.

This adjustment is shown in Appendix A, item (h).

2.) Pre-ACA Total Small Group to 2014 ACA Compliant Individual Plans

We have assumed the pre-ACA small group market is similar to the post-ACA small group market. The adjustment then considers post-ACA small group market to post-ACA total individual market. This factor is based on Wakely's National Risk Adjustment Reporting (WNRAR) project. Using available data from the project for states that are similar to Arizona, we were able to compare the risk scores of the two populations, adjusting for average actuarial value and induced demand.

Arizona has allowed transitional policies to be extended into 2016. In states where transitional policies have been extended, we have observed healthier individuals retaining their transitional policies to avoid the rate increases due to ACA where they cannot benefit from their healthier-than-average risk status. Carriers with individual business pre-ACA will continue to keep a significant portion of that business in pre-ACA plans, which will increase the morbidity of the ACA compliant individual risk pool. Since Issuer 65441's individual enrollment will draw from this sicker risk pool, we adjusted the large group experience to reflect the sicker-than-average individual risk pool.

This adjustment is shown in Appendix A, item (i).

3.) 2014 ACA Compliant Individual to 2016 Individual ACA Compliant Plans

From 2014 to 2015, enrollment in the Arizona individual exchange increased from approximately 110,000 to 206,000. It is likely that those who most needed care obtained insurance in 2014 as soon as they were able, and those who enroll in 2015 and 2016 will be much healthier and likely enrolling due to the penalties getting larger. An adjustment was estimated using uninsured morbidity factors from the SOA study, transitional market morbidity factors from WNRAR, and assumed 2016 member growth in the ACA compliant market.

This adjustment is shown in Appendix A, item (j).

The combined effect of these adjustments is shown in Appendix A, item (5) and item (k).

The projected population morbidity assumes continued availability of federal subsidies for eligible individuals enrolling in coverage through the Marketplace. Elimination of these subsidies or other changes to how the ACA is implemented could result in significant variance between actual and expected experience. Such a change could result in rates that do not adequately cover costs.

Benefits in Addition to Essential Health Benefits (Non-EHB)

Issuer 65441 is offering benefits in addition to EHBs. All plans will include tele-health beyond the EHB requirements as well as a fitness/gym benefit. Six of the 18 plans will also offer adult vision and adult dental.

The inclusion of the non-EHB benefits can be seen in Appendix A, item (d).

Provider Reimbursement Adjustment

Issuer 65441 provided Wakely with provider contracting targets for inpatient facility, outpatient facility and professional categories of service. Wakely analyzed these targets and compared them to market information regarding current commercial reimbursement rates. We assumed provider volume by provider system based on information provided by Issuer 65441. Overall, it is expected that Issuer 65441's individual provider payment rates will be lower than the current commercial market.

This adjustment is shown in Appendix A, item (f).

Inclusion of Capitation Payments

The only capitation arrangement that Issuer 65441 has is for pediatric and adult dental. These additional benefits are only included in the Silver Plus and Gold Plus plans. The premiums for these plans have been increased to reflect the additional costs of this benefit.

6. CREDIBILITY OF EXPERIENCE

Although Issuer 65441 currently offers plans in the individual market, they did not begin to do so until 2015. Therefore, they do not have any credible experience off of which to base their 2016 rates.

7. PAID TO ALLOWED RATIO

The Truven Health Benefit Modeler pricing model uses the data underlying the Truven MarketScan detailed claim data of a nationally-representative sample of over 40 million group lives to develop paid-to-allowed pricing estimates for rate development (as opposed to the actuarial values from the federal AV calculator). The model uses actuarially-sound pricing methods to value the impact of deductibles, copays, coinsurance and maximum out-of-pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions in the model to the allowed cost estimates underlying the manual rate, including adjustments for EHB, trend, provider reimbursement changes and other adjustments discussed elsewhere in this report.

The table of paid to allowed ratios by plan and in aggregate are shown in Appendix B, item (14). These differ from the AV Metal Values reported on Worksheet 2 of the URRT due to differences in the underlying population and methodologies used to develop actuarial values.

The AV Pricing Value on Worksheet 2 of the URRT, also differs from both the Paid to Allowed ratio and the AV Metal Value. The AV Pricing Value reflects all allowable plan level adjustments to the index rate, including induced utilization, network differences, tobacco adjustments and non-benefit expenses.

8. RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustments PMPM

Due to the lack of reliable risk adjustment transfer data at the time of rate submissions, the projected index rate was developed based on our best estimate of the market-wide average risk. As a result, no risk transfers are assumed in our rate development.

The risk adjustment fee of $0.15 PMPM was incorporated into 2016 rates, as shown in appendix B, item (8).

Risk adjustment transfers were applied at the market level in the development of the Market Adjusted Index Rate. Transfer amounts were converted to an allowed amount in the development of the Market Adjusted Index Rate.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The presence of the Federal reinsurance program will reduce costs for Issuers in the individual market. This adjustment is intended to capture the portion of costs that will be reimbursed to health plans for reinsurance. The 2016 reinsurance program has an attachment point of $90,000 and a maximum coverage limit of $250,000 per member. HHS will reimburse health plans 50% of **paid** costs between the attachment point and maximum coverage limit.

To estimate the impact of reinsurance, we reviewed the claims probability distributions from Truven MarketScan detailed medical and pharmacy claim data, adjusted to our estimated allowed PMPMs. To estimate the impact of moving from allowed to paid continuance, we increased the attachment and maximum values from the federal parameters by the MOOP for various plans, since the vast majority of individuals would have already reached their MOOP when costs reach the reinsurance attachment point.

We have assumed that the average reinsurance impact will be a 3% reduction to net allowed claims costs.

Projected reinsurance recoveries, net of the $2.25 PMPM fee, were converted to an allowed basis and applied as a market-wide adjustment in the development of the Market Adjusted Index Rate. We have assumed that the allocated federal reinsurance dollars will be sufficient to fund the 2016 federal reinsurance program parameters, which is not guaranteed.

In the URRT we netted out the reinsurance fee of $2.25 from the PMPM impact of reinsurance. The reinsurance recoveries and fees are included in Appendix B, item (7).

9. NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

Issuer 65441 developed expected administrative costs based on current administrative costs for their Medicaid line of business, adjusted to reflect any differences in functions or level of effort for the commercial product. Admin load (excluding commissions) was developed and applied on a percentage of premium basis.

Issuer 65441 will be using brokers and expects that a portion of the enrollment will utilize brokers. All members enrolling outside of the exchange are expected to do so through brokers. An additional portion of members who enroll on the exchange are expected to utilize brokers.

Profit / Contribution to Surplus & Risk Margin

A portion of proposed 2016 premiums have been allocated to profit, consistent with that used to develop 2015 rates.

Consistent with the URRT worksheet I, on an after-tax basis, the proposed 2016 premiums include a portion of premiums allocated to profit.

The profit load does not vary by plan.

Taxes and Fees

Taxes and regulatory fees included in the development of 2016 rates include the following:

1. PCORI Fee = $0.17 PMPM

2. Risk Adjustment User Fee = $1.75 PMPY ($0.15 PMPM)
3. Issuer Fee
4. Marketplace User Fee = 3.5% of premium for products sold through the Exchange.
5. A premium tax of 2% was loaded into the rates.

The reinsurance charge and risk adjustment user fee are excluded from the Taxes and Fees section of the URRT since they are included in the reinsurance recoveries and risk adjustment transfer lines.

The Marketplace User Fee is calculated in the aggregate as 3.5% of premiums for products sold through the Exchange, however, this fee is spread across all plans in the risk pool, including those not offered through the Marketplace. The Marketplace User Fee is applied in the development of the Market Adjusted Index Rate.

Please note that the actuarial memorandum instructions requires the Index Rate for Projection Period to include the exchange user fee in the Market Adjusted Index Rate. However, since the PMPM components of admin have not been added in, we cannot simply add on the exchange fee since exchange fee is a percentage of final premiums (with the admin PMPM components included). We therefore calculated an equivalent exchange fee of the Market Adjusted Index Rate which produces the same effect as the fee of the final premiums.

10. PROJECTED LOSS RATIO

Wakely's estimates indicate projected MLRs for the individual line of business of over 80% for 2016 based on the federal MLR methodology. Issuer 65441 does not anticipate paying out consumer rebates for the 2016 calendar year.

The Arizona Anticipated Loss Ratio (ALR) is defined as being the present value of expected benefits over the present value of expected premiums for the time period that the premiums are effective. This calculation includes the impact of reinsurance on claims. It does not exclude any regulatory fees or taxes from premiums, which is why it is lower than the MLR calculations.

11. APPLICATION OF MARKET REFORM RATING RULES

Single Risk Pool

Issuer 65441 has established a single risk pool for all of its individual market business. Since Issuer 65441 did not participate in the individual market prior to 2015, all of its individual business is non-grandfathered, non-transitional, and ACA-compliant. The index rate for the projection period reflects all non-grandfathered members expected to be enrolled in a single risk pool compliant plan during the projection period.

Index Rate Development

Index Rate for Projection Period

The projection period index rate is estimated to be $300.42 pmpm. This was calculated based on projected allowed claims for Essential Health Benefits for the single risk pool population during the projection period. Projected allowed claims in the projection period vary from the projection period index rate, because the following non-EHBs will be covered:

- Adult vision
- Adult dental
- Tele-health
- Fitness benefit

This index rate can be seen in Appendix B, item (6).

Market Adjusted Index Rate for Projection Period

We included the impact of reinsurance and risk adjustment, converted to an allowed basis, and the 'equivalent exchange user fee' (as described above) to the index rate for the projection period to develop the Market Adjusted Index Rate.

The development of the Market Adjusted Index Rate can be found in Appendix B, item (10).

Plan Adjusted Index Rate for Projection Period

Plan Adjusted Index Rates were developed by applying allowable plan level adjustments to the Market Adjusted Index Rate. The components of the plan level adjustments used for each plan are provided in Appendix B. The following describes how each component of the adjustments were developed.

AV and Cost Sharing Adjustment

Paid to allowed ratios were developed for each plan based on the Truven Health Benefit Modeler as described previously.

Additional adjustments were made to account for expected induced utilization, driven by cost sharing differences across each plan. The federal induced utilization factors used for the risk adjustment program were applied by metal level. Utilization factors reflect the impact of differences in cost sharing on utilization. Health status differences are not reflected in utilization factors.

The Plan Adjusted Index Rate must be on a non-tobacco user basis. As such, we applied a factor of 0.993 to adjust the market adjusted index rate to a non-tobacco user status. The factor was developed based on the distribution of self-reported tobacco and non-tobacco users in the current population. This adjustment is uniform across plans.

Provider Network, Delivery System and Utilization Management Adjustment

Adjustments were made to account for the relative differences by network. These differences are due to variances in contracts with different networks of providers and differences in expected utilization by network.

The weighted average of network adjustments can be seen in Appendix A, item (f).

Adjustments for benefits in addition to EHB

Benefits in addition to EHB add an aggregate 1.1% to premiums.

Tele-health, beyond the required EHB, and a fitness benefit are both not required EHBs and are covered in all plans. Adult vision and adult dental are also not required EHBs. They are covered in all Silver Plus and Gold Plus plans.

Impact of Specific Eligibility Categories for Catastrophic Plan

The catastrophic plan allows people under 30 and those with financial hardship to enroll in a catastrophic plan that is part of a separate risk pool from the rest of the individual market. Based on our analysis, we assumed that this population is healthier (after normalizing for age) than the rest of the individual market.

The assumption itself is primarily developed from Wakely's National Risk Adjustment Simulation, in which individual and small group risk adjustment transfers were analyzed in over 20 states with 2014 data and enrollment. We saw enrollment in catastrophic plans that was significantly healthier than the average individual market risk pool after accounting for 3:1 allowable rate variation. The variation seen was muted since the number of catastrophic members in the market is not considered to be fully credible. We also modeled potential differences in the catastrophic age distribution due to the eligibility criteria. The total adjustment for risk and age differences is a reduction to 3:1 age specific rates, all else being equal.

The resulting catastrophic adjustment is shown in Appendix B, item (20)

Per the instructions, no catastrophic adjustments were made to non-catastrophic plans.

Adjustment for Distribution and Administrative Costs

As noted earlier, administrative costs are applied on a percent of premium basis.

The development of the Plan Adjusted Index Rates can be found in Appendix B, item (22) – (28).

Tobacco Rating

This factor was developed using 2012 CDC statistics of Arizona residents who indicated tobacco usage as well as the tobacco rate up factors. The factor is intended to convert the rates to a non-tobacco basis. We assumed 2016 tobacco usage will be similar to 2012.

The impact of this adjustment can be seen in Appendix B, item (31).

Calibration

Per the instructions, Plan Adjusted Index Rates are next calibrated to age 21 and to the weighted average geographic factor level. To bring the experience to age 21 rate, we divided the Plan Adjusted Index Rates by the weighted average age factor. The age factor was calculated as the weighted average of ACA age factors and the projected 2016 individual market enrollment by age. The 2016 enrollment is based on 2014 Arizona-specific (where available) and nationwide individual market enrollment statistics. The age associated with this factor is 45 years. Once calibrated, the standard federal age factors can be applied on a multiplicative basis to get to the rates for other ages. The age calibration development can be found in Appendix B, items (50) – (53). Age calibration is applied uniformly to all plans.

Since Issuer 65441 will only be offering plans in Maricopa County, and the base experience data used to develop premiums for the plans was Maricopa County specific, we did not calibrate the rates for area.

Population health risk differences by geography are not reflected in geographic factors.

Consumer Adjusted Index Rate

The Consumer Adjusted Index Rates were calculated by multiplying the calibrated Plan Adjusted Index Rates by the consumer's specific age factor (subject to maximum allowable rating of 3 kids under 21), area factor, and tobacco load as applicable.

Issuer 65441 will utilize the ACA age factors. The rating factor will be 1.0 for all members. For tobacco factors, a maximum rating factor of 1.4 is applied. According to a well-publicized study in the New England Journal of Medicine, "Health care costs for smokers at a given age are as much as 40% higher than non-smokers" [1] Looking at Figure 1 in the article, there is not much of a difference at the younger ages (<40) and the differential increases up through age 65.

The rating factors are shown in Appendix C and the consumer adjusted index rates are provided in the rate templates.

[1] http://www.nejm.org/doi/full/10.1056/NEJM199710093371506, page 1

12. AV METAL LEVELS

The Federal AVC was used to generate the AV metal tiers (URRT, Worksheet 2). Issuer 65441's plans will have six pharmacy tiers rather than the four tiers the Federal AVC shows. The only modification that was made to the traditional inputs of the Federal AVC was blending the cost-sharing of the two tiers of generic drugs and the two tiers of specialty drugs that Issuer 65441 is offering to fit into the Federal AVC inputs.

The Federal AVs for the plans are shown in Appendix E.

13. AV PRICING VALUES

The methodology for development of the AV Pricing Values is explained above in the Plan Adjusted Index Rate section. Only allowable modifiers were used in the development of these values.

Benefit richness utilization adjustments were applied to stratify the market adjusted index rate to levels suitable for each of the metal tiers. We used the following values which are equal to the Federal values published in the Federal Register payment notice.

Bronze and Catastrophic = 1.00

Silver = 1.03

Gold = 1.08

Platinum = 1.15

The adjustment factors above are shown in Appendix B, item (15).

The same underlying cost distribution and cost level was used in the development of cost sharing factors. Therefore, differences in expected morbidity across metal tiers were not included in the pricing development for each metal tier plan.

The pricing AVs are different from the Federal AVCs primarily because the different estimated allowed PMPMs are different than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements like copays, deductibles and MOOPs. The other variance is differences in the methodology of the pricing models.

14. MEMBERSHIP PROJECTIONS

The membership projections for 2016 were developed by Issuer 65441. Actual enrollment is highly dependent on consumer decisions and the competitiveness of rates in the market.

Differences between current and projected membership are driven by new product offerings with more favorable plan benefits and networks.

The following table shows estimates of Issuer 65441 individual enrollment by metal tier and cost-sharing reduction variations:

Distribution of Metal Level						
	Gold	**Gold Plus**	**Silver**	**Silver Plus**	**Bronze**	**Catastrophic**
Percent	6%	4%	45%	20%	15%	10%
Members	480	320	3,600	1,600	1,200	800
Distribution of CSR Membership						
	70%	**73%**	**87%**	**94%**		
Percent	17%	26%	27%	30%		
Members Silver	609	927	968	1,095		
Members Silver Plus	271	412	430	487		

Appendix D shows cost sharing reduction estimated payments and the justification.

15. TERMINATED PLANS AND PRODUCTS

The following tables provides a summary of all single risk pool plans offered or planned to be offered in the experience period, current period and projection period. The following is a high level summary of plan offerings for each of the three years.

	Catastrophic	Bronze	Silver	Gold	Platinum
Total 2014 plans	0	0	0	0	0
2014 plan terminations in 2015	0	0	0	0	0
2015 plan additions	1	1	1	1	0
Total 2015 plans	1	1	1	1	0
2015 plan terminations	1	1	1	1	0
2016 plan additions	3	3	6	6	0
Total 2016 plans	3	3	6	6	0

Issuer 65441 offered four plans in 2015, all of which will be terminated in 2016 and replaced with new products. The following is a crosswalk of the 2015 terminated products to the 2016 new products.

2015 Plan ID	2016 Plan ID
65441AZ0040004	65441AZ0050004
65441AZ0040003	65441AZ0050003
65441AZ0040002	65441AZ0050002
65441AZ0040001	65441AZ0050001

16. PLAN TYPE

The plan types listed in the drop-down box in Worksheet 2, Section I of the URRT describe the plans exactly.

17. URRT WARNINGS

There were no warnings in the URRT.

18. EFFECTIVE RATE REVIEW INFORMATION

Information is available upon request.

19. RELIANCE

Wakely Consulting Group, Inc., 9777 Pyramid Ct, Suite 260, Englewood, CO 80112 relied on information provided by Issuer 65441 and publicly available information to develop the 2016 individual premium rates. This information includes, but is not limited to the following:

- Base data and enrollment
- Trend assumptions and morbidity impacts
- Membership projections
- Provider contracting levels, including descriptions of the relationship between the delivery systems and Issuer 65441 and target pricing
- Administrative cost projections
- Product design information
- CCIIO and the State of Arizona's regulatory and compliance interpretations and rulings
- Commercial rate filings and financial reports of carriers participating in the ACA market.

20. ACTUARIAL CERTIFICATION

I, Julie Peper, am a Fellow in the Society of Actuaries (FSA) and a member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries for preparing premium rate filings for insurers.

This actuarial certification applies to the Issuer 65441 Individual HMO product to be offered in the federal health exchange.

1. The premium rates filed are in compliance with applicable laws, rules and guidelines of the State of Arizona
2. The premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory based on the provisions of the ACA as currently implemented
3. The premium rates are calculated on the basis of sound actuarial principles
4. The premium rates are reasonable when related to the applicable coverage and characteristics of the applicable class of enrollees.
5. The index rates are developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates
6. The premium rates filed are prepared in conformity with the Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board that are listed below:

   ASOP No. 5, Incurred Health and Disability Claims

   ASOP No. 8, Regulatory Filings for Health Plan Entities

   ASOP No. 12, Risk Classification

   ASOP No. 23, Data Quality

   ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

   ASOP No. 41, Actuarial Communication

   ASOP No. 42 - Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

In my opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are neither excessive nor deficient based on the provisions of the ACA as currently implemented. Actual experience will vary from the estimates given the inherent uncertainty in developing premium rates under the ACA.

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.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

The Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used 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 and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Julie Peper, FSA, MAAA
Director and Senior Consulting Actuary
(720) 226-9814
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Appendix A
Issuer 65441 Allowed PMPM Development

Large Group Claims Experience	Medical	Rx	Total
2013 LG Allowed PMPM (without IBNR)	$270.65	$67.84	
2013 LG member months	517,586	517,586	
IBNR completion factor	1.0000	1.0000	
2013 LG Allowed PMPM (with IBNR)	$270.65	$67.84	$338.49
Adjustments to base data	0.8974		
Final Allowed PMPM	**$303.77**		

Appendix B
Issuer 65441 Premium Rate Development

Rating model for individual and small group ACA filings	Step									
Experience - Allowed PMPM - adjusted to rating year basis	(01)	$0.00								
Manual Rate - Allowed PMPM - adjusted to rating year basis	(02)	$303.77								
Experience Period Member Months	(03)	0								
Credibility	(04)	0.0%								
Remove non-EHBs	(05)	0.9890								
Allowed PMPM (with induced demand)	(06)	$300.42		Final Step						
Market Adjusted Index Rate				**Fee**						
Impact of reinsurance	(07)	96.44%	$6.77	$2.25	$9.02					
Risk adjustment factor	(08)	100.08%	($0.15)	$0.15	$0.00					
Equivalent exchange user fee	(09)	3.8%	**Desired Amount**							
Market adjusted index rate	(10)	$301.29								
Plan level adjustments										
HIOS ID ->	(11)	65441AZ0090004	65441AZ0070004	65441AZ0050004	65441AZ0090003	65441AZ0070003	65441AZ0050003	65441AZ0090002	65441AZ0070002	65441AZ0050002
Plan Name ->	(12)	Phoenix Choice Catastrophic HMO Abrazo	Phoenix Choice Catastrophic HMO Abrazo and Phoenix Children's Hospital	Phoenix Choice Catastrophic HMO	Phoenix Choice Bronze HMO Abrazo	Phoenix Choice Bronze HMO Abrazo and Phoenix Children's Hospital	Phoenix Choice Bronze HMO	Phoenix Choice Silver HMO Abrazo	Phoenix Choice Silver HMO Abrazo and Phoenix Children's Hospital	Phoenix Choice Silver HMO
Metal ->	(13)	Catastrophic	Catastrophic	Catastrophic	Bronze	Bronze	Bronze	Silver	Silver	Silver
Pricing AV's	(14)	42.7%	43.0%	43.5%	51.9%	52.1%	53.2%	63.8%	64.1%	64.4%
Induced Demand	(15)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0300	1.0300	1.0300
Induced Demand Normalization	(16)	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275
Projected Enrollment by Plan	(17)	5%	3%	3%	7%	4%	5%	20%	11%	14%
Non-EHBs	(21)	1.0004	1.0004	1.0004	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002
Interim Calculation										
Gross Premium	(29)	$96.39	$98.49	$102.65	$184.98	$188.51	$198.58	$234.21	$238.76	$247.31
Net Premium	(30)	$77.86	$79.56	$82.93	$149.57	$152.43	$160.58	$189.42	$193.10	$200.03
Plan Adjusted Index Rate (before calibration)										
Gross Premium	(31)	$95.69	$97.78	$101.91	$183.65	$187.15	$197.15	$232.52	$237.03	$245.53
Plan Adjusted Calibrated Index Rates Index Rates (at 1.0 HHS)		Plan Adjusted Calibrated Index Rates (f)								
Plan Adjusted Calibrated Index Rates (f)	(53)	$65.74	$67.17	$70.01	$126.16	$128.56	$135.43	$159.73	$162.83	$168.67
Projected Member Months	(54)	4,320	2,400	2,880	6,480	3,600	4,320	19,440	10,800	12,960

ISSUER 65441 Individual Product
2016 Rate Filing

Rating model for individual and small group ACA filings	Step										
Experience - Allowed PMPM - adjusted to rating year basis	(01)										
Manual Rate - Allowed PMPM - adjusted to rating year basis	(02)										
Experience Period Member Months	(03)										
Credibility	(04)										
Remove non-EHBs	(05)										
Allowed PMPM (with induced demand)	(06)										
Market Adjusted Index Rate											
Impact of reinsurance	(07)										
Risk adjustment factor	(08)										
Equivalent exchange user fee	(09)										
Market adjusted index rate	(10)										
Plan level adjustments											
HIOS ID ->	(11)	65441AZ0100002	65441AZ0080002	65441AZ0060002	65441AZ0090001	65441AZ0070001	65441AZ0050001	65441AZ0100001	65441AZ0080001	65441AZ0060001	
Plan Name ->	(12)	Phoenix Choice Silver HMO Abrazo + Dental/Vision	Phoenix Choice Silver HMO Abrazo and Phoenix Children's Hospital + Dental/Vision	Phoenix Choice Silver HMO + Dental/Vision	Phoenix Choice Gold HMO Abrazo	Phoenix Choice Gold HMO Abrazo and Phoenix Children's Hospital	Phoenix Choice Gold HMO	Phoenix Choice Gold HMO Abrazo + Dental /Vision	Phoenix Choice Gold HMO Abrazo and Phoenix Children's Hospital + Dental/Vision	Phoenix Choice Gold HMO + Dental/Vision	
Metal ->	(13)	Silver	Silver	Silver	Gold	Gold	Gold	Gold	Gold	Gold	**Average**
Pricing AV's	(14)	65.0%	65.2%	65.5%	74.2%	74.2%	74.7%	75.3%	75.2%	75.7%	**61.67%**
Induced Demand	(15)	1.0300	1.0300	1.0300	1.0800	1.0800	1.0800	1.0800	1.0800	1.0800	
Induced Demand Normalization	(16)	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	1.0275	
Projected Enrollment by Plan	(17)	9%	5%	6%	3%	2%	2%	2%	1%	1%	**61.67%**
Non-EHBs	(21)	1.0479	1.0470	1.0454	1.0001	1.0001	1.0001	1.0409	1.0403	1.0389	**1.011**
Interim Calculation											**Average**
Gross Premium	(29)	$249.93	$254.49	$263.04	$285.50	$289.79	$300.77	$301.35	$305.64	$316.62	**$226.79**
Net Premium	(30)	$202.15	$205.84	$212.76	$230.94	$234.42	$243.31	$243.77	$247.24	$256.13	**$183.42**
Plan Adjusted Index Rate (before calibration)											
Gross Premium	(31)	$248.13	$252.65	$261.14	$283.44	$287.70	$298.60	$299.17	$303.43	$314.33	**$225.16**
Plan Adjusted Calibrated Index Rates Index Rates (at 1.0 HHS)											**Average**
Plan Adjusted Calibrated Index Rates (f)	(53)	$170.45	$173.56	$179.39	$194.71	$197.64	$205.13	$205.52	$208.44	$215.93	**$154.67**
Projected Member Months	(54)	8,640	4,800	5,760	2,592	1,440	1,728	1,728	960	1,152	**96,000**

Appendix C
Rating Factors

Geographic Factors	
Rating Area	**Factor**
Rating Area 4	1.000

Age and Tobacco Factors			
Age	**Tobacco Load**	**Age Factor**	**With Tobacco Load**
0-20	1.00	0.635	0.635
21	1.05	1.000	1.050
22	1.05	1.000	1.050
23	1.05	1.000	1.050
24	1.05	1.000	1.050
25	1.05	1.004	1.054
26	1.05	1.024	1.075
27	1.05	1.048	1.100
28	1.05	1.087	1.141
29	1.05	1.119	1.175
30	1.05	1.135	1.192
31	1.05	1.159	1.217
32	1.05	1.183	1.242
33	1.05	1.198	1.258
34	1.05	1.214	1.275
35	1.05	1.222	1.283
36	1.05	1.230	1.292
37	1.05	1.238	1.300
38	1.05	1.246	1.308
39	1.05	1.262	1.325
40	1.05	1.278	1.342
41	1.05	1.302	1.367
42	1.05	1.325	1.391
43	1.05	1.357	1.425
44	1.05	1.397	1.467
45	1.05	1.444	1.516
46	1.05	1.500	1.575
47	1.05	1.563	1.641
48	1.05	1.635	1.717
49	1.05	1.706	1.791
50	1.05	1.786	1.875
51	1.05	1.865	1.958
52	1.05	1.952	2.050
53	1.05	2.040	2.142
54	1.05	2.135	2.242
55	1.05	2.230	2.342
56	1.05	2.333	2.450
57	1.05	2.437	2.559
58	1.05	2.548	2.675
59	1.05	2.603	2.733
60	1.05	2.714	2.850
61	1.05	2.810	2.951
62	1.05	2.873	3.017
63	1.05	2.952	3.100
64	1.05	3.000	3.150
65 and over	1.05	3.000	3.150

Family Structure – Family rates can be determined by adding up the rates for an individual. However, when calculating the total family rate, the charge is limited to the first three children under the age of 21. There is no limitation on children over 21.

Example Rate Buildup:
An exchange member with the following characteristics:

- Phoenix Choice Catastrophic HMO Abrazo
- Rating area 4
- Age 25
- Smoker

Would get the following rate:

Calibrated plan adjusted index rate: $65.74
x geographic factor: 1.0
x age factor: 1.004
x tobacco load: 1.05
= Consumer adjusted index rate: $69.30

Appendix D
Issuer 65441 Cost Sharing Reduction Estimates and Justification

	Actuarial Values				Member Months				Allowed	87% and 94%	Advance Payments			
Advance CSR Payments	Base Silver	73% Silver	87% Silver	94% Silver	Base Silver	73% Silver	87% Silver	94% Silver	PMPM	Utilization	73% Silver	87% Silver	94% Silver	Total
Phoenix Choice	70.0%	73.0%	87.0%	94.0%	609	927	968	1,095	$312.88	1.12	$8,704.53	$57,688.81	$92,096.97	$158,490.31
Phoenix Choice Plus	70.0%	73.0%	87.0%	94.0%	271	412	430	487	$312.88	1.12	$3,868.68	$25,639.47	$40,931.99	$70,440.14

Appendix E
Non-Applicable ASOPs

ASOP 26 – Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans was not used in relation to this filing. Issuer 65441's filing is only for Individual business, not small group.

Appendix F
Plan Designs

Plan Metal	Gold	Gold Plus	Silver	Silver Plus	Bronze	Catastrophic
2016 Federal AV	78.0%	78.0%	68.1%	68.1%	60.6%	61.3%
Summary of Benefits (SBC)						
Medical and Drug Deductibles Integrated	No	No	No	No	Yes	Yes
Medical and Drug MOOP Integrated	Yes	Yes	Yes	Yes	Yes	Yes
Multiple Network Tiers	No	No	No	No	No	No
MOOP for Medical, Drug, and Pediatric Dental EHB (if applicable) Total						
Single (In Network)	$4,900	$4,900	$6,700	$6,700	$6,850	$6,850
Family (In Network)	$9,800	$9,800	$13,400	$13,400	$13,700	$13,700
Medical EHB Deductible						
Single (In Network)	$1,800	$1,800	$4,000	$4,000	Integrated	Integrated
Family (In Network)	$3,600	$3,600	$8,000	$8,000	Integrated	Integrated
Default Coinsurance (In Network)	20%	20%	30%	30%	N/A	N/A
Drug EHB Deductible						
Single (In Network)	$0	$0	$0	$0	Integrated	Integrated
Family (In Network)	$0	$0	$0	$0	Integrated	Integrated
Default Coinsurance (In Network)	35%	35%	35%	35%	N/A	N/A
Combined Medical and Drug Deductible						
Single (In Network)	N/A	N/A	N/A	N/A	$6,150	$6,850
Family (In Network)	N/A	N/A	N/A	N/A	$12,300	$13,700
Default Coinsurance (In Network)	N/A	N/A	N/A	N/A	35%	0%
Not Subject to Deductible	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; partially for Office Visits for PCP, Specialist, Nurse/PA, Outpatient Mental Health or Substance Abuse, Tele-health, and Prenatal and Postnatal Care; Medical Foods; Generic and Preferred Generic Drugs; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam.	Preventive care
PCP (Injury or Illness)	$15 copay	$15 copay	$30 copay	$30 copay	For the first 2 visits* $50 copay; deductible and then $50 copay applies to additional visits. * 2 Visits include any combination of PCP, Specialist, Nurse/PA, MH/SA, Tele-health, and Prenatal and Postnatal Care.	$20 copay; after first 3 visits, $0 after deductible
Specialist	$30 copay	$30 copay	$60 copay	$60 copay	For the first 2 visits* $100 copay; deductible and then $100 copay applies to additional visits. * 2 Visits include any combination of PCP, Specialist, Nurse/PA, MH/SA, Tele-health, and Prenatal and Postnatal Care.	$0 after deductible
Nurse/PA	$15 copay	$15 copay	$30 copay	$30 copay	For the first 2 visits* $50 copay; deductible and then $50 copay applies to additional visits. * 2 Visits include any combination of PCP, Specialist, Nurse/PA, MH/SA, Tele-health, and Prenatal and Postnatal Care.	$0 after deductible

ISSUER 65441 Individual Product
2016 Rate Filing

Plan Metal	Gold	Gold Plus	Silver	Silver Plus	Bronze	Catastrophic
Prescription Drugs (Retail 30 day supply - In Network. Retail 90 day supply is 3x 30 day supply)						
Preferred Generic	$2 copay	$2 copay	$3 copay	$3 copay	$10 copay	$0 after deductible
Generic	$6 copay	$6 copay	$12 copay	$12 copay	$50 copay	$0 after deductible
Preferred Brand	$30 copay	$30 copay	$50 copay	$50 copay	$100 copay after deductible	$0 after deductible
Non-Preferred Brand	$65 copay	$65 copay	$100 copay	$100 copay	$200 copay after deductible	$0 after deductible
Specialty Preferred	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance	50% coinsurance after deductible	$0 after deductible
Specialty Non-preferred	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	60% coinsurance after deductible	$0 after deductible
Emergency Room Services	$120 copay after deductible IN and OON	$120 copay after deductible IN and OON	$150 copay after deductible IN and OON	$150 copay after deductible IN and OON	$200 copay after deductible IN and OON	$0 after deductible
Inpatient						
Facility Fee	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible
Physician Services	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible
Outpatient Surgery						
Facility Fee	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible
Physician Services	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible
Testing						
Diagnostic (x-ray, blood work)	$25 copay	$25 copay	$40 copay	$40 copay	$50 copay after deductible	$0 after deductible
Imaging (CT/PET, MRI)	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible
MH/BH Outpatient	$15 copay for office visits; 20% coinsurance after deductible for Outpatient Facility services	$15 copay for office visits; 20% coinsurance after deductible for Outpatient Facility services	$30 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$30 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	For the first 2 visits* $50 copay; deductible and then $50 copay applies to additional visits. * 2 Visits include any combination of PCP, Specialist, Nurse/PA, MH/SA, Tele-health, and Prenatal and Postnatal Care; 35% coinsurance after deductible for Outpatient Facility services	$0 after deductible
MH/BH Inpatient	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible
SA Outpatient	$15 copay for office visits; 20% coinsurance after deductible for Outpatient Facility services	$15 copay for office visits; 20% coinsurance after deductible for Outpatient Facility services	$30 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$30 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	For the first 2 visits* $50 copay; deductible and then $50 copay applies to additional visits. * 2 Visits include any combination of PCP, Specialist, Nurse/PA, MH/SA, Tele-health, and Prenatal and Postnatal Care; 35% coinsurance after deductible for Outpatient Facility services	$0 after deductible
SA Inpatient	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$0 after deductible (Detox 2 treatments/CY)
Rehabilitation Services	20% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	20% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	30% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	30% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	35% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	$0 after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)
Skilled Nursing Care	20% coinsurance after deductible (90 days/CY)	20% coinsurance after deductible (90 days/CY)	30% coinsurance after deductible (90 days/CY)	30% coinsurance after deductible (90 days/CY)	35% coinsurance after deductible (90 days/CY)	$0 after deductible (90 days/CY)
Pediatric Dental	Not offered	Preventive – 0% coinsurance; Basic, Major and Medically Necessary Ortho - 50% coinsurance after $100 deductible; MOOP integrated with medical	Not offered	Preventive – 0% coinsurance; Basic, Major and Medically Necessary Ortho - 50% coinsurance after $100 deductible; MOOP integrated with medical	Not offered	Not offered
Adult Vision (non-EHB)	Not offered	$25 copay for one exam; $100 allowance for hardware	Not offered	$25 copay for one exam; $100 allowance for hardware	Not offered	Not offered
Adult Dental (non-EHB)	Not offered	Preventive – 0% coinsurance; Basic - 50% coinsurance after $100 deductible (no Major/Ortho coverage); $500 Annual Maximum	Not offered	Preventive – 0% coinsurance; Basic - 50% coinsurance after $100 deductible (no Major/Ortho coverage); $500 Annual Maximum	Not offered	Not offered

ISSUER 65441 Individual Product
2016 Rate Filing

Plan Metal	73% - Silver	87% - Silver	94% - Silver	73% - Silver Plus	87% - Silver Plus	94% - Silver Plus
2016 Federal AV	73.1%	87.4%	94.6%	73.1%	87.4%	94.6%
Summary of Benefits (SBC)						
Medical and Drug Deductibles Integrated	No	No	No	No	No	No
Medical and Drug MOOP Integrated	Yes	Yes	Yes	Yes	Yes	Yes
Multiple Network Tiers	No	No	No	No	No	No
MOOP for Medical and Drug EHB Total						
Single (In Network)	$5,350	$1,600	$500	$5,350	$1,600	$500
Family (In Network)	$10,700	$3,200	$1,000	$10,700	$3,200	$1,000
Medical EHB Deductible						
Single (In Network)	$2,600	$850	$250	$2,600	$850	$250
Family (In Network)	$5,200	$1,700	$500	$5,200	$1,700	$500
Default Coinsurance (In Network)	30%	30%	$0	30%	30%	$0
Drug EHB Deductible						
Single (In Network)	$0	$0	$0	$0	$0	$0
Family (In Network)	$0	$0	$0	$0	$0	$0
Default Coinsurance (In Network)	35%	35%	35%	35%	35%	35%
Combined Medical and Drug Deductible						
Single (In Network)	N/A	N/A	N/A	N/A	N/A	N/A
Family (In Network)	N/A	N/A	N/A	N/A	N/A	N/A
Default Coinsurance (In Network)	N/A	N/A	N/A	N/A	N/A	N/A
Not Subject to Deductible	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.	Preventive care; Office visits for PCP, Specialist, Nurse/PA, and Outpatient Mental Health or Substance Abuse; Urgent Care; Prescription Drugs; Tele-health; Diabetes Care Management/Education; Well Baby Visits and Care; Pediatric Glasses and Eye Exam; Home Health Care; Prenatal and Postnatal Care; and Diagnostic.
PCP (Injury or Illness)	$15 copay	$10 copay	$5 copay	$15 copay	$10 copay	$5 copay
Specialist	$60 copay	$40 copay	$20 copay	$60 copay	$40 copay	$20 copay
Nurse/PA	$15 copay	$10 copay	$5 copay	$15 copay	$10 copay	$5 copay
Preventive	$0	$0	$0	$0	$0	$0
Preferred Generic	$3 copay	$3 copay	$3 copay	$3 copay	$3 copay	$3 copay
Generic	$10 copay	$8 copay	$5 copay	$10 copay	$8 copay	$5 copay
Preferred Brand	$50 copay	$40 copay	$30 copay	$50 copay	$40 copay	$30 copay
Non-Preferred Brand	$100 copay	$100 copay	$80 copay	$100 copay	$100 copay	$80 copay
Specialty Preferred	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance
Immediate Medical Attention						
Emergency Room Services	$150 copay after deductible IN and OON	$125 copay after deductible IN and OON	$120 copay after deductible IN and OON	$150 copay after deductible IN and OON	$125 copay after deductible IN and OON	$120 copay after deductible IN and OON
Inpatient						
Facility Fee	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
Physician Services	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible

Plan Metal	73% - Silver	87% - Silver	94% - Silver	73% - Silver Plus	87% - Silver Plus	94% - Silver Plus
Outpatient Surgery						
Facility Fee	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
Physician Services	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
Testing						
Diagnostic (x-ray, blood work)	$40 copay	$30 copay	$15 copay	$40 copay	$30 copay	$15 copay
Imaging (CT/PET, MRI)	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
MH/BH Outpatient	$15 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$10 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$5 copay for office visits; 10% coinsurance after deductible for Outpatient Facility services	$15 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$10 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$5 copay for office visits; 10% coinsurance after deductible for Outpatient Facility services
MH/BH Inpatient	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
SA Outpatient	$15 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$10 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$5 copay for office visits; 10% coinsurance after deductible for Outpatient Facility services	$15 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$10 copay for office visits; 30% coinsurance after deductible for Outpatient Facility services	$5 copay for office visits; 10% coinsurance after deductible for Outpatient Facility services
SA Inpatient	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
Rehabilitation Services	30% coinsurance after deductible (42 visits/CY)	30% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	10% coinsurance after deductible (outpatient 60 visits/CY)	30% coinsurance after deductible (42 visits/CY)	30% coinsurance after deductible (total of 60 visits in the home in connection with home health and outpatient rehabilitative services)	10% coinsurance after deductible (outpatient 60 visits/CY)
Skilled Nursing Care	30% coinsurance after deductible (90 days/CY)	30% coinsurance after deductible (90 days/CY)	10% coinsurance after deductible (90 days/CY)	30% coinsurance after deductible (90 days/CY)	30% coinsurance after deductible (90 days/CY)	10% coinsurance after deductible (90 days/CY)
Pediatric Dental	Not offered	Not offered	Not offered	Preventive – 0% coinsurance; Basic, Major and Medically Necessary Ortho - 50% coinsurance after $100 deductible; MOOP integrated with medical	Preventive – 0% coinsurance; Basic, Major and Medically Necessary Ortho - 50% coinsurance after $100 deductible; MOOP integrated with medical	Preventive – 0% coinsurance; Basic, Major and Medically Necessary Ortho - 50% coinsurance after $100 deductible; MOOP integrated with medical
Adult Vision (non-EHB)	Not offered	Not offered	Not offered	$25 copay for one exam; $100 allowance for hardware	$25 copay for one exam; $100 allowance for hardware	$25 copay for one exam; $100 allowance for hardware
Adult Dental (non-EHB)	Not offered	Not offered	Not offered	Preventive – 0% coinsurance; Basic - 50% coinsurance after $100 deductible (no Major/Ortho coverage); $500 Annual Maximum	Preventive – 0% coinsurance; Basic - 50% coinsurance after $100 deductible (no Major/Ortho coverage); $500 Annual Maximum	Preventive – 0% coinsurance; Basic - 50% coinsurance after $100 deductible (no Major/Ortho coverage); $500 Annual Maximum