Independence Blue Cross

www.ibx.com

1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

Important information about your health plan premium rate

[Letter Date]
[Member Name]
[Street Address]
[City, State, Zip]

Re: [USI]

Dear [First Name] [Last Name]:

I am writing to let you know that the monthly rates for your [Individual HMO health plan], underwritten by Keystone Health Plan East, Inc., will increase on [July x, 2012]. This letter explains the reason for the increase and includes important information about coverage for Medicare beneficiaries.

THE REASON FOR THE RATE INCREASE

To continue to provide you with high-quality coverage in the face of rising health care costs, it is necessary for Independence Blue Cross (IBC) to implement a 9 percent rate increase for all of our Individual Medically Underwritten HMO plans. This rate increase has been approved by the Pennsylvania Insurance Department and will affect your monthly premiums.

We spend about 88.5 cents of every premium dollar our customers give us to pay physicians and hospitals to care for our members. Increasing premiums is not a decision we make without carefully considering all options, and we remain committed to providing you with quality coverage at the greatest value.

The rates for our HMO plans are based on five-year age brackets (e.g., 55-59, 60-64). As a result, your premium payment may go up more than 9 percent. In general, we increase premiums as members get older because experience shows our members use more health services as they age. Your premium may receive an additional adjustment if the oldest member covered under your policy:

- entered a new age bracket since July 2011, when we last adjusted premiums based on age, or;
- will enter a new age bracket when the rate increase goes into effect.

For more information about how your age determines costs of your plan, call 1-888-335-5017.

Beginning with your [July x] premium payment, your monthly premium for your [current plan] will be [amount].

(over)

Independence Blue Cross

YOU MAY QUALIFY FOR A REDUCED RATE

If you are currently enrolled in Medicare Parts A and B, you may qualify for a reduced rate should you decide to continue your individual medically underwritten HMO plan.

In order to receive a reduced rate, you must provide Independence Blue Cross with proof of your Medicare coverage by completing and mailing the enclosed Proof of Medicare Coverage Form along with a copy of your Medicare ID card by [Response Date]. Please submit a form and a copy of the Medicare ID card for each member who is enrolled in Medicare Parts A and B and is covered under your plan.

If you or someone else on your plan may be eligible to enroll in a Medicare Advantage Plan, we would be happy to discuss the various options available. Talk to a member of our Medicare team by calling 1-877-393-6733.

THE NEXT STEPS YOU NEED TO TAKE

Everything you need to proceed is enclosed with this letter. Please take a few moments to consider the following options:

1. If you wish to keep your current coverage, you do not need to do anything. Your benefits will renew automatically at [amount] per month, and your premium bill will be adjusted accordingly.
2. If you are enrolled in Medicare Parts A and B and wish to continue your current coverage at a reduced rate, you must complete the enclosed Proof of Medicare Coverage Form. If you want this change to be reflected in your next invoice, please make sure we receive your completed form and a copy of your Medicare ID card by [Response Date].

If you pay your premiums through a monthly, automatic bank withdrawal, please make note of the new amount that will be deducted from your account.

Thank you for continuing to trust your health insurance needs to Independence Blue Cross. If you have questions concerning this rate increase, or want to learn more about other individual health plan options, please contact your broker or call 1-888-335-5017.

Sincerely,

Paula Sunshine

Paula Sunshine
Vice President, Product Services

Enclosures

Independence Blue Cross

KEYSTONE HEALTH PLAN EAST [INDIVIDUAL HMO]
PROOF OF MEDICARE COVERAGE FORM

Please respond by [Response Date].

[Letter Date]
[Member Name]
[USI #]

By signing this letter, I acknowledge that I am currently enrolled in Medicare Parts A and B and would like to continue my [current Individual medically underwritten HMO plan] at the reduced rate. I have enclosed a copy of my current Medicare ID card as proof of coverage.

Member signature _____ Date _____

Spouse signature _____ Date _____

Submit your completed form

By mail:
Independence Blue Cross
P.O. Box 41452
Philadelphia PA 19101

By fax:
215-238-7067