2025 Rate Filing Guidance for Dental Rate Filings

Nevada Department of Business and Industry
Division of Insurance

Release Date: April 1, 2024

Nevada Division of Insurance

Guidance for Dental Rate Filings

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Nevada Division of Insurance

Guidance for Dental Rate Filings

Section I: Overview

This guidance applies to dental premium rates submitted to the Nevada Division of Insurance ("Division") with effective dates on or after January 1, 2025 for:

- Pediatric only and family (covering both pediatric dental and adult dental services) stand-alone dental plans sold through the Silver State Health Insurance Exchange (SSHIX),
- Pediatric only and family SSHIX-certified dental plans sold outside the SSHIX,
- Dental plans that are not intended to be SSHIX-certified.

All dental rate filings must include an Actuarial Memorandum, an Actuarial Certification, a completed Nevada Dental Filing Checklist and a Rating Manual. Stand-alone dental plans must also submit the required HHS templates as well as the Nevada-specific SADP Enrollment and Experience Template.

Section II: General Guidance for Exchange-Certified Dental Plans

Throughout this document, references to stand-alone dental plans ("SADPs") include all SSHIX-certified dental plans sold both on and off the exchange. A SADP must be submitted as a separate filing from the medical plans. Similarly, the rates for SADPs must be submitted separately from medical plans.

Although the pediatric essential health benefit ("EHB") does not need to be offered at a particular Actuarial Value (AV), the AV of the Pediatric EHB for each plan must be certified by a member of the American Academy of Actuaries. The AV compares the cost of a plan after member cost-sharing is taken into account against the same plan assuming 100% payment by the carrier for all covered dental services.

Note that the federal AV Calculator, which is used for ACA-compliant medical plans, cannot be used to determine the dental actuarial value. The certifying actuary will need to develop a dental pricing model to determine the actuarial value of the proposed pediatric dental plans. This model must use the same standard population to evaluate all the pediatric dental plans offered by the carrier. For a network dental plan, only in-network charges are counted toward the development of the actuarial value. See section 4.11 for further detail relating to this requirement.

Stand-alone dental plans that provide coverage for the pediatric dental EHB should cover members until at least the end of the month in which the member turns age 19.

Stand-alone dental issuers in the Individual market must use the four standardized rating regions:

- Clark and Nye counties
- Washoe county
- Carson City, Lyon, Douglas and Storey counties
- All other counties

Under 45 CFR 155.1065 (a)(2), the pediatric dental EHB offered by stand-alone dental plans must be offered without annual and lifetime limits. Annual and lifetime limits may be used for benefits, in addition to the pediatric dental essential health benefits and for adult dental benefits.

Under 45 CFR 156.150(a), SADPs are required to have a reasonable annual limit on pediatric dental EHB cost sharing. For 2023, a pediatric dental EHB cost sharing annual limit at or below $425 for a plan with one child enrollee, or $850 for a plan with two or more child enrollees is considered reasonable. No higher limit will be approved.

The Health Insurance Providers Fee has been repealed effective January 1, 2021.

Section III: Submitting Filings in the System for Electronic Rate and Form Filing ("SERFF")

Sec 3.1: Type of filing

Dental carriers may choose to submit a separate rate filing or a combined rate/form filing. When submitting a rate or rate/form filing in SERFF, please make sure to include the following items:

a) Actuarial Memorandum (Supporting Documentation Tab)
b) Dental Rate Filing Checklist (Supporting Documentation Tab) – See Exhibit B
c) Rating Manual (Rate/Rule Tab)
d) Additional supporting information (Supporting Documentation Tab)
e) Forms Filing Checklist - for rate/form filing only (Supporting Documentation Tab)
f) Applicable federal templates – for SADPs only (Supporting Documentation Tab)
g) Nevada SADP Enrollment and Experience Template – for SADPs only (Supporting Documentation Tab)
h) Confidentiality request (Note to Reviewer)

Sec 3.2: Standard Naming Convention

Please use the following standard naming convention when naming any files submitted to the Division: **CarrierName_YYYYmkt_ Plantype_v#_ Filedesc.filetype**

- **CarrierName**: Up to 6 Characters which identify the carrier
- **YYYY**: four digit filing year
- **mkt**: **indicate one of the following**:
  - "i" for individual (non-group)
  - "s" for filings that include small groups only, (2 to 50 employees)
  - "l" for filings that include large groups only (more than 50 employees)
  - "g" for filings that include groups of all sizes (more than 2 employees)
- **Plantype: indicate one of the following**
  - Med
  - SADP
  - NSADP (Non SADP)
- **v#**: v followed by the version number (increment for each update to the filing)
- **Filedesc**: indicate one of the following:
  - **SADPT** – Nevada SADP Enrollment and Experience Template
  - **RT** – Rates Template
  - **ECPT -** Essential Community Providers Template

- **PBT** – Plan and Benefit Template
- **SAT** – Service Area Template
- **NT -** Network Template
- **BRT –** Business Rules Template
- **AM** – Actuarial Memorandum
- **RFC** – Rate Filing Checklist
- **RM** – Rating Manual
- **FFC** – Form Filing Checklist

- **Filetype**: the filetype is based on the software used (e.g., Excel, PDF, etc.)

Section IV: Actuarial Memorandum Requirements

Provide the information listed below in the actuarial memorandum as an attachment under the Supporting Documentation tab in SERFF. If a filing includes more than one type of product, e.g., dental and vision, a separate actuarial memorandum is required to be submitted for each different type of product.

The Actuarial Memorandum instructions below provide the minimum information required to be included in the actuarial memorandum when submitting dental rate filings in Nevada. Dental carriers are encouraged to include as much detail and supporting documentation as possible in the initial filing in order to avoid delaying the review process, which may include several rounds of questions from the Division. Failure to provide information on a timely basis or failure to provide accurate information slows the review process and puts the carrier at risk for missing critical deadlines to offer dental products and plans in Nevada.

If any information provided is not broadly applicable to all products and plans included in the submission, please clearly indicate to which products and plans the information applies.

Sec. 4.1: Treatment of Proprietary Information
The Division recognizes that carriers may consider certain information to be proprietary and confidential. In order to ensure that proprietary information is kept confidential by the Division, carriers are encouraged to follow the following procedure:

Submit a written request for specific information to receive confidential treatment pursuant to NRS 679B.190(5)(b). Include the request in the cover letter for the filing and in a "Note to Reviewer" in SERFF. Indicate "proprietary and confidential" directly on each submitted document that is subject to the request, regardless of the file format (Excel, PDF, Word, etc.).

Sec. 4.2: General Information
This section of the Actuarial Memorandum should include general information about the carrier and the policies which are the subject of the submission. The information provided in this section should include at least the following:

a) **Company Identifying Information:** Provide the following information that identifies the carrier submitting the memorandum. The information must be the same as the entries in the general information section of the Dental rate filing checklist:

i) Company Legal Name: the organization's legal entity name.
ii) State: the state that has regulatory authority over the policies (NV).
iii) Type of entity, including the NV statute under which the legal entity is licensed (e.g., NRS 695C, 695D, 695F, 680A, etc.).
iv) HIOS Issuer ID: the HIOS ID assigned to the legal entity (for SADPs only).
v) Market: the market in which the products and plans are offered.
vi) Effective Date: the effective date of the rate proposal.

b) **Related filings:** When submitting rate-only filings, provide a copy of the policy form(s) associated with the rate filing or indicate the appropriate SERFF tracking numbers.

c) **Company Contact Information:** Provide the following information detailing how the Division should contact the company if additional information is needed to complete the review. The primary contact should be the certifying actuary. Please feel free to include as many secondary contacts as needed and include the indicated information.
   i) **Primary contact (required):**
      - Primary Contact Name: Provide the name of the person at the company who will serve as the primary contact for the submission. The regulator will contact this person if there are questions related to the information submitted, or if additional information is needed.
      - Primary Contact Telephone Number: Provide the phone number for the primary contact.
      - Primary Contact Email Address: Provide the email address for the primary contact.

   ii) **Secondary contact(s) (optional):**
      - Secondary Contact Name:
      - Secondary Contact Telephone Number:
      - Secondary Contact Email Address:

d) **Summary of Benefits:** In the Summary of Benefits section of the Actuarial Memorandum, include a benefit chart showing high-level details for applicable member cost-sharing (copays, deductibles, coinsurance, out-of-pocket maximums, waiting periods and annual year limits) for each Plan. A reviewer should have a basic understanding of the benefits provided for each Plan without a review of the Schedule of Benefits.
   i) Provide separate charts for Adult and Pediatric benefits if they vary.
   ii) At a minimum, the benefit chart should contain a row for each Service Category (Diagnostic, Preventive, Basic, Major, Orthodontia).
   iii) If there are multiple levels of member responsibility within a Service Category, please indicate the Range.
   iv) It would also be useful to the reviewer if the Summary of Benefits section included more details describing member cost-sharing for the most common services such as oral evaluations, bitewing x-rays, prophylaxis, topical fluoride, sealants, simple extractions, and composite filings.

Sec. 4.3: Scope and Purpose of the Filing

In this section, the actuary must provide the proposed rate change(s) and information related to the proposed rate(s) and associated change(s). If the proposed rate adjustment varies by product, the information provided should clearly identify which proposed adjustments apply to which products. Include

all products which are intended to be part of this filing, including those products for which no rate adjustment is being proposed. The information that must be provided includes the following items:

a) **Regulatory authority:** Provide the applicable federal and/or state law(s) with which the filing is intended to comply.
b) **HIOS plan ID (SADP only):** Within the Actuarial Memorandum, provide all HIOS Plan IDs and specify which plans were offered in 2024 and which plans will be offered in 2025. Specify if any plans are new or terminated from the prior year. Also, include the specific marketing names for each plan.
c) **Proposed implementation date of rate change.**
d) **Rate change history:** Provide the list of rate changes that have been approved in the past. Include the approved rate change percent with a month/year effective date.
e) **Reason for Rate Change(s):** Provide the quantitative impact and a narrative description of all significant factors driving a proposed rate increase. As an example, these factors could include:
    i) Trend
    ii) Benefit design changes
    iii) Changes in taxes or fees imposed on the carrier
    iv) Changes in federal or state law

e) **Rate change by plan:** Provide an exhibit detailing the rate change by plan. If the requested rate change is not the same across all products and plans, provide an explanation as to why the rate changes vary. Provide in broad terms the aggregate rate change being requested. Provide the range of changes for all plans within this submission, indicate any major changes being sought in the filing and indicate any major changes proposed in the filing, such as termination of products or changes in benefits. For existing plans that will discontinue in the projection period, please apply appropriate mapping of membership for purposes of calculating the average rate change.
f) **Current Rates (For Rate Revisions):** Include a complete set of current rates or the appropriate SERFF tracking number.
g) **Proposed Rates:** Include a complete set of proposed rates, include any guidelines that impact policyholder's premium payment. Indicate if these rates apply to both new and/or existing policyholders.

Sec. 4.4: Historical Experience (For Rate Revisions)

a) Indicate experience period, including paid through date.
b) Provide an exhibit showing Nevada and Nationwide data for the following (For SSHIX-certified plans, please use the SADP Enrollment and Experience Template to provide this information-See Appendix A for instructions on completing this template):
    i) Earned Premium by plan and rating area
        - Provide the historical earned premium for each calendar year from inception.
        - Include all premiums regardless of ownership of this block of business.
            (a) Provide as much of the earned premium paid in the current year since the last calendar year as possible.
        - Include the following items and any other changes that impact policyholder's premium payment. All payments from policyholder are considered premium, including:
            (a) Fees
            (b) Taxes
            (c) Modal loading. Please provide the distribution of business by payment mode.
    ii) Incurred Claims by plan and rating area

- Claims should exclude active life reserves ("ALR"), as applicable and exclude loss adjustment expenses ("LAE"). Show detail of IBNR and indicate the paid-to-date.
- Provide the historical incurred claims for each calendar year from inception (for at least the past three full calendar years).
- Include all claims regardless of ownership of this block of business.
  (a) Provide as much of the incurred claims paid in the current year since the last calendar year as possible.

iii) Member months by plan and rating area
- Provide the number of member months by plan and rating area for each of the last three full calendar years.

Sec. 4.5: COVID-19
Carriers should use CY 2023 experience. Detailed quantitative and qualitive support for any adjustments must be provided. Carriers should provide experience from 2021 to 1Q 2024. Carriers should clarify if the impact of COVID-19 was included in the projection analysis.

Sec. 4.6: Rate Development
Provide a detailed description of the methodology used to develop the rates for the plans/products included in this filing. This should include details of the data used as well as any adjustments used to develop the projected claims.

Sec. 4.7: Projected Experience
All projections should be submitted in Excel format with working formulas. All assumptions used in the projections should be clear to the reviewer.

a) **With Requested Rate Change (For Rate Revisions).** Provide best estimates for the projection period of the following:
   i) Earned Premium with Enrollment Projections, using best estimate assumptions, to the projection period.
   ii) Incurred Claims, using best estimate assumptions, to the projection period.

b) **Without Requested Rate Change.** Provide best estimates for the projection period of the following:
   i) Earned Premium with Enrollment Projections, using best estimate assumptions, to the projection period.
   ii) Incurred Claims, using best estimate assumptions, to the projection period.

Also provide a separate table showing experience projection by duration. This table should provide best estimates after considering lapse rates, waiting period impacts, trend, and other assumptions.

Sec. 4.8: Minimum Projected Loss Ratio
Provide an exhibit showing the expected loss ratio, which demonstrates that, pursuant to NRS 686B.125, the minimum loss ratio requirement for individual and large group plans will be met. Carriers are required to provide a detailed description of the data source and methodology used to develop the expected loss ratio and provide quantitative support where appropriate.

Sec. 4.9: Assumptions

Provide detailed quantitative support along with a detailed description of the basis for each major assumption used in pricing, including:

a) Expected membership (in member months).
b) Credibility of experience data (Explain the credibility standard used and how that standard was developed. Additionally, provide quantitative development of the credibility formula in Excel format with working formulas).
c) Annual Trend Rate.
    i) Provide quantitative support for the assumed annual claim trend. Appropriate quantitative support will include utilization as well as cost per unit statistics. Indicate if the trend support is based on Nationwide or Nevada experience, and whether that experience is in the Individual market, Small Group market, or Any-size Group Market. This support should be provided in Excel format with working formulas.
    ii) Additionally, if the claim trend has changed from the prior year, justify the change.
d) Morbidity – If you are using a prior product as a guideline for claim costs for this product, please provide a comparison of the relative richness of each plan.
e) Lapse Rates (Provide quantitative support, by duration, for actual historic lapse rates and projected lapse rates as used in the projection. Quantitative support should be provided in Excel format with working formulas.)
f) Claim liability and reserves.
g) Active life reserves.
h) Underwriting.
i) Expected distribution of business.
    i) Pediatric.
    ii) Adult.
j) Non-Benefit Expenses
    i) Administrative Expenses (Provide quantitative justification for any changes in administration expenses from the prior filing).
    ii) Sales and Marketing Expenses, including commissions.
    iii) Net Cost of Private Reinsurance.
    iv) Premium Tax.
    v) Other Taxes, License and Fees (e.g., SSHIX user fees – 3.05% of premium). For plans marketed both inside and outside the SSHIX, the Exchange user fee must be spread across the total expected membership. A description of the exchange fee assumption must include the distribution of membership inside and outside the exchange.
    vi) Other Expenses.
j) Risk Margin.
k) Profit or Contribution to Surplus Margin.

Sec. 4.10: Rating Factors

a) Identify which rating structures are used for this product and provide support for the proposed factors, including, but not limited to:
    i) Age Factors.
    ii) Geographic Factors.
    iii) Family Composition.
    iv) Benefit Plan Factors.
b) Carriers are required to provide a detailed description of the data source and methodology used to

determine each of these factors and provide quantitative support where appropriate.

Sec. 4.11: Actuarial justification for the proposed rating tier structure(s).
Provide actuarial support for the proposed rating tier structure**.**

Sec. 4.12: AV Pricing model (SADPs only)
For SADPs, include a discussion of the model used to develop the actuarial value ("AV") along with an exhibit(s) showing the development of the AV for the pediatric EHB part of any stand-alone dental plan. In the derivation of the AV, show the claim cost used for each service classification such as basic services, prevention and diagnostic, etc. The AV Model demonstration should be provided in Excel format with working formulas.

Sec. 4.13: Apportionment for Pediatric Dental (SADPs Only)
Provide the dollar amount of the expected premium allocated for the pediatric dental EHB. This amount will be used in calculations for advance payments of the premium tax credit. This amount may not be changed after certification, even if the rate is estimated.

Sec. 4.14: Guaranteed vs. Estimated Rate (SADPs Only)
As excepted benefits, stand-alone dental plans have additional flexibility to adjust premiums based on other rating factors. The federal dental plan and benefits template includes a data field for the dental carrier to indicate whether it is committing to the rates in the template (guaranteed) and is thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments (estimated).

Indicate if the rate for the submitted stand-alone dental plan is on a guaranteed or an estimated basis. The rates a consumer sees are calculated by CMS using the rate tables and the Business Rules template. By indicating that the rate is a "guaranteed rate," the carrier is committing to charging the premium shown in the rate tables template.

Sec. 4.15: Reliance on Others
If, in preparing the rate filing submission, the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information should be disclosed.

Sec. 4.16: Actuarial Certification
The certifying actuary must be a member of the American Academy of Actuaries, in good standing, and have the education and experience necessary to perform the work. The actuary must develop rates in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs may apply, particular emphasis is placed on the following:

a) ASOP No. 5, Incurred Health and Disability Claims.
b) ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits.
c) ASOP No. 12, Risk Classification.
d) ASOP No. 23, Data Quality.
e) ASOP No. 25, Credibility Procedures.

f) ASOP No. 41, Actuarial Communications.

At a minimum, the actuarial certification must include the following:

a) Identification of the certifying actuary.

b) A statement that he/she is a member of the American Academy of Actuaries and meets the "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States".

c) A certification that the proposed rates are:
   I) In compliance with all applicable state and federal statutes and regulations.
   II) The expected loss ratio meets the minimum requirements of the State of Nevada.
   III) Developed in compliance with the applicable Actuarial Standards of Practice.
   IV) Reasonable in relation to the benefits provided and the population anticipated to be covered.
   V) Neither excessive nor deficient.
   VI) Not unfairly discriminatory.

Appendix A

Nevada SADP Enrollment and Experience Template V2.0
Instructions

Nevada Division of Insurance

Appendix A

Section I: Overview

Carriers are required to complete and submit the Nevada SADP Enrollment and Experience Template ("SADP Template") for all dental rate filings, submitted for the individual or small group market, that are intended to be certified by the Silver State Health Insurance Exchange ("SSHIX"). This includes plans that are sold on or off the Exchange, regardless of whether the filing is for new or existing products. This template is optional for carriers filing dental plans that are not intended to be SSHIX-certified. The data captured in the SADP Template includes information related to enrollment, incurred claims experience, and earned premiums.

The information reported in the SADP Template is intended to be consistent with current State and Federal laws, and applicable sub-regulatory guidance. If any subsequent changes are made to State or Federal law, or other guidance that conflict with these instructions, the revised laws/guidance will supersede these instructions.

Once populated with the required information, the Template should be submitted in the "Supporting Documentation" tab of the NAIC's System for Electronic Rate and Form Filing (SERFF).

Please note the following when completing the Template:

- **Cell Shading:** All cells shaded in light gold are required to be populated. Cells that are not shaded are calculated fields, which do not require any input.

- **Incurred claims** are claims after the removal of any duplicates, claims for non-covered services or coordination of benefits (COBs), and after the application of provider discounts and reduction for any cost sharing by the member or a governmental agency, as applicable. This field also includes runout after the incurred date as well as an appropriate adjustment for claims incurred but not yet paid (IBNP) as of the reporting date.

- **Do not** adjust allowed or incurred claims for non-medical items. The treatment of any claims processed outside of the claims system should be consistent (inclusion or exclusion) with how such claims were handled in pricing. The actuarial memorandum should include documentation of any adjustments made for non-system claims.

- The Standard Component Plan ID field should be populated using the Standard Component Plan ID assigned in the Health Insurance Oversight System (HIOS).

- One version of this exhibit must be submitted for each market segment in which the company operated in 2024. Complete one row for each SADP.

The required information should contain data for all plans included in the submitted filing. Additionally, this includes any plans that existed during the periods indicated in the template, even if the plans are currently terminated or are expected to be terminated.

When completing sections of the template where the number of rows a carrier may enter is variable, please enter the first row of data in the first row of colored cells. Enter all subsequent rows of data in a continuous manner; do not leave any blank rows between the records.

Please do not attempt to alter the format of the worksheet in any way (including adding/copying sheets) since alteration may affect the efficacy of the Division's analytical tools.

Section II: Enrollment and Experience

Sec. 2.1: Membership by Rating Area (Member Months)
This section captures enrollment in member months separated by rating area and plan. Please enter the total member months for the experience period. Please also include any plans that existed during the periods indicated in the template, even if the plans are currently terminated or are expected to be terminated.

Sec. 2.2: Earned Premiums by Rating Area
This section captures the earned premiums in the experience period. Please enter the earned premiums by rating area and plan.

Sec. 2.3: 2020 Claims paid through 3/31/24
This section captures claims incurred as of December 31, 2023 and paid through March 31st by plan and rating area. Please enter the paid claims amount from January 1st through March 31st for claims incurred in the previous plan year.

Sec. 2.4: Incurred but Not Yet Paid (IBNP) Claims by Rating Area
This section captures the incurred but not yet paid (IBNP) estimate for claims incurred in the most recently completed calendar year. Please enter the IBNP estimate for each plan separated by rating area.

Sec. 2.5: Incurred Claims by Rating Area
This section captures the historical incurred claims experience by rating area and plan. Note that incurred claims for the most recently completed calendar year is auto populated after completing Sections II and III. Please complete the colored cells for incurred claims in the applicable calendar year.

Sec. 2.6: Loss Ratio by Rating Area
This section captures the loss ratios by rating area for the past 3 calendar years. This field is auto populated after completing the sections above, and no input is required.

Appendix B

Checklist for Dental Rate Filings

Effective for Plan Years Beginning on or after January 1, 2025

Appendix B

Issuer Name:		**Market:** Individual ☐ Small Group ☐ Large Group ☐
		Exchange-Certification Status: SADP ☐ Certified Off Exchange ☐ Not Exchange Certified ☐
Effective Date:	**Initial Filing Date:**	**Updated Date(s):**

Checklist Instructions:

Please check the applicable boxes in the third column to indicate that the required worksheet ('R" box is checked by the Division) and supporting information have been provided. Specifically, carriers should check the 'P' box to indicate that the required information has been submitted and, if the 'R' box is checked, enter an exhibit number to indicate that a corresponding exhibit has been submitted.

ACTUARIAL MEMORANDUM			
Item	**Description of Required Information**	**Carriers to Complete (See page 2)**	**NVDOI Use Only**
General Information Section	At a minimum, include the following: Company name, state, HIOS ID, as applicable, Contact Information, summary of Benefits, Effective date of requested rate change, SERFF Tracking Number, Binder Number of Prior Filing, etc.	R:☐P:☐#: Click here to enter text.	☐
Scope and Purpose of Filing	Proposed change, Reason for Rate Change, Average Annual Premium, Number of Policyholders and covered Lives	R:☒P:☐#: Click here to enter text.	☐
Rate Change by component	Provide a detailed explanation of the components of the rate change (trend, benefit design, etc.,), along with an exhibit demonstrating the quantitative determination of the components of the rate increase.	R:☒P:☐#: Click here to enter text.	☐
Rate Change by Plan	Provide a detailed explanation, along with an exhibit showing how the rate change by plan, was determined.	R:☒P:☐#: Click here to enter text.	☐

Experience		R:☒P:☐#: Click here to enter text.	☒
Experience and Current Period Premiums Claims and Enrollment	Describe the following: Paid through date, Current Date, historical Premiums, Allowed and Incurred Claims. Provide a detailed description and quantitative support for the calculation of the Incurred but Not Paid estimate ("IBNP").	R:☒P:☐#: Click here to enter text.	☐
Projected Experience	Provide detailed description of the methodology used to develop the best estimate projected claims and earned premiums both with and without the proposed rate change.		
Membership Projections	Provide a detailed description of the methodology and assumptions used to develop membership projections, along with exhibits demonstrating the development of actuarial inputs.	R:☒P:☐#: Click here to enter text.	☐
Minimum Projected Loss Ratio	Provide a detailed description of any adjustment factors as well as an exhibit demonstrating the development of the projected loss ratio. Demonstrate compliance with NRS 686B.125.	R:☒P:☐#: Click here to enter text.	☐
Rate Development	Provide a detailed description used to develop the rates for the plans/products included in this filing. This should include details of the data used as well as any adjustments used to develop the projected claims experience. Also provide supporting exhibits demonstrating the rate development.	R:☒P:☐#: Click here to enter text.	☐
Assumptions		R:☒P:☐#: Click here to enter text.	☐
Trend Assumption	Provide a detailed description and quantitative demonstration (exhibit) of the trend calculation, including source claims data used and methodology used for developing the cost and utilization projection factors, including all adjustments made to the data. Demonstrate the tie-in between the trend information shown on the URRT and that shown on Worksheet 8 of the NVRFT.	R:☒P:☐#: Click here to enter text.	☐
Non-Benefit Expenses and Profit & Risk	Administrative Expense Load (Describe how expenses vary by product, the source data and its use. Provide support the following non-benefit expenses: Commissions and Brokers Fees, General Expenses, Reinsurance and Other Admin Costs.	R:☒P:☐#: Click here to enter text.	☐

Rating Factors	Provide quantitative and qualitative support for the rating factors used	R:☒P:☐#: Click here to enter text.	☐
AV Values	Provide support for the development of the AV for the pediatric EHB part of a standalone dental plan. Provide exhibits demonstrating the calculation of the AV pricing values, along with a detailed description of the methodology used.. In the derivation of the AV, show the claim cost used for each service classification such as basic services, prevention and diagnostic, etc.	R:☒P:☐#: Click here to enter text.	☐
Miscellaneous Instructions		R:☐P:☐#: Click here to enter text.	☐
Reliance Statement	If the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information should be disclosed and a reliance statement should be included. In this event, the extent of any reliance and any adjustments made to the information being relied upon should also be explicitly described and supported. It is not expected that the certifying actuary's staff would be included under this section.	R:☐P:☐#: Click here to enter text.	☐