www.ibx.com

1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

[Date]

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

Re: Account ID No. [ ]

Dear Valued Member:

I am writing to let you know the monthly rates for your Individual HMO plan, which is underwritten by Keystone Health Plan East, are increasing effective [**Date**].

NATURE OF THE RATE CHANGES
The Pennsylvania Insurance Department recently approved a 9.9 percent rate increase for our Individual Medically Underwritten HMO plans that will affect your monthly premiums. Beginning [**Date],** your monthly premium for [**Plan]** will be [**Amount]** per month. Because you were a new Individual HMO member at the time of the increase, you were entitled to a rate guarantee for the first six months of your coverage. The six-month period is now over. We notified you in May that we would be increasing your rate six months from your coverage start date.

We want you to know that we carefully consider all options before increasing premiums and that we have not raised Individual HMO rates since May 2007. However, as the cost of medical care continues to increase, premiums must also be adjusted so that we are able to continue to provide quality health care coverage for our members. Keep in mind that about 90 cents of every health care premium dollar paid to Independence Blue Cross goes to providers to pay for our members' care. As the costs for these services go up, so must the premium rates that our members pay for their coverage.

You do not need to take any action if you wish to continue your coverage under your current Keystone Individual HMO plan.

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 beginning in [**Date**]. Your next billing notice will reflect the new premium.

OTHER PLAN OPTIONS TO CONSIDER
If you do not already have the lowest cost Individual health care plan, you may want to consider changing your current coverage to one that has a lower monthly premium, but has higher cost-sharing. Enclosed is a flyer, Choose the Plan That's Right for You, to help you compare your options.

We also have new Individual Personal Choice® PPO* plans that may provide additional choices for you. Some of these plans offer higher deductibles and lower premiums for those who may be

(over)

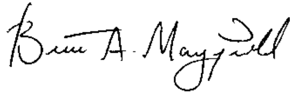
Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield.
Independent licensees of the Blue Cross and Blue Shield Association.

looking for more cost-effective options. For additional information on the Individual health care plan options available to you, go to www.ibx.com/changemyplan, contact your broker, or call 1-866-269-6548.

HOW TO CHANGE PLANS
If you decide to enroll in a lower cost option, please complete the enclosed Plan Change Request Form and submit it to IBC in the postage-paid envelope provided or fax it to 215-238-2280. For your new plan to be reflected in your next invoice, IBC must receive your completed plan change request form within the next two weeks.

Thank you for continuing to trust your health insurance needs to Keystone Health Plan East and Independence Blue Cross. If you have questions concerning this rate adjustment, or want to learn more about other Individual health plan options, please contact your broker or call 1-866-269-6548.

Sincerely,



Brett A. Mayfield
Vice President, Sales

Enclosures

*The QCC Insurance Company PPO Plans are underwritten by QCC Insurance Company.

KEYSTONE HEALTH PLAN EAST
INDIVIDUAL HMO
PLAN CHANGE REQUEST FORM

[DATE]

[MEMBER NAME]
[ACCOUNT ID NO.]

I have reviewed the enclosed Individual HMO Choose the Plan That's Right for You flyer.

Effective **[Date]**, please change my Individual HMO Option Plan to the following plan:

____ HMO $15 Copay at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $20 Copay at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $1500 Deductible at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $2500 Deductible at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $5000 Deductible at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

I understand that if at some future date I wish to change back to the HMO Option Plan in which I was enrolled prior to this change, the change will be subject to medical underwriting.

MEMBER SIGNATURE________________________________ DATE____________

SPOUSE SIGNATURE__________________________________ DATE____________

Completed forms can be faxed to 215-238-2280 or mailed to:

Independence Blue Cross
Individual Medical Underwriting
P.O. Box 41474
Philadelphia, PA 19101-1474