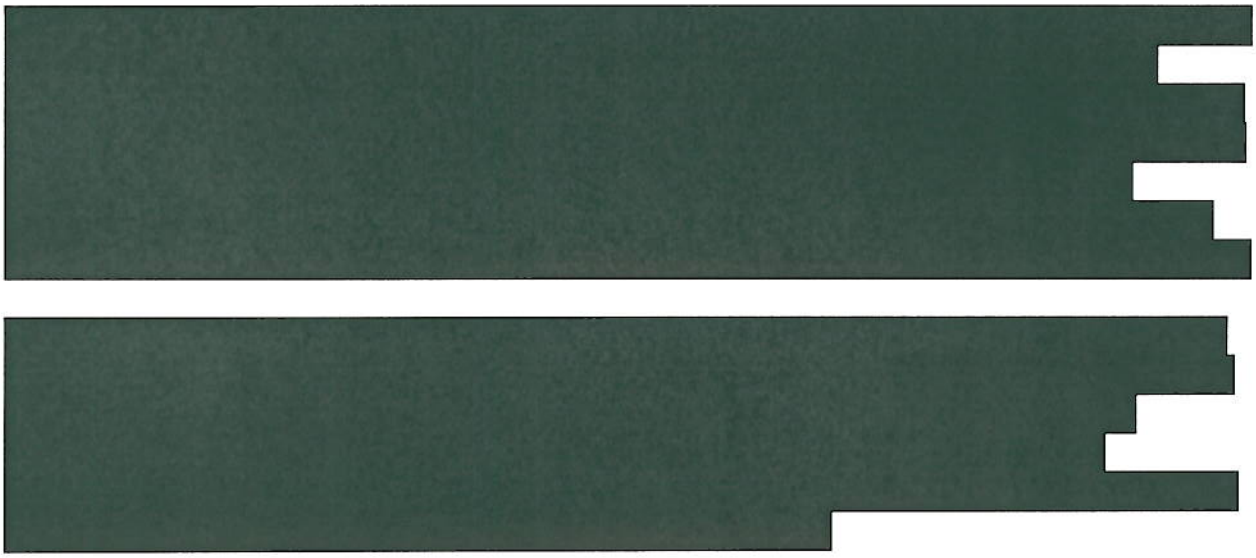
Part III Actuarial Memorandum

Blue Cross and Blue Shield of Oklahoma
Individual Rate Filing
Effective January 1, 2017

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Introduction:

This Actuarial Memorandum supports a rate filing on behalf of Blue Cross and Blue Shield of Oklahoma (BCBSOK), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association for the Individual medical policies.



Sales of these policies began on January 1, 2014. The experience period used for the development of these filed rates is calendar year 2015. Whether this data proves to be reflective of normal patterns or an anomaly due to the transition to the new circumstances remains unknown.

This Actuarial Memorandum has been prepared for the sole purpose of demonstrating compliance with regulatory authority, including the Department of Health and Human Services' Part III Actuarial Memorandum and Certification Instructions and is not intended for and may not be appropriate for any other purpose.

4.2 General Information:

Company Identifying Information:

Company Legal Name	Blue Cross and Blue Shield of Oklahoma
State	Oklahoma
HIOS Issuer ID	87571
Market	Individual
Effective Date	January 1, 2017

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Company Contact Information:

Primary Contact Name	[redacted]
Primary Contact Telephone	[redacted]
Primary Contact Email	[redacted]

4.3 Proposed Rate Increase(s):

The proposed increase is 76.0% across the entire block of BCBSOK Individual ACA-compliant plans effective January 1, 2017. The premium rate changes will vary by plan.

The average rate increase is calculated using the 2016 rate tables and the proposed 2017 rate tables, weighted by the membership distribution by plan, age, tobacco user status, and area for 2016 members in our membership system as of May 31, 2016.

Reason for Rate Increase(s):

The proposed rates are primarily based on the following factors:

- Claim experience for the population insured in the experience period,
- Anticipated medical inflation from the experience period to the projection period,
- Anticipated utilization changes from the experience period to the projection period,
- Changes in member cost sharing,
- Anticipated change in morbidity of the Single Risk Pool population,
- Anticipated change in morbidity of the market wide population,
- Anticipated changes in demographics,
- Anticipated changes in provider networks,
- Anticipated payments from and contributions to the Federal Transitional Reinsurance Program,
- Permitted rating factors (geographic area, age, and tobacco use),
- Anticipated administrative expenses including taxes and fees imposed on the insurer, and
- Anticipated costs associated with the uncertainty regarding continued federal reimbursement for members' access to, eligibility for, and enrollment in Cost-Sharing Reduction (CSR) plans.

The cost relativities among products are different from the experience period to the prospective rating period due to anticipated non-uniform changes in network reimbursement levels. Additionally, the rates vary by plan due to the leveraging and utilization differences driven by variations in member cost sharing. Therefore, the proposed rates may vary by both product and plan.

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

4.4 Market Experience:

4.4.1 Experience Period Premium and Claims:

Paid Through Date:

Payments have been made through May 31, 2016, on claims incurred during the experience period calendar year.

Premiums (net of MLR Rebate) in Experience Period:

Earned premiums were determined using corporate earned premium records. After determining earned premiums, the 2015 accrual for MLR rebates, if any, was backed out.

We do not anticipate refunding premiums through MLR rebates for 2015. The earned premiums and MLR rebates accrued are:

- Total Earned Premium in the Experience Period = $509,634,120
- Expected Risk Adjustment Transfer = [redacted]
- Earned Premium (after risk adjustment transfer and prior to MLR rebates accrued) = [redacted]
- MLR Rebates Accrued = $0
- Earned Premium (after risk adjustment transfer and net of MLR rebates accrued) = [redacted]

The 2015 rebate accrual was calculated in accordance with the prescribed methodology from the HHS MLR Report.

Allowed and Incurred Claims Incurred During the Experience Period:

Allowed claims and Incurred claims are pulled from the same source(s) and calculated using a similar methodology. Only claim amounts for members in the Individual Single Risk Pool for claims which have already been processed are included in our claims data (incomplete claims).

A set of completion factors is applied to the incomplete claims to develop the expected Allowed and Incurred Claims for the experience period.

Both Allowed and Incurred claims were reduced by drug manufacturer rebates. Allowed claims for capitation are assumed to equal the capitation amount in the experience period divided by the total paid to allowed ratio.

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The Allowed claims incurred during the experience period, are:

- Best estimate of claims incurred and paid through the claim system as of the Paid Through Date = [redacted]
- Best estimate of claims incurred and paid outside the claim system as of the Paid Through Date = [redacted]
- Best estimate of claims incurred but not paid as of the Paid Through Date = [redacted]

The Incurred claims incurred during the experience period, are:

- Best estimate of claims incurred and paid through the claim system as of the Paid Through Date = [redacted]
- Best estimate of claims incurred and paid outside the claim system as of the Paid Through Date = [redacted]
- Best estimate of claims incurred but not paid as of the Paid Through Date = [redacted]

Claims paid outside the claim system consist of drug manufacturer rebates.

The methodology used to develop the estimate of claims incurred but not paid for both Allowed Claims and Incurred Claims in the Experience Period is the same. The methodology incorporates estimates based upon developed completion factors. Consideration is given to additional relevant information not fully reflected in the pricing model. Model results are evaluated for reasonableness and actuarial judgment may be applied.

The claims used to develop any completion factors reflect the experience period claims for the information submitted. The incurred but not paid claims are not unusually high or unusually low relative to the experience period claims paid.

4.4.2 Benefit Categories:

The claims experience that appears on Worksheet 1, Section II, is broken into six benefit categories: Inpatient Hospital, Outpatient Hospital, Professional, Other Medical, Capitation, and Prescription Drug. We used a combination of claim/procedure specific attributes (including but not limited to ICD-9, Revenue Codes, CPT4, HCPCS, and NDCs) to determine into which category each claim in the experience period falls.

Benefit Category	Category Description
Inpatient Hospital (Units = Days)	Includes non-capitated facility services for medical, surgical, maternity, and other services provided in an inpatient facility setting and billed by the facility.
Outpatient Hospital (Units = Visits)	Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

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Professional (Units = Services)	Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.
Other Medical (Units = See Below)	Includes non-capitated ambulance, DME, prosthetics, supplies, and other services.
Capitation (Units = See Below)	Includes all services provided under one or more capitated arrangements.
Prescription Drug (Units = Prescriptions)	Includes drugs dispensed by a pharmacy, net of any rebates received from drug manufacturers.

Due to the variability of benefits included in the Other Medical benefit category, we are characterizing this as simply Annual Units per Member, such that the per-unit cost is meant to represent the annual per member allowed charges.

For the Capitation benefit category, a capitation payment is generated for each member's month of coverage. As such, we are characterizing the measurement unit in Worksheet 1, Section II as member months.

4.4.3 Projection Factors:

The projection factors used in the URRT have been calculated in accordance with section 4.4.3 of the 2017 Unified Rate Review instructions.

Changes in the Morbidity of the Population Insured:

[redacted]

Changes in Benefits:

The Change in Benefits projection factor is composed of two components:

- Change in Covered Services
- Change in Benefit Richness

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Change in Covered Services:

All benefits covered in the experience period will also be covered in the projection period with the exception of prescription drug coverage for plans that used our Standard prescription drug formulary. In 2017, all plans will have prescription drug coverage with our Generics Plus prescription drug formulary.

In addition, gender reassignment surgery and related services and supplies will be covered in the projection period. Benefits for gender reassignment surgery and related services and supplies that were previously excluded in the experience period are subject to medical necessity requirements and are eligible for all levels of internal and/or external review.

Note, Pediatric Dental is not included as this benefit has been carved out as a companion plan as permitted by regulation.

The value of the cost impact of these benefits was estimated using internal models, with internal data, that attempt to quantify the expected cost of these benefits relative to all other benefits covered in the experience period.

Change in Benefit Richness:

The change in benefit richness reflects the change in policyholder behavior based on the level of benefits provided by the plan. The change in benefit richness was determined based on the historical enrollment mix, the anticipated projection period enrollment mix, the membership and claims weight of each plan, and [redacted]
The benefit richness adjustment removes the impact of morbidity and is reflective only of behavior patterns associated with each specific plan design.

Changes in Demographics:

The assumptions for changes in demographics were developed by comparing the population mix from the experience period to the assumed population mix in the projection period. The assumed population mix in the projection period was developed in the manner described in the Changes in the Morbidity of the Population Insured section.

Age/gender and area cost relativities were separately developed using internal claims data normalized for other demographic characteristics and applied to each of the 2015 single risk pool and 2017 expected population to determine the expected change in cost due to age/gender and area mix.

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Other Adjustments:

[redacted]

Trend Factors (Cost/Utilization):

[redacted]

The source data has adjustments applied:

- to normalize for age and gender,
- to complete the data,
- for number/type of days of the week, holidays,
- for any one-time events not anticipated to reoccur during the projection period,
- for anticipated changes to the provider contracts that differ from those underlying the experience period, and
- for anticipated changes to prescription drug mix and utilization.

[redacted]

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

[redacted]

4.4.4 Credibility Manual Rate Development:

No manual rate was needed as the experience period claims are deemed fully credible as discussed in section 4.4.5 Credibility of Experience.

4.4.5 Credibility of Experience:

Full credibility has been assigned to the Base Period Experience, appropriately adjusted to reflect the material changes anticipated between the experience period and the projected period.

This assignment of full credibility is consistent relative to:

(1) Actuarial Standard of Practice No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages, specifically section 3.4, "Professional Judgment," the ASOP states, "...in some situations, an acceptable procedure for blending the subject experience with the relevant experience may be based on the actuary assigning full, partial, or zero credibility to the subject experience without using a rigorous mathematical model," and

(2) A review of the MLR credibility standards, as described in 45 CFR Part 158, §158.230(c)(1). An MLR calculation is fully credible if it is based on the experience of 75,000 or more life-years. There is an average of approximately [redacted] in the 2015 base period experience. As such, we felt that applying 100% credibility was appropriate.

There are no material changes from the prior credibility procedures.

4.4.6 Paid to Allowed Ratio:

The paid to allowed average factor in the projection period for the market, shown in Worksheet 1, Section III, uses the assumed population distribution across the metallic plans. Each metallic plan assumes a paid to allowed ratio based entirely on BCBSOK historical experience. The paid to allowed average factor may ultimately differ from the factor presented if member migration to the metallic plans does not follow the distribution assumed.

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

We have made an adjustment to our projected paid claims for the members expected to enroll in a cost sharing reduction (CSR) variant plan to account for the uncertainty regarding continued federal reimbursement for these subsidies.

Worksheet 1, Section III shows an expected aggregate paid to allowed factor of [redacted].

Worksheet 2, Section IV shows an expected aggregate paid to allowed factor of [redacted], based on the following calculation:

Paid Amount = Total Incurred claims, payable with issuer funds (cell F94)
+ Net Amount of Reinsurance (cell F96)
+ Net Amount of Risk Adjustment (cell F97)

Allowed Amount = Total Allowed Claims (cell F87)

Worksheet 2 Paid to Allowed Ratio = [redacted] = [redacted]

The difference between the Worksheet 1 Paid to Allowed Ratio and the Worksheet 2 Paid to Allowed Ratio is the impact of the Risk Adjustment user fees and the Federal Reinsurance contributions which are included in the values in cell F96 and cell F97 in Worksheet 2.

The ratio for each plan is consistent with the corresponding metallic actuarial value, but adjusted for narrow networks to be reasonably lower due to the leveraging impact of anticipated reduced claims costs associated with provider network differences.

4.4.7 Risk Adjustment and Reinsurance:

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

The *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* that was issued by CMS on June 30, 2016, was used to determine the experience period risk adjustment. [redacted]

The Adjusted Reinsurance Payment Report provided to HCSC by CMS on June 30, 2016, for the 2015 benefit year, was used to determine the experience period reinsurance recoveries. [redacted]

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Projected Risk Adjustments PMPM:

Estimates of the risk adjustment revenue in the projection period were developed using information from the process described in the Changes in the Morbidity of the Population Insured section, and incorporating that into the risk adjustment transfer formula provided by HHS in the Final Notice of Benefit and Payment Parameters.

The process described in the Changes in the Morbidity of the Population Insured section provided an estimate of the risk that is expected to be insured by BCBSOK. [redacted]

Market and plan level inputs to the risk adjustment transfer formula are shown in the following table.

[redacted]

The inputs were estimated using the following information. PLRS, IDF, GCF, ARF, and AV are defined by HHS in the Final Notice of Benefit and Payment Parameters as follows:

- PLRS (Plan Liability Risk Score): The baseline is estimated from the process described in the Changes in the Morbidity of the Population Insured section, then adjusted for estimated carrier risk capture efficiency. Risk capture efficiency is the ability of a carrier to properly document the risk it carries. Large carriers and carriers with experience in other risk adjustment markets (such as Medicare Advantage) are expected to more efficiently document the conditions of their members.
- IDF (Induced Demand Factor): [redacted]
- GCF (Geographic Cost Factor): This is sourced from the process described in the Changes in the Morbidity of the Population Insured section and calculated as prescribed by HHS regulations.
- ARF (Allowable Rating Factor): The ages of enrollees are sourced from the process described in the Changes in the Morbidity of the Population Insured section, and the standard CMS age curve is applied to determine the ARF.
- AV (Actuarial Value): [redacted]
- Market share: This is sourced from the process described in the Changes in the Morbidity of the Population Insured section.

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Final calculation of risk adjustment transfer estimate is below. Note that the risk transfer calculation is actually applied at the level of carrier/plan combination as per HHS regulations.

Net Plan Average Risk Adjustment % =

$$\frac{PLRS_{BCBS} \cdot IDF_{BCBS} \cdot GCF_{BCBS}}{\text{Market Avg (PLRS} \cdot \text{IDF} \cdot \text{GCF)}} - \frac{AV_{BCBS} \cdot ARF_{BCBS} \cdot IDF_{BCBS} \cdot GCF_{BCBS}}{\text{Market Avg (AV} \cdot \text{ARF} \cdot \text{IDF} \cdot \text{GCF)}}$$

Net Plan Average Risk Adjustment %	[redacted]
Net Plan Average Risk Adjustment % Adjusted for Market Premium	

Please note that the risk adjustment modeling is completed before final rates are set, which causes the final BCBSOK premium to be different from premium used in this process. This difference does not materially impact rate development. The above exhibit has been slightly adjusted from the original analysis in order to be consistent with the final projected risk adjustment PMPM and BCBSOK premium PMPM.

The pool that buys insurance and the risk of this pool was generated by the process described in the Changes in the Morbidity of the Population Insured section. To the extent that purchasing decisions and risk scores are different from the BCBSOK modeling results, then this could have an impact on the transfers.

The difference between BCBSOK average premium and market average premium is sourced from the process described in the Changes in the Morbidity of the Population Insured section. This difference is the basis for the Net Plan Average Risk Adjustment % Adjusted for Market Premium shown in the table above. To the extent that Market Premium differs from BCBSOK premium other than this assumption, then this could have a significant impact on transfers.

The estimated risk adjustment transfers net of the risk adjustment user fee were allocated uniformly to all products and plans as a percentage of the premium. For the purposes of Worksheet 1, Section III and Worksheet 2, Section IV, we have converted the percentage of premium as described to a PMPM. The final PMPM netted for the user fee is [redacted].

Projected ACA Reinsurance Recoveries Net of Reinsurance:

As stated in the final 2017 Notice of Benefit and Payment Parameters, the Federal Reinsurance Program will end prior to 2017 and therefore there are no anticipated contributions or payments.

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

4.4.8 Non-Benefit Expenses and Profit & Risk:

Administrative Expense Load:

The administrative expense load built into the pricing of the Individual products is based on allocated expenses as they exist in the current operating model, adjusted for expected 2017 membership, expected expense inflation, and other budgeted adjustments related to the Individual block of business. Additionally, all Individual premiums include a flat load to account for commissions, which incorporate the expected external sales commission percentage and Marketplace User Fees.

The source data is based on allocated expenses applicable to each line of business as they exist in the current operating model which has been adjusted for expected expense inflation, expected membership in 2017, and changes in operations as a result of the Marketplace. Membership in 2017 is aligned with the projected membership as described in the Changes in the Morbidity of the Population Insured section.

Administrative expenses are allocated uniformly as a percentage of premium across all products and plans.

Profit (or Contribution to Surplus) & Risk Margin:

The pre-tax target contribution to surplus, inclusive of underwriting gain/ loss margin and any additional risk margin, is [redacted] of the billed premiums. The after-tax target contribution to surplus, inclusive of underwriting gain/ loss margin and any additional risk margin, is [redacted] of the billed premiums. Given that the Federal Risk Corridor Program will end prior to 2017, the margin needed to sustain capital requirements in the long term is [redacted]. As such, the target as a percent of premium has changed from the prior submission.

Please note, there is a distinction between the pricing margin used in ratemaking, which is [redacted], and the [redacted] pre-tax target contribution to surplus. The pricing margin used for ratemaking includes an adjustment for not being able to collect premium from terminating Advanced Premium Tax Credit (APTC) eligible members in the first month of their grace period. Also, due to post-submission instruction received, the trend volatility adjustment originally included in the trend factors for this submission to address the variability and unpredictability of medical and drug costs is now reported in the contribution to surplus and risk margin.

Taxes and Fees:

All taxes and fees, whether calculated as a PMPM, PMPY, or percentage of premium, are allocated uniformly as a percentage of premiums across all products and plans.

The following Taxes and Fees may be subtracted from premiums for purposes of calculating MLR:

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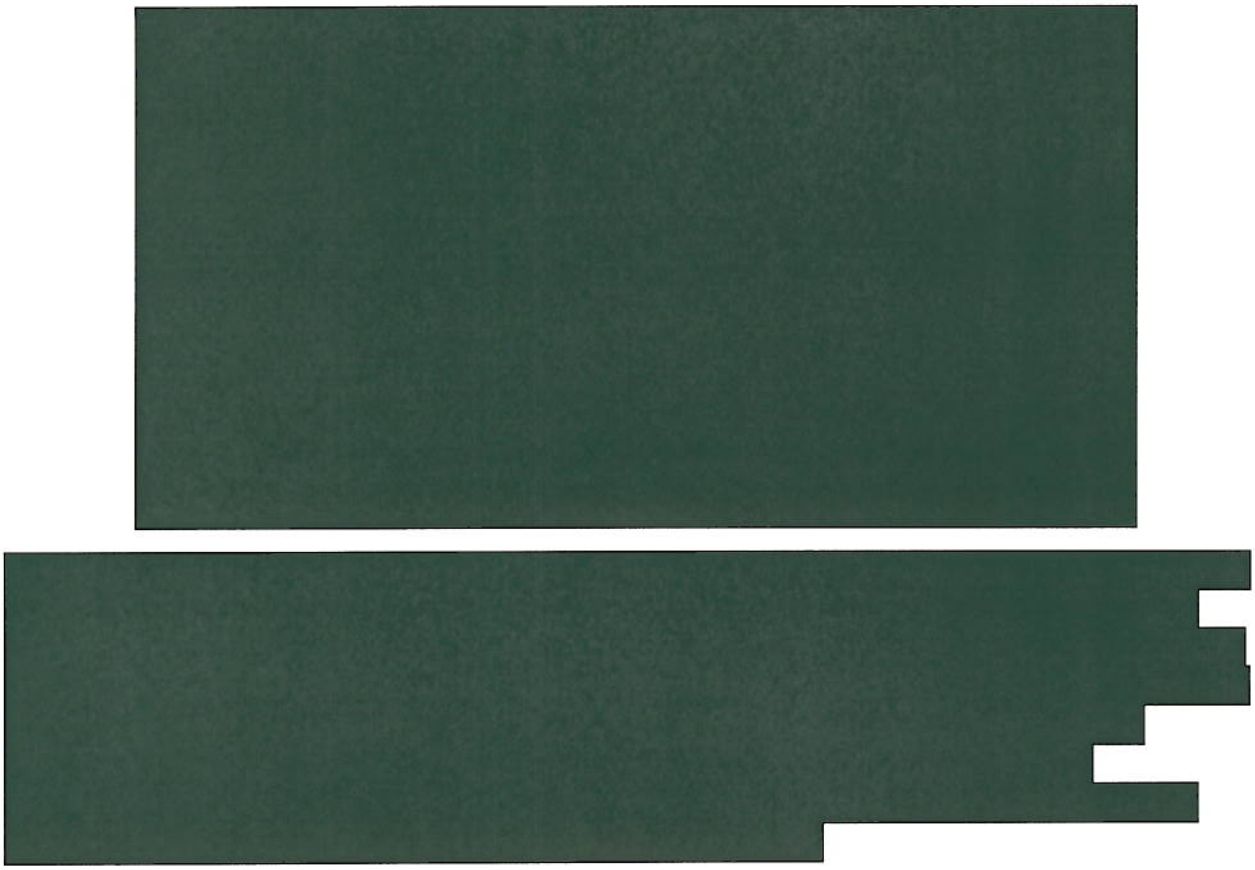

4.5 Projected Loss Ratio:

The projected loss ratio using the Federally prescribed MLR methodology is [redacted]. The MLR calculation is in accordance with the formula in the HHS Notice of Benefits and Payment Parameters.

$$MLR = \left[\frac{(i+q+n-r)}{\{(p-n+r)-t-f-(-n+r)\}}\right] + c$$

Which simplifies to,

$$MLR = \left[\frac{(i+q+n-r)}{\{p-(t+f)\}}\right] + c$$

Where,

- i = incurred claims
- q = expenditures on quality improving activities
- p = earned premiums
- t = Federal and State taxes and assessments

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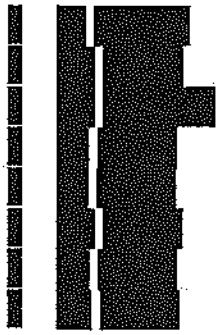
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

- *f* = licensing and regulatory fees, including transitional reinsurance contributions
- *n* = issuer's risk corridors and risk adjustment related payments
- *r* = issuer's risk corridors and risk adjustment related receipts
- *c* = credibility adjustment, if any

The following are the values for each component listed above stated as a percentage of premium:



MLR = [redacted]

The projected MLR is greater than 80%.

4.6 Application of Market Reform Rating Rules:

4.6.1 Single Risk Pool:

The Single Risk Pool for the experience period includes all non-grandfathered covered lives in the Oklahoma Individual market. This includes transitional products and plans, which represents less than [redacted] of the experience period membership. The Single Risk Pool for the projection period includes all covered lives projected to enroll in a fully ACA-compliant plan during the projection period.

4.6.2 Index Rate:

The index rate represents the estimated total allowed claims per member per month (PMPM) for all non-grandfathered plans for essential health benefits (EHBs) in the Oklahoma Individual market.

[redacted]

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

The Index Rate is then adjusted for:

- Expected payments and charges under the Risk Adjustment program including the Risk Adjustment User Fee,
- Expected payments from and contributions to the Transitional Reinsurance Program,
- Marketplace user fees, on a market wide basis,
- Administrative costs excluding Marketplace user fees,
- Other taxes and fees as described in the Taxes and Fees section, and
- Contribution to Surplus & Risk Margin.

The plan rate level can be determined by further adjusting the Index Rate for:

4.6.3 Market Adjusted Index Rate:

The Market Adjusted Index Rate is the Index Rate adjusted for all allowable market wide modifiers defined in the market rating rules, on an allowed basis (grossed up by the expected paid to allowed ratio). These modifiers include the Federal Reinsurance program, Risk Adjustment, and Marketplace user fees.

The Market Adjusted Index Rate is calculated as follows:

MAIR = IR - FRPA - RA + MUFA

Where,

- MAIR = Market Adjusted Index Rate
- IR = Index Rate
- FRPA = Federal Reinsurance Program Adjustment
- RA = Risk Adjustment
- MUFA = Marketplace User Fee Adjustment

MAIR = 

The Payments and Contributions for the Federal Reinsurance Program and Risk Adjustment program are described in the Risk Adjustment and Reinsurance section. The Marketplace User Fee is described in the Taxes and Fees section.

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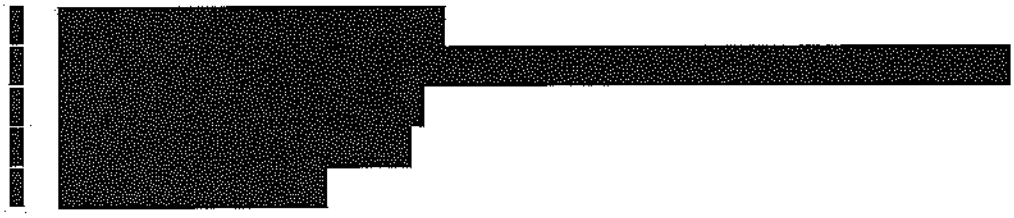
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

4.6.4 Plan Adjusted Index Rate:

The Plan Adjusted Index Rate is the Market Adjusted Index Rate adjusted for the AV Pricing Value.

The AV Pricing Value is made up of the following components:



The AV Pricing Value is the product of these components. The values for each of these components and the final resulting AV Pricing Value for each Standard Component ID can be found in the AV Pricing Values section.

For catastrophic plans, an adjustment was made to reflect the differences in anticipated demographics and morbidity of the catastrophic plans as compared to the Single Risk Pool. The analysis was performed by comparing the CMS standard age curve and internally modelled claims cost relativities by age and gender to determine the adjustment needed so that the expected premium relativity equals the expected cost relativity.

4.6.5 Calibration:

Age Curve Calibration:

The age calibration adjustment is not plan specific, and the same factor is applied for all plans in the projected Single Risk Pool.

The approximate weighted average age associated with the projected 2017 Single Risk Pool is [redacted]. The approximate average age factor associated with the projected Single Risk Pool is [redacted].

This factor was developed using the projected membership for the Single Risk Pool in conjunction with the CMS standard age curve and is adjusted for population aging. It is calculated as (member-weighted average age factor) x (population aging adjustment).

The member-weighted average age factor for the expected 2017 population before population aging is calculated as follows: ∑(CMS Age Factor x 2017 Rated Member Months) / ∑(2017 Total Member Months) and is equal to [redacted].

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According to the 2017 Unified Rate Review instructions (page 63), CMS will allow for the application of a factor of zero (0) for the distribution of members expected to pay no premium when developing the approximate weighted average age to account for the lost revenue due to the three under age 21 child dependent cap. Therefore, a distribution of 2017 projected membership for the Single Risk Pool expected to pay no premium was developed and used in the development of member-weighted average age factor.

An adjustment for population aging to age the projected membership to a 2017 average population basis is then applied. This population aging adjustment to the age calibration is developed based on the expected average increase in age applied to the projected membership weighted by the CMS age curve and is equal to [redacted].

The following table below shows the projected 2017 membership distribution by age before population aging.

[redacted]

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

I have reviewed Actuarial Standard of Practice No. 8, Regulatory Filings for Health Plan Entities, in addition to reviewing Actuarial Standard of Practice No. 41, Actuarial Communications, in determining and disclosing an actuarially sound approach.

Geographic Factor Calibration:

The geographic area calibration adjustment is not plan specific, and the same factor is applied for all plans in the projected Single Risk Pool. The average geographic factor associated with the projected Single Risk Pool is calculated as follows: ∑(Area Factor x Member Months) / ∑(2017 Member Months) and is equal to [redacted].

Experience period geographic factors are developed based on past claims and are adjusted for differences in morbidity and benefit level by area. Each experience period factor is then adjusted for provider contracting changes between the experience period and the projection period and assigned a credibility weight based on membership in the area.

The following table shows the 2017 geographic area factors and the projected membership distribution used to develop the geographic area calibration adjustment.

Rating Area	Geographic Area Factor	Projected Member Months
Rating Area 1: Fort Smith, AR-OK	[redacted]	
Rating Area 2: Lawton, OK		
Rating Area 3: Oklahoma City, OK		
Rating Area 4: Tulsa, OK		

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Rating Area	Geographic Area Factor	Projected Member Months
Rating Area 5: Non MSA	[redacted]	
Total		

4.6.6 Consumer Adjusted Premium Rate Development:

The Consumer Adjusted Premium Rate is calculated by first dividing the Plan Adjusted Index Rate by the age calibration factor and the geographic calibration factor. The result can then be multiplied by the individual's specific age factor, geographic factor, and tobacco factor, to determine the approximate Consumer Adjusted Premium Rate (CAPR). The premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account.

$$CAPR = \frac{\text{Plan Adjusted Index Rate}}{\text{Age Calibration} \times \text{Geographic Calibration}} \times \text{Age Factor} \times \text{Geographic Factor} \times \text{Tobacco Factor}$$

Example Calculation for age 40 in Rating Area 1

Plan: OK Blue Preferred Bronze PPO 006, 87571OK0320033
Plan Adjusted Index Rate = [redacted]
Age Calibration = [redacted]
Geographic Calibration = [redacted]
Age 40 Factor = [redacted]
Non-Tobacco Factor = [redacted]
Rating Area 1 Factor = [redacted]
CAPR= [redacted]

The Premium Rate listed in the Rates Template is [redacted]. Differences are due to rounding.

4.7 Plan Product Info

4.7.1 AV Metal Values:

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template are based on the AV Calculator results. Some of the AV Calculator results are modified for certain cost-sharing features that are not fully compatible with the AV Calculator parameters in accordance with Actuarial Standard of Practice No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act. In most cases our final plans are within [redacted]

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

for each metallic level. Any cost-sharing features that potentially remain unaccounted for are likely small enough that no plan's metallic status would be impacted.

4.7.2 AV Pricing Values:

The AV Pricing value represents the relative cost of each plan. The table below indicates the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the Index Rate, as described in 45 CFR Part 156, §156.80(d)(2).

AV Pricing Value Adjustments Relativities

Standard Component ID	AV Pricing Value	Provider Network	Cost-Sharing	Benefits in Addition to EHBs	Catastrophic Plan Eligibility	Administrative Costs
87571OK0320033	[redacted]					
87571OK0320030						
87571OK0320031						
87571OK0320032						
87571OK0320006						
87571OK0320046						
87571OK0320062						
87571OK0320063						
87571OK0320064						
87571OK0320065						
87571OK0320047						
87571OK0320066						
87571OK0320067						
87571OK0320068						
87571OK0320069						
87571OK0320048						
87571OK0320070						
87571OK0320071						
87571OK0320072						
87571OK0320073						
87571OK0320049						
87571OK0320074						
87571OK0320075						
87571OK0320076						
87571OK0320077						
87571OK0350057						

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Standard Component ID	AV Pricing Value	Provider Network	Cost-Sharing	Benefits in Addition to EHBs	Catastrophic Plan Eligibility	Administrative Costs
87571OK0350022	[redacted]					
87571OK0350006						
87571OK0350023						
87571OK0350024						
87571OK0350058						
87571OK0350025						
87571OK0350030						
87571OK0350031						
87571OK0350032						
87571OK0350059						
87571OK0350026						
87571OK0350033						
87571OK0350034						
87571OK0350035						
87571OK0350060						
87571OK0350027						
87571OK0350036						
87571OK0350037						
87571OK0350038						
87571OK0350061						
87571OK0350028						
87571OK0350039						
87571OK0350040						
87571OK0350041						
87571OK0350062						
87571OK0350029						
87571OK0350042						
87571OK0350043						
87571OK0350044						
87571OK0350046						
87571OK0350051						
87571OK0350052						
87571OK0350053						
87571OK0350064						
87571OK0460001						
87571OK0460004						
87571OK0460005						
87571OK0460006						
87571OK0460007						

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Standard Component ID	AV Pricing Value	Provider Network	Cost-Sharing	Benefits in Addition to EHBs	Catastrophic Plan Eligibility	Administrative Costs
87571OK0460002	[redacted]					
87571OK0460008						
87571OK0460009						
87571OK0460010						
87571OK0460011						
87571OK0460003						
87571OK0460012						
87571OK0460013						
87571OK0460014						
87571OK0460015						

The following table shows the breakdown of the AV and Cost-Sharing Design adjustments factors for each plan.

AV and Cost-Sharing Design Adjustment Factors

Standard Component ID	Paid/Allowed Ratio	Benefit Richness	Non Tobacco User Status	AV and Cost-Sharing Design
87571OK0320033	[redacted]			
87571OK0320030				
87571OK0320031				
87571OK0320032				
87571OK0320006				
87571OK0320046				
87571OK0320062				
87571OK0320063				
87571OK0320064				
87571OK0320065				
87571OK0320047				
87571OK0320066				
87571OK0320067				
87571OK0320068				
87571OK0320069				
87571OK0320048				
87571OK0320070				
87571OK0320071				

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Standard Component ID	Paid/Allowed Ratio	Benefit Richness	Non Tobacco User Status	AV and Cost-Sharing Design
87571OK0320072				
87571OK0320073				
87571OK0320049				
87571OK0320074				
87571OK0320075				
87571OK0320076				
87571OK0320077				
87571OK0350057				
87571OK0350022				
87571OK0350006				
87571OK0350023				
87571OK0350024				
87571OK0350058				
87571OK0350025				
87571OK0350030				
87571OK0350031				
87571OK0350032				
87571OK0350059				
87571OK0350026				
87571OK0350033				
87571OK0350034				
87571OK0350035				
87571OK0350060				
87571OK0350027				
87571OK0350036				
87571OK0350037				
87571OK0350038				
87571OK0350061				
87571OK0350028				
87571OK0350039				
87571OK0350040				
87571OK0350041				
87571OK0350062				
87571OK0350029				
87571OK0350042				
87571OK0350043				
87571OK0350044				
87571OK0350046				
87571OK0350051				

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Standard Component ID	Paid/Allowed Ratio	Benefit Richness	Non Tobacco User Status	AV and Cost-Sharing Design
87571OK0350052	[redacted]			
87571OK0350053				
87571OK0350064				
87571OK0460001				
87571OK0460004				
87571OK0460005				
87571OK0460006				
87571OK0460007				
87571OK0460002				
87571OK0460008				
87571OK0460009				
87571OK0460010				
87571OK0460011				
87571OK0460003				
87571OK0460012				
87571OK0460013				
87571OK0460014				
87571OK0460015				

The AV and Cost-Sharing Design adjustment factors include the following:

- Paid to allowed ratio
- Benefit richness factor
- Adjustment for non-tobacco user status

The paid-to-allowed factor reflects the percentage of allowed claims expected to be BCBSOK's liability based on the plan provisions and underlying claim mix for a standardized population.

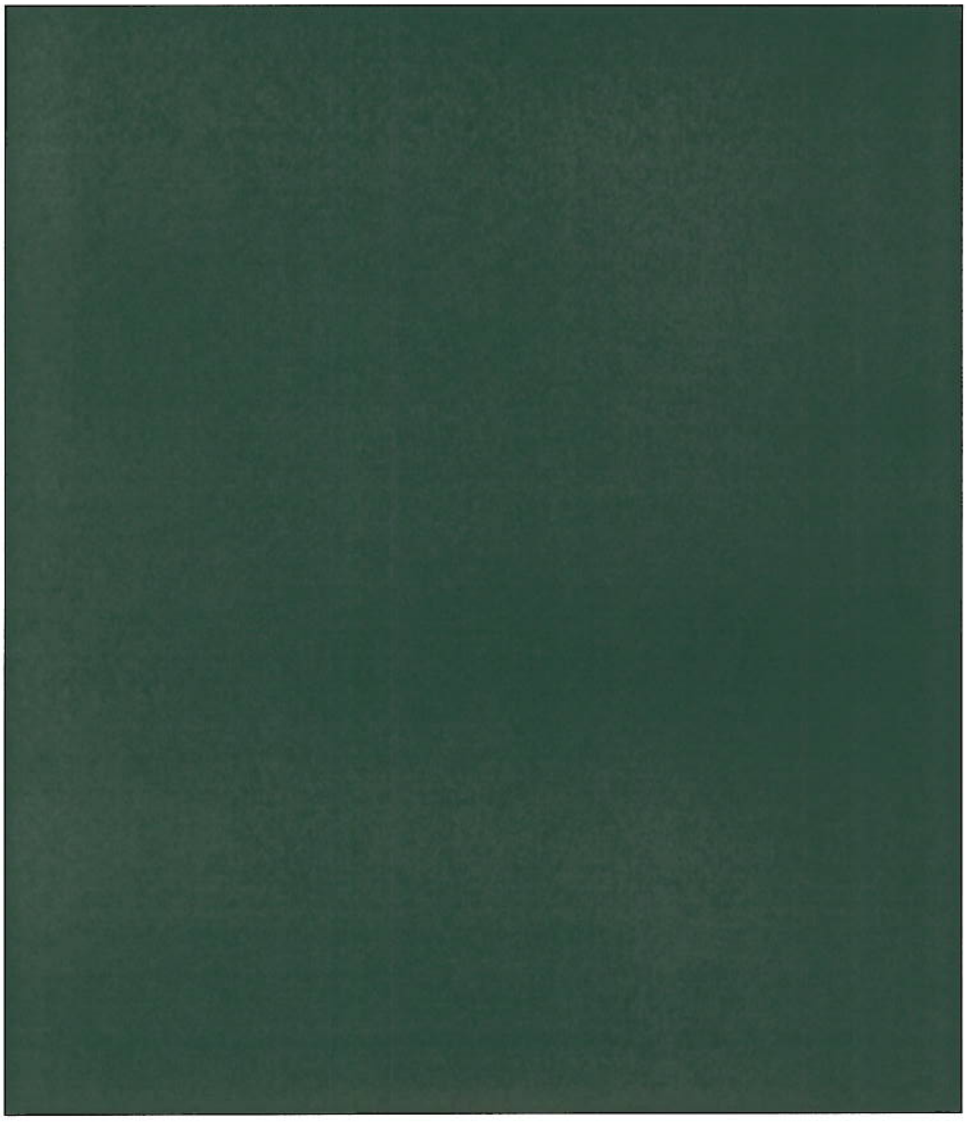
The benefit richness factor represents expected differences in utilization due to differences in cost-sharing. This expected difference in utilization is based on an internal model using internal data. The methodology consisted of grouping members by plan design and comparing the average risk score adjusted allowed claims PMPM across plan designs with each plan's paid to allowed ratio.

In order to ensure that differences due to health status are not included in the adjustment, the analysis incorporated adjustment by risk score. Risk scores represent the expected health burden of an individual based on chronic conditions plus an expected risk based on age and gender. Adjusting for this risk score is intended to remove differences in health status across populations resulting from differences in age and gender in addition to the presence of chronic conditions.

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Additionally, an adjustment for non-tobacco user status was applied to remove the portion of the cost that is expected to be recouped through the tobacco surcharge. This adjustment was developed based on the expected member-weighted tobacco user factor for our projected membership distribution by age. The adjustment for non-tobacco user status is not plan specific. The same approximate average age factor was applied to all plans in the projected Single Risk Pool.

The following table shows the tobacco user surcharge factors by age (note that non-tobacco users have a factor of 1.0000).



CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

4.7.3 Membership Projections:

The following table shows the 2017 projected member months by plan, exchange status, and subsidy level.

Projected Member Months by Standard Component ID and Cost-Sharing Reduction Variant

Standard Component ID	00	01	02	03	04	05	06	Total
87571OK0320033								
87571OK0320030								
87571OK0320031								
87571OK0320032								
87571OK0320006								
87571OK0320046								

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Standard Component ID	00	01	02	03	04	05	06	Total
87571OK0320062	[redacted]							
87571OK0320063								
87571OK0320064								
87571OK0320065								
87571OK0320047								
87571OK0320066								
87571OK0320067								
87571OK0320068								
87571OK0320069								
87571OK0320048								
87571OK0320070								
87571OK0320071								
87571OK0320072								
87571OK0320073								
87571OK0320049								
87571OK0320074								
87571OK0320075								
87571OK0320076								
87571OK0320077								
87571OK0350057								
87571OK0350022								
87571OK0350006								
87571OK0350023								
87571OK0350024								
87571OK0350058								
87571OK0350025								
87571OK0350030								
87571OK0350031								
87571OK0350032								
87571OK0350059								
87571OK0350026								
87571OK0350033								
87571OK0350034								
87571OK0350035								
87571OK0350060								
87571OK0350027								

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Standard Component ID	00	01	02	03	04	05	06	Total
87571OK0350036								
87571OK0350037								
87571OK0350038								
87571OK0350061								
87571OK0350028								
87571OK0350039								
87571OK0350040								
87571OK0350041								
87571OK0350062								
87571OK0350029								
87571OK0350042								
87571OK0350043								
87571OK0350044								
87571OK0350046								
87571OK0350051								
87571OK0350052								
87571OK0350053								
87571OK0350064								
87571OK0460001								
87571OK0460004								
87571OK0460005								
87571OK0460006								
87571OK0460007								
87571OK0460002								
87571OK0460008								
87571OK0460009								
87571OK0460010								
87571OK0460011								
87571OK0460003								
87571OK0460012								
87571OK0460013								
87571OK0460014								
87571OK0460015								

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

The following is the definition of each cost sharing reduction (CSR) variant:

- 00 = Off Marketplace
- 01 = On Marketplace with no CSR
- 02 = Zero Cost Sharing Plan
- 03 = Limited Cost Sharing Plan
- 04 = 73% AV Level Silver Plan CSR (200% to 250% of FPL)
- 05 = 87% AV Level Silver Plan CSR (150% to 200% of FPL)
- 06 = 94% AV Level Silver Plan CSR (100% to 150% of FPL)

4.7.4 Terminated Products:

The following products will be terminated prior to January 1, 2017. The 2017 Standard Component ID listed is the plan to which the terminated plan will be mapped.

Original Standard Component ID	Original Plan Name	Mapped Standard Component ID
87571OK0290006*	Blue Choice Bronze PPO 006	[redacted]
87571OK0290006*	Blue Choice Bronze PPO 006	
87571OK0290006*	Blue Choice Bronze PPO 006	
87571OK0290006*	Blue Choice Bronze PPO 006	
87571OK0290006*	Blue Choice Bronze PPO 006	
87571OK0290010*	Blue Security Choice PPO 010	
87571OK0320008*	Blue Preferred Security PPO 008	
87571OK0290001*	Blue Choice Gold PPO 001	
87571OK0290002*	Blue Choice Gold PPO 002	
87571OK0290003*	Blue Choice Silver PPO 003	
87571OK0290004*	Blue Choice Silver PPO 004	
87571OK0290011*	Blue Choice Gold PPO 011	
87571OK0290012*	Blue Choice Gold PPO 012	
87571OK0320009*	Blue Preferred Gold PPO 009	
87571OK0320011*	Blue Preferred Gold PPO 001	
87571OK0320017*	Blue Preferred Gold PPO 002	
87571OK0320021	Blue Preferred Silver PPO 003	
87571OK0320025*	Blue Preferred Silver PPO 004	
87571OK0320035*	Blue Preferred Gold PPO 007	
87571OK0380009*	Blue Options Gold PPO 001	
87571OK0380013*	Blue Options Gold PPO 002	
87571OK0380015*	Blue Options Gold PPO 003	

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Original Standard Component ID	Original Plan Name	Mapped Standard Component ID
87571OK0380021*	Blue Options Silver PPO 004	[redacted]
87571OK0380025*	Blue Options Silver PPO 005	
87571OK0290005*	Blue Choice Bronze PPO 005	
87571OK0320029	Blue Preferred Bronze PPO 005	
87571OK0290010*	Blue Security Choice PPO 010	
87571OK0320038	Blue Preferred Security PPO 008	
87571OK0290010*	Blue Security Choice PPO 010	
87571OK0320039	Blue Preferred Security PPO 008	
87571OK0290010*	Blue Security Choice PPO 010	
87571OK0320040	Blue Preferred Security PPO 008	
87571OK0290010*	Blue Security Choice PPO 010	
87571OK0320041	Blue Preferred Security PPO 008	
87571OK0290003*	Blue Choice Silver PPO 003	
87571OK0290004*	Blue Choice Silver PPO 004	
87571OK0320010*	Blue Preferred Gold PPO 001	
87571OK0320014*	Blue Preferred Gold PPO 002	
87571OK0320018	Blue Preferred Silver PPO 003	
87571OK0320022*	Blue Preferred Silver PPO 004	
87571OK0320034*	Blue Preferred Gold PPO 007	
87571OK0320042*	Blue Preferred Gold PPO 009	
87571OK0380018*	Blue Options Silver PPO 004	
87571OK0380022*	Blue Options Silver PPO 005	
87571OK0290003*	Blue Choice Silver PPO 003	
87571OK0290004*	Blue Choice Silver PPO 004	
87571OK0320001*	Blue Preferred Gold PPO 001	
87571OK0320007*	Blue Preferred Gold PPO 007	
87571OK0320015*	Blue Preferred Gold PPO 002	
87571OK0320019	Blue Preferred Silver PPO 003	
87571OK0320023*	Blue Preferred Silver PPO 004	
87571OK0320043*	Blue Preferred Gold PPO 009	
87571OK0380019*	Blue Options Silver PPO 004	
87571OK0380023*	Blue Options Silver PPO 005	
87571OK0290003*	Blue Choice Silver PPO 003	
87571OK0290004*	Blue Choice Silver PPO 004	
87571OK0320012*	Blue Preferred Gold PPO 001	
87571OK0320016*	Blue Preferred Gold PPO 002	

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Original Standard Component ID	Original Plan Name	Mapped Standard Component ID
87571OK0320020	Blue Preferred Silver PPO 003	
87571OK0320024*	Blue Preferred Silver PPO 004	
87571OK0320036*	Blue Preferred Gold PPO 007	
87571OK0320044*	Blue Preferred Gold PPO 009	
87571OK0380020*	Blue Options Silver PPO 004	
87571OK0380024*	Blue Options Silver PPO 005	
87571OK0290001*	Blue Choice Gold PPO 001	
87571OK0290002*	Blue Choice Gold PPO 002	
87571OK0290003*	Blue Choice Silver PPO 003	
87571OK0290004*	Blue Choice Silver PPO 004	
87571OK0290011*	Blue Choice Gold PPO 011	
87571OK0290012*	Blue Choice Gold PPO 012	
87571OK0320002*	Blue Preferred Gold PPO 002	
87571OK0320003	Blue Preferred Silver PPO 003	
87571OK0320004*	Blue Preferred Silver PPO 004	
87571OK0320013*	Blue Preferred Gold PPO 001	
87571OK0320037*	Blue Preferred Gold PPO 007	
87571OK0320045*	Blue Preferred Gold PPO 009	
87571OK0380001*	Blue Options Gold PPO 001	
87571OK0380002*	Blue Options Gold PPO 002	
87571OK0380004*	Blue Options Silver PPO 004	
87571OK0380005*	Blue Options Silver PPO 005	
87571OK0380017*	Blue Options Gold PPO 003	
87571OK0290005*	Blue Choice Bronze PPO 005	
87571OK0320026	Blue Preferred Bronze PPO 005	
87571OK0290005*	Blue Choice Bronze PPO 005	
87571OK0320027	Blue Preferred Bronze PPO 005	
87571OK0290005*	Blue Choice Bronze PPO 005	
87571OK0320028	Blue Preferred Bronze PPO 005	
87571OK0290005*	Blue Choice Bronze PPO 005	
87571OK0320005*	Blue Preferred Bronze PPO 005	
87571OK0290001*	Blue Choice Gold PPO 001	
87571OK0290002*	Blue Choice Gold PPO 002	
87571OK0290011*	Blue Choice Gold PPO 011	
87571OK0290012*	Blue Choice Gold PPO 012	
87571OK0350007*	Blue Advantage Gold PPO 001	

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Original Standard Component ID	Original Plan Name	Mapped Standard Component ID
87571OK0350010*	Blue Advantage Gold PPO 002	
87571OK0380006*	Blue Options Gold PPO 001	
87571OK0380010*	Blue Options Gold PPO 002	
87571OK0380014*	Blue Options Gold PPO 003	
87571OK0350016	Blue Advantage Silver PPO 004	
87571OK0350013	Blue Advantage Silver PPO 003	
87571OK0350019	Blue Advantage Bronze PPO 005	
87571OK0290001*	Blue Choice Gold PPO 001	
87571OK0290002*	Blue Choice Gold PPO 002	
87571OK0290011*	Blue Choice Gold PPO 011	
87571OK0290012*	Blue Choice Gold PPO 012	
87571OK0350001*	Blue Advantage Gold PPO 001	
87571OK0350002*	Blue Advantage Gold PPO 002	
87571OK0380003*	Blue Options Gold PPO 003	
87571OK0380007*	Blue Options Gold PPO 001	
87571OK0380011*	Blue Options Gold PPO 002	
87571OK0290001*	Blue Choice Gold PPO 001	
87571OK0290002*	Blue Choice Gold PPO 002	
87571OK0290011*	Blue Choice Gold PPO 011	
87571OK0290012*	Blue Choice Gold PPO 012	
87571OK0350008*	Blue Advantage Gold PPO 001	
87571OK0350011*	Blue Advantage Gold PPO 002	
87571OK0380008*	Blue Options Gold PPO 001	
87571OK0380012*	Blue Options Gold PPO 002	
87571OK0380016*	Blue Options Gold PPO 003	
87571OK0350009*	Blue Advantage Gold PPO 001	
87571OK0350012*	Blue Advantage Gold PPO 002	
87571OK0350004	Blue Advantage Silver PPO 004	
87571OK0350017	Blue Advantage Silver PPO 004	
87571OK0350018	Blue Advantage Silver PPO 004	
87571OK0350003	Blue Advantage Silver PPO 003	
87571OK0350014	Blue Advantage Silver PPO 003	
87571OK0350015	Blue Advantage Silver PPO 003	
87571OK0350005	Blue Advantage Bronze PPO 005	
87571OK0350020	Blue Advantage Bronze PPO 005	
87571OK0350021	Blue Advantage Bronze PPO 005	

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

Original Standard Component ID	Original Plan Name	Mapped Standard Component ID
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan	[redacted]
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan	[redacted]
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan	[redacted]
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan	[redacted]
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan	[redacted]
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan	[redacted]
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan	[redacted]
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan	[redacted]
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan	[redacted]
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan	[redacted]
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan	[redacted]
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan	[redacted]
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan	[redacted]
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan	[redacted]
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan	[redacted]
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan	[redacted]
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan	[redacted]
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan	[redacted]
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan	[redacted]
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan	[redacted]
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan	[redacted]
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan	[redacted]
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan	[redacted]
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan	[redacted]
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan	[redacted]
87571OK026**	Oklahoma Association of Realtors	[redacted]
87571OK027**	OK Society of CPAs	[redacted]

*For purposes of the URRT Worksheet 2, this 2015 Standard Component ID is not mapped to a 2017 Standard Component ID.
**The product ID is listed for terminated non-single risk pool compliant plans.

Warning Alerts:

Warning Alert 1: Worksheet 2, Section III has a Warning Alert in cell A68 referencing the Total Incurred claims, payable with issuer funds. The value is compared to the Aggregate Incurred Claims in the Experience Period in Worksheet 1. The difference in the comparison values is [redacted]. This difference is a result of the effects of the Risk Adjustment and Reinsurance

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5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

programs, which are not included in the total experience in Worksheet 1, but are included in the plan level experience in Worksheet 2.

Warning Alert 2: Worksheet 2, Section III has a Warning Alert in cell A73 referencing the Incurred Claims PMPM. The value is compared to the PMPM Incurred Claims in the Experience Period in Worksheet 1. The difference in the comparison values is [redacted]. This difference is a result of the effects of the Risk Adjustment and Reinsurance programs, which are not included in the total experience in Worksheet 1, but are included in the plan level experience in Worksheet 2.

4.8 Miscellaneous Instructions:

4.8.2 Reliance:

I have relied upon financial data, summaries and analyses prepared by responsible officers and employees of Health Care Service Corporation, and my analysis included such review of the assumptions as I considered necessary.

4.8.3 Actuarial Certification:

I, [redacted], am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries in good standing, and I meet the qualification standards necessary to prepare and certify rate filings for health plan entities.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice, including:

- ASOP No. 1, Introductory Actuarial Standard of Practice
- 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 Communications
- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws.

I hereby certify to the best of my knowledge that:

1. I am a member of the American Academy of Actuaries;
2. The projected index rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
    b. Developed in compliance with the applicable Actuarial Standards of Practice,
    c. Reasonable in relation to the benefits provided and the population anticipate to be covered,
    d. Neither excessive nor deficient;
3. 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;
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice;
5. 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; and
6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer 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 Marketplaces and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,

[redacted]

Date: September 16, 2016

[redacted]

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO:
5 U.S.C. § 552(b)(4), 45 C.F.R. § 5.65, the Trade Secrets Act (18 U.S.C. § 1905) and applicable state laws