MEDICA®

Actuarial Memorandum

1. Purpose and Limitations

The purpose of this document, which is submitted in conjunction with the Part I Unified Rate Review Template (URRT), is to comply with the requirements of the Part III Actuarial Memorandum and to support the premium rates developed for Medica Insurance Company's (Medica's) individual Affordable Care Act (ACA) products, with an effective date of January 1st, 2018. [redacted] This rate filing is not intended to be used for other purposes.

This memorandum reflects Medica's current assumptions and working knowledge of the ACA's regulatory framework as of August 15th, 2017 which includes assumed defunding of the cost sharing reduction (CSR) program. If further information is shared that puts this assumption at risk, Medica reserves the right to modify components of the rate filing submission.

Medica designates the information submitted by Medica through HIOS as exempt from disclosure under Exemption 4 of the HHS's Freedom of Information Act (FOIA). Additionally, Medica designates the information submitted by Medica through SERFF as trade secret.

2. General Information

Company Identifying Information

- Company Legal Name: Medica Insurance Company
- State: NE
- HIOS Issuer ID: 20305
- Market: Individual
- Effective Date: January 1, 2018

Company Contact Information

- Primary Contact Name: Jacob Dority
- Primary Contact Telephone Number: (952) 992-3629
- Primary Contact Email Address: jacob.dority@medica.com

Policy Form Numbers

- NE-INSURE-PC-18-01; NE-CHI-PC-18-01

3. Proposed Rate Increase

The proposed rate increase for Medica's individual business rates effective January 1, 2018 is 31.0% over rates effective January 1, 2017. This rate increase reflects an estimate of the average increase that will be offered to current members based on April 2017 in-force business absent of rate changes due to attained age.

The proposed annual rate changes by plan in this filing range from 20.6% to 34.7%.

Reason for Rate Increase(s)

The significant factors driving the proposed rate increase primarily include:
- Anticipated medical trend, in both utilization and the cost of services.
- Reinstatement of the ACA health insurer fee.

- Unprecedented amount of uncertainty and risk inherent in the marketplace.
- Assumed impact of defunding the CSR payment program.

Additional Information

- The proposed benefit factor changes will result in rate changes that vary across plan designs.
- Medica's rate change history is documented in Exhibit B.
- Select plans include cost sharing modifications due to actuarial value compliance.
- The corresponding plan mapping is summarized in Section 7.4.

4. Market Experience

4.1 Experience Period Premium and Claims

Paid Through Date

The experience period for this filing is calendar year 2016. The paid through date is July 31st, 2017.

Premiums (net of MLR Rebate) in Experience Period

As shown in Worksheet 1, Section I of the URRT, the calendar year 2016 experience period includes $30,798,109 of earned premium. Medica does not expect to pay medical loss ratio (MLR) rebates to policyholders for the base period.

Allowed and Incurred Claims Incurred During the Experience Period

As shown in Worksheet 1, Section I of the URRT, the calendar year 2016 experience period includes $49,739,057 of incurred claims and $60,070,240 of allowed claims.

All incurred and allowed claims are reported through Medica's claim system. Claims incurred but not paid (IBNP) as of July 31st, 2017 for the calendar year 2016 experience period are estimated to be approximately 0.7% (or $382,925) of total paid claims. The same set of completion factors are used for both paid claims and allowed claims.

The Corporate Finance team calculates the IBNP and has provided the following summary:

Medica uses Reserve Production System (RPS) to identify adjudicated claims paid in the current year, and the two most recent historical years. The RPS is used for claims reimbursed on a fee-for-service basis. A completion factor is applied to each of the adjudicated claims amounts to arrive at a "best estimate" of incurred claims for each of the aforementioned years.

A standard methodology has been developed to derive the completion factors. For older lags (duration 4+), a pure lag factor method is used based on 5 of 7 factors as of the most current claims triangles. For more recent durations (durations 1-3), a blend of the lag method described above along with a projection method is used. The projection method calculates a "base period" average PMPM using the middle 5 of 7 months of 100% credible incurral months, normalizes them for working days in the month, and projects the PMPM to recent months using trends that vary by type of service and product. Projected PMPMs are blended with lag method incurred estimates to get a final incurred claim PMPM estimate. The higher the completion factor, the higher the weight placed on the lag method.

4.2 Benefit Categories

Utilization and cost information are categorized by benefit using Milliman's *Health Cost Guidelines*™ (HCGs) categories. Milliman's categories are assigned based on place and type of service using a detailed claims mapping algorithm summarized as follows:

- Inpatient Hospital (facility charges with an overnight stay)
- Outpatient Hospital (facility charges without an overnight stay)
- Professional (with units measured as a mix of visits, cases, procedures, etc.)
- Other Medical (with units measured as a mix of visits, cases, procedures, etc.)
- Capitation (not applicable)
- Prescription Drug (prescriptions not billed by a facility or professional)

4.3 Projection Factors

Population Risk Morbidity

Medica is assuming a change in the population risk morbidity from the experience period to the projection period of . This adjustment reflects the anticipated change in claim costs outside the underlying demographics of the covered population. This change in morbidity is also assumed when estimating the risk adjustment transfer for the 2018 plan year.

Changes in Benefits

Medica applied an adjustment to the experience period claims to account for projected changes in the average utilization of services due to differences in average cost sharing. A value of is included in Worksheet 1, Section II of the URRT.

Changes in Demographics

A demographic adjustment of was applied to the experience period claims to account for the projected changes in the age and geographic region mix of the underlying experience data.

Other Adjustments

An adjustment of is included in Worksheet 1, Section II of the URRT to account for the projected changes in pharmacy rebates from the experience period to the projection period.

An adjustment of is included in Worksheet 1, Section II of the URRT to account for the projected changes in network mix from the experience period to the projection period.

Trend Factors (Cost/Utilization)

The trend used to get from the experience period to the projection period is based on an un-leveraged prospective annual trend of . The trend assumptions used in the projection are based on Medica's standard trend projection process. Due to historical individual market experience not being credible to set an accurate trend forecast, all trends are currently based on a review of claim experience from Medica's group medical lines of business. The trend assumptions do not include the impact of changes in demographics, benefit design, or morbidity.

4.4 Credibility Manual Rate Development

Not applicable. The projected experience described in Section 4 is assumed to be fully credible for rate development, so no credibility manual is needed.

4.5 Credibility of Experience

In accordance with *Actuarial Standards of Practice (ASOP) #25 – Credibility Procedures*, Medica's Nebraska experience includes 68,551 member months and is assumed to be fully credible for purposes of developing claim projections.

The methodology used determines the credibility factor as the square root of the ratio of the total number of member months over the 12-month experience period divided by 75,000. Within the context of this methodology Medica considers experience with at least 75,000 member months to be fully credible. The resulting credibility level assigned

to the base period experience under this methodology is 95.6%. Medica exercised actuarial judgment and assigned a credibility level of 100%.

4.6 Paid to Allowed Ratio

Table 1 details the paid-to-allowed ratio by plan design and is consistent with the membership projections by plan in Worksheet 2, Section IV of the URRT.

Table 1
Paid-to-Allowed Average Factor

Plan	Projected Member Months	Allowed Claims PMPM[1]	Paid Claims PMPM[1]	Paid / Allowed
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[1] Before risk adjustment.

4.7 Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

Medica's risk adjustment transfer for the 2016 plan year as documented in the *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year* (CMS Report) (published by the Centers for Medicare and Medicaid Services on June 30th, 2017) was a net receivable of $161.34 PMPM. This amount is included in Worksheet 2, Section III of the URRT.

Medica's net reinsurance recovery attributable to the experience period and supported in the CMS Report was $42.85 PMPM.

Projected Risk Adjustment PMPM

[redacted] Any resulting risk adjustment transfer payments would be allocated proportionally across all plans in Medica's individual market single risk pool.

The 2018 risk adjustment user fee of $0.14 PMPM is reflected in Worksheet 1, Section III of the URRT.

4.8 Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

The components of the administrative expense load as shown in Worksheet 1, Section III of the URRT are summarized in Table 2.

Table 2 Summary of Administrative Expenses		
Description	**PMPM**	**% of Premium**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Medica's administrative expense load includes general administration, commissions paid to brokers and agents, and Health Care Quality Improvements (HCQI). Medica allocates administrative expenses by product, state and legal entity. Base fees paid to third party administrators on a PMPM basis are charged directly to the appropriate product. With the exception of regulatory costs and Medica Health Management (MHM) costs, the remaining administrative expenses are allocated to the market business segments to determine a PMPM. Regulatory costs are charged directly to the appropriate entity. MHM costs are captured in specific cost centers which are charged directly to MHM. The support cost centers (Human Resources, Facilities and a portion of IT and General Administration) are allocated to each of the other cost centers. Medica's Corporate Finance staff meets periodically with a representative of each cost center to review the allocation method.

Contribution to Surplus and Risk Margin

The targeted risk margin after federal income taxes is [redacted] applied proportionally to all plans. The silver metal level plans include additional margin to account for the expected defunding of the CSR program.

Taxes and Fees

Table 3 summarizes the components of the taxes and fees shown in Worksheet 1, Section III of the URRT.

Table 3 Summary of Taxes and Fees		
Description	**PMPM**	**% of Premium**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

The exchange user fee is calculated as 3.5% of anticipated on-exchange premiums, and then spread across the entire single risk pool as required by regulation. [redacted].

The risk adjustment user fee and reinsurance contributions are not reflected here, as documented in Section 4.7.

5. Projected Loss Ratio

The projected MLR for Medica based on the federally-prescribed methodology is [redacted]. The numerator of the projected MLR contains projected claim costs and HCQI expenses net of receipts from the risk adjustment program. The denominator consists of total premiums net of premium taxes and regulatory fees. Please note that the MLR presented here does not capture all adjustments, including multi-year averaging, credibility, deductible, and defunding of the CSR program.

Exhibit C provides a summary of the components included in the MLR projection.

6. Application of Market Reform Rating Rules

6.1 Single Risk Pool

This filing, including the URRT, complies with the single risk pool requirements documented in 45 CFR Part 156, §156.80(d). The experience period data is based on all Medica individual market policies in Nebraska. The projection period reflects all projected covered lives for every non-grandfathered product/plan combination for Medica in the Nebraska individual market.

6.2 Index Rate

Experience Period

As shown in Worksheet 1, Section I of the URRT, the index rate for the experience period is $876.29. The experience period index rate reflects the estimated total combined allowed EHB claims experience PMPM in the single risk pool, and is not adjusted for payments and charges under the risk adjustment and reinsurance programs, or for marketplace user fees.

Projection Period

The index rate for the projection period is developed based on the anticipated claim level of all policies in the single risk pool as described in the manual rate development process detailed in Section 4.4. The index rate defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives is [redacted].

6.3 Market-Adjusted Index Rate

The market-adjusted index rate is calculated as the sum of the projection period index rate, the net impact of the risk adjustment program, and the exchange user fees. Table 4 details the projection period index rate, allowable market-wide modifiers as defined in 45 CFR Part 156, §156.80(d)(1), and the resulting market-adjusted index rate.

Table 4
Market-Adjusted Index Rate

Description	PMPM
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

The adjustments in Table 4 reflect all of the market-wide modifiers allowed in federal regulation and the average demographic characteristics of the single risk pool. Please note the allowable market-wide modifiers were adjusted to an allowed basis in the development of the market-adjusted index rate which is consistent with the basis of the projected index rate.

6.4 Plan-Adjusted Index Rates

Exhibit D summarizes the plan-adjusted index rates determined as the market-adjusted index rate further adjusted for all the allowable plan-level modifiers defined in 45 CFR Part 156, §156.80(d)(2).

The allowable modifiers as described in 45 CFR Part 156, §156.80(d)(2) are the following:

- Actuarial value and cost-sharing design of the plan,
- Plan's provider network and delivery system characteristics, as well as utilization management practices,

- Plan benefits in addition to the EHBs,
- Administrative costs, excluding exchange user fees, and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

AV and Cost-Sharing Adjustment

The impact of each plan's AV and cost-sharing adjustment includes a benefit factor adjustment and an adjustment to account for the expected impact of the plan's cost sharing amounts on the member's utilization of services. Medica's internal benefit factor model, which uses a single continuance table for all plans, was used to estimate how members purchase services differently based on the amount of plan-specific cost sharing. By utilizing a single continuance table, the model's adjustments assume the same demographic and risk characteristics for each plan priced and therefore exclude expected differences in the health status of members assumed to select the plan.

Plan's Provider Network and Delivery System Characteristics

Network adjustments are developed based on an analysis of variation in cost by provider network. The adjustments are developed by analyzing the cost variation among providers in the care system networks against the open access network as a whole. Additionally, network-specific discounts were applied to the cost relativities, where applicable.

Exhibit E provides a summary of the proposed provider network adjustments applied to the plan-adjusted index rates.

Adjustment for Benefits in Addition to the EHBs

Medica's plans do not include any benefits other than EHBs (neither supplemental benefits nor state mandates eligible for state reimbursement), so the plan adjusted index rates do not include a plan-level adjustment for benefits in addition to the EHBs.

Impact of the Specific Eligibility Categories for the Catastrophic Plan

A specific eligibility adjustment reflects the difference in expected demographics between the catastrophic plan and the non-catastrophic plans due to the unique eligibility requirements of the catastrophic plans (i.e. that only individuals under the age of 30 or eligible by reason of financial hardship can enroll). This adjustment reflects that costs vary by age, and that the cost of the population expected to enroll in this plan is anticipated to be lower than the non-catastrophic plans.

6.5 Calibration

A single calibration adjustment is applied uniformly to all plans. The market-wide calibration factor is . Detailed support of the calibration factor is provided in Exhibit F.

Age Curve Calibration

The average age factor used in the calibration process is and was determined by applying the standard age curve established by HHS to the projected member distribution by age, with an adjustment for the maximum of three child dependents under the age of 21.

Under this methodology, the approximate average age rounded to a whole number associated to the single risk pool average age factor is .

Geographic Factor Calibration

The average geographic factor used in the calibration process is .

Exhibit G provides a summary of the proposed geographic rating factors applied to the plan-adjusted index rates.

The geographic rating factors are developed based on an analysis of variation in cost by geographic region. Using Medica's individual market data for the 2016 plan year, the membership and allowed claims are distributed into the rating areas based on the location of the member. Inpatient claims are truncated at $75,000 annually. Each service category is assigned a credibility level based on the utilization in that category and credibility-weighted with the overall state average PMPM for that service category. These credibility-weighted allowed PMPM costs by service category are then added up for each rating area and adjusted for the risk of the population in that area.

Finally, the observed factors are calculated by dividing each rating area's adjusted credibility-weighted allowed PMPM by the overall average for the state in total. To smooth changes from year to year, Medica makes business decisions on the materiality of the proposed rating factor change for each geographic region.

Tobacco Factor Calibration

The average tobacco rating factor used in the calibration process is .

A tobacco load of will be applied to adult tobacco users age 18 and older. In developing this factor, Medica relied on a 2009 Milliman research report regarding the impact of smoking on medical claim costs, since data on tobacco users in Medica's current populations continues to be limited in volume. It was assumed that the more general under age 65 population in the Milliman study would provide a better proxy for the population in the individual market. The Milliman study was based on Medical Expenditure Panel Survey (MEPS) data.

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Consumer-Adjusted Premium Rate Development

Medica derives consumer adjusted premium rates by calibrating the plan-adjusted index rate and applying the rating factors specified by 45 CFR Part 147, §147.102. See Exhibit A for the proposed rate manual and sample rate calculation.

7. Plan Product Info

7.1 AV Metal Values

The AV metal levels were developed using only the federal AV calculator. Medica does not believe any of the plans requires an alternative methodology.

7.2 AV Pricing Values

Exhibit H provides a summary of the AV pricing values by plan as displayed in Worksheet 2, Section I of the URRT and a breakdown of the components attributable to each of the allowable modifiers to the index rate as described in 45 CFR Part 156, §156.80(d)(2).

7.3 Membership Projections

Medica projected membership as displayed in Worksheet 2, Section IV of the URRT by considering the size of the projected Nebraska individual market in 2018 and an assumed penetration rate of this market.

For silver level plans in the individual market, an estimate was made for the portion of projected enrollment that will be eligible for cost sharing reduction (CSR) subsidies at each subsidy level. Table 5 displays the distribution and projected members for all the silver plans, including the alternative silver plans which CSR eligibles can purchase.

Table 5 Distribution of Membership Across Silver Metal Tier		
Silver Metal Tier	**Membership Distribution**	**Membership**
Standard	26.7%	16,595
94% AV Level Silver Plan	31.6%	19,600
87% AV Level Silver Plan	23.2%	14,395
73% AV Level Silver Plan	18.5%	11,459
Limited Cost Sharing	0.0%	8
Zero Cost Sharing	0.0%	29
Total	100.0%	62,085

7.4 Terminated Products

Medica is modifying its plan portfolio for the 2018 plan year. Table 6 summarizes both the terminated plans that were included in the single risk pool during the experience period or made available thereafter and the corresponding mapped plans.

Table 6 Terminated Plan Cross-Walk			
Terminated Plan Name	**Terminated HIOS ID**	**Mapped Plan Name**	**Mapped HIOS ID**
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]

7.5 Plan Type

Not Applicable. The plan types listed in Worksheet 2, Section I of the URRT appropriately describe Medica's plans.

7.6 Warning Alerts

Two warning alerts appear in Worksheet 2, Section IV of the URRT. Both warnings are triggered due to the material risk adjustment transfer in the experience period.

8. Miscellaneous Instructions

8.1 Effective Rate Review Information

Medica believes all other information specific to Nebraska Department of Insurance's (DOI)'s filing requirements are reflected elsewhere in this filing.

8.2 Reliance

In developing this rate filing, I have relied on several internal departments for information. This information includes Corporate Actuarial providing rating factors, projections of claim trend and Corporate Finance providing non-benefit expenses. I have performed a limited review of this information, and have deemed it to be reasonable.

8.3 Actuarial Certification

I, Jacob Dority, am the Manager of Actuarial Services for Medica. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable state and federal statutes and regulations (45 CFR 156.80 and 147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice,
- Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- Neither excessive nor deficient.

I further certify that:

- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates,
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV of the Part I URRT were calculated in accordance with actuarial standards of practice,
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area, and
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I URRT for all plans.

The Part I URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally Facilitated Exchanges (FFE) and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.

Jacob D. Dority
Fellow, Society of Actuaries
Member, American Academy of Actuaries
Medica
401 Carlson Parkway
Minnetonka, MN 55305-5387
August 15th, 2017

Exhibit A
Rate Manual

Sample Rate Calculation

Table 1 - Plan-Adjusted Index Rates and Actuarial Values

Plan Name	HIOS Plan ID	Metal Level	Actuarial Value	Plan-Adjusted Index Rate
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Exhibit A (continued)
Rate Manual

Table 2 - Age

Age	Factor
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
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[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Table 3 - Geographic

Rating Area	Area Factor
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Table 4 - Tobacco

Tobacco Factor
[illegible]

Table 5 - Calibration

Calibration Factor
[illegible]

Exhibit B
Rate History

Effective Date	Rate Change
January 1, 2016	New Product
January 1, 2017	51.3%
January 1, 2018	31.0%

Exhibit C
Medical Loss Ratio (MLR)

Projected MLR for 2018

Exhibit D
Plan-Adjusted Index Rates

Plan Name	HIOS Plan ID	Metal Level	Market-Adjusted Index Rate	Proposed AV Pricing Value	Plan-Adjusted Index Rate
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[1] Plan-Adjusted Index Rate = Market-Adjusted Index Rate x Proposed AV Pricing Value

Exhibit E
Provider Network Adjustments

Network	Current Adjustment	Proposed Adjustment
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Exhibit F
Calibration Development

Age Calibration		
Age	Member Distribution	Age Factor
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]

Geographic Calibration		
Rating Area	Member Distribution	Area Factor
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Exhibit G
Geographic Rating Factors

Rating Area	Current Adjustment	Proposed Adjustment
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Exhibit H
AV Pricing Values

Plan Name	AV and Cost Sharing Adjustment	Benefit Induced Utilization	Provider Network	EHB Adjustment	Catastrophic Specific Eligibility	Administrative Costs	AV Pricing Value
	A	B	C	D	E	F	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[1] AV Pricing Value = A x B x C x D x E x F