
State:	Illinois	Filing Company:	Health Care Service Corporation, A Mutual Legal Reserve Company
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other		
Product Name:	ACT DOI-Illinois SG 202601		
Project Name/Number:	/		

Filing at a Glance

Company:	Health Care Service Corporation, A Mutual Legal Reserve Company
Product Name:	ACT DOI-Illinois SG 202601
State:	Illinois
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.003G Small Group Only - Other
Filing Type:	Rate
Date Submitted:	06/04/2025
SERFF Tr Num:	ILCP-134536831
SERFF Status:	Pending State Action
State Tr Num:	OFF-EXCHANGE
State Status:	Assigned to Reviewer
Co Tr Num:	SG202601
Effective	01/01/2026
Date Requested:	
Author(s):	Doug Bass, Angie Sweet, Joyce Hong, Alec Mora
Reviewer(s):	Eric Anderson (primary), Christina Roy, Becky Sheppard, Andrew Larocque
Disposition Date:	
Disposition Status:	
Effective Date:	
State Filing Description:	

State: Illinois **Filing Company:** Health Care Service Corporation, A Mutual Legal Reserve Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: ACT DOI-Illinois SG 202601

Project Name/Number: /

General Information

Project Name: Status of Filing in Domicile: Not Filed

Project Number: Date Approved in Domicile:

Requested Filing Mode: File & Use Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small

Group Market Type: Overall Rate Impact:

Filing Status Changed: 06/06/2025

State Status Changed: 06/05/2025 Deemer Date:

Created By: Angie Sweet Submitted By: Angie Sweet

Corresponding Filing Tracking Number:

State TOI: H16G Group Health - Major Medical State Sub-TOI: H16G.003G Small Group Only - Other

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: This rate filing includes off Exchange products.

Filing Description:

The scope of this filing is for Blue Cross Blue Shield (BCBSIL), a division of Health Care Service Corporation, fully-insured, Small Group single risk pool benefits. This filing is intended to comply with Sections 2701 and 2794 of the Public Health Service Act. It is further intended to comply with 215 ILCS 5/355 and 215 ILCS 93/1 et seq., to the extent such laws are not preempted by federal law. This memorandum complies with the Actuarial Memorandum section as described in the Review Requirements Checklist.

The purpose of this rate filing is to update the rate manuals effective 1/1/2026 for the Illinois Small Group single risk pool benefits. The filing is also intended to demonstrate the reasonableness of rates in relation to premiums. The filing may not be appropriate for other purposes.

Company and Contact

Filing Contact Information

Robert Hastings, Sr. Director Robert_W_Hastings@bcbsil.com

300 East Randolph 312-653-9280 [Phone]

Chicago, IL 60601

Filing Company Information

Health Care Service Corporation, CoCode: 70670 State of Domicile: Illinois

A Mutual Legal Reserve Company Group Code: Company Type:

300 E. Randolph Group Name: State ID Number:

Chicago, IL 60601 FEIN Number: 36-1236610

(312) 653-5494 ext. [Phone]

State: Illinois

Filing Company: Health Care Service Corporation, A Mutual Legal Reserve Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: ACT DOI-Illinois SG 202601

Project Name/Number: /

Filing Fees

State Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

Per Company: Yes

Company	Amount	Date Processed	Transaction #
Health Care Service Corporation, A Mutual Legal Reserve Company	\$25.00	06/04/2025 05:13 PM	317716386
EFT Total	\$25.00		

State:IllinoisFiling Company:Health Care Service Corporation, A Mutual Legal Reserve Company

TOI/Sub-TOI:H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name:ACT DOI-Illinois SG 202601

Project Name/Number:/

Rate Information

Rate data applies to filing.

Filing Method:SERFF

Rate Change Type:Increase

Overall Percentage of Last Rate Revision:9.900%

Effective Date of Last Rate Revision:10/01/2025

Filing Method of Last Filing:SERFF

SERFF Tracking Number of Last Filing:ILCP-134528735

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Health Care Service Corporation, A Mutual Legal Reserve Company	Increase	13.450%	13.450%	\$405,316,896	38,802	\$3,013,508,522	24.680%	2.000%

State: Illinois **Filing Company:** Health Care Service Corporation, A Mutual Legal Reserve Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: ACT DOI-Illinois SG 202601

Project Name/Number: /

Rate Review Detail

COMPANY:

Company Name: Health Care Service Corporation, A Mutual Legal Reserve Company

HHS Issuer Id: 36096

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Blue PPO	36096IL077		307178
Blue Precision HMO	36096IL082		49090

Trend Factors: Included on URRT

FORMS:

New Policy Forms: IL_G_BC_(H)_OF_2026, IL_G_BC_OF_2026, IL_G_BOP_(H)_OF_2026, IL_G_BOP_OF_2026, IL_G_H_OF_2026, IL_G_P_(H)_OF_2026, IL_G_P_OF_2026

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly

Member Months: 4,374,567

Benefit Change: Increase

Percent Change Requested: Min: 2.0 Max: 24.68 Avg: 13.45

PRIOR RATE:

Total Earned Premium: 3,013,508,522.00

Total Incurred Claims: 2,654,479,117.00

Annual \$: Min: 228.83 Max: 2,254.41 Avg: 704.87

REQUESTED RATE:

Projected Earned Premium: 3,418,825,418.00

Projected Incurred Claims: 2,952,771,137.00

Annual \$: Min: 239.98 Max: 2,588.43 Avg: 799.68

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		2026_RTT		New		36096_IL_SG_2026_RTT_20250604.xlsb, 36096_IL_SG_2026_RTT_20250604.zip,

SERFF Tracking #:	ILCP-134536831	State Tracking #:	OFF-EXCHANGE	Company Tracking #:	SG202601
State:	Illinois	Filing Company:	Health Care Service Corporation, A Mutual Legal Reserve Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	ACT DOI-Illinois SG 202601				
Project Name/Number:	/				

Attachment 36096_IL_SG_2026_RTT_20250604.xlsb is not a PDF document and cannot be reproduced here.

Attachment 36096_IL_SG_2026_RTT_20250604.zip is not a PDF document and cannot be reproduced here.

SERFF Tracking #:	ILCP-134536831	State Tracking #:	OFF-EXCHANGE	Company Tracking #:	SG202601
State:	Illinois	Filing Company:	Health Care Service Corporation, A Mutual Legal Reserve Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	ACT DOI-Illinois SG 202601				
Project Name/Number:	/				

URRT

State Determination

Review Status:	Incomplete
-----------------------	------------

SERFF Tracking #:	ILCP-134536831	State Tracking #:	OFF-EXCHANGE	Company Tracking #:	SG202601
State:	Illinois	Filing Company:	Health Care Service Corporation, A Mutual Legal Reserve Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	ACT DOI-Illinois SG 202601				
Project Name/Number:	/				

URRT Items

Item Name	Attachment(s)
Actuarial Memorandum - Redacted	36096_IL_SG_2026_RegulatorAM_20250604_Redacted.pdf

Part III Actuarial Memorandum

Blue Cross and Blue Shield of Illinois Small Group Rate Filing Effective January 1, 2026

4.2 GENERAL INFORMATION	3
4.3 PROPOSED RATE CHANGES	4
4.4 MARKET EXPERIENCE	5
4.4.1 Experience and Current Period Premium, Claims, and Enrollment	5
4.4.2 Benefit Categories.....	6
4.4.3 Projection Factors	7
4.4.4 Plan Adjusted Index Rate	11
4.4.5 Calibration.....	14
4.4.6 Consumer Adjusted Premium Rate Development	15
4.5 PROJECTED LOSS RATIO	15
4.6 PLAN PRODUCT INFORMATION	16
4.6.1 AV Metal Values	16
4.6.2 Membership Projections.....	17
4.6.3 Terminated Plans and Products	17
4.6.4 Plan Type.....	17
4.7 MISCELLANEOUS INSTRUCTIONS	17
4.7.2 Reliance.....	17
4.7.3 Actuarial Certification	17

Introduction

This actuarial memorandum supports a rate filing on behalf of Blue Cross and Blue Shield of Illinois (BCBSIL), 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 Small Group medical policies.

This actuarial memorandum and certifications do not guarantee the adequacy of the proposed rates. Rather, they certify that the proposed rates would be adequate if the assumptions were realized. In particular, in the event of any change to and/or modifications by statute, regulation, court decision, agency sub-regulatory guidance, implementation, administration, and/or interpretation, the proposed rates may not be adequate. In such circumstance, the proposed rates would be subject to amendment, revision and/or withdrawal (in whole or in part), if determined necessary by BCBSIL, the attestor(s), and/or the certifying actuary.

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

<i>Company Legal Name</i>	Blue Cross and Blue Shield of Illinois
<i>State</i>	Illinois
<i>HIOS Issuer ID</i>	36096
<i>Market</i>	Small Group
<i>Effective Date</i>	January 1, 2026

Company Contact Information

<i>Primary Contact Name</i>	[REDACTED]
<i>Primary Contact Telephone</i>	[REDACTED]
<i>Primary Contact Email</i>	[REDACTED]

4.3 Proposed Rate Changes

For groups renewing during the first quarter of 2026, we propose a [REDACTED] across the entire block of BCBSIL Small Group ACA-compliant metallic plans effective January 1, 2026. The premium rate changes will vary by plan, area, and quarter.

[REDACTED]

The average rate increase is calculated using the 2025 rate tables, the proposed 2026 rate tables and the membership distribution by plan, age and area as of April 30, 2025. This assumes the 2025 quarter four rates will be approved as filed. The calculation does not include any new or terminating plans nor any mapping of members to available plans.

Reason for Rate Increases:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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 rate changes may vary by area, plan, and quarter.

4.4 Market Experience

The single risk pool includes all covered lives for every small group non-grandfathered product/plan combination including transitional products. Transitional product experience has been removed from the experience period and projection period base rate calculations. We do not anticipate a significant number of the members in those policies will be enrolled in metallic plans during the projection period.

4.4.1 Experience and Current Period Premium, Claims, and Enrollment

Paid Through Date:

Payments have been made through April 30, 2025, on claims incurred during calendar year 2024.

Current Date:

Current enrollment and premiums are as of April 30, 2025.

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 accounts in the Small Group 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 adjusted for drug manufacturer rebates.

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 primarily of drug manufacturer rebates and provider incentives.

The same methodology was used to develop the estimate of claims incurred but not paid for both allowed claims and incurred claims in the experience period. 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 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, ICD-10, Revenue Codes, CPT4, HCPCS and NDCs) to determine the category into which each claim in the experience period falls.

Benefit Category	Category Description
Inpatient Hospital	Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse disorder, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
Outpatient Hospital	Includes non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.
Professional	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.

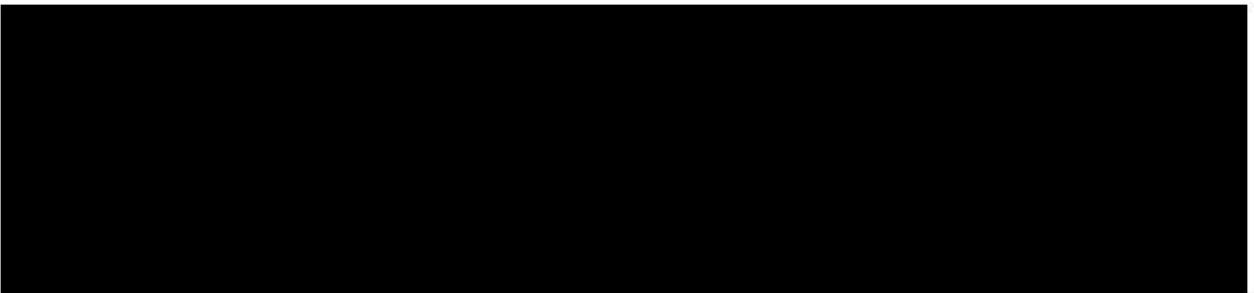
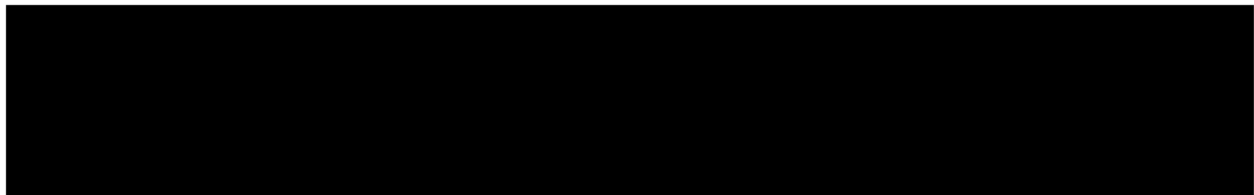
Benefit Category	Category Description
Other Medical	Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services.
Capitation	Includes all services provided under one or more capitated arrangements.
Prescription Drug	Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

4.4.3 Projection Factors

The projection factors used in the URRT have been calculated in accordance with Section 4.4.3 of the most recent Unified Rate Review (URR) Instructions.

4.4.3.1 Trend Factors

Trend Factors (cost/utilization):



The source data has adjustments applied:

- to normalize for age, gender, and morbidity,
- for number/type of days of the week and 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, unit cost and utilization.



[REDACTED]

[REDACTED]

4.4.3.2 Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment:

[REDACTED]

Demographic Shift:

[REDACTED]

Plan Design Changes:

[REDACTED]

Other Adjustments:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

4.4.3.3 Manual Rate Adjustments

No manual rate was needed as the experience period claims are deemed fully credible as discussed in Section 4.4.3.4.

4.4.3.4 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, 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 Medical Loss Ratio (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.

[REDACTED]. As such, we felt that applying 100% credibility was appropriate.

There are no material changes from the prior credibility procedures.

4.4.3.5 Establishing the Index Rate

As reported in Worksheet 1 of the URRT, the index rate for this filing is [REDACTED]. It represents the estimated total allowed claims per member per month (PMPM) for the single risk pool for EHBs in the Illinois Small Group market.

For the experience period, the index rate equals the total allowed charges PMPM, less coverage for benefits in excess of the EHBs.

For the projection period, the index rate equals the total expected allowed charges PMPM, less coverage for benefits in excess of EHBs. Any benefits covered in addition to the essential health benefits are accounted for in the pricing plan factors.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

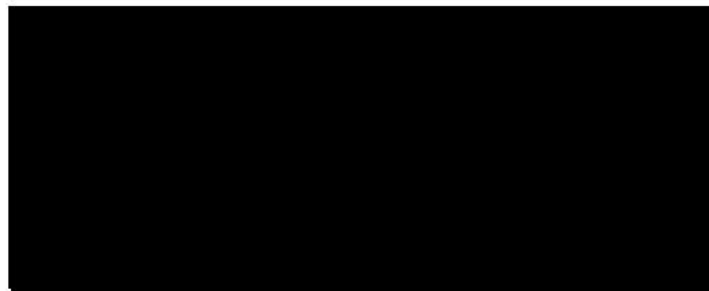
[REDACTED]

4.4.3.6 Development of the Market-wide Adjusted Index Rate

The Market-wide Adjusted Index Rate (MAIR) 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 federal risk adjustment and Exchange user fees.

The MAIR is calculated by subtracting the reinsurance and risk adjustment amounts from the index rate and dividing by 1 minus the Exchange user fee percentage.

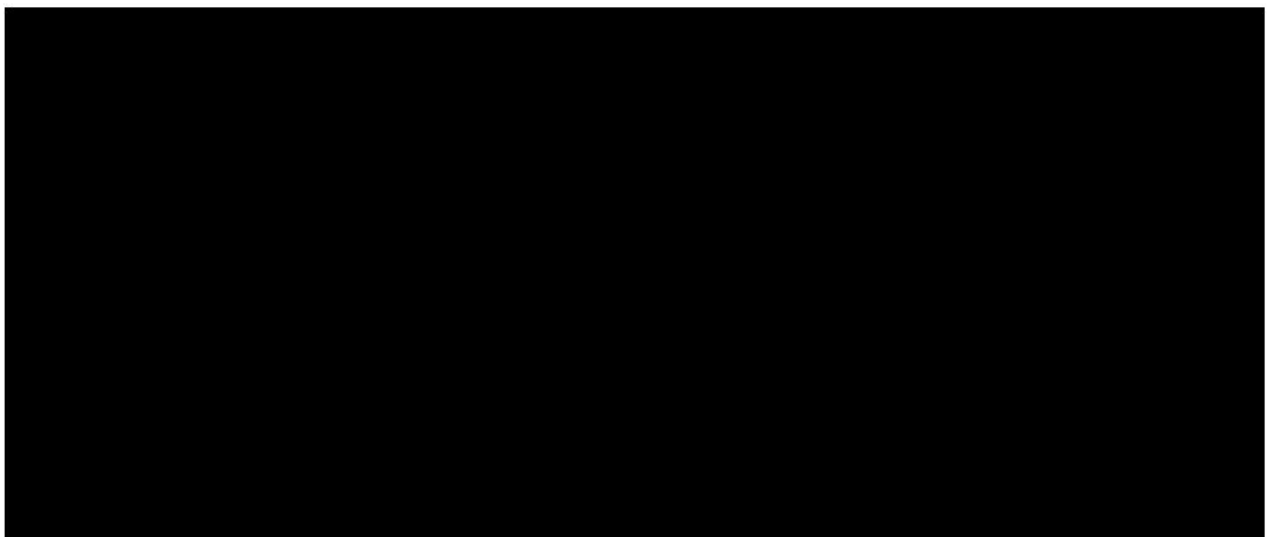
The table below provides a summary of the development of the projection period MAIR as shown on Worksheet 1 of the URRT:

A large black rectangular box redacting the content of the table.

Reinsurance:

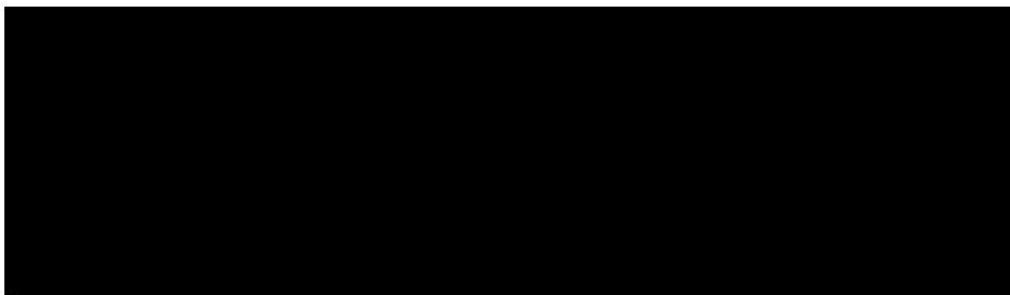
The 2016 benefit year was the final year of the Federal Reinsurance Program, as stated in the 2026 Notice of Benefit and Payment Parameters. As a result, neither the Experience Period nor the Projection Period include Reinsurance payments/contributions.

Risk Adjustment Payment/Charge:

A large black rectangular box redacting the content of the table.

The estimated risk adjustment transfers were allocated uniformly to all plans as a percentage of premium. For the purposes of Worksheet 1, Section II and Worksheet 2, Section IV, we have converted the percentage of premium as described to a market level dollar amount.

The development of final projected risk adjustment receivable PMPM is shown in the table below:



Exchange User Fees:



The Exchange user fee equals 1.5% of premium sold through the SHOP Marketplace, per regulation.



4.4.4 Plan Adjusted Index Rate

The Plan Adjusted Index Rate (PAIR) is the MAIR adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR 156.80(d)(2). Only the following adjustments were made:

- Actuarial value and cost sharing design of the plan, which includes a uniform leveraging increase assumption applied equally to all plans and quarters,
- The plan's provider network, delivery system characteristics, and utilization management practices,
- Benefits provided under the plan that are in addition to EHBs, and
- Administrative costs, excluding Exchange user fees.

As provided in Worksheet 2 of the URRT, the PAIR is the MAIR multiplied by the product of the "AV and Cost Sharing Design of Plan," "Provider Network Adjustment," and "Benefits in Addition to EHB" components, divided by 1 minus the sum of "Administrative Expense," "Taxes and Fees" and "Profit & Risk Load." These components are described below.

AV and Cost Sharing Design of Plan:

The AV and Cost Sharing Design of Plan considers differences in cost sharing and the resulting induced demand. Paid to allowed ratios are created using the same claim distribution for each plan design.

The AV and Cost-Sharing Design of Plan takes into account the benefit and utilization differences due to differences in cost-sharing. Furthermore, paid to allowed ratios used in the rate development reflect the percentage of allowed claims expected to be BCBSIL's liability based on the plan provisions and underlying claim mix for a standardized population and do not reflect differences in health status.

Induced demand factors by metallic are based on the Federal Benefit Richness curve and adjusted for capitation.

Provider Network Adjustment:

The Provider Network Adjustment reflects changing unit cost and practice patterns by area and network, due to providers joining, terminating, and renegotiating rates throughout the year. Changes in signed and expected contracts are reflected.

Benefits in Addition to EHB:

According to the 2026 Unified Rate Review Instructions, coverage for routine non-pediatric eye exam services and services covered under the Illinois Reproductive Health Act are benefits that should not be considered EHBs but are required by the State of Illinois. [REDACTED]

Administrative Costs:

Administrative Costs include Administrative Expenses, Taxes and Fees, and Profit & Risk Load.

Administrative Expenses

The administrative expense load built into the pricing of the Small Group products is based on allocated expenses as they exist in the current operating model, adjusted for expected 2026 membership, expected expense inflation, and other budgeted adjustments related to the Small Group block of business. Additionally, all Small Group premiums include a flat load to account for commissions, which incorporate the expected external sales commission percentage, and total expected expenses related to internal distribution costs for direct business.

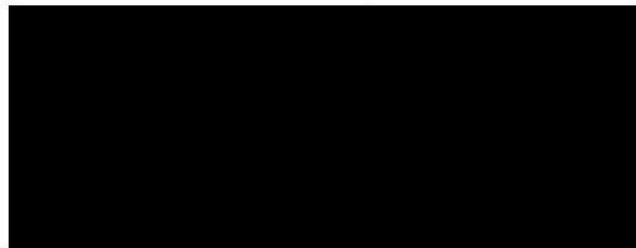
The source data is based on allocated expenses applicable to each line of business as they exist in the current operating model which has been adjusted for expected expense inflation, expected membership in 2026, and changes in operations because of the regulatory changes. Membership in 2026 is described in Section 4.6.2.

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

Taxes and Fees

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

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



Profit & Risk Load

The target contribution to surplus, inclusive of underwriting gain/loss margin and any additional risk margin, [REDACTED] Target margins may vary by area and product to meet business objectives.

4.4.5 Calibration

Age Curve Calibration:



The age curve calibration factor is calculated as follows:

$$ACCF = \frac{\sum Mbrs}{\sum Mbrs * AF}, \text{ where}$$

ACCF = Age Curve Calibration Factor

Mbrs = Projected Members

AF = CMS Rating Age Factor for a given subset of members; 0 for members not expected to pay premium

The age curve calibration adjustment is not plan-specific. The same factor was applied to all plans in the projected single risk pool.

This calculation reflects the uncollected premium for families with more than three dependents under age 21.

A demonstration of how the PAIR and the age curve are used to generate the schedule of premium rates for each plan is described in Section 4.4.6.

Geographic Factor Calibration:

[REDACTED]

In developing the geographic factors, we normalize our experience for benefit richness and risk levels, therefore removing the impact of morbidity from our factors. The remaining difference in PMPMs reflects unit cost and practice patterns between different areas.

The geographic factors used are displayed in URRT Worksheet 3.

[REDACTED]

The geographic calibration factor is calculated as follows:

$$GCF = \frac{\sum Mbrs}{\sum Mbrs * GF}, \text{ where}$$

GCF = Geographic Calibration Factor

Mbrs = Projected Members

GF = Projected Geographic Factor for a given subset of members

The geographic factor calibration adjustment is not plan-specific. The same approximate average geographic factor was applied to all plans in the projected single risk pool.

Tobacco Use Rating Factor Calibration:

[REDACTED]

4.4.6 Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by first multiplying the PAIR by the age calibration factor, the geographic calibration factor, and the tobacco calibration factor. The result can then be multiplied by the individual's specific age factor and geographic factor to determine the approximate Consumer Adjusted Premium Rate. 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 considered.

CAPR = Consumer Adjusted Premium Rate

$$\text{CAPR} = \text{PAIR} \times \text{Age Calibration} \times \text{Geographic Calibration} \times \text{Tobacco Calibration} \times \text{Age Factor} \times \text{Geographic Factor}$$

Example Q1 2026 Rate Calculation for age 40 in Rating Area 1

Plan: Blue PPO Bronze 132, 36096IL0770048

Plan Adjusted Index Rate = [REDACTED]

Age Calibration = [REDACTED]

Geographic Calibration = [REDACTED]

Tobacco Calibration = [REDACTED]

Age 40 Factor = [REDACTED]

Rating Area 1 Factor = [REDACTED]

[REDACTED]

The Premium Rate listed in the Rates Template is [REDACTED]. Any differences are due to the intermediate rounding of values implied in the URRT's rate development and actual rate development.

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

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
- 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:

- i = [REDACTED]
- q = [REDACTED]
- p = [REDACTED]
- t = [REDACTED]
- f = [REDACTED]
- n = [REDACTED]
- r = [REDACTED]
- c = [REDACTED]

[REDACTED]

The projected MLR is greater than 80.0%.

4.6 Plan Product Information

4.6.1 AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template are based entirely on the AV Calculator results. While certain member cost sharing features may not be fully compatible with the AV Calculator parameters and potentially remain unaccounted for, the impact of these features is likely small enough that no plan's metallic status would be impacted.

4.6.2 Membership Projections

[REDACTED]

4.6.3 Terminated Plans and Products

[REDACTED]

4.6.4 Plan Type

All health plans fit the plan types listed in the drop-down box in Worksheet 2, Section I of the URRT.

4.7 Miscellaneous Instructions

4.7.2 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.

4.7.3 Actuarial Certification

I, [REDACTED], am an Associate 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:

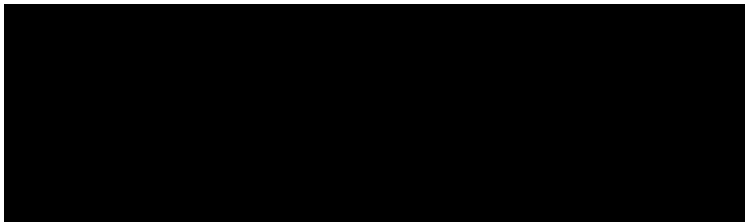
- ASOP No. 1, Introductory Actuarial Standard of Practice
- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

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 and 147.102),
 - b. Developed in compliance with the applicable Actuarial Standards of Practice,
 - c. Reasonable in relation to the benefits provided and the population anticipated 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.
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 Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



Date: June 4, 2025

SERFF Tracking #:	ILCP-134536831	State Tracking #:	OFF-EXCHANGE	Company Tracking #:	SG202601
State:	Illinois	Filing Company:	Health Care Service Corporation, A Mutual Legal Reserve Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	ACT DOI-Illinois SG 202601				
Project Name/Number:	/				

Supporting Document Schedules

Satisfied - Item:	Review Requirement Checklist
Comments:	
Attachment(s):	HealthPremiumRateReviewChecklist_202601.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Certification of Compliance
Comments:	
Attachment(s):	2025 Certificate of Compliance Signed FINAL.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Rate Filing Summary
Comments:	
Attachment(s):	36096_IL_SG_2026-public-rate-filing-summary_20250604.xlsx
Item Status:	
Status Date:	

SERFF Tracking #:	ILCP-134536831	State Tracking #:	OFF-EXCHANGE	Company Tracking #:	SG202601
State:	Illinois	Filing Company:	Health Care Service Corporation, A Mutual Legal Reserve Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	ACT DOI-Illinois SG 202601				
Project Name/Number:	/				

Attachment 36096_IL_SG_2026-public-rate-filing-summary_20250604.xlsx is not a PDF document and cannot be reproduced here.

Contact Person:**Illinois Division of Insurance****320 West Washington Street
Springfield, IL 62767-0001****Review Requirements Checklist****Effective 05/01/2022****Health Actuarial Unit****DOI.HealthActuarial@Illinois.gov****Line(s) of Business****For Policies issued after 01/01/2014****Health Premium Rates****Line(s) of Insurance****Individual/Small Group Major Medical
Surgical/Medical/Hospital PPO and Non PPO and HMO**

Illinois Insurance Code Link	Illinois Compiled Statutes Online		
Illinois Administrative Code Link	Administrative Regulations Online		
Product Coding Matrix	Product Coding Matrix		
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
		NOTE: These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Department of Insurance.	
COMPANY REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
Cover Letter	50 IL Adm. Code 916.40 (b)	Cover Letters must generally describe the intent of the rate filing and whether the filing is a new rate, rate revision or justification of an existing rate. It is necessary to provide a listing of the policy form filing company tracking number(s) and company form number(s) to show the association between the rate being filed and those forms affected by the rate change. ** The Filing Description field in the General Information Tab in SERFF may be used in place of a cover letter.	This is completed in Supporting Documentation Tab "Actuarial Memorandum and Certifications" section.

COMPANY REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
Grandfathered Status		<p>1.) Not Grandfathered- This rate filing is not being made in support of a grandfathered plan.</p> <p>2.) Grandfathered Plan- This rate filing is being made in support of a grandfathered plan. None of the changes that have been made to this plan since the last rate filing have caused the plan to lose its grandfathered status.</p> <p>3.) Formerly a Grandfathered Plan- This rate filing is being made in support of a formerly grandfathered plan. The following SERFF filing(s) contained changes that caused the plan to lose its grandfathered status: _____.</p>	This is completed in the General Information tab.
Implementation Date		The proposed effective date of rate revision implementation.	1/1/2026
Rate Filing Requirements	215 ILCS 5/355	<p>The Federal Patient Protection and Affordable Care Act (PPACA) has established premium reporting and review processes for all health insurance issuers. The Rate Data Collection Form is available on the Department's web site. The revised Actuarial Memorandum requirements are found in the "Actuarial Memorandum" section of this checklist.</p> <p>Rates must be submitted in a separate SERFF filing from policy forms.</p>	N/A
Rate Filing Submission		Rate Filings must be submitted in their entirety into both SERFF and the Web Portal for review.	N/A
TOI (Type of Insurance)		<p>A health insurance issuer offering any group or individual health insurance coverage, including managed care and HMO plans (regardless of whether the plans are grandfathered or non-grandfathered) must submit all new rate filings and rate revisions for review.</p> <p>Inserted directly below is a link to SERFF's Website for the TOI's required.</p> <p>http://www.serff.com/documents/index_ppaca_tois.pdf</p>	This is completed in the filing header.
Federal Unified Rate Review Templates		<p>Parts I and III must be submitted with each filing.</p> <p>Parts I and III are required to be completed and Submitted for all rate increases the issuer has in a state. Link to the Rate Review Templates:</p> <p>https://www.qhpcertification.cms.gov/s/Unified%20Rate%20Review</p>	This is completed in the URRT tab and the Supporting Documentation Tab "Unified Rate Review Template".
Rate Data Collection Form		<p>The filing must contain an Excel spreadsheet (.xls or .xlsx format), along with a PDF version of the spreadsheet, according to format found at http://www2.illinois.gov/sites/Insurance/Companies/Documents/Experience.xlsx</p>	This is completed in Supporting Documentation Tab "Rate Data Collection Form"

COMPANY REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
Actuarial Memorandum		<p>The Actuarial Memorandum is required and is to contain the complete justification for the submitted rates, including background information and an explanation of the rationale for the requested rate action, as well as other relevant information. The small group or individual Actuarial Memorandum requirements checklist must be completed for each filing.</p> <p>Small Group Checklist: http://www2.illinois.gov/sites/Insurance/Companies/documents/RateReviewChecklistSmallGroup.pdf</p> <p>Individual Checklist: http://www2.illinois.gov/sites/Insurance/Companies/documents/RateReviewChecklistIndividual.pdf</p>	This is completed in Supporting Documentation Tab "Actuarial Memorandum" section.
Actuarial Certification		The Actuarial Certification must be completed for all filings. http://www2.illinois.gov/sites/Insurance/Companies/documents/ActuarialCertificationForRateFilings.pdf	This is completed in Supporting Documentation Tab "Actuarial Memorandum" section.
Rate Schedules/Manuals		Shall be attached in SERFF as separate attachments from other documents required in SERFF.	This is completed in Rate/Rule Schedule Tab.
HHS Rate Data Requirements		Data required to be entered in the Rate Review Detail tab in SERFF must be complete and accurate. DOI does not require all of this data for rate review but HHS reviews the data contained in this section for accuracy.	This is completed in Rate/Rule Schedule Tab.
Public Access	215 ILCS 5/404	In order to maintain confidentiality, the Actuarial Memorandum should be attached in the Supporting Documentations Tab. It should be attached separately from any other attachments. Also, it is necessary to name them as Actuarial Memorandums to assist DOI in recognizing the type of document that is being attached.	This is completed in Supporting Documentation Tab "Actuarial Memorandum" section.
Have you included the following forms?		<ol style="list-style-type: none"> 1. Federal Unified Rate Review Template 2. Rate Data Collection Form 3. Actuarial Memorandum 4. Actuarial Certification 	This is completed in Supporting Documentation Tab.

CERTIFICATE OF COMPLIANCE

Health Care Service Corporation, a Mutual Legal Reserve Company

(Company Name)

By: Justin Capp

Title: VP Sales Operations

certifies that the policy forms submitted or referenced in this filing do comply:

- a) with all provisions of the Illinois Insurance Code applicable to the policy forms; and
- b) with all provisions of 50 Ill. Adm. Code applicable to policy forms;

and does further certify to the best of our knowledge and belief that:

- 1) the forms do not contain any inconsistent, ambiguous or misleading clauses;
- 2) the forms do not contain specifications or conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy forms;
- 3) the only variation from the usual provisions of the policy forms are clearly marked or otherwise indicated;
- 4) the language of the policy form, as submitted or approved, shall be exactly as it has been or will be offered for issuance or delivery in the State of Illinois as approved by the Director, except for hypothetical data and other appropriate variable material; and
- 5) the policy forms do not contain any provision or clause currently being disapproved by the Director.

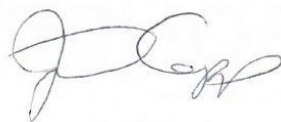
In utilizing the procedure for policy form filing and approval set forth in 50 Ill. Adm. Code 916, Health Care Service Corporation hereby expressly agrees and consents to a review, by the Director, to be made at any time, and further hereby expressly agrees and consents to the discontinuance by the company of future use of the approved policy forms, 30 days from the date of mailing an order of withdrawal issued by the Director pursuant to Section 143(1) of the Illinois Insurance Code. The order shall set forth the reasons why the previously approved policy forms are violative of or contrary to the provisions of the Illinois Insurance Code or all provisions of 50 Ill. Adm. Code applicable to policy forms. Each company shall have the right to request a hearing within that 30 day period. The request shall be made in writing to the Director. The order of withdrawal shall be stayed and the company shall be given a hearing under the provisions of Sections 143(1), 401(c), 401.1, 402(2), 426 and 429 of the Illinois Insurance Code [215 ILCS 5/143(1), 401(c), 401.1, 402(2), 426 and 429] and 50 Ill. Adm. Code 2402, as may be applicable, to determine:

- a) whether the policy form shall be disapproved; and
- b) whether further orders of the Director may be appropriate.

Health Care Service Corporation, a Mutual Legal Reserve Company

(Company Name)

By:



(Signature)

Title: VP Sales Operations

Date: 5/27/2025