Filing at a Glance

Company:	Asuris Northwest Health
Product Name:	2026 Nongrandfathered Individual Rate Filing ANH
State:	Washington
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Rate
Date Submitted:	05/15/2025
SERFF Tr Num:	RGWA-134498926
SERFF Status:	Assigned
State Tr Num:	484661
State Status:	Review Pending
Co Tr Num:	ASURINH533OE
Effective Date Requested:	01/01/2026
Author(s):	Paul Harmon, Daniel Boeder, Isaac Justus, Julia Shabalov, Lisa Mudgett, Janessa Sanchez, Chris Jasperson, Brittany Chan, Jaakob Sundberg, Andy Seymore, Mary Katayama, Summer Baek, Trey Norton
Reviewer(s):	Rocky Patterson II (primary), Amy Peach
Disposition Date:	
Disposition Status:	
Effective Date:	
Destruction Date:	

State Filing Description:

State: *Washington* ***Filing Company:*** *Asuris Northwest Health*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Nongrandfathered Individual Rate Filing ANH*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact: 15.15%

Deemer Date:
Submitted By: Jaakob Sundberg

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/15/2025
State Status Changed: 05/15/2025
Created By: Jaakob Sundberg
Corresponding Filing Tracking Number: RGWA-WA26-125119774, RGWA-134490715

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions:

Outside Market Only

Filing Description:
This filing was prepared with the intention of following the Speed to Market Tools.

Company and Contact

Filing Contact Information

Dan Boeder, Manager, Actuarial Pricing
200 SW Market St
11th Floor
Portland, OR 97201

daniel.boeder@cambiahealth.com
206-332-5619 [Phone]

Filing Company Information

Asuris Northwest Health
1111 Lake Washington Blvd N
Suite 900
Renton, WA 98056
(888) 344-6347 ext. [Phone]

CoCode: 47350
Group Code:
Group Name:
FEIN Number: 91-0495743

State of Domicile: Washington
Company Type:
State ID Number:

State: *Washington* ***Filing Company:*** *Asuris Northwest Health*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Nongrandfathered Individual Rate Filing ANH*
Project Name/Number: */*

Filing Fees

State Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

If you are filing a Healthcare or Disability filing, is the Co Tracking # field populated on the General Information Tab? (yes/no): Yes
Form Tab Only - Are the Form # and Form Description fields populated corresponding to the attached form? (yes/no): Yes
If your are submitting a File and Use product, have you populated the Implementation Date field? (yes/no): Yes

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

Correspondence Summary

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Notice for Second Set of Rates Review Process	Note To Filer	Rocky Patterson II	05/19/2025	05/19/2025
Rate Request Summary	Reviewer Note	Kelli Armfield	05/27/2025	

State: *Washington* ***Filing Company:*** *Asuris Northwest Health*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Nongrandfathered Individual Rate Filing ANH*
Project Name/Number: */*

Note To Filer

Created By:

Rocky Patterson II on 05/19/2025 05:51 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:47 PM

Subject:

Notice for Second Set of Rates Review Process

Comments:

We are sending this note to clarify when you should update the second set of rate documents included in your rate filing.
Do NOT update the second set of rate documents submitted under the Supporting Documentation tab in SERFF during the normal objection-and-response process, unless an objection specifically instructs you to do so.
Do NOT update the Company Rate Information or Rate Review Detail sections in SERFF unless an objection explicitly requests it.
If a material change in federal or state law occurs during the review process, the OIC will send an objection with instructions on how to make the necessary updates to your filing.
Please note that only one set of rates may remain active when the OIC takes a positive final action on a rate filing. At the appropriate time, we will send an objection instructing you on how to finalize the rate filing and deactivate the unused set of rates.

State: *Washington* ***Filing Company:*** *Asuris Northwest Health*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Nongrandfathered Individual Rate Filing ANH*
Project Name/Number: */*

Reviewer Note

Created By:

Kelli Armfield on 05/27/2025 12:46 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:47 PM

Subject:

Rate Request Summary

Comments:

See attached

Asuris Northwest Health – Individual plans

This information is supplied by the company. It has not been verified by the Office of the Insurance Commissioner and may change.

Overview

Requested rate change: 15.15% *average**
Requested effective date: Jan. 1, 2026
Plans impacted: Asuris Northwest Health's Individual plans
People impacted: 964
Counties: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman

Key information used to develop the rate request

(Jan. 2024 - Dec. 2024)

Premiums	$6,589,078
Claims	$7,883,687
Administrative expenses	$904,373
Risk adjustment	$960,505
Company lost	**-$1,238,476**

The company expects its annual medical costs to increase 10.40%.

How it plans to spend your premium

If these rates are approved, here's how your insurance company plans to spend your premium in 2026:

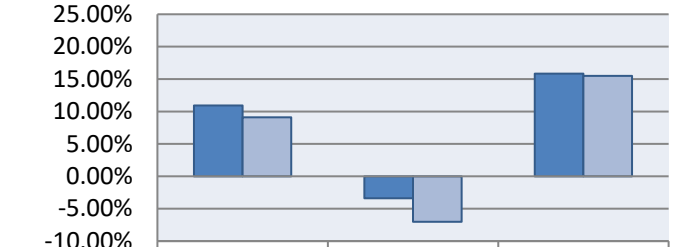
Claims: 85.81**%**
Administration: 10.69**%**
Profit: 3.50**%**

Are there any benefit changes?

Yes. To see a description of the changes, look for the attachment called "Uniform Product Modification Justification" in the 'initial request'.

***Your premium may vary based on the plan you choose, your age, the age and number of family members covered, where you live, and whether you or your family members smoke.*

Company's annual rate request history *(Data source: previous OIC decision memos)*



	2023	2024	2025
Requested	10.93%	-3.39%	15.84%
Accepted	9.10%	-7.03%	15.49%

Need Help?

- Call our Insurance Consumer Hotline at 1-800-562-6900
- 8 a.m. to 5 p.m., Monday – Friday.

Glossary

Actuarial value: The average share or percentage of essential health benefits that are paid by the plan compared to what you pay out-of-pocket. For example, in a plan with a 70% actuarial value, the plan pays for 70% of your covered expenses for essential health benefits and you pay the rest through deductibles, copays and coinsurance.

Administrative expenses: Any expenses not related to medical claims including employee and executive salaries, the cost of the company's offices and equipment, agent commissions, and taxes.

Annual rate change: Companies normally file a rate change each year due to their medical claims experience. The annual rate request may or may not include benefit changes.

Average rate change: The average amount rates will change for all plan members. The amount of your rate change may vary based on the plan you choose, your age, the age and number of family members covered, where you live, and whether you or your family members smoke.

Cascade Care: Enacted by the Washington state Legislature in 2020, Cascade Care created new coverage options (standardized plans and public option plans) that are available through Washington Healthplanfinder.

Catastrophic health plan: A health plan that covers the essential health benefits, but only after you've met your out-of-pocket maximum (in 2026, it's $10,150 for individual coverage and $20,300 for family coverage). These plans are only available to people under age 30 and to people the Washington Health Benefit Exchange has determined can't afford the other plans.

Essential health benefits: All individual and small group health plans must cover these 10 benefits: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services – including oral and vision care.

Geographical regions: Rates for each health plan may differ by nine geographical areas. The areas include:

Geographical region	Counties
Area 1	*King*
Area 2	*Clallam, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Pacific, and Wahkiakum*
Area 3	*Clark, Klickitat, and Skamania*
Area 4	*Ferry, Lincoln, Pend Oreille, Spokane, and Stevens*
Area 5	*Mason, Pierce, and Thurston*
Area 6	*Benton, Franklin, Kittitas, and Yakima*
Area 7	*Adams, Chelan, Douglas, Grant, and Okanogan*
Area 8	*Island, San Juan, Skagit, Snohomish, and Whatcom*
Area 9	*Asotin, Columbia, Garfield, Walla Walla, and Whitman*

Health Benefit Exchange (HBE): Under health reform, states are required to set up health insurance marketplaces, called Exchanges. Washington state's Exchange is a public/private partnership overseen by an 11-member board. It's charged with creating and running an online marketplace, wahealthplanfinder.org.

Healthplanfinder: An online marketplace, wahealthplanfinder.org, run by Washington's Health Benefit Exchange, where you can shop for individual and small employer health plans. Here, you can compare plans, get free unbiased help understanding your options, and depending on your income, get help paying for coverage.

Medical costs: What the health plan spends on direct medical services including hospital stays, providers, and prescription drugs.

Medical Loss Ratio rebate: The Affordable Care Act requires health insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR standards require insurers to spend at least 80% or 85% of premium dollars on medical care. If they fail to meet these standards, they are required to provide a rebate to their customers.

Metal levels: Individual and small group health plans can have four different metal levels – bronze, silver, gold, and platinum – based on the level of coverage they provide for essential health benefits ("actuarial value"). For example, bronze plans cover 60% of the cost of medical services, silver plans cover 70%, gold plans cover 80%, and platinum plans cover 90%.

Profit: The amount of money remaining after paying claims and administrative expenses.

Public Option plan: A qualified health plan that has a standardized benefit design and meets additional quality and value requirements.

Qualified Health Plan (QHP): A health plan that is certified to be sold through wahealthplanfinder.org and that provides the essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

Risk Adjustment: The Affordable Care Act established a permanent risk adjustment program to reduce incentives for health insurance plans to avoid covering people with pre-existing conditions or those in poor health. The risk adjustment program transfers funds from lower-risk plans to higher-risk plans annually.

Standardized (or Standard) plan: A qualified health plan that has a standard benefit design across health insurers.

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	Electronic
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	15.490%
Effective Date of Last Rate Revision:	01/01/2025
Filing Method of Last Filing:	Electronic
SERFF Tracking Number of Last Filing:	RGWA-134064617

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):
Asuris Northwest Health	Increase	15.150%	15.150%	$996,923	563	$7,847,105	15.870%	14.480%

State: *Washington* ***Filing Company:*** *Asuris Northwest Health*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Nongrandfathered Individual Rate Filing ANH*
Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name: Asuris Northwest Health
HHS Issuer Id: 69364

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Asuris Direct EPO	69364WA122		964

Trend Factors: This filing uses an overall annual trend of 10.4%

FORMS:

New Policy Forms:
Affected Forms: N/A
Other Affected Forms: WA0126PEPOD, WA0126PHSEPOD, WA0125PESEPOD

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 11,716
Benefit Change: None
Percent Change Requested: Min: 14.5 Max: 15.9 Avg: 15.2

PRIOR RATE:

Total Earned Premium: 7,847,105.00
Total Incurred Claims: 7,984,961.00
Annual $: Min: 246.00 Max: 1,841.00 Avg: 664.00

REQUESTED RATE:

Projected Earned Premium: 8,844,028.00
Projected Incurred Claims: 8,499,155.00
Annual $: Min: 279.00 Max: 2,117.00 Avg: 764.00

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		2026 ANH Rate Sheets	WA0126PEPOD, WA0126PHSEPOD, WA0125PESEPOD	Revised	Previous State Filing Number: RGWA-134064617 Percent Rate Change Request: 15.15	Rate Schedule Duplicate.xlsx, Rate Schedule.pdf, ANH IND Rating Example.pdf,

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Bronze HSA 7750
HIOS Plan ID: 69364WA1220006
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				291.49		308.46	333.75		327.58				291.49		308.46	333.75		327.58
15				317.40		335.87	363.41		356.69				317.40		335.87	363.41		356.69
16				327.31		346.36	374.76		367.83				327.31		346.36	374.76		367.83
17				337.21		356.84	386.10		378.96				337.21		356.84	386.10		378.96
18				347.88		368.13	398.32		390.95				347.88		368.13	398.32		390.95
19				358.55		379.42	410.53		402.94				358.55		379.42	410.53		402.94
20				369.60		391.11	423.18		415.36				369.60		391.11	423.18		415.36
21				381.03		403.21	436.27		428.21				381.03		403.21	436.27		428.21
22				381.03		403.21	436.27		428.21				381.03		403.21	436.27		428.21
23				381.03		403.21	436.27		428.21				381.03		403.21	436.27		428.21
24				381.03		403.21	436.27		428.21				381.03		403.21	436.27		428.21
25				382.55		404.82	438.02		429.92				382.55		404.82	438.02		429.92
26				390.18		412.89	446.75		438.49				390.18		412.89	446.75		438.49
27				399.32		422.56	457.21		448.76				399.32		422.56	457.21		448.76
28				414.18		438.29	474.23		465.46				414.18		438.29	474.23		465.46
29				426.37		451.19	488.19		479.16				426.37		451.19	488.19		479.16
30				432.47		457.64	495.17		486.01				432.47		457.64	495.17		486.01
31				441.62		467.32	505.64		496.29				441.62		467.32	505.64		496.29
32				450.77		477.00	516.11		506.57				450.77		477.00	516.11		506.57
33				456.48		483.05	522.66		513.00				456.48		483.05	522.66		513.00
34				462.58		489.50	529.64		519.85				462.58		489.50	529.64		519.85
35				465.62		492.72	533.12		523.27				465.62		492.72	533.12		523.27
36				468.67		495.95	536.62		526.70				468.67		495.95	536.62		526.70
37				471.72		499.17	540.10		530.12				471.72		499.17	540.10		530.12
38				474.77		502.40	543.60		533.55				474.77		502.40	543.60		533.55
39				480.86		508.85	550.58		540.40				480.86		508.85	550.58		540.40
40				486.96		515.30	557.55		547.25				486.96		515.30	557.55		547.25
41				496.11		524.98	568.03		557.53				496.11		524.98	568.03		557.53
42				504.87		534.25	578.06		567.37				504.87		534.25	578.06		567.37
43				517.07		547.16	592.03		581.08				517.07		547.16	592.03		581.08
44				532.30		563.28	609.47		598.20				532.30		563.28	609.47		598.20
45				550.22		582.24	629.98		618.34				550.22		582.24	629.98		618.34
46				571.55		604.82	654.42		642.32				571.55		604.82	654.42		642.32
47				595.56		630.22	681.90		669.29				595.56		630.22	681.90		669.29
48				622.99		659.25	713.31		700.12				622.99		659.25	713.31		700.12
49				650.05		687.88	744.29		730.53				650.05		687.88	744.29		730.53
50				680.52		720.13	779.18		764.78				680.52		720.13	779.18		764.78
51				710.63		751.99	813.65		798.61				710.63		751.99	813.65		798.61
52				743.78		787.07	851.61		835.87				743.78		787.07	851.61		835.87
53				777.31		822.55	890.00		873.55				777.31		822.55	890.00		873.55
54				813.50		860.85	931.44		914.22				813.50		860.85	931.44		914.22
55				849.71		899.16	972.89		954.91				849.71		899.16	972.89		954.91
56				888.95		940.69	1017.83		999.01				888.95		940.69	1017.83		999.01
57				928.58		982.62	1063.19		1043.54				928.58		982.62	1063.19		1043.54
58				970.87		1027.38	1111.63		1091.08				970.87		1027.38	1111.63		1091.08
59				991.83		1049.56	1135.62		1114.63				991.83		1049.56	1135.62		1114.63
60				1034.12		1094.31	1184.04		1162.16				1034.12		1094.31	1184.04		1162.16
61				1070.70		1133.02	1225.93		1203.27				1070.70		1133.02	1225.93		1203.27
62				1094.71		1158.42	1253.41		1230.24				1094.71		1158.42	1253.41		1230.24
63				1124.81		1190.28	1287.88		1264.08				1124.81		1190.28	1287.88		1264.08
64 and over				1143.09		1209.63	1308.81		1284.63				1143.09		1209.63	1308.81		1284.63

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Bronze Essential 9000
HIOS Plan ID: 69364WA1220004
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				279.40		295.66	319.90		313.99				279.40		295.66	319.90		313.99
15				304.24		321.95	348.35		341.91				304.24		321.95	348.35		341.91
16				313.73		331.99	359.21		352.57				313.73		331.99	359.21		352.57
17				323.23		342.04	370.09		363.25				323.23		342.04	370.09		363.25
18				333.46		352.87	381.81		374.75				333.46		352.87	381.81		374.75
19				343.69		363.69	393.51		386.24				343.69		363.69	393.51		386.24
20				354.28		374.90	405.64		398.14				354.28		374.90	405.64		398.14
21				365.23		386.49	418.18		410.45				365.23		386.49	418.18		410.45
22				365.23		386.49	418.18		410.45				365.23		386.49	418.18		410.45
23				365.23		386.49	418.18		410.45				365.23		386.49	418.18		410.45
24				365.23		386.49	418.18		410.45				365.23		386.49	418.18		410.45
25				366.70		388.04	419.86		412.10				366.70		388.04	419.86		412.10
26				374.00		395.77	428.22		420.31				374.00		395.77	428.22		420.31
27				382.76		405.04	438.25		430.15				382.76		405.04	438.25		430.15
28				397.00		420.11	454.56		446.16				397.00		420.11	454.56		446.16
29				408.69		432.48	467.94		459.29				408.69		432.48	467.94		459.29
30				414.54		438.67	474.64		465.87				414.54		438.67	474.64		465.87
31				423.30		447.94	484.67		475.71				423.30		447.94	484.67		475.71
32				432.07		457.22	494.71		485.57				432.07		457.22	494.71		485.57
33				437.55		463.02	500.99		491.73				437.55		463.02	500.99		491.73
34				443.39		469.20	507.67		498.29				443.39		469.20	507.67		498.29
35				446.31		472.29	511.02		501.57				446.31		472.29	511.02		501.57
36				449.23		475.38	514.36		504.85				449.23		475.38	514.36		504.85
37				452.15		478.47	517.70		508.14				452.15		478.47	517.70		508.14
38				455.08		481.57	521.06		511.43				455.08		481.57	521.06		511.43
39				460.92		487.75	527.75		517.99				460.92		487.75	527.75		517.99
40				466.76		493.93	534.43		524.55				466.76		493.93	534.43		524.55
41				475.53		503.21	544.47		534.41				475.53		503.21	544.47		534.41
42				483.93		512.10	554.09		543.85				483.93		512.10	554.09		543.85
43				495.62		524.47	567.48		556.99				495.62		524.47	567.48		556.99
44				510.23		539.93	584.20		573.41				510.23		539.93	584.20		573.41
45				527.40		558.09	603.85		592.69				527.40		558.09	603.85		592.69
46				547.85		579.74	627.28		615.68				547.85		579.74	627.28		615.68
47				570.86		604.08	653.61		641.53				570.86		604.08	653.61		641.53
48				597.15		631.91	683.73		671.09				597.15		631.91	683.73		671.09
49				623.09		659.35	713.42		700.23				623.09		659.35	713.42		700.23
50				652.31		690.27	746.87		733.07				652.31		690.27	746.87		733.07
51				681.16		720.80	779.91		765.49				681.16		720.80	779.91		765.49
52				712.94		754.43	816.29		801.20				712.94		754.43	816.29		801.20
53				745.08		788.44	853.09		837.32				745.08		788.44	853.09		837.32
54				779.78		825.16	892.82		876.32				779.78		825.16	892.82		876.32
55				814.47		861.87	932.54		915.31				814.47		861.87	932.54		915.31
56				852.09		901.68	975.62		957.58				852.09		901.68	975.62		957.58
57				890.08		941.88	1019.11		1000.28				890.08		941.88	1019.11		1000.28
58				930.62		984.78	1065.53		1045.84				930.62		984.78	1065.53		1045.84
59				950.70		1006.03	1088.52		1068.40				950.70		1006.03	1088.52		1068.40
60				991.24		1048.93	1134.94		1113.96				991.24		1048.93	1134.94		1113.96
61				1026.31		1086.04	1175.10		1153.37				1026.31		1086.04	1175.10		1153.37
62				1049.32		1110.39	1201.44		1179.23				1049.32		1110.39	1201.44		1179.23
63				1078.17		1140.92	1234.48		1211.66				1078.17		1140.92	1234.48		1211.66
64 and over				1095.69		1159.47	1254.54		1231.35				1095.69		1159.47	1254.54		1231.35

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Bronze 8000
HIOS Plan ID: 69364WA1220016
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				291.96		308.95	334.28		328.10				291.96		308.95	334.28		328.10
15				317.91		336.41	364.00		357.27				317.91		336.41	364.00		357.27
16				327.83		346.91	375.36		368.42				327.83		346.91	375.36		368.42
17				337.75		357.41	386.72		379.57				337.75		357.41	386.72		379.57
18				348.44		368.72	398.96		391.58				348.44		368.72	398.96		391.58
19				359.12		380.02	411.18		403.58				359.12		380.02	411.18		403.58
20				370.18		391.73	423.85		416.02				370.18		391.73	423.85		416.02
21				381.64		403.85	436.97		428.89				381.64		403.85	436.97		428.89
22				381.64		403.85	436.97		428.89				381.64		403.85	436.97		428.89
23				381.64		403.85	436.97		428.89				381.64		403.85	436.97		428.89
24				381.64		403.85	436.97		428.89				381.64		403.85	436.97		428.89
25				383.17		405.47	438.72		430.61				383.17		405.47	438.72		430.61
26				390.80		413.54	447.45		439.18				390.80		413.54	447.45		439.18
27				399.95		423.23	457.93		449.47				399.95		423.23	457.93		449.47
28				414.84		438.98	474.98		466.20				414.84		438.98	474.98		466.20
29				427.05		451.91	488.97		479.93				427.05		451.91	488.97		479.93
30				433.16		458.37	495.96		486.79				433.16		458.37	495.96		486.79
31				442.32		468.06	506.44		497.08				442.32		468.06	506.44		497.08
32				451.47		477.75	516.93		507.37				451.47		477.75	516.93		507.37
33				457.20		483.81	523.48		513.81				457.20		483.81	523.48		513.81
34				463.31		490.27	530.47		520.67				463.31		490.27	530.47		520.67
35				466.36		493.50	533.97		524.10				466.36		493.50	533.97		524.10
36				469.42		496.74	537.47		527.54				469.42		496.74	537.47		527.54
37				472.47		499.97	540.97		530.97				472.47		499.97	540.97		530.97
38				475.52		503.20	544.46		534.40				475.52		503.20	544.46		534.40
39				481.63		509.66	551.45		541.26				481.63		509.66	551.45		541.26
40				487.73		516.12	558.44		548.12				487.73		516.12	558.44		548.12
41				496.89		525.81	568.93		558.41				496.89		525.81	568.93		558.41
42				505.67		535.10	578.98		568.28				505.67		535.10	578.98		568.28
43				517.88		548.02	592.96		582.00				517.88		548.02	592.96		582.00
44				533.15		564.18	610.44		599.16				533.15		564.18	610.44		599.16
45				551.09		583.16	630.98		619.32				551.09		583.16	630.98		619.32
46				572.46		605.78	655.45		643.34				572.46		605.78	655.45		643.34
47				596.50		631.22	682.98		670.36				596.50		631.22	682.98		670.36
48				623.97		660.29	714.43		701.23				623.97		660.29	714.43		701.23
49				651.08		688.97	745.47		731.69				651.08		688.97	745.47		731.69
50				681.61		721.28	780.42		766.00				681.61		721.28	780.42		766.00
51				711.76		753.18	814.94		799.88				711.76		753.18	814.94		799.88
52				744.96		788.32	852.96		837.20				744.96		788.32	852.96		837.20
53				778.54		823.85	891.41		874.93				778.54		823.85	891.41		874.93
54				814.80		862.22	932.92		915.68				814.80		862.22	932.92		915.68
55				851.06		900.59	974.44		956.43				851.06		900.59	974.44		956.43
56				890.36		942.18	1019.44		1000.60				890.36		942.18	1019.44		1000.60
57				930.05		984.18	1064.88		1045.20				930.05		984.18	1064.88		1045.20
58				972.41		1029.01	1113.39		1092.81				972.41		1029.01	1113.39		1092.81
59				993.40		1051.22	1137.42		1116.40				993.40		1051.22	1137.42		1116.40
60				1035.77		1096.05	1185.93		1164.01				1035.77		1096.05	1185.93		1164.01
61				1072.40		1134.82	1227.88		1205.18				1072.40		1134.82	1227.88		1205.18
62				1096.45		1160.26	1255.40		1232.20				1096.45		1160.26	1255.40		1232.20
63				1126.60		1192.17	1289.93		1266.08				1126.60		1192.17	1289.93		1266.08
64 and over				1144.91		1211.55	1310.90		1286.67				1144.91		1211.55	1310.90		1286.67

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Gold 2000
HIOS Plan ID: 69364WA1220014
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Gold
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				410.04		433.91	469.49		460.81				410.04		433.91	469.49		460.81
15				446.49		472.48	511.22		501.77				446.49		472.48	511.22		501.77
16				460.42		487.22	527.17		517.43				460.42		487.22	527.17		517.43
17				474.36		501.97	543.13		533.09				474.36		501.97	543.13		533.09
18				489.37		517.85	560.31		549.96				489.37		517.85	560.31		549.96
19				504.38		533.74	577.51		566.83				504.38		533.74	577.51		566.83
20				519.92		550.18	595.29		584.29				519.92		550.18	595.29		584.29
21				536.00		567.20	613.71		602.37				536.00		567.20	613.71		602.37
22				536.00		567.20	613.71		602.37				536.00		567.20	613.71		602.37
23				536.00		567.20	613.71		602.37				536.00		567.20	613.71		602.37
24				536.00		567.20	613.71		602.37				536.00		567.20	613.71		602.37
25				538.15		569.47	616.17		604.78				538.15		569.47	616.17		604.78
26				548.87		580.81	628.44		616.82				548.87		580.81	628.44		616.82
27				561.74		594.43	643.17		631.28				561.74		594.43	643.17		631.28
28				582.64		616.55	667.11		654.78				582.64		616.55	667.11		654.78
29				599.79		634.70	686.75		674.05				599.79		634.70	686.75		674.05
30				608.36		643.77	696.56		683.68				608.36		643.77	696.56		683.68
31				621.22		657.38	711.29		698.14				621.22		657.38	711.29		698.14
32				634.10		671.00	726.02		712.60				634.10		671.00	726.02		712.60
33				642.14		679.51	735.23		721.64				642.14		679.51	735.23		721.64
34				650.71		688.58	745.04		731.27				650.71		688.58	745.04		731.27
35				655.00		693.12	749.96		736.09				655.00		693.12	749.96		736.09
36				659.29		697.66	754.87		740.91				659.29		697.66	754.87		740.91
37				663.57		702.19	759.77		745.73				663.57		702.19	759.77		745.73
38				667.86		706.73	764.68		750.55				667.86		706.73	764.68		750.55
39				676.44		715.81	774.51		760.19				676.44		715.81	774.51		760.19
40				685.01		724.88	784.32		769.82				685.01		724.88	784.32		769.82
41				697.87		738.49	799.05		784.28				697.87		738.49	799.05		784.28
42				710.21		751.54	813.17		798.14				710.21		751.54	813.17		798.14
43				727.36		769.69	832.80		817.41				727.36		769.69	832.80		817.41
44				748.80		792.38	857.36		841.51				748.80		792.38	857.36		841.51
45				773.99		819.04	886.20		869.82				773.99		819.04	886.20		869.82
46				804.01		850.80	920.57		903.55				804.01		850.80	920.57		903.55
47				837.77		886.53	959.23		941.49				837.77		886.53	959.23		941.49
48				876.36		927.37	1003.41		984.87				876.36		927.37	1003.41		984.87
49				914.42		967.64	1046.99		1027.63				914.42		967.64	1046.99		1027.63
50				957.30		1013.02	1096.09		1075.83				957.30		1013.02	1096.09		1075.83
51				999.65		1057.83	1144.57		1123.42				999.65		1057.83	1144.57		1123.42
52				1046.28		1107.17	1197.96		1175.81				1046.28		1107.17	1197.96		1175.81
53				1093.45		1157.09	1251.97		1228.83				1093.45		1157.09	1251.97		1228.83
54				1144.37		1210.97	1310.27		1286.05				1144.37		1210.97	1310.27		1286.05
55				1195.29		1264.86	1368.58		1343.28				1195.29		1264.86	1368.58		1343.28
56				1250.50		1323.28	1431.79		1405.32				1250.50		1323.28	1431.79		1405.32
57				1306.25		1382.27	1495.62		1467.97				1306.25		1382.27	1495.62		1467.97
58				1365.74		1445.23	1563.74		1534.83				1365.74		1445.23	1563.74		1534.83
59				1395.22		1476.42	1597.49		1567.96				1395.22		1476.42	1597.49		1567.96
60				1454.71		1539.38	1665.61		1634.82				1454.71		1539.38	1665.61		1634.82
61				1506.17		1593.83	1724.52		1692.65				1506.17		1593.83	1724.52		1692.65
62				1539.94		1629.57	1763.19		1730.60				1539.94		1629.57	1763.19		1730.60
63				1582.28		1674.37	1811.67		1778.18				1582.28		1674.37	1811.67		1778.18
64 and over				1608.00		1701.60	1841.13		1807.10				1608.00		1701.60	1841.13		1807.10

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Silver 5000
HIOS Plan ID: 69364WA1220008
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Silver
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				331.48		350.77	379.53		372.52				331.48		350.77	379.53		372.52
15				360.94		381.95	413.27		405.63				360.94		381.95	413.27		405.63
16				372.21		393.87	426.17		418.29				372.21		393.87	426.17		418.29
17				383.47		405.79	439.06		430.95				383.47		405.79	439.06		430.95
18				395.61		418.63	452.96		444.59				395.61		418.63	452.96		444.59
19				407.74		431.47	466.85		458.22				407.74		431.47	466.85		458.22
20				420.30		444.76	481.23		472.34				420.30		444.76	481.23		472.34
21				433.30		458.52	496.12		486.95				433.30		458.52	496.12		486.95
22				433.30		458.52	496.12		486.95				433.30		458.52	496.12		486.95
23				433.30		458.52	496.12		486.95				433.30		458.52	496.12		486.95
24				433.30		458.52	496.12		486.95				433.30		458.52	496.12		486.95
25				435.03		460.35	498.10		488.89				435.03		460.35	498.10		488.89
26				443.70		469.52	508.02		498.63				443.70		469.52	508.02		498.63
27				454.10		480.53	519.93		510.32				454.10		480.53	519.93		510.32
28				471.00		498.41	539.28		529.31				471.00		498.41	539.28		529.31
29				484.86		513.08	555.15		544.89				484.86		513.08	555.15		544.89
30				491.80		520.42	563.09		552.69				491.80		520.42	563.09		552.69
31				502.19		531.42	575.00		564.37				502.19		531.42	575.00		564.37
32				512.60		542.43	586.91		576.06				512.60		542.43	586.91		576.06
33				519.10		549.31	594.35		583.37				519.10		549.31	594.35		583.37
34				526.02		556.64	602.28		591.15				526.02		556.64	602.28		591.15
35				529.49		560.31	606.26		595.05				529.49		560.31	606.26		595.05
36				532.96		563.98	610.23		598.95				532.96		563.98	610.23		598.95
37				536.43		567.65	614.20		602.84				536.43		567.65	614.20		602.84
38				539.90		571.32	618.17		606.74				539.90		571.32	618.17		606.74
39				546.82		578.65	626.10		614.53				546.82		578.65	626.10		614.53
40				553.76		585.99	634.04		622.32				553.76		585.99	634.04		622.32
41				564.16		596.99	645.94		634.00				564.16		596.99	645.94		634.00
42				574.13		607.54	657.36		645.21				574.13		607.54	657.36		645.21
43				587.99		622.21	673.23		660.79				587.99		622.21	673.23		660.79
44				605.32		640.55	693.08		680.26				605.32		640.55	693.08		680.26
45				625.68		662.10	716.39		703.15				625.68		662.10	716.39		703.15
46				649.95		687.78	744.18		730.42				649.95		687.78	744.18		730.42
47				677.25		716.67	775.44		761.10				677.25		716.67	775.44		761.10
48				708.45		749.68	811.15		796.16				708.45		749.68	811.15		796.16
49				739.22		782.24	846.38		830.74				739.22		782.24	846.38		830.74
50				773.88		818.92	886.07		869.69				773.88		818.92	886.07		869.69
51				808.11		855.14	925.26		908.16				808.11		855.14	925.26		908.16
52				845.80		895.03	968.42		950.52				845.80		895.03	968.42		950.52
53				883.93		935.38	1012.08		993.37				883.93		935.38	1012.08		993.37
54				925.10		978.94	1059.21		1039.63				925.10		978.94	1059.21		1039.63
55				966.26		1022.50	1106.35		1085.90				966.26		1022.50	1106.35		1085.90
56				1010.89		1069.73	1157.45		1136.05				1010.89		1069.73	1157.45		1136.05
57				1055.95		1117.41	1209.04		1186.69				1055.95		1117.41	1209.04		1186.69
58				1104.05		1168.31	1264.11		1240.75				1104.05		1168.31	1264.11		1240.75
59				1127.89		1193.53	1291.40		1267.53				1127.89		1193.53	1291.40		1267.53
60				1175.98		1244.42	1346.46		1321.57				1175.98		1244.42	1346.46		1321.57
61				1217.58		1288.44	1394.09		1368.32				1217.58		1288.44	1394.09		1368.32
62				1244.88		1317.33	1425.35		1399.00				1244.88		1317.33	1425.35		1399.00
63				1279.10		1353.55	1464.54		1437.47				1279.10		1353.55	1464.54		1437.47
64 and over				1299.90		1375.56	1488.36		1460.84				1299.90		1375.56	1488.36		1460.84

Rating Example

Individual rates are determined by multiplying the:

(A) plan base rate;
(B) age factor;
(C) tobacco factor; and
(D) rating area factor

Family rates are determined by summing rates for individual members. The charge for covered children under the age of 21 is capped at the three oldest. There is no limit to the number of children age 21 and over included in the family rate. Rates are rounded to the nearest penny after each rating factor is applied during separate calculation steps.

Example 1:
Subscriber only policy, age 35, tobacco user, living in Rating Area 4, choosing the Bronze Essential 9000 Plan.

Member	(A) Plan Base Rate	(B) Age Factor	(C) Tobacco Factor	(D) Rating Area Factor	Final Rate = (A) x (B) x (C) x (D)
Subscriber - Age 35, Tobacco user	$386.49	1.222	1.00	0.945	$446.31

Example 2:
Family policy including: the subscriber, age 47, non-tobacco user, living in Rating Area 4;
spouse, age 46, tobacco user;
dependent, age 24, tobacco user;
dependent, age 14, non-tobacco user;
dependent, age 12, non-tobacco user;
dependent, age 8, non-tobacco user; and
dependent, age 6, non-tobacco user;
choosing the Bronze Essential 9000 Plan.

Family Member	(A) Plan Base Rate	(B) Age Factor	(C) Tobacco Factor	(D) Rating Area Factor	Final Rate = (A) x (B) x (C) x (D)
Subscriber - Age 47, Non-tobacco user	$386.49	1.563	1.00	0.945	$570.86
Spouse - Age 46, Tobacco user	$386.49	1.500	1.00	0.945	$547.85
Dependent - Age 24, Tobacco user	$386.49	1.000	1.00	0.945	$365.23
Dependent - Age 14, Non-tobacco user	$386.49	0.765	1.00	0.945	$279.40
Dependent - Age 12, Non-tobacco user	$386.49	0.765	1.00	0.945	$279.40
Dependent - Age 8, Non-tobacco user	$386.49	0.765	1.00	0.945	$279.40
Dependent - Age 6, Non-tobacco user	$386.49	0.000	1.00	0.945	$0.00
		Total = Sum of Individual Rates =			$2,322.14

Note: Due to Rating System component methodology, rates may occasionally vary from the base rate multiplied by applicable factors due to rounding; generally the difference is one penny.

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

URRT

State Determination

Review Status:	Incomplete

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

URRT Items

Item Name	Attachment(s)
Unified Rate Review Template	*PartIUnifiedRateReviewTemplateDuplicate.xml*
Actuarial Memorandum	*PartIIIRateFilingDocumentationandActuarialMemorandum.pdf*
Actuarial Memorandum - Redacted	*PartIIIRateFilingDocumentationandActuarialMemorandumRedacted.pdf*
Consumer Justification Narrative	*PartIIWrittenDescriptionJustifyingtheRateIncrease.pdf*
Other Supporting Documents	*PartIUnifiedRateReviewTemplate_v1.pdf, ANHINDPartIIIAppendix_v1.pdf*

Asuris Northwest Health – Individual
Actuarial Memorandum and Certification – Part III
Rates Effective January 1, 2026

Table of Contents

Sections are generally numbered to be consistent with the current Unified Rate Review (URR) Instructions. Sections ending with a letter are not explicitly numbered in the URR Instructions; the labeling is added for organizational purposes.

4.1: Redacted Actuarial Memorandum

This document is intended to serve as both the "CMS Version" and the "public version" of the Part III Actuarial Memorandum; no items are redacted.

4.2: General Information

Company Identifying Information

- Company Legal Name: Asuris Northwest Health
- State: Washington
- HIOS Issuer ID: 69364
- Market: Individual
- Effective Date: January 1, 2026

Company Contact Information

- Primary Contact Name: Dan Boeder
- Primary Contact Telephone Number: (206) 332-5619
- Primary Contact Email Address: daniel.boeder@cambiahealth.com

Purpose

This Actuarial Memorandum is prepared to provide transparency regarding the assumptions and methods used to calculate the rates proposed in the Asuris Northwest Health (hereafter referred to as ANH) January 2026 Individual Filing. Information is also included, where applicable, to support the information shown in the Part I Unified Rate Review template (URRT). The intended purpose of this document is to demonstrate the proposed rates included in this filing and the template are reasonable in relationship to the benefits provided and meet all rating requirements in the applicable laws and regulations in the state of Washington. The intended audience for this document is the Washington State Office of the Insurance Commissioner (OIC).

Two Appendix exhibits show the key framework supporting the rate filing. The process to develop the rate change for this filing is shown in "Exhibit A1: Development of 2026 Rate Change." Development of the URRT projection period index rate is shown in "Exhibit E1: Development of 2026 Index Rate."

Please note in reviewing this memorandum and its accompanying exhibits that ANH developed rates directly from incurred claims experience. The URRT requires issuers to include an index rate calculation based on allowed claims experience following a prescribed calculation methodology. Because ANH does not develop rates on an allowed claims basis, the URRT was populated indirectly such that the resulting projected average premium was consistent with the underlying rate development. Explanations regarding how the URRT was populated, consistent with the URR instructions, are included throughout this memorandum and explained relative to the actual rate development.

Per the Unified Rate Review Instructions released March 2022, the actuary may state: *"The URRT 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."*

4.3: Proposed Rate Changes

This filing proposes an average annual rate change of 15.15% on January 1, 2026, for the Individual line of business, as shown in "Exhibit A1: Development of 2026 Rate Change." The 2026 projected average premium is $764.49 per member per month (PMPM).

The average annual rate change is calculated based on Individual enrollment data as of March 2025, and includes the mapped rate impact for membership enrolled in plans terminating in 2026. A summary of the rate changes by plan is shown in "Exhibit D1: 2026 Average Change in Plan Base Rates."

Factor Changes

This filing includes updates to the plan and area factors. Rating factor tables and changes since the last filing are shown in the "Rate Factors" document. The average annual rate change impact of 15.15% includes the impact of these factor changes and is on a member-weighted basis.

Plan pricing factors are updated using the most recent data and factors from the pricing relativity model, with benefit design changes incorporated. Rate differences between plans reflect objective plan design differences and not differences in population morbidity.

Based on OIC guidance, only on-exchange Silver plan premium should be increased to cover the additional costs associated with providing benefits to all Silver plan enrollees, in the event the CSR subsidies are not funded. In 2026, ANH is offering plans off-exchange only, and therefore no additional load for CSR has been applied to any plan.

Area factors reflect relative cost differences between rating areas and, as required, do not include differences for population morbidity by geographic area. Area factors were updated to reflect relative cost differences between rating areas based on changes in unit cost and normalized PMPM claims cost.

Starting in 2026, ANH will no longer use tobacco use as a rating factor for Individual products.

Pool Base Rate

The pool base rate is $643.08 as of January 1, 2026. The pool base rate is the starting amount such that multiplying the base rate by the member's rating factors (plan, age, and area) and adjusting for family composition results in the member's premium.

Reasons for Proposed Rate Change

The following components are the most significant factors contributing to the proposed rate change: medical trend and utilization and financial experience.

Medical Trend and Utilization: These adjustments refer to what is commonly known as healthcare trend. They reflect contractual changes in the the payments to healthcare providers and expected changes in the volume and types of services utilized by a carrier's members.

Financial Experience: Each year ANH evaluates the most recent financial results in the Washington Individual market and incorporates that information into pricing.

Changes in Network: Each year, ANH evaluates the impact of underlying provider network contracts and incorporates that information into pricing. Additionally, the impacts of discontinued and new networks are evaluated and incorporated.

Market Morbidity: ANH expects increased market morbidity due to the discontinuance of enhanced Premium Tax Credits.

The above descriptions are intended to provide an overall understanding of the significant factors contributing to the rate change, and each item is described in detail later in this memorandum.

The following table is a decomposition of the rate increase into the various underlying factors but is not intended to directly reflect or replace the rate calculation developed on Exhibit A1.

Contributing Factor	Approximate Impact
Changes due to Medical Trend and Utilization	10%
Changes due to Experience[1]	7%
Changes due to Network Arrangements	-6%
Changes Due to Market wide Average Morbidity	4%
Total	**15%**

[1]Includes the impact of overestimate or underestimate of medical trend

4.4: Market Experience

This filing demonstrates that ANH followed federal guidance and market reform rating requirements in establishing a single risk pool in the Washington Individual market. The experience data includes all of ANH 's non-grandfathered covered lives in the Washington Individual market. Throughout this filing, "single risk pool" refers to the entire Washington Individual market.

4.4.1: Experience Period Premium, Claims, and Enrollment

The premium and claims used to develop this filing were incurred during calendar year 2024 and includes payments and adjustments paid through March 2025. They are shown in "Exhibit E1: Development of 2026 Index Rate." Current enrollment and premium are reported as of March 2025.

For rate development purposes, experience from multiple years of ANH Individual was used. ANH Individual experience from 2022 and 2023, trended to the projection period were combined with the 2024 experience, weighted by enrollment, to arrive at a fully credible population.

ANH analyzes financial performances for each company and line of business regularly and over/under-predictions are corrected for in the rate development the following year. Overall, premium and claims experience is unfavorable compared to expectations in 2024. ANH included an adjustment to the rates to reflect the unfavorable experience.

In completing the Experience Period Data section of the URRT, Worksheet 1, only ANH Individual 2024 information is reflected, as required by the instructions. The combined ANH 2022 and 2023 company experience projected to 2026 appears in the Manual EHB Allowed Claims section of the URRT, Worksheet 1, as described in the Credibility of Experience section of this memorandum.

Medical allowed claims and incurred claims were extracted directly from company claim records. Pharmacy claims are administered by a Pharmacy Benefits Manager and those allowed and incurred claims were extracted from their records. Unpaid claims liability (UCL) for incurred claims was developed directly with experience data using the following methodology, which is consistent with the corporate reserve development methodology. Unpaid claims liability for allowed claims was estimated using the same factors that were developed for incurred claims. Allowed and incurred claims from the experience period are shown in "WA Exh 1 – Experience Data" within "ANH IND OIC Health Exhibits."

Review and Analyze Data

- Check data for inconsistencies and anomalies
- Reconcile paid claims data against the general ledger
- Monitor unpaid claims inventory
- Assess impact of large claims
- Review claims on a per exposure basis for reasonableness (PMPM)
- Compare past UCL estimates to actual claims run-out on an ongoing basis to assess the reasonability of past calculations

Develop UCL Estimates Using Multiple Methods

- Basic Claims Development Method
- Paid PMPM Method

Determine UCL for Recent Incurred Months

The UCL was selected using judgment and considered factors such as recent observed and expected claims trends, seasonality, product design, and changes in membership and claims inventory.

For rate development purposes, pharmaceutical manufacturer rebates were not subtracted from experience period claims because an overall adjustment occurs in a later step of the claims projection process. In contrast, in the URRT, Worksheet 1, pharmacy rebates are subtracted from experience period claims. The Pharmacy Rebates section of this memorandum contains additional information about the adjustments.

There are no capitation payment arrangements anticipated to be in place for the projection period.

4.4.2: Benefit Categories

Each allowed claim is assigned to one of the following benefit categories: Inpatient Hospital, Outpatient Hospital, Professional, Other Medical, and Prescription Drugs. Examples of claims in the Other Medical category are home health care, ambulance, durable medical equipment, and prosthetics. The categorization is derived from each claim's type of service, provider type, and place of service and is an automated process within the data warehouse. This categorization is consistent with the definitions described in the URR Instructions, section 2.1.3.1 "Benefit Category and Manual Rate."

4.4.3: Projection Factors

Following is a description of the projection factors used in the filing. As described in the Purpose section of this memorandum, rate development is performed on an incurred claims basis (Exhibit A1) while development of the URRT projection period index rate is performed on an allowed claims basis (Exhibit E1).

Each projection factor's description addresses first how the adjustment is developed for rate development purposes (incurred claims basis). Then, any modifications needed to use the adjustment for developing the URRT projection period index rate (allowed claims basis) are described. Fixed dollar cost sharing measures such as deductibles and copays amplify the impact of cost changes on an incurred claims basis, so generally, a dampening adjustment is necessary to convert a factor on an incurred claims basis to an allowed claims basis.

4.4.3.1: Trend Factors

Projected Rating Trend

The trend factor used in rate development is shown on the "Trend Factor to Rating Period" line in "Exhibit A1: Development of 2026 Rate Change," reflecting twenty-four months of trend at an annual rate of 10.4%. The table below shows the expected components of the annual trend used to project incurred claims costs to the rating period. Note that the leverage component does not impact allowed claims; this trend applies to incurred, paid claims.

Components of Projected Trend

Reimbursement	5.10%
Utilization	2.00%
Mix/Intensity	1.10%
Leverage	2.20%

For reporting purposes, trend and its respective components are reported throughout the filing on a medical and prescription drug combined basis. This combined trend is applied to all service categories including EHB and non-EHB claims.

To determine projected trend for the rating period, ANH analyzed the individual components of trend, change in reimbursement, utilization, mix/intensity, and leverage, to determine the aggregate expected trend. Trend were developed separately for Medical and Rx, and then weighted together. Reimbursement trends were developed using internal contracted and anticipated contracting increases to providers. Currently, 36% of provider contracting is complete for plan year 2026. Utilization and mix trends were developed using actuarial judgment by examining specific company data in this market, as well as overall company and market trends. Development of projected utilization and mix/intensity trend considers trend across entire book of business rather than just Individual experience to neutralize population morbidity changes in a single line of business. Finally, major fixed plan design features were modeled to estimate the leverage impact to paid trend. Company data has a direct impact on the single risk pool, with specific data being directly applicable, while overall company data contributes to determining health trends that are relevant to the market.

The reimbursement component captures unit cost changes, including negotiated rate changes with providers. The utilization component measures the difference in number of services per 1,000 members. The mix/intensity component measures the shift within service categories (e.g., using more MRIs versus X-Rays or more specialty drug prescriptions as a percentage of total prescriptions) and between service categories (utilizing outpatient services instead of inpatient services). Fixed dollar cost sharing measures, such as deductibles and copays, serve to amplify trend since the member portion of total costs remains

fixed while the insurer portion increases over time. This effect is captured in the leveraging component of trend.

ANH considers historical experience, state and federal mandates, new technologies, cost shifting, drug patents, and anticipated economic conditions in determining the utilization and mix/intensity components of projected trend.

Additionally, ANH actively reviews and implements opportunities to improve the quality of health care delivery and achieve sustainable costs. This filing reflects an explicit reduction to overall projected trend of 0.3% due to expected incremental impacts of program changes from the base period to projection period. These initiatives are focused on lowering the utilization, mix/intensity, and reimbursement components of trend.

A few examples of new or expanded initiatives include:

- Creating a billing interface that re-establishes reasonable reimbursement of provider-administered medications.
- Launching a new provider rating methodology to identify and surface for our members providers with proven track records of using evidence-based practices, adhering to best practices for patient care and delivering cost-efficiencies.
- Expanding inpatient short stay program to enable real-time admission reviews, optimizing care settings and maintaining quality of care.
- Expanding utilization management to ensure medical appropriateness and manage outcomes.
- Reducing overpayments through data mining as well as pre-pay and post-pay edits and audits.
- Ensuring emergency department visit level coding aligns with Centers for Medicare & Medicaid Services (CMS) Guidelines.
- Engaging with network providers to align financial incentives and support better outcomes for episodes of care.

The following trend variables are not considered when calculating trend: margin, fluctuation, anti-selection, or underwriting wear-off.

The selected projected rating trend assumption and the resulting rate change consider but do not rely on differences in projected and observed trend levels in prior periods.

In the URRT, Worksheet 1, Section II, the annualized “Cost” trend factor is populated with the Reimbursement component shown above. The “Util” trend factor is populated with a blend of the Utilization and Mix/Intensity components in the projected trend. Trend is developed for a 24 month projection, so Years 1 and 2 are populated with identical annualized values. Additionally, please note the URRT trend is on an allowed basis and thus excludes the leverage trend component while remaining an actuarially equivalent claims projection.

Normalized Experience Trend
ANH reviews experience trend by calculating rolling twelve month historical paid claims trend on both an observed and underlying basis. In order to differentiate between the observed trend and the underlying trend, claims are normalized for differences in benefits, demographics, health risk, and large

claims. Demographic adjustments are developed using the current filed factors for age and area, benefit adjustments are developed using a benefit relativity model, and health risk adjustments are developed using risk score data.
A summary of the underlying allowed experience is included in "WA Exh 4 – Normalized Trend" within the "ANH IND OIC Health Exhibits." The analysis shows an underlying average allowed claim trend of 8.2% when comparing calendar year 2024 to calendar year 2023. This estimate of recent underlying trend experience is a single point of reference and is not the sole predictor of future trends.

4.4.3.2: Adjustments to Trended EHB Allowed Claims PMPM
4.4.3.2(a): Morbidity Adjustment
This assumption reflects the anticipated change in morbidity from calendar year 2024 ("base period") to calendar year 2026 ("projection period") for ANH Individual ACA plans. The morbidity adjustment reflects a change in the expected health risk of the pool regardless of the underlying demographics.

The morbidity adjustment used for rate development is shown on the "Changes in Morbidity" line in "Exhibit A1: Development of 2026 Rate Change." Development of the claims adjustment for morbidity is shown in "WA Exh 10 - Risk Adjustment" within "ANH IND OIC Health Exhibits." This exhibit also shows the projected risk adjustment transfer, which is closely related to the assumed projection period morbidity. An explanation of the risk adjustment transfer and its relation to company and market morbidity assumptions is provided in the "Risk Adjustment Payment/Charge" section of this memorandum.

The claims adjustment for morbidity was developed using the following process:

- Estimate morbidity level of base period company experience
- Estimate ANH Individual morbidity change from base period to projection period
- Adjust base period experience to projection period ANH Individual morbidity level

Morbidity Level of Base Period Company Experience
Morbidity for each base period experience pool was estimated using risk score data normalized for demographic and benefit differences. Because the risk scores were calculated on a consistent basis for each pool, the relativities between the risk scores represent the relative morbidities.

ANH Individual Morbidity Change from Base Period to Projection Period
A wide range of outcomes is possible for the average morbidity change between the base period and projection period for the population insured on ANH Individual plans. Population enrollment change is the biggest driver of morbidity change. Similar to claims variability, the average morbidity of an insured population will vary from one year to the next, even with no change in covered members.

Some drivers of insured population changes include macroeconomic conditions, market competitiveness, and consumer behavior changes; however, none of these factors or their resulting impacts can be forecasted with certainty.

An estimate for the projected morbidity change between the base period and projection period is shown in "WA Exh 10 - Risk Adjustment" within "ANH IND OIC Health Exhibits." Changes to each of the risk adjustment transfer components between 2024 and 2026 are shown in the exhibit. The projection

of 2026 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2024 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts. The calculation of the 2026 transfer payments reflects the 14 percent administrative cost reduction to state average premium.

ANH does not anticipate any substantive impact to market or company morbidity from the inclusion of the 1332 wavier and no adjustments were made in the development of rates to account for the waiver.

Adjust Base Period Experience to Projection Period ANH Individual Morbidity Level
The final factor used to adjust company base period morbidity to the projection period ANH Individual morbidity is derived by taking the ratio of the projection period ANH Individual morbidity to the base period company morbidity.

For purposes of incorporating the morbidity adjustment into the "Morbidity Adjustment" projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment was applied to convert the factor to an allowed claims basis. The projection factor for the URRT for each experience pool is shown in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.2(b): Demographic Shift
A demographic adjustment is reflected to account for population demographic differences between the experience period and the projection period. Adjustments are developed consistent with current filed factors for age and area.

The demographic adjustment used for rate development is shown on the "Changes in Demographics" line in "Exhibit A1: Development of 2026 Rate Change" and in "Exhibit C3: Demographic Factor Comparison." The most significant contributor to this shift is the observed change in the population between 2024 and March 2025.

For purposes of incorporating this adjustment into the "Demographic Shift" projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment was applied to convert the factor to an allowed claims basis. The projection factor used in the URRT for each experience pool can be found in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.2(c): Plan Design Changes
Company experience period claim costs are adjusted to reflect anticipated changes in covered benefits (Essential Health Benefits, Mandated Benefits, and Other Benefits) and changes in cost sharing.

The overall benefit design adjustment used for rate development is shown on the "Changes in Benefits" line in "Exhibit A1: Development of 2026 Rate Change."

Essential Health Benefits
Plans offered in 2026 must include covered benefits following Washington's essential health benefits (EHB) benchmark package for Individual plans. Covered benefits included in the base period plans were

reviewed against the 2026 EHB benchmark plan. 2026 premiums reflect the updates to the EHB Benchmark plan.

Experience period covered benefits for ACA plans satisfy Washington's 2026 requirements. Therefore, no specific experience period adjustments are applied to ACA plan experience.

Pediatric dental benefits are included as an embedded set of benefits in all ANH 2026 ACA products.

Mandated Benefits
ANH included an adjustment in the rate development to account for the impact of 2025 Washington legislative changes including expanded hormone therapy and removal of prior authorization on MHSUD.

Other Benefits
This adjustment reflects anticipated differences in non-EHB benefits between the experience period and projection period. There are no material differences that require an adjustment. The Individual Assistance Program non-EHB benefit is included in retention, and therefore does not require an adjustment to claims. For 2026, Gene Therapy is now considered an Essential Health Benefit.

Changes in Cost Sharing
This adjustment reflects anticipated changes in the average cost sharing requirements between the base period and projection period, which was derived by comparing the base period average benefit design to the projection period average benefit design, independent of changes in covered benefits and population health status. It includes anticipated changes in the average utilization and cost of services due to differences in average cost sharing requirements.

The "Plan Design Changes" projection factor in the URRT, Worksheet 1, Section II, includes corresponding adjustments to the changes in covered benefits and changes in cost sharing described above. The changes in cost sharing component only includes the portion of the adjustment attributable to anticipated changes in the average utilization of services due to differences in average cost sharing requirements. Anticipated changes in the average cost sharing requirements were excluded because they do not affect allowed claims.

4.4.3.2(d): Other Adjustments
This section describes cost adjustments other than changes in morbidity, demographic shift, and plan design changes.

Changes in Network
A network adjustment is reflected to account for expected network differences between the experience period and the projection period. The network adjustment used for rate development is shown on the "Changes in Network" line in "Exhibit A1: Development of 2026 Rate Change."

A proprietary network model is used to determine the projected cost relativities between different networks, based on historical experience projected to the rating period. The model allows the inclusion or exclusion of providers on a group-by-group basis. As a provider group is excluded from the network, the services that were delivered by that group are redistributed to other providers within the same specialty. As care is shifted among providers, adjustments are made to reflect utilization efficiency and

unit cost differences between the providers. For plans paired with an accountable health network, the relativities also reflect expected savings due to managed care and provider incentive arrangements.

If the network also has a risk sharing arrangement with the provider with an incentive component, a second model is used to calculate the cost impact of this arrangement. An additional reduction in cost is assumed due to improvements in care management for these members and a simulation model is used to estimate the value of the shared savings and/or deficit repayment. The value of these arrangements is included in the network factors.

The Individual and Family network will be discontinued in 2026. In 2026, ANH will offer plans on the new Individual Connect network. The Individual Connect network is a statewide network offered in all covered service areas.

For purposes of incorporating this adjustment into the "Other" projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment is applied to convert the factor to an allowed claims basis. The projection factor used in the URRT for each experience pool is shown in "Exhibit E1: Development of 2026 Index Rate."

Pharmacy Rebates
Incurred claims in the experience period are not reduced by estimated pharmaceutical manufacturer rebates, so a pharmacy rebates adjustment is reflected to account for estimated rebates in the projection period. The pharmacy rebates adjustment for rate development is shown on the "Pharmacy Rebates" line in "Exhibit A1: Development of 2026 Rate Change." Pharmacy rebates are estimated by projecting 2026 aggregate rebate-eligible script counts companywide from base period experience, adjusting for expected changes in average per script rebate guarantees, and then allocating the projected rebates to each line of business using base period pharmacy experience.

Because experience period allowed claims used in the URRT are net of pharmacy rebates, for purposes of incorporating this adjustment into the "Other" projection factor in the URRT, Worksheet 1, Section II, only the estimated difference in pharmacy rebates between the experience period and the projection period is reflected. The projection factor used in the URRT for each experience pool is shown in "Exhibit E1: Development of 2026 Index Rate."

Overall, the "Other" projection factor in the URRT, Worksheet 1, Section II, includes adjustments for network and pharmacy rebates.

4.4.3.3: Manual Rate Adjustments

Source and Appropriateness of Experience Data Used
As described previously in the Experience and Current Period Premium, Claims and Enrollment section, 2022, 2023, and 2024 calendar year data for ANH Individual ACA plans are used to develop 2026 rates. This experience is deemed to be fully credible to develop the framework for a statewide single risk pool.

For purposes of completing the URRT, Worksheet 1, all ANH non-grandfathered Individual 2024 experience was included to develop the Adjusted Trended EHB Allowed Claims PMPM Combined 2022 and 2023 ANH experience used to develop rates was reflected in the Manual EHB Allowed Claims PMPM

item in the URRT, Worksheet 1. A detailed summary is included in "Exhibit E1: Development of 2026 Index Rate."

Adjustments Made to the Data
Adjustments made to the data underlying the Manual EHB Allowed Claims PMPM section of the URRT are similar to the adjustments made to the data included in the URRT, Worksheet 1, Section II. A detailed summary of the adjustments is included in "Exhibit E1: Development of 2026 Index Rate." Descriptions of the adjustments are included in the corresponding sections of this memorandum.

Inclusion of Capitation Payments
No services are provided under a capitation arrangement.

4.4.3.4: Credibility of Experience
To develop 2026 rates, the overall projected claim cost was derived by taking a weighted average based on enrollment from ANH 2022, 2023, and 2024 experience pools.

In accordance with ASOP 25, blending multiple years of ANH experience is an appropriate procedure in the development of projected claim costs. Differences in population between experience years have been accounted for by adjusting each year's claims experience to reflect unique population characteristics and improve homogeneity.

The adjustment from each year to reflect the characteristics of the projection pool was calculated as follows for Morbidity, Benefits, Demographics, and Networks:

- Estimate a relative value for the base period experience for each year of ANH experience (a)
- Estimate ANH individual 2024 experience relative value for the projection period (b)
- The adjustment applied to each experience pool is equal to (b) divided by (a)

The claims cost weight assigned to each experience year is shown in "Exhibit A1: Development of the 2026 Rate Change." The resulting overall projected incurred claims cost is $656.05 PMPM.
For purposes of completing the URRT, the credibility percentage applied to the experience included in the Manual EHB Allowed Claims PMPM section is consistent with the weights for rate development. The resulting projected allowed claims cost is $924.14 PMPM.

4.4.3.5: Establishing the Index Rate
The experience period index rate is $878.17 PMPM; the projected period index rate is $924.14 PMPM. Non-EHB benefit categories are excluded from the calculation based upon the benefit category code assigned automatically within the data warehouse. The Individual Assistance Program (IAP) benefits are excluded from all plans. Please note the index rate does not demonstrate the process used to develop the rates; it was prepared for reporting purposes and is calculated consistently with the results of the underlying rate development process.

For purposes of determining non-EHB benefits, only material benefit categories not covered in the EHB benchmark plan are identified. In cases where the company provided offering is richer than the EHB benchmark plan, the benefits are not considered non-EHB. For instance, if 15 service visits are covered

compared to 10 visits in the benchmark plan, then the additional 5 visits would not be considered non-EHB.

Development of the index rate is shown in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.6: Development of the Market-wide Adjusted Index Rate

The market-wide adjusted index rate is $829.91 PMPM. It is calculated as the projection period index rate adjusted for the following allowable market-wide modifiers:

- Net impact of the risk adjustment program
- Exchange user fees

Development of the market adjusted index rate is shown in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.6(a): Reinsurance

There are no state or federal reinsurance programs in effect for the experience or projection periods. The reinsurance amount entered into the URRT, Worksheet 1 is $0.00.

Cambia Health Solutions, the parent company to ANH, was engaged in a private reinsurance arrangement for all its insured business during the experience period. This agreement reimbursed a portion of claims in excess of $4.0M in the experience period, and a similar arrangement is expected for the projection period in exchange for a small premium. The net impact of this arrangement is expected to be negligible, so the amounts are excluded from this filing.

4.4.3.6(b): Risk Adjustment Payment/Charge

2024 risk adjustment transfers are populated in the "Risk Adjustment Transfer Amount" line of the URRT, Worksheet 2, Section II. Amounts were allocated by plan in proportion to premium. The risk adjustment user fee for 2024 was $0.21 PMPM. The experience period risk adjustment transfer PMPM, including net HCRP receipts and before reduction for the risk adjustment user fee, is $82.31 as shown in "WA Exh 10 - Risk Adjustment" within the "ANH IND OIC Health Exhibits."

The URRT, Worksheet 1 shows the experience period risk adjustment PMPM as $81.98 because it is calculated as the projected 2024 risk adjustment transfer divided by the 2024 experience period membership. The risk adjustment transfer PMPM shown in "WA Exh 10 - Risk Adjustment" within the "ANH IND OIC Health Exhibits" is calculated as the projected 2024 risk adjustment transfer divided by the billable member months. Experience period member months differ from the billable member months due to differences in counting billable member months and total member months, and due to differences in the run out period.

The projected risk adjustment PMPM reflects the difference in projection period expected relative risk between the ANH block of business and the overall market. The estimated risk adjustment transfer used for rate development is shown on the "Risk Adjustment Transfer" line in "Exhibit A1: Development of 2026 Rate Change." The risk adjustment user fee for 2026 is $0.20 PMPM and is shown in the "Retention Development" section of Exhibit A1. Information regarding the transfer estimate is shown in "WA Exh 10 - Risk Adjustment" within the "ANH IND OIC Health Exhibits," including the detailed internal data and projections by metal level used to develop the estimate. A positive amount represents an anticipated

risk adjustment payment receipt, and a negative amount represents an anticipated risk adjustment charge.

The federal risk adjustment program transfers funds from carriers with relatively lower risk enrollees to carriers with relatively higher risk enrollees, which mitigates the potential concern of adverse selection in a guaranteed issue market. The transfer formula operates such that, in general, changes in a carrier's enrolled risk profile results in corresponding changes to the transfer amount. That is, a carrier enrolling relatively higher risk members would expect to receive a higher transfer payment (or pay a lower transfer charge). Similarly, a carrier whose enrolled risk profile stayed the same while the market-wide average risk improved would also expect a higher transfer payment (or lower transfer charge).

A carrier's risk transfer results from HHS's risk transfer formula will inherently vary from year-to-year even with no significant carrier or market morbidity changes. For example, periodic updates to the transfer formula methodology and carrier differences in diagnosis coding practices and data submission capabilities will introduce additional variation. For carriers whose enrollees have a significantly different average risk profile than market average, the variability in risk adjustment results may be even higher.

The 2026 projected risk adjustment PMPM is developed considering expected changes in market-wide morbidity and company enrollment profile changes, combined with risk adjustment transfer formula relationships and reasonable judgment. Considerations included 2023 actual risk adjustment results, 2024 estimated risk adjustment results, projected changes in the market-wide morbidity level between 2024 and 2026, and projected changes in company morbidity of the population insured between 2024 and 2026.

The projection of 2026 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2024 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts.

In projecting Risk Adjustment transfers, internally counted medical member months will differ from the CMS methodology for billable member months. The difference between the two is that CMS billable member month methodology excludes children who are not charged a premium and counts 30 days as a month. These two differences directionally offset and are generally of a similar magnitude, so this filing uses the simplifying assumption that projected member months are equal to projected billable member months.

Continuing in 2026, a federal high-cost risk pooling program (HCRP) is expected to partially reimburse carriers for claims over one million dollars, with a fee assessed to the pool to cover the cost of the claims. For rate development purposes, both claim and premium adjustments are made to account for the impact of this program. For claims projection, expected reimbursement amounts from HCRP are removed from the experience period before trending to the projection period. For the anticipated HCRP program assessment, an estimated value of 0.50% of premium is used in rate development. For the purposes of populating the URRT, the HCRP assessment is added to the risk adjustment transfer

amount. The premium charge for the HCRP is not finalized; this amount is based on an estimate developed by an external consultant.

ANH anticipates $0 in HCRP recoveries for 2024 and had $0 in HCRP recoveries for 2022 and 2023.

The risk adjustment data validation (RADV) program was established with the primary purpose of validating the accuracy of data submitted by issuers for the purposes of risk adjustment transfer calculations. Any RADV findings are used to adjust the risk scores used in risk adjustment transfers in the following year. Because the risk adjustment program is revenue-neutral within a state and market, an issuer's Individual risk adjustment results would be impacted by a RADV finding for any issuer in their state and market. In developing a projection for future years, risk adjustment transfers are projected without any assumed RADV impact in the experience period year. It is assumed that any impacts of RADV findings in the experience period year are a one-time item, and that continuous improvements by issuers in their data submissions and validations will eliminate systemic findings that could be predictive of adjustments in future years.

The "Risk Adjustment Transfer Amount" item in the URRT, Worksheet 2, Section IV is the plan allocation of the aggregate risk adjustment transfer amount on a paid basis. Note that this will differ from the URRT, Worksheet 1, Section III, which is on an allowed basis. Single risk pool pricing requirements require anticipated risk adjustment transfers to be allocated proportionally as a market level adjustment, so the risk adjustment transfer amounts were similarly allocated, by plan and in proportion to premium. Note that the HCRP premium charge is included in the aggregate transfer amount and spread uniformly across all plans.

4.4.3.6(c): Exchange User Fees
This filing reflects exchange user fees of $0.00 PMPM because products will not be offered on a marketplace in 2026.

4.4.4: Plan Adjusted Index Rate
The plan adjusted index rates are calculated as the market adjusted index rate adjusted for allowable plan-level modifiers, as shown in Exhibit E2. The following adjustments are made:

- AV and cost-sharing design, which considers the expected allowed claims by benefit category, adjustments for utilization and plan design features, claim probability distributions (CPDs) and healthcare cost trends. The AV and cost sharing design does not account for differences in health status.
- Network, delivery system characteristics, and utilization management practices. Network factors were developed internally using a proprietary network model to determine the projected cost relativities, as discussed in the "Changes in Network" subsection of section 4.4.3.2(d): Other Adjustments.
- Non-EHB benefits, discussed in the "Other Benefits" subsection of section 4.4.3.2(c): Plan Design Changes. Benefits in addition to EHB were estimated using internal claims data to project the future costs of each benefit as a percent of total projected costs.
- Administrative costs, excluding exchange user fees and reinsurance fees, discussed in section 4.4.7: Non-Benefit Expenses.

Development of the plan adjusted index rates from the market adjusted index rate and allowable plan-level modifiers is shown in "Exhibit E2: Plan Adjusted Index Rate Development." Included in the exhibit are explanations of how the modifiers are developed.

The components of the AV and cost-sharing design factors are Induced Demand Factors, EHB Paid to Allowed Factors, and Projected CSR Adjustment factors as shown in Exhibit E2. Induced Demand Factors for 2026 are prescribed by emergency rule CR-103E (R 2025-01) and included in "WA Exh 9 – AV and Cost-Share" within the "ANH IND OIC Health Exhibits." EHB Paid to Allowed Factors are derived values for the purpose of the URRT and are not used in rate development.

The base product factors were developed using a proprietary benefit relativity model that does not account for health status. The base product factor is used to normalize the projected average premium to get us to our pool base rate in Exhibit A1. These factors are based on paid claims. The base product factor is the pricing value based on benefit design only, before network adjustments and non-EHB benefits.

4.4.5: Calibration

The URRT and actuarial memorandum instructions require the plan adjusted index rates to be calibrated for age, area, and tobacco use factors. Calibration adjustments for these factors were applied uniformly to all plans.

The plan adjusted index rates calibrated for age, area, and tobacco factors are expected to approximate plan starting costs for premium determination, before applying the allowable consumer-specific rating factors for age, area, and tobacco, as well as family composition adjustments. Reconciliation of the plan adjusted index rates and the 2026 plan base rates is shown in "Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping."

Exhibit E3 displays the actual 2026 Plan Base Rates which are analogous to, but may not exactly match the URRT, Worksheet 2, Section III Calibrated Plan Adjusted Index Rates. As noted in the URR Instructions, section 2.2.3, "It is understood [the Calibrated Plan Adjusted Index Rate] may not match exactly to rates submitted in the Rates Table Template document due to rounding and truncation of variables in the URRT, however it is expected the rates will be reasonably close to each other."

Age Curve Calibration

The age factor calibration adjustment was calculated by applying the age curve premium factors to the projection period population. An age factor of 0 was used for the projected population under age 21 subject to the three-child family rating limitation. Development of the calibration adjustment is shown in "Exhibit C1: Age Curve and Tobacco Calibration Factors."

Geographic Factor Calibration

The geographic factor calibration adjustment is calculated by applying the 2026 area factors to the projection period population. This adjustment is shown in "Exhibit C2: Geographic Factors."

Tobacco Use Rating Factor Calibration

In 2026 Tobacco use status is not used as a rating factor for ANH Individual products.

4.4.6: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate charged to an individual or family. Premiums are determined starting from each plan's base rate. Premium rates may vary due to the following factors, as permitted by 45 CFR 147.102:

- Plan
- Age
- Area
- Family status

To distribute the projected average premium across the projected population, ANH determined an overall pool base rate using a normalization calculation. The pool base rate represents the starting amount for premium determination purposes before applying consumer-specific premium factors.

The 2026 pool base rate of $643.08 and the average factors for normalization are shown in "Exhibit A1: Development of 2026 Rate Change."

The pool base rate is determined by dividing the projected average premium by the projected population's average factors. The average age factor is adjusted to reflect the three child dependent premium limit. Area factors reflect geographical delivery cost differences with respect to unit cost and provider practice pattern differences; as required, they do not include differences for population morbidity.

A plan base rate is calculated for each plan by multiplying the pool base rate with the plan's corresponding plan factor. Plan factors are developed as the product of the internally developed base product pricing factor, and network discount factor.

Each member's premium is developed by multiplying the plan base rate for the member's selected plan with the member's applicable age, and area factors. The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

4.4.7: Non-Benefit Expenses

The "Retention Development" section of "Exhibit A1: Development of 2026 Rate Change" shows non-benefit expenses included in the premium development.

4.4.7(a): Administrative Expense Load

The administrative expense load is comprised of expected plan operating expenses and commissions paid to agents and brokers, offset by investment earnings on claim reserves.

Operating expenses for 2026 are projected at $48.48 PMPM or 6.34% of premium. Operating expenses are developed by the cost accounting department consistent with company policy and were reviewed for reasonability compared to prior results. When possible, operating expenses are assigned directly as a claim or non-claim related expense to the appropriate line of business. When costs cannot be assigned directly to a specific line of business, the expenses are allocated based upon appropriate objective

statistical measures. As such, reliance is placed on the internal cost accounting department's expertise in developing these estimates.

Commission expenses for 2026 are projected at $14.27 PMPM or 1.87% of premium. Historical utilization of distribution channels was analyzed against the 2026 commission schedule. Commissions may apply to members purchasing off exchange if a broker is utilized.

Investment earnings on claim reserves are projected to impact premiums by -$1.70 PMPM or -0.22% of premium. This value reflects a projected T-bill rate of 2.38% applied to the claim reserves. Earnings are expressed as a percentage of premium.

The following tables show the components of "Administrative Expense Load" in the URRT, Worksheet 2, Section III, from the 2026 rate filings.

2026 Administrative Expense Components

Component	Percent of Premium	PMPM
Administrative Expenses	6.34%	$48.48
Commissions	1.87%	$14.27
Investment Earnings	-0.22%	-$1.70
Total Administrative Expense Load	7.99%	$61.05

2026 Projected Average Premium PMPM: $764.49

PMPM values shown here match the rate development and may differ from the URRT due to rounding. Prior years projected and actuals are included in "WA Exh 11 - Retention" within "ANH IND OIC Health Exhibits"

4.4.7(b): Profit and Risk Load

Rate setting for ACA plans includes many pricing risks. Claims experience continues to be more volatile and less predictable relative to recent years because the covered population may change materially from year-to-year. These changes increase uncertainty with how closely morbidity adjustments align to final risk adjustment transfer amounts. There is further underlying variability with risk adjustment transfers due to differences between carriers in diagnosis coding practices and data submission capabilities, which are factors that cannot be predicted. Also, while the risk adjustment program is intended to compensate for morbidity differences between carriers, it does not protect against the risk of market morbidity being less favorable than projected across all carriers.

As described in actuarial standards of practice and WAC 284-43-6040(c), a provision for the impact of adverse deviation sufficient to cover anticipated costs under moderately adverse experience has been included in this filing as a risk and contingency margin. The table below shows a variety of items considered as potential risks, with a range of impacts for each item under moderately adverse conditions estimated based on actuarial judgement and experience. The cumulative range is strictly less than the sum of the individual endpoints, as it is recognized that not all impacts would occur simultaneously under a moderately adverse scenario.

Items considered as risks under moderately adverse conditions:	**Estimated Range:**
Changes in unit cost, provider contracts, drug costs, and new technology	0.5% - 2.0%
Changes in utilization not otherwise compensated through risk adjustment	0.5% - 1.0%
Claims fluctuation from catastrophic claims or pool size	1.0% - 2.0%
Changes in market enrollment and/or morbidity	0.5% - 2.0%
Impact of unanticipated regulatory changes	0.5% - 2.0%
Unexpected issuer or market RADV findings	0.5% - 2.5%
Unanticipated variation in commissions, taxes, or administrative costs	0.5% - 1.0%
Cumulative Range of Moderately Adverse Impacts:	**2.0% – 6.0%**

The following table summarizes risk and contingency margin for this filing.

Risk and Contingency Margin	
Filing Year	2026
Percent of Premium	3.5%
PMPM	$26.76

This information is included in "Profit & Risk Load" in the URRT, Worksheet 2, Section III. Prior years projected and actuals are included in "WA Exh 11 - Retention" within "ANH IND OIC Health Exhibits"

4.4.7(c): Taxes and Fees

The taxes and fees for the Individual line of business are comprised of state premium taxes, Patient Centered Outcomes Research Institute (PCORI) fees, exchange user fees, HCRP fees, risk adjustment program fees, WSHIP assessments, regulatory surcharge, insurance fraud surcharge, and WPAL fee. Note that HCRP and exchange user fees are not included in URRT, Worksheet 2, Line 3.7.

- State premium tax is set at 2.0% by the state of Washington.
- ANH is subject to federal income taxes. As this filing includes no explicit contribution to surplus, no adjustment is made for income taxes.
- The estimated PCORI fee for 2026 plans is $0.32 PMPM. The PCORI fee is calculated as the $3.00 annual fee for plan years ending October 1, 2024 through September 30, 2025, divided by 12, and trended for 2 years at an annual rate of 4.9% and 5.0%, the projected trend from the National Health Expenditures, and rounded to the nearest penny.
- This filing reflects exchange user fees of $0.00 PMPM because products will not be offered on exchange in 2026.
- The risk adjustment program fee for 2026 is $0.20 PMPM.
- This filing assumes an HCRP assessment of 0.50% of premium, as discussed in section 4.4.3.6(b). On the URRT, this amount is included in the risk transfer amounts and is not included in the Taxes and Fees section.
- An amount of $0.32 PMPM is included in this filing for the WSHIP assessment. This is based on WSHIP's preliminary financial projection anticipating total 2026 assessments of $6 million. The following table shows the development of this amount starting from WSHIP's anticipated total assessment.
- The regulatory surcharge from RCW 48.02.190 is calculated to be 0.08% of premium by using the 2025 fee as a proxy for 2026.

- The insurance fraud surcharge from RCW 48.02.190 is calculated to be 0.00% of premium by using the 2025 fee as a proxy for 2026.
- The WPAL fee, which is a new fee funding the WA Partnership Access Line, is calculated to be $0.07PMPM by using the projected annual program costs divided by WSHIP enrollment as a proxy.

WSHIP Assessment Allocation

Description	Amount	Calculation
(A) Total Estimated 2026 WSHIP Assessment	$10,500,000	
(B) Cambia Portion of Total WSHIP Assessment (%)	8.0%	
(C) Cambia Portion of Total WSHIP Assessment ($)	$839,177	A * B
(D) Projected Member Months for WSHIP Allocation	2,611,106	
(E) PMPM Average Estimate WSHIP Allocation	$0.32	C / D

The following tables summarize the components of "Taxes & Fees" in the URRT, Worksheet 2, Section III from the 2026 rate filings.

2026 Taxes & Fees Components

Component	Percent of Premium	PMPM
Premium Tax	2.00%	$15.29
PCORI Fee	0.04%	$0.32
Risk Adjustment Program Fee	0.03%	$0.20
WSHIP Assessment	0.04%	$0.32
Regulatory Surcharge	0.08%	$0.58
Insurance Fraud Surcharge	0.00%	$0.03
WPAL Fee	0.01%	$0.07
Total Taxes & Fees	2.20%	$16.81

2026 Projected Average Premium PMPM: $764.49

PMPM values shown here match the rate development and may differ from the URRT due to rounding.

The regulatory and insurance fraud surcharges from RCW 48.02.190 are built into the premium as described in subsection (7)(d). Prior years projected and actuals are included in "WA Exh 11 - Retention" within "ANH IND OIC Health Exhibits"

4.5: Projected Loss Ratio

The projected federal loss ratio calculated using federally-prescribed methodology for medical loss ratio (MLR) rebates calculations is 88.2%, which is greater than the federally prescribed MLR requirement of 80.0%. Due to the complexity of the federal MLR rebate methodology, which is beyond the scope of this filing, the only adjustment reflected is subtracting projected taxes and fees from the premium denominator. This simplified MLR calculation is strictly less than or equal to the federal MLR methodology, so the federal MLR must also be greater than 80.0%. The numerator for this ratio is projected incurred claims net of projected risk adjustment transfers, $656.05 PMPM. The denominator

of this simplified calculation is equal to projected average premium, less the Total Taxes & Fees PMPM described in the preceding Taxes & Fees section: $743.92.
ANH considered potential impacts resulting from the 2026 MLR reporting regulation changes and deemed no changes in rating methodology to be required.

The URRT, Worksheet 2, Line 4.10 includes a different loss ratio calculation which adds transfer receipts to the denominator (Claims divided by Premium plus Transfer Receipts). Due to varying claims experience by plan and large projected risk transfers for some metal levels, the projected loss ratios shown for some plans may be significantly below 80%, which is not unreasonable.

The projected federal loss ratio is shown in "Exhibit A1: Development of 2026 Rate Change."

4.6: Plan Product Information

4.6.1: AV Metal Values

ANH followed applicable guidance in determining AV Metal Values using the prescribed AV Calculator methodology, including guidance issued by CMS on May 16, 2014, titled "Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards." This CMS guidance states, "A plan design is incompatible when the use of the AV Calculator yields a materially different AV result from using the other approved methodologies." A materially different AV result is interpreted as one that changes a plan's metal tier.

Some ANH plans include an Optimum Value Medication (OVM) benefit that is not supported by the AV calculator. The OVM is a list of drugs considered important to longterm health for which the deductible is waived to encourage continued prescription adherence. ANH estimated the impact of the OVM on the actuarial value and considers it to be immaterial.

The AV Calculator does not differentiate cost sharing for outpatient mental health office visits and other mental health services. Some ANH plans include a copay for mental health office visits and coinsurance for other mental health services. The portion of services that are non-office visit was determined to be negligible and ANH considers the impact to actuarial value to be immaterial. The mental health office visit copay was used in the AV Calculator for determining the actuarial value.

As required, ANH used an actuarially justifiable process for inputting plan designs into the AV Calculator. For non-standard cost shares, AV Metal Values were tested using an alternate methodology under 45 CFR 156.135(b), and all plan designs were determined to be compatible with the AV Calculator, as the alternate methodologies did not produce materially different results. Therefore, AV Metal Values included in the URRT, Worksheet 2 for all plans were determined entirely based on the AV Calculator. A separate certification is included in this filing, "ANH IND CMS Unique Plan Design Documentation," which contains further details on how the alternate methods were applied.

Please note that AV Metal Value determinations follow the AV Calculator methodology prescribed by HHS, and these actuarial values are only to be used to determine a plan's metal tier. They do not reflect the best estimate of the portion of allowed costs covered by the health plan.

4.6.2: Membership Projections
Projected member months by plan for the URRT, Worksheet 2, are estimated based on data through March 2025, assuming minimal changes in the enrollment distribution by plan to ensure non-zero enrollment in each 2026 plan.

2026 product selections are assumed to be similar to 2025 product selections. ANH implicitly assumes that there will be additional enrollment changes that are immaterial to rate development.

No members are expected to enroll in cost-sharing reduction subsidy plans in 2026 because ANH is only offering products outside the exchange.

4.6.3: Terminated Plans and Products
ANH does not have any 2025 plans terminating in 2026.

4.6.4: Plan Type
ANH does not offer any plans that do not meet the plan type definitions in the URRT, Worksheet 2.

4.7 Miscellaneous Instructions

4.7.1: Effective Rate Review Information and Additional Requirements

This rate filing includes information meeting Washington's rate filing speed-to-market requirements:

- AV Screenshots
- Benefit Components
- CMS Unique Plan Documentation
- Commission Certification
- Filing Checklist
- Mental Health and Substance Use Disorder Financial Requirement Certification
- OIC Health Exhibits
- Part I Unified Rate Review Data Template
- Part II Written Description Justifying the Rate Increase
- Part III Rate Filing Documentation and Actuarial Memorandum
- Rate Factors
- Rate Review Detail in SERFF
- Rate Schedule
- Rating Example
- Supplemental Exhibits
- Uniform Product Modification Justification
- WAC 284-43-6660
- 1332 Waiver Checklist

Additional information satisfying the items requested by the Washington State Office of the Insurance Commissioner in the "2026 Plan Year Individual Nongrandfathered Health Plan (Pool) Rate Filing Checklist" is as follows:

A table summarizing the plan-level factors used to adjust the market adjusted index rate to the plan adjusted index rates can be found in "Exhibit E4: Plan Variation from Market Adjusted Index Rate for

Renewal Plans." The table includes each renewal plan in 2026 and the applicable factors from the 2025 and 2026 filings. Plan-level factors adjusting the market adjusted index rate to the plan adjusted index rate will always vary from year-to-year due to routine calculation updates following the URRT required calculation methodology. Factor changes are attributable to plan pricing updates, network relativity updates, differences in non-EHB estimates, and differences in administrative costs.

As well, the "Benefit Components" template has been completed to provide detailed information on benefits covered and cost- sharing structures by plan, including network information and whether out of network coverage is offered.

For changes to network factors, an explanation is provided in the "Projection Factors" section on how the previous factor was determined, whether the network factors incorporate efficiency, fee schedule, fee for service, or bundled payments, whether the factors are based on historical data or future anticipated experience, and whether the company's provider compensation includes bonuses and/or other payments. Documentation as to how the adjustments were made to the URRT, Worksheet 1, Section II is also included.

A summary of the factors included in the 2022 - 2026 URRTs, Worksheet 1, Section II, is included in "WA Exh 5 – w1 Pool Factors" within the "ANH IND OIC Health Exhibits."

In the URRT, Worksheet 2, Section I, the product and plan information is entered in accordance with the current Unified Rate Review Instructions. The instructions for Worksheet 2, Section I, specify how to determine which products and plans to enter, how to determine whether a plan is a new plan, renewing plan, or terminated plan, and how to enter product and plan information.

In the URRT, Worksheet 2, Section II, the experience period data is entered for the twelve month period corresponding to the base experience period. Experience for terminated plans is entered in accordance with the URRT instructions. A description of how the estimated risk adjustment transfers and reinsurance recoveries are calculated is described earlier in section 4.4.3.6 of the memorandum.

In the URRT, Worksheet 2, Section IV, the projected enrollment is generally set equal to the current enrollment with minor adjustments to ensure new plans have nonzero projected enrollment.

A summary of the age, area, and tobacco factors used in the 2023 - 2026 filings is included in "Exhibit C3: Demographic Factor Comparison."

Regarding checklist item 17(a), The Tobacco Use factor is not applicable for 2026.

Regarding checklist items 11(a) and 20, parent company Cambia Health Solutions purchases reinsurance for all its fully insured business. This agreement reimbursed a portion of claims in excess of $4.0M in the experience period, and a similar arrangement is expected for claims in excess of $4.0M in the projection period. Due to the volatility in projecting such large claims, no explicit projection is made. Details for development of the Market-wide Adjusted Index Rate are included in section 4.4.3.6 of the memorandum. Details about pricing and parameters of the arrangement are proprietary and not included here.

Regarding checklist items 23(a)&(b), the experience rate change by plan in UPMJ Q5(g) is the remainder of the total change in 5(j), removing 5(h) and 5(i). This varies by plan due to many factors, including changes in network pricing, geographic area factors, the mapping of terminated plan members, changes in CSR load, and changes to the underlying proprietary benefit relativity model used in developing the pricing AVs by plan.

Regarding checklist items 23(c), 23(d), and 28(h), a summary of enrollment, premium, claims, and rates across various documents in the filing is included in "Exhibit F1: Checklist Value Comparison." Inconsistencies may be due to rounding and order of operations in the URRT Worksheet 2 and the Rate Review Detail, which are slightly different than the methodology in the rate development and rate template formulas. In addition, the Rate Review Detail values may correspond to initially filed rates, but not necessarily to subsequent rate updates.

Regarding checklist item 11 and 27, voluntary abortion services are priced at 0.2% of premium to reflect the minimum required amount under 45 CFR §156.280(e)(4). The actual estimated cost of these services is less than one dollar per enrollee, per month. The non-EHB percent listed in the binder filing is 0.2%.

Regarding checklist items 28(e) and 30(c), the member-weighted rate change is demonstrated in "Exhibit D1: 2026 Average Change in Plan Base Rates" and UPMJ Question 5. The premium weighted rate change appears in item 1.12 and 1.13 in URRT Worksheet 2, Section I, at the product level and in total, respectively.

Regarding checklist item 6(a), the Proportion of Claim Dollars for trends in the WAC 284-43-6660 summary is calculated using the information in section II of "Wksh 1 – Market Experience" in the Unified Rate Review Template. The Experience Period Index Rates PMPM for each benefit category are compared to the total PMPM to derive the proportion of claim dollars.

The Mental Health Substance Use Disorder (MHSUD) financial requirement was tested for parity for all proposed plan designs. Only Outpatient In-Network benefits were tested; all other benefit categories have the same cost sharing for Mental Health and Medical/Surgical services. The allowed amounts (before enrollee cost sharing) for all Outpatient In-Network claims incurred in 2024 and paid through March, 31 2026 were summarized by benefit category for all of Cambia's individuallegi ACA plans in Washington. The allowed amounts were converted to PMPM values using the corresponding enrollment for the same time period. All mental health related claims were removed as required in the testing.

Plan-level testing used the trended PMPMs only for the benefits that are available on that plan and applied projected enrollment. The benefit structure and member cost sharing of the plan was used to test the plan design for parity under the financial requirement rules.

The testing and the certification can be found in the following files: "ANH IND MHSUD Certification", "ANH IND MHSUD Exhibit", "ANH IND MHSUD Exhibit Duplicate".

4.7.2: Reliance

Other than as previously identified, I did not rely on any other information or underlying assumptions provided by another individual in preparing the Part I Unified Rate Review Template.

Caveats and Limitations

The index rate and premium projections contained in this filing reflect best estimates of future costs that were developed based on available data, review of the literature, applicable rules and regulations, best thinking regarding the market population, and actuarial judgment. Actual experience and financial results will likely differ from these estimates for many reasons, including material differences in the population that enrolls, demographic mix, new treatments and technologies, economic conditions, catastrophic claims, and random claim fluctuations. Changes in rules and regulations may require revisions to the premium rates included in this filing.

4.7.3: Actuarial Certification

I, Daniel Boeder, am an actuary employed by Cambia Health Solutions, the parent company of ANH. I am a member of the American Academy of Actuaries (AAA), in good standing, and meet the education and experience standards necessary to complete this actuarial certification.

On behalf of ANH, I have reviewed this rate filing for a January 1, 2026 effective date for the Individual block of business. I hereby certify that, in my opinion:

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations
    - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
    - Reasonable in relation to the benefits provided and the population anticipated to be covered
    - Neither excessive nor deficient
- 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 factor representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, was calculated in accordance with actuarial standards of practice
- 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
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2. Unique plan designs were fit appropriately in accordance with generally accepted actuarial principles and methodologies, as detailed in a separate certification.
- This rate filing is consistent with internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- 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. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*
- Professional Code of Conduct

Daniel Boeder Digitally signed by Daniel Boeder
Date: 2025.05.15 09:40:42 -07'00'

Daniel Boeder, FSA, MAAA
Manager, Actuarial Pricing
Cambia Health Solutions, on behalf of Asuris Northwest Health

Asuris Northwest Health – Individual
Actuarial Memorandum and Certification – Part III
Rates Effective January 1, 2026

Table of Contents

Sections are generally numbered to be consistent with the current Unified Rate Review (URR) Instructions. Sections ending with a letter are not explicitly numbered in the URR Instructions; the labeling is added for organizational purposes.

4.1: Redacted Actuarial Memorandum

This document is intended to serve as both the "CMS Version" and the "public version" of the Part III Actuarial Memorandum; no items are redacted.

4.2: General Information

Company Identifying Information

- Company Legal Name: Asuris Northwest Health
- State: Washington
- HIOS Issuer ID: 69364
- Market: Individual
- Effective Date: January 1, 2026

Company Contact Information

- Primary Contact Name: Dan Boeder
- Primary Contact Telephone Number: (206) 332-5619
- Primary Contact Email Address: daniel.boeder@cambiahealth.com

Purpose

This Actuarial Memorandum is prepared to provide transparency regarding the assumptions and methods used to calculate the rates proposed in the Asuris Northwest Health (hereafter referred to as ANH) January 2026 Individual Filing. Information is also included, where applicable, to support the information shown in the Part I Unified Rate Review template (URRT). The intended purpose of this document is to demonstrate the proposed rates included in this filing and the template are reasonable in relationship to the benefits provided and meet all rating requirements in the applicable laws and regulations in the state of Washington. The intended audience for this document is the Washington State Office of the Insurance Commissioner (OIC).

Two Appendix exhibits show the key framework supporting the rate filing. The process to develop the rate change for this filing is shown in "Exhibit A1: Development of 2026 Rate Change." Development of the URRT projection period index rate is shown in "Exhibit E1: Development of 2026 Index Rate."

Please note in reviewing this memorandum and its accompanying exhibits that ANH developed rates directly from incurred claims experience. The URRT requires issuers to include an index rate calculation based on allowed claims experience following a prescribed calculation methodology. Because ANH does not develop rates on an allowed claims basis, the URRT was populated indirectly such that the resulting projected average premium was consistent with the underlying rate development. Explanations regarding how the URRT was populated, consistent with the URR instructions, are included throughout this memorandum and explained relative to the actual rate development.

Per the Unified Rate Review Instructions released March 2022, the actuary may state: *"The URRT 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."*

4.3: Proposed Rate Changes

This filing proposes an average annual rate change of 15.15% on January 1, 2026, for the Individual line of business, as shown in "Exhibit A1: Development of 2026 Rate Change." The 2026 projected average premium is $764.49 per member per month (PMPM).

The average annual rate change is calculated based on Individual enrollment data as of March 2025, and includes the mapped rate impact for membership enrolled in plans terminating in 2026. A summary of the rate changes by plan is shown in "Exhibit D1: 2026 Average Change in Plan Base Rates."

Factor Changes

This filing includes updates to the plan and area factors. Rating factor tables and changes since the last filing are shown in the "Rate Factors" document. The average annual rate change impact of 15.15% includes the impact of these factor changes and is on a member-weighted basis.

Plan pricing factors are updated using the most recent data and factors from the pricing relativity model, with benefit design changes incorporated. Rate differences between plans reflect objective plan design differences and not differences in population morbidity.

Based on OIC guidance, only on-exchange Silver plan premium should be increased to cover the additional costs associated with providing benefits to all Silver plan enrollees, in the event the CSR subsidies are not funded. In 2026, ANH is offering plans off-exchange only, and therefore no additional load for CSR has been applied to any plan.

Area factors reflect relative cost differences between rating areas and, as required, do not include differences for population morbidity by geographic area. Area factors were updated to reflect relative cost differences between rating areas based on changes in unit cost and normalized PMPM claims cost.

Starting in 2026, ANH will no longer use tobacco use as a rating factor for Individual products.

Pool Base Rate

The pool base rate is $643.08 as of January 1, 2026. The pool base rate is the starting amount such that multiplying the base rate by the member's rating factors (plan, age, and area) and adjusting for family composition results in the member's premium.

Reasons for Proposed Rate Change

The following components are the most significant factors contributing to the proposed rate change: medical trend and utilization and financial experience.

Medical Trend and Utilization: These adjustments refer to what is commonly known as healthcare trend. They reflect contractual changes in the the payments to healthcare providers and expected changes in the volume and types of services utilized by a carrier's members.

Financial Experience: Each year ANH evaluates the most recent financial results in the Washington Individual market and incorporates that information into pricing.

Changes in Network: Each year, ANH evaluates the impact of underlying provider network contracts and incorporates that information into pricing. Additionally, the impacts of discontinued and new networks are evaluated and incorporated.

Market Morbidity: ANH expects increased market morbidity due to the discontinuance of enhanced Premium Tax Credits.

The above descriptions are intended to provide an overall understanding of the significant factors contributing to the rate change, and each item is described in detail later in this memorandum.

The following table is a decomposition of the rate increase into the various underlying factors but is not intended to directly reflect or replace the rate calculation developed on Exhibit A1.

Contributing Factor	Approximate Impact
Changes due to Medical Trend and Utilization	10%
Changes due to Experience[1]	7%
Changes due to Network Arrangements	-6%
Changes Due to Market wide Average Morbidity	4%
Total	**15%**

[1]Includes the impact of overestimate or underestimate of medical trend

4.4: Market Experience

This filing demonstrates that ANH followed federal guidance and market reform rating requirements in establishing a single risk pool in the Washington Individual market. The experience data includes all of ANH 's non-grandfathered covered lives in the Washington Individual market. Throughout this filing, "single risk pool" refers to the entire Washington Individual market.

4.4.1: Experience Period Premium, Claims, and Enrollment

The premium and claims used to develop this filing were incurred during calendar year 2024 and includes payments and adjustments paid through March 2025. They are shown in "Exhibit E1: Development of 2026 Index Rate." Current enrollment and premium are reported as of March 2025.

For rate development purposes, experience from multiple years of ANH Individual was used. ANH Individual experience from 2022 and 2023, trended to the projection period were combined with the 2024 experience, weighted by enrollment, to arrive at a fully credible population.

ANH analyzes financial performances for each company and line of business regularly and over/under-predictions are corrected for in the rate development the following year. Overall, premium and claims experience is unfavorable compared to expectations in 2024. ANH included an adjustment to the rates to reflect the unfavorable experience.

In completing the Experience Period Data section of the URRT, Worksheet 1, only ANH Individual 2024 information is reflected, as required by the instructions. The combined ANH 2022 and 2023 company experience projected to 2026 appears in the Manual EHB Allowed Claims section of the URRT, Worksheet 1, as described in the Credibility of Experience section of this memorandum.

Medical allowed claims and incurred claims were extracted directly from company claim records. Pharmacy claims are administered by a Pharmacy Benefits Manager and those allowed and incurred claims were extracted from their records. Unpaid claims liability (UCL) for incurred claims was developed directly with experience data using the following methodology, which is consistent with the corporate reserve development methodology. Unpaid claims liability for allowed claims was estimated using the same factors that were developed for incurred claims. Allowed and incurred claims from the experience period are shown in "WA Exh 1 – Experience Data" within "ANH IND OIC Health Exhibits."

Review and Analyze Data

- Check data for inconsistencies and anomalies
- Reconcile paid claims data against the general ledger
- Monitor unpaid claims inventory
- Assess impact of large claims
- Review claims on a per exposure basis for reasonableness (PMPM)
- Compare past UCL estimates to actual claims run-out on an ongoing basis to assess the reasonability of past calculations

Develop UCL Estimates Using Multiple Methods

- Basic Claims Development Method
- Paid PMPM Method

Determine UCL for Recent Incurred Months

The UCL was selected using judgment and considered factors such as recent observed and expected claims trends, seasonality, product design, and changes in membership and claims inventory.

For rate development purposes, pharmaceutical manufacturer rebates were not subtracted from experience period claims because an overall adjustment occurs in a later step of the claims projection process. In contrast, in the URRT, Worksheet 1, pharmacy rebates are subtracted from experience period claims. The Pharmacy Rebates section of this memorandum contains additional information about the adjustments.

There are no capitation payment arrangements anticipated to be in place for the projection period.

4.4.2: Benefit Categories

Each allowed claim is assigned to one of the following benefit categories: Inpatient Hospital, Outpatient Hospital, Professional, Other Medical, and Prescription Drugs. Examples of claims in the Other Medical category are home health care, ambulance, durable medical equipment, and prosthetics. The categorization is derived from each claim's type of service, provider type, and place of service and is an automated process within the data warehouse. This categorization is consistent with the definitions described in the URR Instructions, section 2.1.3.1 "Benefit Category and Manual Rate."

4.4.3: Projection Factors

Following is a description of the projection factors used in the filing. As described in the Purpose section of this memorandum, rate development is performed on an incurred claims basis (Exhibit A1) while development of the URRT projection period index rate is performed on an allowed claims basis (Exhibit E1).

Each projection factor's description addresses first how the adjustment is developed for rate development purposes (incurred claims basis). Then, any modifications needed to use the adjustment for developing the URRT projection period index rate (allowed claims basis) are described. Fixed dollar cost sharing measures such as deductibles and copays amplify the impact of cost changes on an incurred claims basis, so generally, a dampening adjustment is necessary to convert a factor on an incurred claims basis to an allowed claims basis.

4.4.3.1: Trend Factors

Projected Rating Trend

The trend factor used in rate development is shown on the "Trend Factor to Rating Period" line in "Exhibit A1: Development of 2026 Rate Change," reflecting twenty-four months of trend at an annual rate of 10.4%. The table below shows the expected components of the annual trend used to project incurred claims costs to the rating period. Note that the leverage component does not impact allowed claims; this trend applies to incurred, paid claims.

Components of Projected Trend

Reimbursement	5.10%
Utilization	2.00%
Mix/Intensity	1.10%
Leverage	2.20%

For reporting purposes, trend and its respective components are reported throughout the filing on a medical and prescription drug combined basis. This combined trend is applied to all service categories including EHB and non-EHB claims.

To determine projected trend for the rating period, ANH analyzed the individual components of trend, change in reimbursement, utilization, mix/intensity, and leverage, to determine the aggregate expected trend. Trend were developed separately for Medical and Rx, and then weighted together. Reimbursement trends were developed using internal contracted and anticipated contracting increases to providers. Currently, 36% of provider contracting is complete for plan year 2026. Utilization and mix trends were developed using actuarial judgment by examining specific company data in this market, as well as overall company and market trends. Development of projected utilization and mix/intensity trend considers trend across entire book of business rather than just Individual experience to neutralize population morbidity changes in a single line of business. Finally, major fixed plan design features were modeled to estimate the leverage impact to paid trend. Company data has a direct impact on the single risk pool, with specific data being directly applicable, while overall company data contributes to determining health trends that are relevant to the market.

The reimbursement component captures unit cost changes, including negotiated rate changes with providers. The utilization component measures the difference in number of services per 1,000 members. The mix/intensity component measures the shift within service categories (e.g., using more MRIs versus X-Rays or more specialty drug prescriptions as a percentage of total prescriptions) and between service categories (utilizing outpatient services instead of inpatient services). Fixed dollar cost sharing measures, such as deductibles and copays, serve to amplify trend since the member portion of total costs remains

fixed while the insurer portion increases over time. This effect is captured in the leveraging component of trend.

ANH considers historical experience, state and federal mandates, new technologies, cost shifting, drug patents, and anticipated economic conditions in determining the utilization and mix/intensity components of projected trend.

Additionally, ANH actively reviews and implements opportunities to improve the quality of health care delivery and achieve sustainable costs. This filing reflects an explicit reduction to overall projected trend of 0.3% due to expected incremental impacts of program changes from the base period to projection period. These initiatives are focused on lowering the utilization, mix/intensity, and reimbursement components of trend.

A few examples of new or expanded initiatives include:

- Creating a billing interface that re-establishes reasonable reimbursement of provider-administered medications.
- Launching a new provider rating methodology to identify and surface for our members providers with proven track records of using evidence-based practices, adhering to best practices for patient care and delivering cost-efficiencies.
- Expanding inpatient short stay program to enable real-time admission reviews, optimizing care settings and maintaining quality of care.
- Expanding utilization management to ensure medical appropriateness and manage outcomes.
- Reducing overpayments through data mining as well as pre-pay and post-pay edits and audits.
- Ensuring emergency department visit level coding aligns with Centers for Medicare & Medicaid Services (CMS) Guidelines.
- Engaging with network providers to align financial incentives and support better outcomes for episodes of care.

The following trend variables are not considered when calculating trend: margin, fluctuation, anti-selection, or underwriting wear-off.

The selected projected rating trend assumption and the resulting rate change consider but do not rely on differences in projected and observed trend levels in prior periods.

In the URRT, Worksheet 1, Section II, the annualized “Cost” trend factor is populated with the Reimbursement component shown above. The “Util” trend factor is populated with a blend of the Utilization and Mix/Intensity components in the projected trend. Trend is developed for a 24 month projection, so Years 1 and 2 are populated with identical annualized values. Additionally, please note the URRT trend is on an allowed basis and thus excludes the leverage trend component while remaining an actuarially equivalent claims projection.

Normalized Experience Trend
ANH reviews experience trend by calculating rolling twelve month historical paid claims trend on both an observed and underlying basis. In order to differentiate between the observed trend and the underlying trend, claims are normalized for differences in benefits, demographics, health risk, and large

claims. Demographic adjustments are developed using the current filed factors for age and area, benefit adjustments are developed using a benefit relativity model, and health risk adjustments are developed using risk score data.
A summary of the underlying allowed experience is included in "WA Exh 4 – Normalized Trend" within the "ANH IND OIC Health Exhibits." The analysis shows an underlying average allowed claim trend of 8.2% when comparing calendar year 2024 to calendar year 2023. This estimate of recent underlying trend experience is a single point of reference and is not the sole predictor of future trends.

4.4.3.2: Adjustments to Trended EHB Allowed Claims PMPM
4.4.3.2(a): Morbidity Adjustment
This assumption reflects the anticipated change in morbidity from calendar year 2024 ("base period") to calendar year 2026 ("projection period") for ANH Individual ACA plans. The morbidity adjustment reflects a change in the expected health risk of the pool regardless of the underlying demographics.

The morbidity adjustment used for rate development is shown on the "Changes in Morbidity" line in "Exhibit A1: Development of 2026 Rate Change." Development of the claims adjustment for morbidity is shown in "WA Exh 10 - Risk Adjustment" within "ANH IND OIC Health Exhibits." This exhibit also shows the projected risk adjustment transfer, which is closely related to the assumed projection period morbidity. An explanation of the risk adjustment transfer and its relation to company and market morbidity assumptions is provided in the "Risk Adjustment Payment/Charge" section of this memorandum.

The claims adjustment for morbidity was developed using the following process:

- Estimate morbidity level of base period company experience
- Estimate ANH Individual morbidity change from base period to projection period
- Adjust base period experience to projection period ANH Individual morbidity level

Morbidity Level of Base Period Company Experience
Morbidity for each base period experience pool was estimated using risk score data normalized for demographic and benefit differences. Because the risk scores were calculated on a consistent basis for each pool, the relativities between the risk scores represent the relative morbidities.

ANH Individual Morbidity Change from Base Period to Projection Period
A wide range of outcomes is possible for the average morbidity change between the base period and projection period for the population insured on ANH Individual plans. Population enrollment change is the biggest driver of morbidity change. Similar to claims variability, the average morbidity of an insured population will vary from one year to the next, even with no change in covered members.

Some drivers of insured population changes include macroeconomic conditions, market competitiveness, and consumer behavior changes; however, none of these factors or their resulting impacts can be forecasted with certainty.

An estimate for the projected morbidity change between the base period and projection period is shown in "WA Exh 10 - Risk Adjustment" within "ANH IND OIC Health Exhibits." Changes to each of the risk adjustment transfer components between 2024 and 2026 are shown in the exhibit. The projection

of 2026 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2024 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts. The calculation of the 2026 transfer payments reflects the 14 percent administrative cost reduction to state average premium.

ANH does not anticipate any substantive impact to market or company morbidity from the inclusion of the 1332 wavier and no adjustments were made in the development of rates to account for the waiver.

Adjust Base Period Experience to Projection Period ANH Individual Morbidity Level
The final factor used to adjust company base period morbidity to the projection period ANH Individual morbidity is derived by taking the ratio of the projection period ANH Individual morbidity to the base period company morbidity.

For purposes of incorporating the morbidity adjustment into the "Morbidity Adjustment" projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment was applied to convert the factor to an allowed claims basis. The projection factor for the URRT for each experience pool is shown in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.2(b): Demographic Shift
A demographic adjustment is reflected to account for population demographic differences between the experience period and the projection period. Adjustments are developed consistent with current filed factors for age and area.

The demographic adjustment used for rate development is shown on the "Changes in Demographics" line in "Exhibit A1: Development of 2026 Rate Change" and in "Exhibit C3: Demographic Factor Comparison." The most significant contributor to this shift is the observed change in the population between 2024 and March 2025.

For purposes of incorporating this adjustment into the "Demographic Shift" projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment was applied to convert the factor to an allowed claims basis. The projection factor used in the URRT for each experience pool can be found in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.2(c): Plan Design Changes
Company experience period claim costs are adjusted to reflect anticipated changes in covered benefits (Essential Health Benefits, Mandated Benefits, and Other Benefits) and changes in cost sharing.

The overall benefit design adjustment used for rate development is shown on the "Changes in Benefits" line in "Exhibit A1: Development of 2026 Rate Change."

Essential Health Benefits
Plans offered in 2026 must include covered benefits following Washington's essential health benefits (EHB) benchmark package for Individual plans. Covered benefits included in the base period plans were

reviewed against the 2026 EHB benchmark plan. 2026 premiums reflect the updates to the EHB Benchmark plan.

Experience period covered benefits for ACA plans satisfy Washington's 2026 requirements. Therefore, no specific experience period adjustments are applied to ACA plan experience.

Pediatric dental benefits are included as an embedded set of benefits in all ANH 2026 ACA products.

Mandated Benefits
ANH included an adjustment in the rate development to account for the impact of 2025 Washington legislative changes including expanded hormone therapy and removal of prior authorization on MHSUD.

Other Benefits
This adjustment reflects anticipated differences in non-EHB benefits between the experience period and projection period. There are no material differences that require an adjustment. The Individual Assistance Program non-EHB benefit is included in retention, and therefore does not require an adjustment to claims. For 2026, Gene Therapy is now considered an Essential Health Benefit.

Changes in Cost Sharing
This adjustment reflects anticipated changes in the average cost sharing requirements between the base period and projection period, which was derived by comparing the base period average benefit design to the projection period average benefit design, independent of changes in covered benefits and population health status. It includes anticipated changes in the average utilization and cost of services due to differences in average cost sharing requirements.

The "Plan Design Changes" projection factor in the URRT, Worksheet 1, Section II, includes corresponding adjustments to the changes in covered benefits and changes in cost sharing described above. The changes in cost sharing component only includes the portion of the adjustment attributable to anticipated changes in the average utilization of services due to differences in average cost sharing requirements. Anticipated changes in the average cost sharing requirements were excluded because they do not affect allowed claims.

4.4.3.2(d): Other Adjustments
This section describes cost adjustments other than changes in morbidity, demographic shift, and plan design changes.

Changes in Network
A network adjustment is reflected to account for expected network differences between the experience period and the projection period. The network adjustment used for rate development is shown on the "Changes in Network" line in "Exhibit A1: Development of 2026 Rate Change."

A proprietary network model is used to determine the projected cost relativities between different networks, based on historical experience projected to the rating period. The model allows the inclusion or exclusion of providers on a group-by-group basis. As a provider group is excluded from the network, the services that were delivered by that group are redistributed to other providers within the same specialty. As care is shifted among providers, adjustments are made to reflect utilization efficiency and

unit cost differences between the providers. For plans paired with an accountable health network, the relativities also reflect expected savings due to managed care and provider incentive arrangements.

If the network also has a risk sharing arrangement with the provider with an incentive component, a second model is used to calculate the cost impact of this arrangement. An additional reduction in cost is assumed due to improvements in care management for these members and a simulation model is used to estimate the value of the shared savings and/or deficit repayment. The value of these arrangements is included in the network factors.

The Individual and Family network will be discontinued in 2026. In 2026, ANH will offer plans on the new Individual Connect network. The Individual Connect network is a statewide network offered in all covered service areas.

For purposes of incorporating this adjustment into the "Other" projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment is applied to convert the factor to an allowed claims basis. The projection factor used in the URRT for each experience pool is shown in "Exhibit E1: Development of 2026 Index Rate."

Pharmacy Rebates
Incurred claims in the experience period are not reduced by estimated pharmaceutical manufacturer rebates, so a pharmacy rebates adjustment is reflected to account for estimated rebates in the projection period. The pharmacy rebates adjustment for rate development is shown on the "Pharmacy Rebates" line in "Exhibit A1: Development of 2026 Rate Change." Pharmacy rebates are estimated by projecting 2026 aggregate rebate-eligible script counts companywide from base period experience, adjusting for expected changes in average per script rebate guarantees, and then allocating the projected rebates to each line of business using base period pharmacy experience.

Because experience period allowed claims used in the URRT are net of pharmacy rebates, for purposes of incorporating this adjustment into the "Other" projection factor in the URRT, Worksheet 1, Section II, only the estimated difference in pharmacy rebates between the experience period and the projection period is reflected. The projection factor used in the URRT for each experience pool is shown in "Exhibit E1: Development of 2026 Index Rate."

Overall, the "Other" projection factor in the URRT, Worksheet 1, Section II, includes adjustments for network and pharmacy rebates.

4.4.3.3: Manual Rate Adjustments

Source and Appropriateness of Experience Data Used
As described previously in the Experience and Current Period Premium, Claims and Enrollment section, 2022, 2023, and 2024 calendar year data for ANH Individual ACA plans are used to develop 2026 rates. This experience is deemed to be fully credible to develop the framework for a statewide single risk pool.

For purposes of completing the URRT, Worksheet 1, all ANH non-grandfathered Individual 2024 experience was included to develop the Adjusted Trended EHB Allowed Claims PMPM Combined 2022 and 2023 ANH experience used to develop rates was reflected in the Manual EHB Allowed Claims PMPM

item in the URRT, Worksheet 1. A detailed summary is included in "Exhibit E1: Development of 2026 Index Rate."

Adjustments Made to the Data
Adjustments made to the data underlying the Manual EHB Allowed Claims PMPM section of the URRT are similar to the adjustments made to the data included in the URRT, Worksheet 1, Section II. A detailed summary of the adjustments is included in "Exhibit E1: Development of 2026 Index Rate." Descriptions of the adjustments are included in the corresponding sections of this memorandum.

Inclusion of Capitation Payments
No services are provided under a capitation arrangement.

4.4.3.4: Credibility of Experience
To develop 2026 rates, the overall projected claim cost was derived by taking a weighted average based on enrollment from ANH 2022, 2023, and 2024 experience pools.

In accordance with ASOP 25, blending multiple years of ANH experience is an appropriate procedure in the development of projected claim costs. Differences in population between experience years have been accounted for by adjusting each year's claims experience to reflect unique population characteristics and improve homogeneity.

The adjustment from each year to reflect the characteristics of the projection pool was calculated as follows for Morbidity, Benefits, Demographics, and Networks:

- Estimate a relative value for the base period experience for each year of ANH experience (a)
- Estimate ANH individual 2024 experience relative value for the projection period (b)
- The adjustment applied to each experience pool is equal to (b) divided by (a)

The claims cost weight assigned to each experience year is shown in "Exhibit A1: Development of the 2026 Rate Change." The resulting overall projected incurred claims cost is $656.05 PMPM.
For purposes of completing the URRT, the credibility percentage applied to the experience included in the Manual EHB Allowed Claims PMPM section is consistent with the weights for rate development. The resulting projected allowed claims cost is $924.14 PMPM.

4.4.3.5: Establishing the Index Rate
The experience period index rate is $878.17 PMPM; the projected period index rate is $924.14 PMPM. Non-EHB benefit categories are excluded from the calculation based upon the benefit category code assigned automatically within the data warehouse. The Individual Assistance Program (IAP) benefits are excluded from all plans. Please note the index rate does not demonstrate the process used to develop the rates; it was prepared for reporting purposes and is calculated consistently with the results of the underlying rate development process.

For purposes of determining non-EHB benefits, only material benefit categories not covered in the EHB benchmark plan are identified. In cases where the company provided offering is richer than the EHB benchmark plan, the benefits are not considered non-EHB. For instance, if 15 service visits are covered

compared to 10 visits in the benchmark plan, then the additional 5 visits would not be considered non-EHB.

Development of the index rate is shown in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.6: Development of the Market-wide Adjusted Index Rate

The market-wide adjusted index rate is $829.91 PMPM. It is calculated as the projection period index rate adjusted for the following allowable market-wide modifiers:

- Net impact of the risk adjustment program
- Exchange user fees

Development of the market adjusted index rate is shown in "Exhibit E1: Development of 2026 Index Rate."

4.4.3.6(a): Reinsurance

There are no state or federal reinsurance programs in effect for the experience or projection periods. The reinsurance amount entered into the URRT, Worksheet 1 is $0.00.

Cambia Health Solutions, the parent company to ANH, was engaged in a private reinsurance arrangement for all its insured business during the experience period. This agreement reimbursed a portion of claims in excess of $4.0M in the experience period, and a similar arrangement is expected for the projection period in exchange for a small premium. The net impact of this arrangement is expected to be negligible, so the amounts are excluded from this filing.

4.4.3.6(b): Risk Adjustment Payment/Charge

2024 risk adjustment transfers are populated in the "Risk Adjustment Transfer Amount" line of the URRT, Worksheet 2, Section II. Amounts were allocated by plan in proportion to premium. The risk adjustment user fee for 2024 was $0.21 PMPM. The experience period risk adjustment transfer PMPM, including net HCRP receipts and before reduction for the risk adjustment user fee, is $82.31 as shown in "WA Exh 10 - Risk Adjustment" within the "ANH IND OIC Health Exhibits."

The URRT, Worksheet 1 shows the experience period risk adjustment PMPM as $81.98 because it is calculated as the projected 2024 risk adjustment transfer divided by the 2024 experience period membership. The risk adjustment transfer PMPM shown in "WA Exh 10 - Risk Adjustment" within the "ANH IND OIC Health Exhibits" is calculated as the projected 2024 risk adjustment transfer divided by the billable member months. Experience period member months differ from the billable member months due to differences in counting billable member months and total member months, and due to differences in the run out period.

The projected risk adjustment PMPM reflects the difference in projection period expected relative risk between the ANH block of business and the overall market. The estimated risk adjustment transfer used for rate development is shown on the "Risk Adjustment Transfer" line in "Exhibit A1: Development of 2026 Rate Change." The risk adjustment user fee for 2026 is $0.20 PMPM and is shown in the "Retention Development" section of Exhibit A1. Information regarding the transfer estimate is shown in "WA Exh 10 - Risk Adjustment" within the "ANH IND OIC Health Exhibits," including the detailed internal data and projections by metal level used to develop the estimate. A positive amount represents an anticipated

risk adjustment payment receipt, and a negative amount represents an anticipated risk adjustment charge.

The federal risk adjustment program transfers funds from carriers with relatively lower risk enrollees to carriers with relatively higher risk enrollees, which mitigates the potential concern of adverse selection in a guaranteed issue market. The transfer formula operates such that, in general, changes in a carrier's enrolled risk profile results in corresponding changes to the transfer amount. That is, a carrier enrolling relatively higher risk members would expect to receive a higher transfer payment (or pay a lower transfer charge). Similarly, a carrier whose enrolled risk profile stayed the same while the market-wide average risk improved would also expect a higher transfer payment (or lower transfer charge).

A carrier's risk transfer results from HHS's risk transfer formula will inherently vary from year-to-year even with no significant carrier or market morbidity changes. For example, periodic updates to the transfer formula methodology and carrier differences in diagnosis coding practices and data submission capabilities will introduce additional variation. For carriers whose enrollees have a significantly different average risk profile than market average, the variability in risk adjustment results may be even higher.

The 2026 projected risk adjustment PMPM is developed considering expected changes in market-wide morbidity and company enrollment profile changes, combined with risk adjustment transfer formula relationships and reasonable judgment. Considerations included 2023 actual risk adjustment results, 2024 estimated risk adjustment results, projected changes in the market-wide morbidity level between 2024 and 2026, and projected changes in company morbidity of the population insured between 2024 and 2026.

The projection of 2026 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2024 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts.

In projecting Risk Adjustment transfers, internally counted medical member months will differ from the CMS methodology for billable member months. The difference between the two is that CMS billable member month methodology excludes children who are not charged a premium and counts 30 days as a month. These two differences directionally offset and are generally of a similar magnitude, so this filing uses the simplifying assumption that projected member months are equal to projected billable member months.

Continuing in 2026, a federal high-cost risk pooling program (HCRP) is expected to partially reimburse carriers for claims over one million dollars, with a fee assessed to the pool to cover the cost of the claims. For rate development purposes, both claim and premium adjustments are made to account for the impact of this program. For claims projection, expected reimbursement amounts from HCRP are removed from the experience period before trending to the projection period. For the anticipated HCRP program assessment, an estimated value of 0.50% of premium is used in rate development. For the purposes of populating the URRT, the HCRP assessment is added to the risk adjustment transfer

amount. The premium charge for the HCRP is not finalized; this amount is based on an estimate developed by an external consultant.

ANH anticipates $0 in HCRP recoveries for 2024 and had $0 in HCRP recoveries for 2022 and 2023.

The risk adjustment data validation (RADV) program was established with the primary purpose of validating the accuracy of data submitted by issuers for the purposes of risk adjustment transfer calculations. Any RADV findings are used to adjust the risk scores used in risk adjustment transfers in the following year. Because the risk adjustment program is revenue-neutral within a state and market, an issuer's Individual risk adjustment results would be impacted by a RADV finding for any issuer in their state and market. In developing a projection for future years, risk adjustment transfers are projected without any assumed RADV impact in the experience period year. It is assumed that any impacts of RADV findings in the experience period year are a one-time item, and that continuous improvements by issuers in their data submissions and validations will eliminate systemic findings that could be predictive of adjustments in future years.

The "Risk Adjustment Transfer Amount" item in the URRT, Worksheet 2, Section IV is the plan allocation of the aggregate risk adjustment transfer amount on a paid basis. Note that this will differ from the URRT, Worksheet 1, Section III, which is on an allowed basis. Single risk pool pricing requirements require anticipated risk adjustment transfers to be allocated proportionally as a market level adjustment, so the risk adjustment transfer amounts were similarly allocated, by plan and in proportion to premium. Note that the HCRP premium charge is included in the aggregate transfer amount and spread uniformly across all plans.

4.4.3.6(c): Exchange User Fees
This filing reflects exchange user fees of $0.00 PMPM because products will not be offered on a marketplace in 2026.

4.4.4: Plan Adjusted Index Rate
The plan adjusted index rates are calculated as the market adjusted index rate adjusted for allowable plan-level modifiers, as shown in Exhibit E2. The following adjustments are made:

- AV and cost-sharing design, which considers the expected allowed claims by benefit category, adjustments for utilization and plan design features, claim probability distributions (CPDs) and healthcare cost trends. The AV and cost sharing design does not account for differences in health status.
- Network, delivery system characteristics, and utilization management practices. Network factors were developed internally using a proprietary network model to determine the projected cost relativities, as discussed in the "Changes in Network" subsection of section 4.4.3.2(d): Other Adjustments.
- Non-EHB benefits, discussed in the "Other Benefits" subsection of section 4.4.3.2(c): Plan Design Changes. Benefits in addition to EHB were estimated using internal claims data to project the future costs of each benefit as a percent of total projected costs.
- Administrative costs, excluding exchange user fees and reinsurance fees, discussed in section 4.4.7: Non-Benefit Expenses.

Development of the plan adjusted index rates from the market adjusted index rate and allowable plan-level modifiers is shown in "Exhibit E2: Plan Adjusted Index Rate Development." Included in the exhibit are explanations of how the modifiers are developed.

The components of the AV and cost-sharing design factors are Induced Demand Factors, EHB Paid to Allowed Factors, and Projected CSR Adjustment factors as shown in Exhibit E2. Induced Demand Factors for 2026 are prescribed by emergency rule CR-103E (R 2025-01) and included in "WA Exh 9 – AV and Cost-Share" within the "ANH IND OIC Health Exhibits." EHB Paid to Allowed Factors are derived values for the purpose of the URRT and are not used in rate development.

The base product factors were developed using a proprietary benefit relativity model that does not account for health status. The base product factor is used to normalize the projected average premium to get us to our pool base rate in Exhibit A1. These factors are based on paid claims. The base product factor is the pricing value based on benefit design only, before network adjustments and non-EHB benefits.

4.4.5: Calibration

The URRT and actuarial memorandum instructions require the plan adjusted index rates to be calibrated for age, area, and tobacco use factors. Calibration adjustments for these factors were applied uniformly to all plans.

The plan adjusted index rates calibrated for age, area, and tobacco factors are expected to approximate plan starting costs for premium determination, before applying the allowable consumer-specific rating factors for age, area, and tobacco, as well as family composition adjustments. Reconciliation of the plan adjusted index rates and the 2026 plan base rates is shown in "Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping."

Exhibit E3 displays the actual 2026 Plan Base Rates which are analogous to, but may not exactly match the URRT, Worksheet 2, Section III Calibrated Plan Adjusted Index Rates. As noted in the URR Instructions, section 2.2.3, "It is understood [the Calibrated Plan Adjusted Index Rate] may not match exactly to rates submitted in the Rates Table Template document due to rounding and truncation of variables in the URRT, however it is expected the rates will be reasonably close to each other."

Age Curve Calibration

The age factor calibration adjustment was calculated by applying the age curve premium factors to the projection period population. An age factor of 0 was used for the projected population under age 21 subject to the three-child family rating limitation. Development of the calibration adjustment is shown in "Exhibit C1: Age Curve and Tobacco Calibration Factors."

Geographic Factor Calibration

The geographic factor calibration adjustment is calculated by applying the 2026 area factors to the projection period population. This adjustment is shown in "Exhibit C2: Geographic Factors."

Tobacco Use Rating Factor Calibration

In 2026 Tobacco use status is not used as a rating factor for ANH Individual products.

4.4.6: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate charged to an individual or family. Premiums are determined starting from each plan's base rate. Premium rates may vary due to the following factors, as permitted by 45 CFR 147.102:

- Plan
- Age
- Area
- Family status

To distribute the projected average premium across the projected population, ANH determined an overall pool base rate using a normalization calculation. The pool base rate represents the starting amount for premium determination purposes before applying consumer-specific premium factors.

The 2026 pool base rate of $643.08 and the average factors for normalization are shown in "Exhibit A1: Development of 2026 Rate Change."

The pool base rate is determined by dividing the projected average premium by the projected population's average factors. The average age factor is adjusted to reflect the three child dependent premium limit. Area factors reflect geographical delivery cost differences with respect to unit cost and provider practice pattern differences; as required, they do not include differences for population morbidity.

A plan base rate is calculated for each plan by multiplying the pool base rate with the plan's corresponding plan factor. Plan factors are developed as the product of the internally developed base product pricing factor, and network discount factor.

Each member's premium is developed by multiplying the plan base rate for the member's selected plan with the member's applicable age, and area factors. The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

4.4.7: Non-Benefit Expenses

The "Retention Development" section of "Exhibit A1: Development of 2026 Rate Change" shows non-benefit expenses included in the premium development.

4.4.7(a): Administrative Expense Load

The administrative expense load is comprised of expected plan operating expenses and commissions paid to agents and brokers, offset by investment earnings on claim reserves.

Operating expenses for 2026 are projected at $48.48 PMPM or 6.34% of premium. Operating expenses are developed by the cost accounting department consistent with company policy and were reviewed for reasonability compared to prior results. When possible, operating expenses are assigned directly as a claim or non-claim related expense to the appropriate line of business. When costs cannot be assigned directly to a specific line of business, the expenses are allocated based upon appropriate objective

statistical measures. As such, reliance is placed on the internal cost accounting department's expertise in developing these estimates.

Commission expenses for 2026 are projected at $14.27 PMPM or 1.87% of premium. Historical utilization of distribution channels was analyzed against the 2026 commission schedule. Commissions may apply to members purchasing off exchange if a broker is utilized.

Investment earnings on claim reserves are projected to impact premiums by -$1.70 PMPM or -0.22% of premium. This value reflects a projected T-bill rate of 2.38% applied to the claim reserves. Earnings are expressed as a percentage of premium.

The following tables show the components of "Administrative Expense Load" in the URRT, Worksheet 2, Section III, from the 2026 rate filings.

2026 Administrative Expense Components

Component	Percent of Premium	PMPM
Administrative Expenses	6.34%	$48.48
Commissions	1.87%	$14.27
Investment Earnings	-0.22%	-$1.70
Total Administrative Expense Load	7.99%	$61.05

2026 Projected Average Premium PMPM: $764.49

PMPM values shown here match the rate development and may differ from the URRT due to rounding. Prior years projected and actuals are included in "WA Exh 11 - Retention" within "ANH IND OIC Health Exhibits"

4.4.7(b): Profit and Risk Load

Rate setting for ACA plans includes many pricing risks. Claims experience continues to be more volatile and less predictable relative to recent years because the covered population may change materially from year-to-year. These changes increase uncertainty with how closely morbidity adjustments align to final risk adjustment transfer amounts. There is further underlying variability with risk adjustment transfers due to differences between carriers in diagnosis coding practices and data submission capabilities, which are factors that cannot be predicted. Also, while the risk adjustment program is intended to compensate for morbidity differences between carriers, it does not protect against the risk of market morbidity being less favorable than projected across all carriers.

As described in actuarial standards of practice and WAC 284-43-6040(c), a provision for the impact of adverse deviation sufficient to cover anticipated costs under moderately adverse experience has been included in this filing as a risk and contingency margin. The table below shows a variety of items considered as potential risks, with a range of impacts for each item under moderately adverse conditions estimated based on actuarial judgement and experience. The cumulative range is strictly less than the sum of the individual endpoints, as it is recognized that not all impacts would occur simultaneously under a moderately adverse scenario.

Items considered as risks under moderately adverse conditions:	**Estimated Range:**
Changes in unit cost, provider contracts, drug costs, and new technology	0.5% - 2.0%
Changes in utilization not otherwise compensated through risk adjustment	0.5% - 1.0%
Claims fluctuation from catastrophic claims or pool size	1.0% - 2.0%
Changes in market enrollment and/or morbidity	0.5% - 2.0%
Impact of unanticipated regulatory changes	0.5% - 2.0%
Unexpected issuer or market RADV findings	0.5% - 2.5%
Unanticipated variation in commissions, taxes, or administrative costs	0.5% - 1.0%
Cumulative Range of Moderately Adverse Impacts:	**2.0% – 6.0%**

The following table summarizes risk and contingency margin for this filing.

Risk and Contingency Margin	
Filing Year	2026
Percent of Premium	3.5%
PMPM	$26.76

This information is included in "Profit & Risk Load" in the URRT, Worksheet 2, Section III. Prior years projected and actuals are included in "WA Exh 11 - Retention" within "ANH IND OIC Health Exhibits"

4.4.7(c): Taxes and Fees

The taxes and fees for the Individual line of business are comprised of state premium taxes, Patient Centered Outcomes Research Institute (PCORI) fees, exchange user fees, HCRP fees, risk adjustment program fees, WSHIP assessments, regulatory surcharge, insurance fraud surcharge, and WPAL fee. Note that HCRP and exchange user fees are not included in URRT, Worksheet 2, Line 3.7.

- State premium tax is set at 2.0% by the state of Washington.
- ANH is subject to federal income taxes. As this filing includes no explicit contribution to surplus, no adjustment is made for income taxes.
- The estimated PCORI fee for 2026 plans is $0.32 PMPM. The PCORI fee is calculated as the $3.00 annual fee for plan years ending October 1, 2024 through September 30, 2025, divided by 12, and trended for 2 years at an annual rate of 4.9% and 5.0%, the projected trend from the National Health Expenditures, and rounded to the nearest penny.
- This filing reflects exchange user fees of $0.00 PMPM because products will not be offered on exchange in 2026.
- The risk adjustment program fee for 2026 is $0.20 PMPM.
- This filing assumes an HCRP assessment of 0.50% of premium, as discussed in section 4.4.3.6(b). On the URRT, this amount is included in the risk transfer amounts and is not included in the Taxes and Fees section.
- An amount of $0.32 PMPM is included in this filing for the WSHIP assessment. This is based on WSHIP's preliminary financial projection anticipating total 2026 assessments of $6 million. The following table shows the development of this amount starting from WSHIP's anticipated total assessment.
- The regulatory surcharge from RCW 48.02.190 is calculated to be 0.08% of premium by using the 2025 fee as a proxy for 2026.

- The insurance fraud surcharge from RCW 48.02.190 is calculated to be 0.00% of premium by using the 2025 fee as a proxy for 2026.
- The WPAL fee, which is a new fee funding the WA Partnership Access Line, is calculated to be $0.07PMPM by using the projected annual program costs divided by WSHIP enrollment as a proxy.

WSHIP Assessment Allocation

Description	Amount	Calculation
(A) Total Estimated 2026 WSHIP Assessment	$10,500,000	
(B) Cambia Portion of Total WSHIP Assessment (%)	8.0%	
(C) Cambia Portion of Total WSHIP Assessment ($)	$839,177	A * B
(D) Projected Member Months for WSHIP Allocation	2,611,106	
(E) PMPM Average Estimate WSHIP Allocation	$0.32	C / D

The following tables summarize the components of "Taxes & Fees" in the URRT, Worksheet 2, Section III from the 2026 rate filings.

2026 Taxes & Fees Components

Component	Percent of Premium	PMPM
Premium Tax	2.00%	$15.29
PCORI Fee	0.04%	$0.32
Risk Adjustment Program Fee	0.03%	$0.20
WSHIP Assessment	0.04%	$0.32
Regulatory Surcharge	0.08%	$0.58
Insurance Fraud Surcharge	0.00%	$0.03
WPAL Fee	0.01%	$0.07
Total Taxes & Fees	2.20%	$16.81

2026 Projected Average Premium PMPM: $764.49

PMPM values shown here match the rate development and may differ from the URRT due to rounding.

The regulatory and insurance fraud surcharges from RCW 48.02.190 are built into the premium as described in subsection (7)(d). Prior years projected and actuals are included in "WA Exh 11 - Retention" within "ANH IND OIC Health Exhibits"

4.5: Projected Loss Ratio

The projected federal loss ratio calculated using federally-prescribed methodology for medical loss ratio (MLR) rebates calculations is 88.2%, which is greater than the federally prescribed MLR requirement of 80.0%. Due to the complexity of the federal MLR rebate methodology, which is beyond the scope of this filing, the only adjustment reflected is subtracting projected taxes and fees from the premium denominator. This simplified MLR calculation is strictly less than or equal to the federal MLR methodology, so the federal MLR must also be greater than 80.0%. The numerator for this ratio is projected incurred claims net of projected risk adjustment transfers, $656.05 PMPM. The denominator

of this simplified calculation is equal to projected average premium, less the Total Taxes & Fees PMPM described in the preceding Taxes & Fees section: $743.92.
ANH considered potential impacts resulting from the 2026 MLR reporting regulation changes and deemed no changes in rating methodology to be required.

The URRT, Worksheet 2, Line 4.10 includes a different loss ratio calculation which adds transfer receipts to the denominator (Claims divided by Premium plus Transfer Receipts). Due to varying claims experience by plan and large projected risk transfers for some metal levels, the projected loss ratios shown for some plans may be significantly below 80%, which is not unreasonable.

The projected federal loss ratio is shown in "Exhibit A1: Development of 2026 Rate Change."

4.6: Plan Product Information

4.6.1: AV Metal Values

ANH followed applicable guidance in determining AV Metal Values using the prescribed AV Calculator methodology, including guidance issued by CMS on May 16, 2014, titled "Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards." This CMS guidance states, "A plan design is incompatible when the use of the AV Calculator yields a materially different AV result from using the other approved methodologies." A materially different AV result is interpreted as one that changes a plan's metal tier.

Some ANH plans include an Optimum Value Medication (OVM) benefit that is not supported by the AV calculator. The OVM is a list of drugs considered important to longterm health for which the deductible is waived to encourage continued prescription adherence. ANH estimated the impact of the OVM on the actuarial value and considers it to be immaterial.

The AV Calculator does not differentiate cost sharing for outpatient mental health office visits and other mental health services. Some ANH plans include a copay for mental health office visits and coinsurance for other mental health services. The portion of services that are non-office visit was determined to be negligible and ANH considers the impact to actuarial value to be immaterial. The mental health office visit copay was used in the AV Calculator for determining the actuarial value.

As required, ANH used an actuarially justifiable process for inputting plan designs into the AV Calculator. For non-standard cost shares, AV Metal Values were tested using an alternate methodology under 45 CFR 156.135(b), and all plan designs were determined to be compatible with the AV Calculator, as the alternate methodologies did not produce materially different results. Therefore, AV Metal Values included in the URRT, Worksheet 2 for all plans were determined entirely based on the AV Calculator. A separate certification is included in this filing, "ANH IND CMS Unique Plan Design Documentation," which contains further details on how the alternate methods were applied.

Please note that AV Metal Value determinations follow the AV Calculator methodology prescribed by HHS, and these actuarial values are only to be used to determine a plan's metal tier. They do not reflect the best estimate of the portion of allowed costs covered by the health plan.

4.6.2: Membership Projections
Projected member months by plan for the URRT, Worksheet 2, are estimated based on data through March 2025, assuming minimal changes in the enrollment distribution by plan to ensure non-zero enrollment in each 2026 plan.

2026 product selections are assumed to be similar to 2025 product selections. ANH implicitly assumes that there will be additional enrollment changes that are immaterial to rate development.

No members are expected to enroll in cost-sharing reduction subsidy plans in 2026 because ANH is only offering products outside the exchange.

4.6.3: Terminated Plans and Products
ANH does not have any 2025 plans terminating in 2026.

4.6.4: Plan Type
ANH does not offer any plans that do not meet the plan type definitions in the URRT, Worksheet 2.

4.7 Miscellaneous Instructions

4.7.1: Effective Rate Review Information and Additional Requirements

This rate filing includes information meeting Washington's rate filing speed-to-market requirements:

- AV Screenshots
- Benefit Components
- CMS Unique Plan Documentation
- Commission Certification
- Filing Checklist
- Mental Health and Substance Use Disorder Financial Requirement Certification
- OIC Health Exhibits
- Part I Unified Rate Review Data Template
- Part II Written Description Justifying the Rate Increase
- Part III Rate Filing Documentation and Actuarial Memorandum
- Rate Factors
- Rate Review Detail in SERFF
- Rate Schedule
- Rating Example
- Supplemental Exhibits
- Uniform Product Modification Justification
- WAC 284-43-6660
- 1332 Waiver Checklist

Additional information satisfying the items requested by the Washington State Office of the Insurance Commissioner in the "2026 Plan Year Individual Nongrandfathered Health Plan (Pool) Rate Filing Checklist" is as follows:

A table summarizing the plan-level factors used to adjust the market adjusted index rate to the plan adjusted index rates can be found in "Exhibit E4: Plan Variation from Market Adjusted Index Rate for

Renewal Plans." The table includes each renewal plan in 2026 and the applicable factors from the 2025 and 2026 filings. Plan-level factors adjusting the market adjusted index rate to the plan adjusted index rate will always vary from year-to-year due to routine calculation updates following the URRT required calculation methodology. Factor changes are attributable to plan pricing updates, network relativity updates, differences in non-EHB estimates, and differences in administrative costs.

As well, the "Benefit Components" template has been completed to provide detailed information on benefits covered and cost- sharing structures by plan, including network information and whether out of network coverage is offered.

For changes to network factors, an explanation is provided in the "Projection Factors" section on how the previous factor was determined, whether the network factors incorporate efficiency, fee schedule, fee for service, or bundled payments, whether the factors are based on historical data or future anticipated experience, and whether the company's provider compensation includes bonuses and/or other payments. Documentation as to how the adjustments were made to the URRT, Worksheet 1, Section II is also included.

A summary of the factors included in the 2022 - 2026 URRTs, Worksheet 1, Section II, is included in "WA Exh 5 – w1 Pool Factors" within the "ANH IND OIC Health Exhibits."

In the URRT, Worksheet 2, Section I, the product and plan information is entered in accordance with the current Unified Rate Review Instructions. The instructions for Worksheet 2, Section I, specify how to determine which products and plans to enter, how to determine whether a plan is a new plan, renewing plan, or terminated plan, and how to enter product and plan information.

In the URRT, Worksheet 2, Section II, the experience period data is entered for the twelve month period corresponding to the base experience period. Experience for terminated plans is entered in accordance with the URRT instructions. A description of how the estimated risk adjustment transfers and reinsurance recoveries are calculated is described earlier in section 4.4.3.6 of the memorandum.

In the URRT, Worksheet 2, Section IV, the projected enrollment is generally set equal to the current enrollment with minor adjustments to ensure new plans have nonzero projected enrollment.

A summary of the age, area, and tobacco factors used in the 2023 - 2026 filings is included in "Exhibit C3: Demographic Factor Comparison."

Regarding checklist item 17(a), The Tobacco Use factor is not applicable for 2026.

Regarding checklist items 11(a) and 20, parent company Cambia Health Solutions purchases reinsurance for all its fully insured business. This agreement reimbursed a portion of claims in excess of $4.0M in the experience period, and a similar arrangement is expected for claims in excess of $4.0M in the projection period. Due to the volatility in projecting such large claims, no explicit projection is made. Details for development of the Market-wide Adjusted Index Rate are included in section 4.4.3.6 of the memorandum. Details about pricing and parameters of the arrangement are proprietary and not included here.

Regarding checklist items 23(a)&(b), the experience rate change by plan in UPMJ Q5(g) is the remainder of the total change in 5(j), removing 5(h) and 5(i). This varies by plan due to many factors, including changes in network pricing, geographic area factors, the mapping of terminated plan members, changes in CSR load, and changes to the underlying proprietary benefit relativity model used in developing the pricing AVs by plan.

Regarding checklist items 23(c), 23(d), and 28(h), a summary of enrollment, premium, claims, and rates across various documents in the filing is included in "Exhibit F1: Checklist Value Comparison." Inconsistencies may be due to rounding and order of operations in the URRT Worksheet 2 and the Rate Review Detail, which are slightly different than the methodology in the rate development and rate template formulas. In addition, the Rate Review Detail values may correspond to initially filed rates, but not necessarily to subsequent rate updates.

Regarding checklist item 11 and 27, voluntary abortion services are priced at 0.2% of premium to reflect the minimum required amount under 45 CFR §156.280(e)(4). The actual estimated cost of these services is less than one dollar per enrollee, per month. The non-EHB percent listed in the binder filing is 0.2%.

Regarding checklist items 28(e) and 30(c), the member-weighted rate change is demonstrated in "Exhibit D1: 2026 Average Change in Plan Base Rates" and UPMJ Question 5. The premium weighted rate change appears in item 1.12 and 1.13 in URRT Worksheet 2, Section I, at the product level and in total, respectively.

Regarding checklist item 6(a), the Proportion of Claim Dollars for trends in the WAC 284-43-6660 summary is calculated using the information in section II of "Wksh 1 – Market Experience" in the Unified Rate Review Template. The Experience Period Index Rates PMPM for each benefit category are compared to the total PMPM to derive the proportion of claim dollars.

The Mental Health Substance Use Disorder (MHSUD) financial requirement was tested for parity for all proposed plan designs. Only Outpatient In-Network benefits were tested; all other benefit categories have the same cost sharing for Mental Health and Medical/Surgical services. The allowed amounts (before enrollee cost sharing) for all Outpatient In-Network claims incurred in 2024 and paid through March, 31 2026 were summarized by benefit category for all of Cambia's individuallegi ACA plans in Washington. The allowed amounts were converted to PMPM values using the corresponding enrollment for the same time period. All mental health related claims were removed as required in the testing.

Plan-level testing used the trended PMPMs only for the benefits that are available on that plan and applied projected enrollment. The benefit structure and member cost sharing of the plan was used to test the plan design for parity under the financial requirement rules.

The testing and the certification can be found in the following files: "ANH IND MHSUD Certification", "ANH IND MHSUD Exhibit", "ANH IND MHSUD Exhibit Duplicate".

4.7.2: Reliance

Other than as previously identified, I did not rely on any other information or underlying assumptions provided by another individual in preparing the Part I Unified Rate Review Template.

Caveats and Limitations

The index rate and premium projections contained in this filing reflect best estimates of future costs that were developed based on available data, review of the literature, applicable rules and regulations, best thinking regarding the market population, and actuarial judgment. Actual experience and financial results will likely differ from these estimates for many reasons, including material differences in the population that enrolls, demographic mix, new treatments and technologies, economic conditions, catastrophic claims, and random claim fluctuations. Changes in rules and regulations may require revisions to the premium rates included in this filing.

4.7.3: Actuarial Certification

I, Daniel Boeder, am an actuary employed by Cambia Health Solutions, the parent company of ANH. I am a member of the American Academy of Actuaries (AAA), in good standing, and meet the education and experience standards necessary to complete this actuarial certification.

On behalf of ANH, I have reviewed this rate filing for a January 1, 2026 effective date for the Individual block of business. I hereby certify that, in my opinion:

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations
    - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
    - Reasonable in relation to the benefits provided and the population anticipated to be covered
    - Neither excessive nor deficient
- 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 factor representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, was calculated in accordance with actuarial standards of practice
- 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
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2. Unique plan designs were fit appropriately in accordance with generally accepted actuarial principles and methodologies, as detailed in a separate certification.
- This rate filing is consistent with internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- 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. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*
- Professional Code of Conduct

Daniel Boeder Digitally signed by Daniel Boeder
Date: 2025.05.15 09:40:42 -07'00'

Daniel Boeder, FSA, MAAA
Manager, Actuarial Pricing
Cambia Health Solutions, on behalf of Asuris Northwest Health

Asuris Northwest Health
Individual
Rates Effective January 1, 2026
Part II - Written Description Justifying the Rate Increase

Asuris Northwest Health (Asuris) is filing a rate change request for its Individual metallic products. These plans comply with federal Affordable Care Act (ACA) plan design and benefit requirements, and Asuris has approximately 1,000 members enrolled in this line of business as of March 2025. Asuris is projecting total enrollment for 2026 to be approximately 11,600 member months. This filing is based on claims experience from January 2024 through December 2024, with claims paid through March 2025.

Rate Change

The projected average rate change for plans effective in 2026 is 15.15%, which is an average rate change of about $101 per member per month (pmpm). Because 15.15% (or about $101) is an average, it is possible to have a different rate change. Rate changes vary from about 12.6% to 16.4% and this variability in rate changes is driven by plan design and geographic factor changes. Factors affecting a member's premium are age, family composition, plan, and geographic area. Expected cost differences by product are updated every year to ensure premium differences are appropriate. The table below shows the breakout of the factors contributing to the increase.

Contributing Factor	Approximate Impact
Medical Trend	10%
Market-wide Average Morbidity	4%
Network Arrangements	-6%
Higher than Expected Claims	7%
Total	**15%**

Contributing Factors - Medical Trend

The increasing cost of medical care is a significant driver of the rate change. This filing reflects projected claims expenses increasing approximately 10% annually. About 7% of this increase is due to cost and utilization changes.

Contributing Factors - Higher than Expected Claims

The 2026 premium increase reflects the 2026 claims expectations based on actual 2024 claims experience which was higher than expected.

Contributing Factors - Other

Asuris is committed to using member premium dollars responsibly and consistently pays out a high percentage of premium dollars towards member claims. Asuris expects this rate filing to exceed the ACA’s minimum Medical Loss Ratio (MLR) requirement.

Administrative expenses are expected to be 8.0% of premium, compared to 9.3% in the 2025 rates. Regulatory payments including taxes and fees required by the ACA are expected to be 2.2%, compared to 2.2% in the 2025 rates. Provisions for adverse deviation estimates to account for inherent variability in predicting future claims and anticipated contribution to surplus are included as 3.5% of premium, compared to 3.5% in the 2025 rates.

Changes in Benefits

Asuris’s metallic products continue to meet the ACA’s essential health benefit coverage standards. Renewing plans may have changes in member cost-sharing components (deductible, out-of-pocket maximum, coinsurance, etc.) to reflect anticipated changes in cost and utilization as well as changes required to maintain the plan metal level. Details of these changes are reflected in the Uniform Product Modification Justification.

Financial Experience

The 2024 estimated incurred claims net of pharmacy rebates and excluding non-claims expenses were $677 pmpm, compared to unadjusted average premium revenue of $562 pmpm. This resulted in 2024 claims being paid out as 120% of premium. Premium revenue will be adjusted by the 2024 Risk Adjustment transfer and net HCRP receipts, a receipt of $82 pmpm. The 2024 Risk Adjustment transfer amount and net HCRP receipts are estimates.

Asuris expects to pay out 96% of premium as claims in 2026, prior to any adjustments for the federal MLR methodology. When using Federally prescribed methodology, which excludes some taxes from the denominator, the loss ratio exceeds 80%. With the approval of the requested rate change we expect average premium revenue of $764 pmpm. 2026 incurred claims net of pharmacy rebates and excluding non-claim expenses are projected to be $735 pmpm. The expected 2026 risk adjustment and estimated HCRP assessment results in a receivable amount of $75 pmpm. As a tax paying not-for-profit, Asuris does not project any profit for 2026.

Summary of Pooled Experience

	Experience Period				First Prior Period			
	From	1/1/2024	To	12/31/2024	From	1/1/2023	To	12/31/2023
Member Months				11,716				12,208
Earned Premium				$6,589,078.40				$7,472,394.72
Paid Claims				$7,419,295.72				$8,732,849.66
Beginning Claim Reserve				$892,738.93				$1,378,161.30
Ending Claim Reserve				$1,404,275.78				$892,738.93
Incurred Claims				$7,930,832.57				$8,247,427.29
Expenses				$904,372.87				$969,827.76
Gain/Loss				-$2,246,127.04				-$1,744,860.33
Loss Ratio Percentage				120.36%				110.37%

Experience for the periods above do not include adjustments for Risk Adjustment.
Pharmacy Rebates and Non-Claim Expenses are removed from the Incurred Claims in this table.

Summary of Pooled Experience with Adjustments

	2024 Experience Period	2023 Experience Period	2022 Experience Period
Member Months	11,716	12,208	13,858
Earned Premium	$6,589,078	$7,472,395	$7,661,257
Paid Claims	$7,419,296	$8,732,850	$6,589,327
Beginning Claim Reserve	$892,739	$1,378,161	$1,141,847
Ending Claim Reserve	$1,404,276	$892,739	$1,378,161
Incurred Claims	$7,930,833	$8,247,427	$6,825,640
Expenses	$904,373	$969,828	$1,018,300
Ceded Claims	$47,146	$42,508	$44,082
Gain/Loss	-$2,198,981	-$1,702,352	-$138,602
Loss Ratio Percentage	120.36%	110.37%	89.09%
Risk Adjustment	$983,932	$2,477,871	$1,615,582
HCRP Assessment	-$23,427	-$27,261	-$28,298
HCRP Transfer	$0	$0	$0
RADV	$0	$0	$0
Gain/Loss with Risk Adj	-$1,238,476	$748,258	$1,448,683

Risk Adjustment, HCRP Assessment, HCRP Transfer, and RADV are estimates for 2024.

Unified Rate Review v6.1

To add a pr
To add a pl
To validate,
To finalize,

Company Legal Name:	**Asuris Northwest Health**		
HIOS Issuer ID:	**69364**	State:	**WA**
Effective Date of Rate Change(s):	**1/1/2026**	Market:	**Individual**

Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period: 1/1/2024 to 12/31/2024

	Total	PMPM
Allowed Claims	$10,309,180.57	$879.92
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$7,930,832.57	$676.92
Risk Adjustment	$960,505.10	$81.98
Experience Period Premium	$6,589,078.40	$562.40
Experience Period Member Months	11,716	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$228.72	1.050	1.025	1.050	1.025	$264.99
Outpatient Hospital	$256.11	1.050	1.025	1.050	1.025	$296.73
Professional	$171.22	1.050	1.025	1.050	1.025	$198.38
Other Medical	$36.40	1.050	1.025	1.050	1.025	$42.17
Capitation	$0.00	1.050	1.025	1.050	1.025	$0.00
Prescription Drug	$185.72	1.055	1.044	1.055	1.044	$225.19
Total	$878.17					**$1,027.46**

Morbidity Adjustment	0.998
Demographic Shift	1.007
Plan Design Changes	0.998
Other	0.900
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$927.84**

Manual EHB Allowed Claims PMPM	$922.48
Applied Credibility %	31.02%

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$924.14**	$10,690,451.52
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	$94.23	$1,090,037.05
Exchange User Fees	0.00%	$0.00
Market Adjusted Index Rate	**$829.91**	**$9,600,414.47**

Projected Member Months	**11,568**

Product-Plan Data Collection

Company Legal Name: **Asuris Northwest Health**
HIOS Issuer ID: **69364** State: **WA**
Effective Date of Rate Change(s): **1/1/2026** Market: **Individual**

Product/Plan Level Calculations

Field #	**Section I: General Product and Plan Information**						
1.1	Product Name		Asuris Direct EPO				
1.2	Product ID		69364WA122				
1.3	Plan Name		Bronze Essential	Bronze HSA 7750	Silver 5000	Gold 2000	Bronze 8000
1.4	Plan ID (Standard Component ID)		69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
1.5	Metal		Bronze	Bronze	Silver	Gold	Bronze
1.6	AV Metal Value		0.626	0.626	0.700	0.786	0.644
1.7	Plan Category		Renewing	Renewing	Renewing	Renewing	Renewing
1.8	Plan Type		EPO	EPO	EPO	EPO	EPO
1.9	Exchange Plan?		No	No	No	No	No
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		14.48%	15.87%	15.15%	14.76%	14.96%
1.12	Product Rate Increase %		15.15%				
1.13	Submission Level Rate Increase %		15.15%				

Worksheet 1 Totals		**Section II: Experience Period and Current Plan Level Information**						
	2.1	Plan ID (Standard Component ID)	Total	69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
$10,309,181	2.2	Allowed Claims	$10,309,181	$1,216,039	$3,201,172	$2,583,087	$3,308,882	$0
$0	2.3	Reinsurance	$0	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$2,378,348	$420,230	$753,523	$547,914	$656,681	$0
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$7,930,833	2.6	Incurred Claims	$7,930,833	$795,809	$2,447,649	$2,035,173	$2,652,201	$0
$960,505	2.7	Risk Adjustment Transfer Amount	$960,505	-$191,277	-$229,468	$84,088	$1,297,162	$0
$6,589,078	2.8	Premium	$6,589,078	$1,544,620	$2,007,325	$1,710,110	$1,327,023	$0
11,716	2.9	Experience Period Member Months	11,716	2,970	3,563	3,206	1,977	0
	2.10	Current Enrollment	964	235	305	263	158	3
	2.11	Current Premium PMPM	$667.65	$598.06	$658.55	$650.09	$823.41	$379.58
	2.12	Loss Ratio	105.05%	58.80%	137.67%	113.43%	101.07%	#DIV/0!
		Per Member Per Month						
	2.13	Allowed Claims	$879.92	$409.44	$898.45	$805.70	$1,673.69	#DIV/0!
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
	2.15	Member Cost Sharing	$203.00	$141.49	$211.49	$170.90	$332.16	#DIV/0!
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
	2.17	Incurred Claims	$676.92	$267.95	$686.96	$634.80	$1,341.53	#DIV/0!
	2.18	Risk Adjustment Transfer Amount	$81.98	-$64.40	-$64.40	$26.23	$656.13	#DIV/0!
	2.19	Premium	$562.40	$520.07	$563.38	$533.41	$671.23	#DIV/0!

	Section III: Plan Adjustment Factors						
3.1	Plan ID (Standard Component ID)		69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
3.2	Market Adjusted Index Rate		$829.91				
3.3	AV and Cost Sharing Design of Plan		0.6953	0.7261	0.8257	1.0214	0.7272
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB		1.0020	1.0010	1.0010	1.0010	1.0010
	Administrative Costs						
3.6	Administrative Expense		7.99%	7.99%	7.99%	7.99%	7.99%
3.7	Taxes and Fees		2.20%	2.20%	2.20%	2.20%	2.20%
3.8	Profit & Risk Load		3.50%	3.50%	3.50%	3.50%	3.50%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**		$669.87	$698.85	$794.71	$983.08	$699.96
3.11	Age Calibration Factor	0.5944	0.5944				
3.12	Geographic Calibration Factor	0.9707	0.9707				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$386.50	$403.22	$458.53	$567.22	$403.86

	Section IV: Projected Plan Level Information						
4.1	Plan ID (Standard Component ID)	Total	69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
4.2	Allowed Claims	$10,703,715	$2,556,840	$3,315,140	$2,944,388	$1,854,739	$32,608
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$2,204,559	$593,745	$726,017	$586,818	$290,856	$7,125
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$8,499,155	$1,963,095	$2,589,123	$2,357,570	$1,563,884	$25,483
4.7	Risk Adjustment Transfer Amount	$865,542	-$279,689	-$363,001	$30,295	$1,481,507	-$3,570
4.8	Premium	$8,844,028	$1,889,029	$2,557,785	$2,508,099	$1,863,916	$25,199
4.9	Projected Member Months	11,568	2,820	3,660	3,156	1,896	36
4.10	Loss Ratio	87.53%	121.98%	117.97%	92.88%	46.75%	117.83%
	Per Member Per Month						
4.11	Allowed Claims	$925.29	$906.68	$905.78	$932.95	$978.24	$905.78
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$190.57	$210.55	$198.37	$185.94	$153.40	$197.90
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$734.71	$696.13	$707.41	$747.01	$824.83	$707.87
4.16	Risk Adjustment Transfer Amount	$74.82	-$99.18	-$99.18	$9.60	$781.39	-$99.18
4.17	Premium	$764.53	$669.87	$698.85	$794.71	$983.08	$699.96

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 4	0.9450
Rating Area 6	1.0000
Rating Area 7	1.0820
Rating Area 9	1.0620

PART III APPENDIX
Table of Contents

The Part III appendix exhibits include numerical support for the actuarial memorandum and the filing checklist. The actuarial memorandum is the guide for understanding the rate development and the exhibits.

EXHIBIT A1: DEVELOPMENT OF 2026 RATE CHANGE
Asuris Northwest Health - Individual

Experience Period: 1/1/2024 - 12/31/2024 Projection Period: 1/1/2026 - 12/31/2026	Asuris Northwest Health Individual 2026 Projection		Projected Claim Cost Development by Experience Pool Asuris Northwest Health Individual ACA Experience		ANH 2023 Individual ACA Experience		ANH 2022 Individual ACA Experience	
Experience	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**
Member Months			11,716		12,200		13,858	
Earned Premium			$6,589,078	$562.40	$7,471,036	$612.38	$7,661,257	$552.84
Estimated Incurred Claims			$8,678,393	$740.73	$8,929,058	$731.89	$7,328,942	$528.86
BlueCard Access Fees			$0	$0.00	$0	$0.00	$0	$0.00
HCRP Receipts			$0	$0.00	$0	$0.00	$0	$0.00
Adjusted Estimated Incurred Claims			$8,678,393	$740.73	$8,929,058	$731.89	$7,328,942	$528.86
Projected Claims Cost Development	**Factors**	**PMPM**	**Factors**	**PMPM**	**Factors**	**PMPM**	**Factors**	**PMPM**
Average Experience Morbidity Factor			*1.284*		*1.400*		*1.138*	
Average Projected Morbidity Factor			*1.282*		*1.282*		*1.282*	
Changes in Morbidity			0.998		0.915		1.127	
Average Experience Benefits Factor			*0.690*		*0.708*		*0.704*	
Average Projected Benefits Factor			*0.688*		*0.688*		*0.688*	
Changes in Benefits			0.996		0.972		0.977	
Average Experience Demographics Factor			*1.735*		*1.746*		*1.731*	
Average Projected Demographics Factor			*1.749*		*1.749*		*1.749*	
Changes in Demographics			1.008		1.002		1.010	
Average Experience Network Arrangements Factor			*0.998*		*1.002*		*1.000*	
Average Projected Network Arrangements Factor			*0.943*		*0.943*		*0.943*	
Changes in Network Arrangements			0.945		0.941		0.943	
Pharmacy Rebates			0.922		0.922		0.920	
Experience Adjustment			0.940		1.000		1.000	
Reinsurance Receipts			1.000		1.000		1.000	
Trend Factor to Rating Period			1.219		1.314		1.414	
Projected Claims Cost by Pool				$740.98		$743.87		$721.30
Overall Projected Claims Cost		$734.69	31%		32%		37%	
Risk Adjustment Transfer		$78.64						
Net Projected Claims Cost		**$656.05**						

Retention Development	Percent	PMPM
Risk Adjustment Program Fee	0.03%	$0.20
Operating Expenses	6.34%	$48.48
Commission Expenses	1.87%	$14.27
Federal HCRP Charge	0.50%	$3.82
Investment Earnings	-0.22%	-$1.70
Regulatory Surcharge	0.08%	$0.58
Insurance Fraud Surcharge	0.00%	$0.03
Risk and Profit	3.50%	$26.76
Premium Tax	2.00%	$15.29
Insurer Tax	0.00%	$0.00
Patient-Centered Outcomes Research Fee	0.04%	$0.32
Marketplace Fee	0.00%	$0.00
WSHIP	0.04%	$0.32
WPAL	0.01%	$0.07
Vendor Fees	0.00%	$0.00
Total Retention	14.2%	**$108.44**

Base Rate Development and Rate Change	Total	PMPM
Projected Average Premium		**$764.49**
Average Plan Factor	0.6859	
Average Area Factor	1.0302	
Average Tobacco Factor	1.0000	
Age Curve Factor	1.6824	
Composite Rating Factor	1.1888	
2026 Pool Base Rate		$643.08
Average Annual Rate Change (from UPMJ #5)		**15.15%**
Projected Federal Loss Ratio	88.2%	

WSHIP Fee Development	
Line of Business	Projected Member Months
Small Group	1,249,849
Large Group	1,045,228
Individual	316,029
Total	2,611,106
2026 Assessment	$839,177
2026 PMPM Assumption	**$0.32**

Commission Expenses Development			
Broker Tier	Base	Credentialing	Performance
2026 PMPM Commission Rate	$20.00	$21.00	$28.00
% of Projected Brokers	66.0%	33.0%	1.0%
Average Broker Rate			**$20.41**
Projected Broker Utilization Percentage			69.9%
2026 PMPM Assumption			**$14.27**

Pharmacy rebates are not removed from Experience Estimated Incurred Claims. Instead, the Pharmacy Rebates projection factor represents total projected rebates, rather than an incremental change.
Claims in the "Projected Claim Cost Development" are on an incurred basis.
Due to underlying calculations being performed with additional precision, there may be small rounding differences.
The "Base Rate" is the pool starting amount used to determine premiums. Plan premiums are equal to the "Base Rate" multiplied by applicable rating factors. See the "Rate Factors" document for details.
The Projected Federal Loss Ratio subtracts Taxes and Fees from the premium denominator. This simplified version of the ratio used for federal MLR rebate demonstrates compliance with the federal MLR threshold of 80%.
The Average Plan Factor represents plan design relativitiy and is used in Exhibit E3 to calculate the Calibrated Plan Adjusted Index Rates.

EXHIBIT C1: AGE CURVE AND TOBACCO CALIBRATION FACTORS
Asuris Northwest Health - Individual

		Distribution			
Member Age	**Age Factor**	**Non-Tobacco**	**Tobacco**	**Total**	**Total Prior Year**
Capped 0-14	0.000	2.0%	0.0%	2.0%	0.0%
Capped 15	0.000	0.0%	0.0%	0.0%	0.0%
Capped 16	0.000	0.0%	0.0%	0.0%	0.0%
Capped 17	0.000	0.0%	0.0%	0.0%	0.0%
Capped 18	0.000	0.0%	0.0%	0.0%	0.0%
Capped 19	0.000	0.0%	0.0%	0.0%	0.0%
Capped 20	0.000	0.0%	0.0%	0.0%	0.0%
0-14	0.765	11.9%	0.0%	11.9%	14.2%
15	0.833	1.3%	0.0%	1.3%	1.4%
16	0.859	1.7%	0.0%	1.7%	1.2%
17	0.885	1.6%	0.0%	1.6%	1.9%
18	0.913	2.2%	0.0%	2.2%	1.5%
19	0.941	1.0%	0.0%	1.0%	1.1%
20	0.970	1.0%	0.0%	1.0%	1.4%
21	1.000	0.8%	0.0%	0.8%	0.8%
22	1.000	0.9%	0.0%	0.9%	1.1%
23	1.000	1.0%	0.0%	1.0%	1.1%
24	1.000	0.7%	0.0%	0.7%	0.5%
25	1.004	0.4%	0.0%	0.4%	1.0%
26	1.024	0.8%	0.0%	0.8%	0.9%
27	1.048	0.8%	0.0%	0.8%	0.9%
28	1.087	1.2%	0.0%	1.2%	0.7%
29	1.119	0.6%	0.0%	0.6%	0.7%
30	1.135	1.0%	0.0%	1.0%	0.7%
31	1.159	0.7%	0.0%	0.7%	0.7%
32	1.183	0.7%	0.0%	0.7%	0.9%
33	1.198	0.8%	0.0%	0.8%	0.9%
34	1.214	0.8%	0.0%	0.8%	0.9%
35	1.222	0.8%	0.0%	0.8%	1.3%
36	1.230	1.3%	0.0%	1.3%	1.4%
37	1.238	1.2%	0.0%	1.2%	1.3%
38	1.246	1.5%	0.0%	1.5%	1.3%
39	1.262	1.3%	0.0%	1.3%	1.6%
40	1.278	1.6%	0.0%	1.6%	2.0%
41	1.302	2.2%	0.0%	2.2%	1.5%
42	1.325	1.8%	0.0%	1.8%	1.6%
43	1.357	1.2%	0.0%	1.2%	2.2%
44	1.397	2.4%	0.0%	2.4%	2.9%
45	1.444	2.3%	0.0%	2.3%	2.0%
46	1.500	2.0%	0.0%	2.0%	2.3%
47	1.563	2.6%	0.0%	2.6%	1.8%
48	1.635	1.8%	0.0%	1.8%	1.3%
49	1.706	1.2%	0.0%	1.2%	1.8%
50	1.786	2.7%	0.0%	2.7%	1.6%
51	1.865	1.1%	0.0%	1.1%	1.5%
52	1.952	1.8%	0.0%	1.8%	1.9%
53	2.040	1.6%	0.0%	1.6%	1.7%
54	2.135	1.7%	0.0%	1.7%	2.2%
55	2.230	2.5%	0.0%	2.5%	2.3%
56	2.333	2.3%	0.0%	2.3%	2.5%
57	2.437	2.6%	0.0%	2.6%	2.2%
58	2.548	1.8%	0.0%	1.8%	2.5%
59	2.603	3.0%	0.0%	3.0%	2.0%
60	2.714	2.4%	0.0%	2.4%	2.3%
61	2.810	2.3%	0.0%	2.3%	2.5%
62	2.873	3.1%	0.0%	3.1%	3.5%
63	2.952	4.6%	0.0%	4.6%	4.4%
64+	3.000	7.2%	0.0%	7.2%	6.2%
Total Percent of Members		100.0%	0.0%	100.0%	100.0%
Age Curve Factor				**1.6824**	**1.6814**
Age Curve Factor, No Dependent Limit				**1.6975**	**1.6814**
3-Child Limit Factor				**1.0090**	**1.0000**
Tobacco Surcharge		**1.0000**	**1.0000**		

Nearest whole age corresponding to the calibration factor:	49
Age Factor assuming all members are charged a premium:	1.6975
Family Rating Adjustment for three child dependent limit:	0.9911
Tobacco Factor	1.0000

Overall Average Age	40
Average Age of Individuals 0-14	8
Average Age of Individuals 65+	68
Distribution of Individuals age 64	5.12%
Distribution of Individuals age 65+	1.64%

EXHIBIT C2: GEOGRAPHIC FACTORS
Asuris Northwest Health - Individual

Rating Area	Geographic Factor	March 2025 Membership	Distribution	Prior Year Distribution
4	0.945	128	13.3%	8.8%
6	1.000	357	37.0%	42.9%
7	1.082	321	33.3%	32.4%
9	1.062	158	16.4%	15.8%
Average Geographic Factor Projected	**1.0302**			
Average Geographic Factor Experience	**1.0316**			

Geographic Factor Analysis

Unit cost differences were analyzed using allowed claims experience data, including Washington experience from affiliated companies.

The cost per relative value unit (RVU) was calculated for each rating area and normalized such that the factor for rating area 1 is 1.0. See table below for detailed calculation.

Comparing costs per RVU allow a direct comparison of unit costs across services and procedures by normalizing to a standard unit of measure.

The following health-status related factors were not used to establish a rating factor for a geographic rating area:

(i) Health status of enrollees or the population in an area;
(ii) Medical condition of enrollees or the population in an area, including both physical and mental illnesses;
(iii) Claims experience;
(iv) Health services utilization in the area;
(v) Medical history of enrollees or the population in an area;
(vi) Genetic information of enrollees or the population in an area;
(vii) Disability status of enrollees or the population in an area;
(viii) Other evidence of insurability applicable in the area.

	A	B	C	D	E	F	G	H	I
Area	Current Allowed/RVU Relativities	Prior Year Final Area factors	March 2025 Membership	Adjusted Prior Year Final Area factors	% Change, capped	2026 Provider Contracting Impacts	Preliminary Factor	Area Factor	Final Factor
Rate Area 1	0.965	0.964	64,074	0.965	0.1%	0.3%	0.967	0.968	
Rate Area 2	1.080	1.094	9,313	1.095	-1.3%	-0.1%	1.079	1.095	
Rate Area 3	1.048	1.041	15,988	1.042	0.7%	-0.9%	1.038	1.040	
Rate Area 4	0.952	0.963	3,461	0.964	-1.1%	0.2%	0.954	0.956	0.945
Rate Area 5	1.004	1.007	19,557	1.008	-0.3%	-0.1%	1.003	1.004	
Rate Area 6	1.009	1.008	3,521	1.009	0.1%	0.1%	1.011	1.012	1.000
Rate Area 7	1.327	1.089	1,069	1.090	2.0%	0.2%	1.114	1.095	1.082
Rate Area 8	1.019	1.021	23,270	1.022	-0.2%	0.1%	1.020	1.021	
Rate Area 9	1.038	1.093	620	1.094	-2.0%	0.2%	1.074	1.075	1.062

A: Current Allowed/RVU Relativities - represent the ratio of 2024 Allowed Claims $/Relative Value Unit (RVU) for each area compared to the entire state.
The relativities include minor adjustments to account for estimated changes to unit cost from 2024 to 2025, by area. Both Individual and Small Group data is included in the relativity calculation.

B: 2025 final area factors.

C: March 2025 membership, includes all Cambia WA Individual and Small Group membership.

D: 2025 final area factors are scaled to March 2025 membership distribution.

E: % Change, capped - Cap the year over year relativity change at +/- 2% to minimize rate impacts.

F: 2026 Provider Contracting Impacts - reflects the estimated change in unit cost by area, from 2025 to 2026

G: Preliminary Factor - Applies the capped % change and 2026 provider contracting impacts to the prior relativities.

H: Area Factor - Rescales preliminary factor based on current enrollment such that composite is 1.0

I: Final Factor - Normalizes Area factor by setting the most populated rating area within the service area to a 1.0

Rating Area	2024 Geographic Factor	2025 Geographic Factor	2026 Geographic Factor	2024 to 2025 Change	2025 to 2026 Change
4	0.917	0.955	0.945	4.1%	-1.0%
6	1.000	1.000	1.000	0.0%	0.0%
7	1.049	1.080	1.082	3.0%	0.2%
9	1.049	1.084	1.062	3.3%	-2.0%

*Adjusted preliminary factor to limit the difference in rating area factors to meet the 1.15 ratio specified in WAC 284-43-6681

EXHIBIT C3: DEMOGRAPHIC FACTOR COMPARISON
Asuris Northwest Health - Individual

Description	2023	2024	2025	2026
Age Curve Factor	1.6702	1.6773	1.6549	1.6824
Geographic Factor	1.0163	1.0177	1.0353	1.0302
3-Child Limit Factor	1.0077	1.0082	1.0097	1.0090
Tobacco Factor	1.0041	1.0035	1.0035	1.0000

*Calibration factors entered into the URRT are the inverse of those used for rate development

Description	Calibration Factors*
Age Curve Calibration Factor	0.5944
Geographic Calibration Factor	0.9707
3-Child Limit Calibration Factor	0.9911
Tobacco Calibration Factor	1.0000

EXHIBIT C4: NETWORK FACTOR CHANGE

Asuris Northwest Health - Individual

Network	2024 Network Factor	2024 Enrollment Distribution	2026 Network Factor	2026 Enrollment Distribution
Individual and Family Network	0.998	100.0%		
Individual Connect			0.943	100.0%
Average Network Factor		0.998		0.943

EXHIBIT D1: 2026 AVERAGE CHANGE IN PLAN BASE RATES
Asuris Northwest Health - Individual

2025 Plan ID	2025 Plan Name	2026 Plan ID	March 2025 Membership	Renewal or Mapped Plan	2025 AV Pricing Value	2026 AV Pricing Value	2025 Plan Base Rate	2026 Plan Base Rate	Experience Impact (Other than Demographic Changes)	Benefit Rate Change	Cost Share Rate Change	Plan Base Rate Change	Average Change in Area Factor	Average Change in Age Factor	Average Rate Change to Renewal or Mapped Plan
69364WA1220004	Bronze Essential 8700	69364WA1220004	235	Renewal	0.6167	0.6010	$336.30	$386.49	17.48%	0.00%	-2.55%	14.92%	-0.39%	0.00%	14.48%
69364WA1220006	Bronze HSA 7250	69364WA1220006	305	Renewal	0.6378	0.6270	$346.95	$403.21	17.86%	0.00%	-1.69%	16.22%	-0.30%	0.00%	15.87%
69364WA1220008	Silver 5000	69364WA1220008	263	Renewal	0.7190	0.7130	$395.90	$458.52	16.11%	0.00%	-0.83%	15.82%	-0.58%	0.00%	15.15%
69364WA1220014	Gold 2000	69364WA1220014	158	Renewal	0.8861	0.8820	$492.39	$567.20	15.29%	0.00%	-0.46%	15.19%	-0.38%	0.00%	14.76%
69364WA1220016	Bronze 8000	69364WA1220016	3	Renewal	0.6400	0.6280	$349.07	$403.85	17.16%	0.00%	-1.88%	15.69%	-0.64%	0.00%	14.96%
		Total Enrollment	**964**												**15.15%**

Due to underlying calculations being performed with additional precision, there may be small rounding differences.
UPMJ Q5 Experience Rate Change Factor 5(g) is equivalent to the product of (1 + Experience Impact), (1+ Average Change in Area Factor) and (1+ Average Change in Age Factor)

EXHIBIT D2: TERMINATED PLAN MAPPING
Asuris Northwest Health - Individual

		TERMINATED PLAN				MAPPED PLAN	
2024 Offered	2025 Offered	Plan ID	Plan Name	Year	2025 Plan ID	2026 Plan ID	2026 Plan Name

*There were no mapped plans between 2024 and 2026

EXHIBIT E1: DEVELOPMENT OF 2026 INDEX RATE
Asuris Northwest Health - Individual

	Experience - Total	Experience	Manual - Total	Credibility Manual	Credibility Manual
	Asuris Northwest Health	Asuris Northwest Health		ANH 2023	ANH 2022
Experience Period: 1/1/2024 - 12/31/2024	**Individual**	Individual		Individual	Individual
Projection Period: 1/1/2026 - 12/31/2026	**Total**	ACA Experience	**Total**	ACA Experience	ACA Experience

URRT, Section I: Experience Period Data	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**
Earned Premium	$6,589,078	$562.40	$6,589,078	$562.40	$15,132,293	$580.72	$7,471,036	$612.38	$7,661,257	$552.84
MLR Rebates	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Risk Adjustment Transfers[1]	$983,932	$84.32	$983,932	$84.32	$2,094,767	$80.39	$1,523,969	$95.21	$570,798	-$48.03
HCRP Receipts	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Premiums (net of MLR Rebate) in Experience Period	**$7,573,011**	**$646.72**	$7,573,011	$646.72	$17,227,059	$661.10	$8,995,005	$707.59	$8,232,054	$504.81
Incurred Claims Paid through March 2025	$8,594,037	$733.53	$8,594,037	$733.53	$16,257,024	$623.88	$8,928,082	$731.81	$7,328,942	$528.86
Incurred Claims UCL	$84,355	$7.20	$84,355	$7.20	$976	$0.04	$976	$0.08	$0	$0.00
Estimated Incurred Claims	$8,678,393	$740.73	$8,678,393	$740.73	$16,258,000	$623.92	$8,929,058	$731.89	$7,328,942	$528.86
Pharmacy Rebates	$747,560	$63.81	$747,560	$63.81	$1,865,710	$71.60	$941,405	$77.16	$924,305	$66.70
BlueCard Access Fees	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Reinsurance	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Incurred Claims in Experience Period	**$7,930,833**	**$676.92**	$7,930,833	$676.92	$14,392,290	$552.32	$7,987,653	$654.73	$6,404,637	$462.16
Allowed Claims Paid through March 2025	$10,954,694	$935.02	$10,954,694	$935.02	$21,198,875	$813.53	$11,381,868	$932.94	$9,817,007	$708.40
Allowed Claims UCL	$102,046	$8.71	$102,046	$8.71	$1,098	$0.04	$1,098	$0.09	$0	$0.00
Estimated Allowed Claims	$11,056,741	$943.73	$11,056,741	$943.73	$21,199,973	$813.57	$11,382,966	$933.03	$9,817,007	$708.40
Pharmacy Rebates	$747,560	$63.81	$747,560	$63.81	$1,865,710	$71.60	$941,405	$77.16	$924,305	$66.70
BlueCard Access Fees	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Allowed Claims	**$10,309,181**	**$879.92**	$10,309,181	$879.92	$19,334,263	$741.97	$10,441,561	$855.87	$8,892,702	$641.70
Experience EHB Percent[4]		99.8%		99.8%		99.8%		99.8%		99.8%
Index Rate		**$878.17**		$878.17		$740.49		$854.16		$640.42
Member Months	**11,716**		11,716		26,058		12,200		13,858	

URRT, Section II: Projections	**Factor**	**PMPM**	**Factor**	**PMPM**	**Factor**	**PMPM**	**Factor**	**PMPM**	**Factor**	**PMPM**
Experience Period Allowed Claims		$878.17		$878.17		$740.49		$854.16		$640.42
Medical / Rx Cost Trend	**1.050**	**1.055**	**1.050**	**1.055**						
Medical / Rx Utilization Trend	**1.025**	**1.044**	**1.025**	**1.044**						
Overall Cost Trend	**1.051**		1.051		**1.051**		1.051		1.051	
Overall Utilization Trend	**1.029**		1.029		**1.029**		1.029		1.029	
Trended Allowed Claims PMPM		$1,027.46		$1,027.46		$937.68		$1,055.42		$834.03
Pop'l risk Morbidity	**0.998**		0.998		**1.011**		0.926		1.110	
Demographic Shift	**1.007**		1.007		**1.005**		1.001		1.009	
Plan Design Changes	**0.998**		0.998		**0.987**		0.986		0.989	
Other	**0.900**		0.900		**0.981**		0.974		0.990	
Network		0.952		0.952		0.950		0.949		0.950
Pharmacy Rebates		0.997		0.997		1.031		1.024		1.040
Experience Adjustment		0.948		0.948		1.000		1.000		1.000
Projected EHB Change		1.001		1.001		1.002		1.002		1.002
Adjusted Trended EHB Allowed Claims PMPM		**$927.84**		$927.84		**$922.48**		$939.52		$914.59
Weighting	**31%**		31%		**69%**		32%		37%	

Factor to Translate Paid Claims Factor to Allowed Claims Factor[2]: 1.15000

Development of Market Adjusted Index Rate	
Index Rate for Projection Period	$924.14
Reinsurance Program Adjustment[3]	$0.00
Risk Adjustment[3]	$94.23
Marketplace User Fee Adjustment[3]	0.00%
Market Adjusted Index Rate	$829.91

Due to underlying calculations being performed with additional precision, there may be small rounding differences.

This exhibit (Exhibit E1) demonstrates the development of results appearing in the URRT. Certain development items are prescribed by the URRT instructions.

Exhibits A1 and E1 have similarly labeled items but their values may differ due to methodology differences. Please see the actuarial memorandum for additional details.

[1]Risk adjustment transfer amounts in this exhibit do not reflect net HCRP receipts.

[2]This factor is used to translate claims projection factors from a paid basis (Exhibit A1) to an allowed basis (Exhibit E1). This factor was developed from a historical study using actuarial judgment.

[3]These adjustments have been converted from paid amounts to allowed amounts.

[4]The experience period EHB adjustment is based on the expected proportion of Estimated Incurred Claims without EHB to Estimated Incurred Claims with EHB.

EXHIBIT E2: PLAN ADJUSTED INDEX RATE DEVELOPMENT
Asuris Northwest Health - Individual

					AV PRICING VALUE COMPONENTS					PLAN ADJUSTMENTS TO MARKET ADJUSTED INDEX RATE						
2026 Plan ID	2026 Plan Name	Projected Member Months	AV Pricing Value[1]	Projected Benefit Factor	Base Product[2]	CSR Load	Network	Benefits in Addition to EHB	Market Adjusted Index Rate	AV and Cost-Sharing Design[3]	Projected CSR Adjustment	EHB Paid To Allowed Factor	Network (Normalized)[4]	Benefits in Addition to EHB[5]	Administrative Costs[6]	Plan Adjusted Index Rate
69364WA1220014	Gold 2000	1,896	0.8820	0.8820	0.8811	1.0000	1.0000	1.0010	$829.91	1.0214	1.0000	0.8916	1.0000	1.0010	1.1586	**$983.08**
69364WA1220008	Silver 5000	3,156	0.7130	0.7130	0.7123	1.0000	1.0000	1.0010	$829.91	0.8257	1.0000	0.8075	1.0000	1.0010	1.1586	**$794.71**
69364WA1220016	Bronze 8000	36	0.6280	0.6280	0.6274	1.0000	1.0000	1.0010	$829.91	0.7272	1.0000	0.7652	1.0000	1.0010	1.1586	**$699.96**
69364WA1220006	Bronze HSA 7750	3,660	0.6270	0.6270	0.6264	1.0000	1.0000	1.0010	$829.91	0.7261	1.0000	0.7647	1.0000	1.0010	1.1586	**$698.85**
69364WA1220004	Bronze Essential 9000	2,820	0.6010	0.6010	0.5998	1.0000	1.0000	1.0020	$829.91	0.6953	1.0000	0.7518	1.0000	1.0020	1.1586	**$669.87**
	Total / Average	**11,568**	**0.6859**	**0.6859**	**0.6851**	**1.0000**	**1.0000**	**1.0012**	**$829.91**	**0.7941**	**1.0000**	**0.7940**	**1.0000**	**1.0012**	**1.1586**	**$764.53**

Due to underlying calculations being performed with additional precision, there may be small rounding differences.

[1]The AV Pricing Value is the plan factor that is multiplied by the 2024 Base Rate, age factor and geographic factor to arrive at a member rate.

[2]The Base Product factor is the pricing value based on benefit design only, before CSR Load, Network adjustments and non-EHB benefits.

[3]AV and Cost-Sharing Design factors represent an adjustment from the Market Adjusted Index Rate to the expected incurred claims PMPM for each plan, are based on AV and Cost-Sharing Design, and exclude adjustment for Network and Benefits in Addition to EHB.

[4]Network factors represent the projected cost relativities between networks.

[5]Benefits in addition to EHB factors are applied to the Market Adjusted Index rate (which excludes non-EHBs).

[6]Administrative Costs calculated using percentages from Exhibit A1: 1/[1-(Total Retention % - Marketplace Fee % - Federal HCRP Charge %)].

Due to the expectation that CSR payments will not be made for 2024, the AV Pricing Value is adjusted for on-exchange silver plans

EXHIBIT E3: PLAN ADJUSTED INDEX RATE TO BASE RATE MAPPING
Asuris Northwest Health - Individual

		(A)	(B)	(C)	(D)	(A) / [(B) * (C) * (D)]									
2026 Plan ID	**2026 Plan Name**	**Plan Adjusted Index Rate[1]**	**Age Curve Factor**	**Geographic Factor**	**Tobacco Factor**	**2026 Plan Base Rate**	**Calibrated Plan Adjusted Index Rate**	**Difference in Rate**	**Projected Member Months**	**Allowed Claims for URRT Section IV**	**Incurred Claims for URRT Section IV**	**Member Cost Sharing for URRT Section IV**	**Risk Adjustment Transfer Amount for URRT Section IV**	**Premium for URRT Section IV**	**Retention for URRT Section IV**
69364WA1220014	Gold 2000	**$983.08**	1.6824	1.0302	1.0000	$567.20	$567.22	-$0.02	1,896	$1,854,736	$1,564,193	$290,543	$1,481,507	$1,863,920	$255,196
69364WA1220008	Silver 5000	**$794.71**	1.6824	1.0302	1.0000	$458.52	$458.53	-$0.01	3,156	$2,944,382	$2,358,036	$586,346	$30,295	$2,508,105	$343,394
69364WA1220016	Bronze 8000	**$699.96**	1.6824	1.0302	1.0000	$403.85	$403.86	-$0.01	36	$32,608	$25,488	$7,120	-$3,571	$25,199	$3,450
69364WA1220006	Bronze HSA 7750	**$698.85**	1.6824	1.0302	1.0000	$403.21	$403.22	-$0.01	3,660	$3,315,133	$2,589,636	$725,497	-$363,001	$2,557,791	$350,197
69364WA1220004	Bronze Essential 9000	**$669.87**	1.6824	1.0302	1.0000	$386.49	$386.50	-$0.01	2,820	$2,556,835	$1,961,524	$595,311	-$279,689	$1,889,033	$258,635
Total										**$10,703,715**	**$8,499,155**	**$2,204,559**	**$865,542**	**$8,844,028**	**$1,210,873**
Total (PMPM)										**$925.29**	**$734.71**	**$190.57**	**$74.82**	**$764.53**	**$104.67**

Index Rate for Projection Period: 924.14

Metal	Induced Demand Factor[2]
Bronze	0.98
Silver	1.01
Gold	1.06
Platinum	0.00

Due to underlying calculations being performed with additional precision, there may be small rounding differences.

[1]The Plan Adjusted Index Rate is equivalent to the Projected Premium PMPM the URRT Section IV

[2]The Induced Demand Factors are the prescribed metal-based factors utilized in the Risk Adjustment modeling process, normalized to an average of 1.0 using the average induced demand factor for projected membership

EXHIBIT E4: PLAN VARIATION FROM MARKET ADJUSTED INDEX RATE FOR RENEWAL PLANS

APPENDIX

Asuris Northwest Health - Individual

		ADJUSTMENTS FROM 2025 MARKET ADJUSTED INDEX RATE				ADJUSTMENTS FROM 2026 MARKET ADJUSTED INDEX RATE			
2026 Plan ID	2026 Plan Name	AV and Cost-Sharing Design	Network (Normalized)	Benefits in Addition to EHB	Administrative Costs	AV and Cost-Sharing Design	Network (Normalized)	Benefits in Addition to EHB	Administrative Costs
69364WA1220004	Bronze Essential 9000	0.6828	1.0000	1.0020	1.1766	0.6953	1.0000	1.0020	1.1586
69364WA1220006	Bronze HSA 7750	0.7045	1.0000	1.0020	1.1766	0.7261	1.0000	1.0010	1.1586
69364WA1220008	Silver 5000	0.8038	1.0000	1.0020	1.1766	0.8257	1.0000	1.0010	1.1586
69364WA1220014	Gold 2000	0.9998	1.0000	1.0020	1.1766	1.0214	1.0000	1.0010	1.1586
69364WA1220016	Bronze 8000	0.7088	1.0000	1.0020	1.1766	0.7272	1.0000	1.0010	1.1586

EXHIBIT E7: BENEFIT FACTOR EXPERIENCE
Asuris Northwest Health - Individual

2024 Product	2024 Membership	2024 Experience Benefit Factor
Bronze HSA 7000	3,563	0.636
Bronze Essential 8500	2,970	0.604
Gold 2500	1,977	0.875
Silver 4500	3,206	0.716
Average Benefit Factor		0.690

EXHIBIT F1: CHECKLIST VALUE COMPARISON
Asuris Northwest Health - Individual

	URRT Wksh 2	View Rate Review Detail[5]	Part II	UPMJ	WAC 284-43-6660	Part III Appendix: Exhibit A1	2026 Average Change in Plan Base Rates: Exhibit D1	Plan Adjusted Index Rate Development: Exhibit E2
Renewing Plan Rate Change[1]	15.15%	15.15%	15.15%	15.15%	15.15%	15.15%		
Number of Members Affected for this Program:	964	964	1,000	964			964	
Current Policyholder Count		563						
Projected Enrollment	11,568	11,568						11,568

Financial Data Summary as of March 2025

	URRT Wksh 1	WAC 284-43-6660
2024 Member Months	11,716	11,716
2024 Earned Premium	$6,589,078.40	$6,589,078.40
2022 Incurred Claims[2]	$7,930,832.57	$7,930,832.57

	View Rate Review Detail[5]	URRT Wksh 2	WAC 284-43-6660	URRT Worksheet 2 3.10 Weighted Average
2025 Average PMPM3	$669.78		$663.94	
Proposed Community Rate[4]	$764.53	$764.53	$764.53	$764.53

	View Rate Review Detail[5]	UPMJ Q5	URRT Wksh 2
Minimum Rate Change[6]	14.48%	14.48%	14.48%
Maximum Rate Change[6]	15.87%	15.87%	15.87%

	View Rate Review Detail[5]	2025 Rate Schedule
Minimum Rate PMPM Prior	$245.69	$245.69
Maximum Rate PMPM Prior	$1,841.45	$1,841.43

Product Name	Product ID	Continuing Membership	New Membership
Asuris Direct EPO	69364WA122	964	0

[1]Note that the submission level increase in the URRT, Worksheet 2 is premium-weighted and differs slightly from the member-weighted average increase in the UPMJ and Part II.

2Note that the 2024 incurred claims amount as displayed in URRT, Worksheet 1 deducts HCRP receivable amounts from claims experience, while the amount displayed in the WAC 284-43-6660 summary does not. Thus, some discrepancy between the two values is expected.

[3]Requested rate less requested rate change

[4]Rates may not match exactly due to rounding and truncation of variables in the URRT

[5]Rate Review Detail values may correspond to initially filed rates, and therefore may not match other exhibits due to rate updates

[6]Note that Average Rate Changes in the Rate Review Detail and UPMJ are calculated on a plan-level by considering average changes to plan factors between the experience period and the filing period for each 2026 plan. The URRT, Worksheet 2 values calculate the average rate change for each 2026 plan including all membership mapped to that plan. Thus, there may be instances in which minimum and maximum rate changes vary considerably between URRT, Worksheet 2 and other exhibits.

EXHIBIT F3: Medical and Drug Trend Assumptions
Asuris Northwest Health - Individual

	Trend Assumptions by Major Type of Service		
Trend Component	Medical	Prescription Drugs	**Total**[1]
Unit Cost	5.0%	5.5%	**5.1%**
Utilization	1.8%	2.8%	**2.0%**
Mix/Intensity	0.9%	1.9%	**1.1%**
Leverage	2.3%	1.7%	**2.2%**
Total	**10.0%**	**11.9%**	**10.4%**

[1]Total trends calculated by taking the average of medical and prescription drug trends, weighted by their claims distribution.

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Written Description Justifying the Rate Increase
Comments:	The part II justification is on the URRT tab.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Filing Checklist
Comments:	
Attachment(s):	ANH IND Filing Checklist.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Supporting Documentation
Comments:	
Attachment(s):	ANH IND 1332 Checklist.pdf ANH IND Additional Data Reconciliation.pdf ANH IND AV Screenshots.pdf ANH IND CMS Unique Plan Design Appendix Duplicate.xlsx ANH IND CMS Unique Plan Design Appendix.pdf ANH IND CMS Unique Plan Design Documentation.pdf ANH IND Commission Information and Officer Certification.pdf ANH IND MHSUD Certification.pdf ANH IND MHSUD Exhibit Duplicate.xlsm ANH IND MHSUD Exhibit.pdf ANH IND OIC Health Exhibits Duplicate.xlsx ANH IND OIC Health Exhibits.pdf ANH IND Part III Appendix Duplicate.xlsx ANH IND Rate Factors.pdf ANH IND Supp Exhibits Duplicate.xlsx ANH IND Supp Exhibits.pdf ANH IND Uniform Product Modification Justification Duplicate.xlsx ANH IND Uniform Product Modification Justification.pdf Benefit Components Duplicate.xlsm Benefit Components.pdf WAC 284-43-6660 Duplicate.xlsx WAC 284-43-6660.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rating Documents for Extended ARPA Subsidies

SERFF Tracking #:	*RGWA-134498926*	***State Tracking #:***	*484661*	***Company Tracking #:***	*ASURINH533OE*

State:	*Washington*	***Filing Company:***	*Asuris Northwest Health*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Nongrandfathered Individual Rate Filing ANH*		
Project Name/Number:	*/*		

Comments:	
Attachment(s):	PartIUnifiedRateReviewTemplateWithARPAExtensionDuplicate.xlsm PartIUnifiedRateReviewTemplateWithARPAExtension.pdf Rate Schedule With ARPA Extension Duplicate.xlsx Rate Schedule With ARPA Extension.pdf SupplementalMemoandCertificationWithARPAExtension.pdf
Item Status:	
Status Date:	

2026 Plan Year (PY)
Individual Nongrandfathered Health Plan (Pool)
Rate Filing Checklist

Instructions:

For each item in Section I, provide the response in this document. For each item in Section II, provide the rate filing document name as well as relevant section, page, and/or exhibit numbers.

Any Excel workbook must be submitted with a corresponding PDF that includes all information from the workbook.

- All content in the Excel file and PDF must be visible; hidden cells, hidden worksheets, and non-visible font colors are not allowed, except for functionality that was already included in official templates from the WA OIC or CMS.
- The file names must match except that the Excel workbook name should end with "duplicate."
- For ease of reference, please add numbering to each spreadsheet tab and to a title line in the exhibits.
- **IMPORTANT: Storing amounts as values rather than linking to the source calculations results in several objections every year.**
- Retain all internal links and formulas but break all links to external files. Ensure your rate development exhibits, for example, show how inputs and assumptions flow through the rating methodology to the final projected premium base rates; this is important for review purposes and to ensure appropriate rate development.
- *Be aware that the PDF documents are relied upon as public records. As such, prior to submitting a PDF, please review each PDF for completeness and readability*. Note: the PDF version of the actuarial memorandum exhibits can be submitted on the URRT tab rather than the Supporting Documentation tab in SERFF so that it will be uploaded to CMS. The URRT is the only Excel file that should be submitted on the URRT tab in SERFF; all other Excel files must be submitted on the Supporting Documentation tab.
- Please be aware that for plan year 2026, the OIC launched an Excel template for certain Washington State exhibits. Specific exhibits are referenced throughout this checklist. Please complete and submit the Excel file of WA Exhibits ("Format – Rates – 2026 Individual and Small Group NonGF Health Exhibits") as well as the corresponding PDF file version. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.

Section I – General Information:

Carrier: **Asuris Northwest Health**

A. **Market:** Medical – Individual

B. **Exchange Intentions:** Check only one box.

☐ Exchange Only ☒ Outside Market Only ☐ Exchange and Outside Market

Note: The Exchange Intentions field on the General Information tab in SERFF should match the wording for the item selected above (see the Additional Information section for the Sub-TOI by searching by TOI under Filing Rules/Submission Requirements in SERFF).

C. **We will offer the following:** Check all boxes that apply.

☐ Catastrophic plan offered only through the Exchange. See RCW 48.43.700(3).

☐ At least one qualified health plan (QHP) silver plan and at least one QHP gold plan in each service area in which we offer coverage through the Exchange. See 45 CFR §156.200(c)(1).

☐ At least one standardized gold plan on the Exchange and at least one standardized silver plan on the Exchange so that we can offer coverage through the Exchange. Additionally, if bronze plans are offered through the Exchange, at least one standardized bronze plan is offered on the Exchange. See RCW 43.71.095(2)(a).

☐ In each county where we offer a qualified health plan:
a standardized health plan under RCW 43.71.095 **and** at most two non-standardized gold plans, two non-standardized bronze plans, one non-standardized silver plan, one non-standardized platinum plan, and one non-standardized catastrophic plan. See RCW 43.71.095(2)(b)(i).

☐ Each non-standardized silver health plan offered on the Exchange has an AV Metal Value that is not less than the AV Metal Value of the standardized silver health plan with the lowest AV Metal Value. See RCW 43.71.095(2)(b)(iii).

☒ At least one silver plan and one gold plan throughout each service area outside the Exchange whenever we offer a bronze plan outside the Exchange. See RCW 48.43.700.

☒ One or more plans with a unique benefit design. See Section II #9 below.

☒ Pediatric dental embedded.

☒ Non-essential health benefits (Non-EHBs). See Section II #13 below.

☐ New plans have been added, and we confirm that no previously retired Plan IDs have been reused in this rate filing. We are aware that the reuse of retired Plan IDs can cause risk adjustment reconciliation complications.

Standard Plans Offered (excluding the subsidized benefit plan variations)

HIOS Plan ID	Standard Plan Name	Public Option Plan (Yes, Cascade Select/ No, Cascade)	Metal Level	AV Metal Value
NA – All off exchange				

All Plans Offered (excluding the subsidized benefit plan variations)

HIOS Plan ID	Plan Name	Unique Benefit Design (UBD)		Pediatric Dental Embedded (Yes/No)	Description of Non-Essential Health Benefits (Non-EHBs)
		(Yes/No)	If yes, briefly explain why. If no, "N/A."		
69364WA1220004	Bronze Essential 9000	Yes	See Footnote	Yes	IAP; 4 Behavioral Health Sessions,
69364WA1220006	Bronze HSA 7750	No	See Footnote	Yes	IAP; 4 Behavioral Health Sessions,
69364WA1220008	Silver 5000	Yes	See Footnote	Yes	IAP; 4 Behavioral Health Sessions,
69364WA1220014	Gold 2000	Yes	See Footnote	Yes	IAP; 4 Behavioral Health Sessions,
69364WA1220016	Bronze 8000	Yes	See Footnote	Yes	IAP; 4 Behavioral Health Sessions,

See the "ANH IND CMS Unique Plan Design Documentation" document.

D. **Do you have any expanded bronze plans as described under 45 CFR §156.140(c) in which the variation in AV Metal Value is between +2% and +5% (i.e., the AV is between 62% and 65%)?**

☐ No

☒ Yes, and they are listed in the table below. We confirm each of the following:

(a) That the plans' member cost-shares are equivalent to less than 50% coinsurance and

(b) That each plan is either

(1) A High Deductible Health Plan [1] or

(2) Has at least one major service [2], other than preventive services, covered prior to the deductible.

Note: Only one major service needs to be listed in the table even if multiple major services are covered prior to the deductible.

HIOS Plan ID	Plan Name	High Deductible Health Plan (Yes/No) [1]	Major Service covered prior to the deductible [2]	
			Yes/No	Service
69364WA1220004	Bronze Essential 9000	No	Yes	Generic Drugs

HIOS Plan ID	Plan Name	High Deductible Health Plan (Yes/No) [1]	Major Service covered prior to the deductible [2]	
			Yes/No	Service
69364WA1220006	Bronze HSA 7750	Yes	No	N/A
69364WA1220016	Bronze 8000	No	Yes	Generic Drugs, Primary Care

[1] The plan meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C.233(c)(2) as established at 45 CFR §156.140(c).

[2] The following are considered major services. The major service covered before the deductible must apply a reasonable cost-sharing rate to the service to ensure that the service is affordably covered (HHS Notice of Benefit and Payment Parameters (NBPP) for 2018).

(i) At least three primary care visits.
(ii) Specialist office visits.
(iii) Inpatient hospital services.
(iv) Emergency room services.
(v) Generic drugs.
(vi) Preferred brand drugs.
(vii) Specialty drugs.

E. **Is your service area changing from Plan Year 2025?**

☒ No

☐ Yes. We are making the following changes:

Geographic Rating Area	Additional Counties Covered	Terminated Counties (a.k.a. Exited or No Longer Covered)
1		
2		
3		
4		
5		
6		
7		
8		
9		

F. **Network Information:**

Network Name	Type (EPO, HMO, POS, or PPO)	Tiered or Single	Date Filed
Individual Connect	EPO	Single	5/15/2025

G. **Rate filing file names for Parts I, II, and III of HHS Forms:** (Requirements per RCW 48.02.120(5) and 45 CFR §154.215.)

☒ Name the Parts I, II, and III according to the instructions provided in Washington State SERFF Life, Health and Disability Rate Filing General Instructions.

Section II – Experience Data and Projections

For each item, provide the rate filing document name and section number, page number, and/or exhibit number that addresses the item.
For example: (1) "Part III Rate Filing Documentation and Actuarial Memorandum," Section III or (2) "Supporting Documentation File," Exhibit 5.

For items that require justification, please indicate where to find both narrative and technical details.

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
EXPERIENCE PERIOD DATA			
1	**Complete Experience:** Include the complete experience for all 2024 individual non-grandfathered plans which includes subsidized populations defined under the Cost Sharing Reduction (CSR) programs. • Per CCIIO, include experience data for the American Indian/Alaska Native (AIAN) population (see https://www.healthcare.gov/american-indians-alaska-natives/coverage/). • Include experience for membership covered by plans with benefits and subsidy levels (73%, 87%, and 94% AV levels, as well as any zero cost-share subsidies for the AIAN population) sold in the market. Note: per CCIIO, the AIAN population is not restricted to silver level plans, however, eligible individuals must select a metal level plan (i.e., they are not eligible for AIAN-related subsidies with a catastrophic plan). • Net of Rx rebates: Any prescription drug claims should be net of rebates received from drug manufacturers; please document in the Part III Actuarial Memorandum where and how this is addressed. • Note: if financial data paid through March 2025 is not directly used as the foundation for this rate filing, discuss why the March 2025 data was not available. Discuss what data was used instead and how it was or was not adjusted to mimic data paid through March 2025.		
a	Financial data consistency: Demonstrate that the financial data, including the member months, in (i) URRT Worksheet 1, Section I General Product and Plan Information, (ii) URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, (iii) the WAC 284-43-6660 summary, and (iv) the actuarial memorandum exhibits are consistent as of March 2025. If not consistent, explain why the discrepancy is appropriate.	Part I Unified Rate Review Template, WAC 284-43-6660	Confirmed that the financial data is consistent.

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	b	Support for URRT Worksheet 1, Section I experience period data for 2024: Provide separately for medical and prescription drugs (Rx), as appropriate: • By incurred month and paid month, for claims paid through March 2025: allowed claims and incurred claims (Note that any embedded pediatric dental claims experience should also be included and will be considered part of EHB experience; see URR Instructions' section 1.4 for additional information.) • Any annual estimated payable and/or receivable amounts (e.g., reserves, reinsurance, overpayments, rebates, and other) as of March 2025, including justification of such amounts • Any annual risk adjustment transfer amounts, including justification of such amounts • Monthly premium amounts • Monthly membership	ANH IND Supp Exhibits, ANH IND Part III Appendix Part III Rate Filing Documentation and Actuarial Memorandum ANH IND OIC Health Exhibits	Supp Exhibits: "Medical and Rx Paid Claims Triangle", "Medical and Rx Allowed Claims Triangle"; "Data Summary" Part III Appendix: "Exhibit E1: Development of 2026 Index Rate" "Risk Adjustment Payment / Charge" / Section 4.4.3.6(b) WA Exh 1 – Experience Data
	c	Consistent with #1.b above, provide the following to support benefit category experience data in URRT Worksheet 1, Section II, and the WAC 284-43-6660 summary: (i) Provide the following separately for 2024 allowed claims and incurred claims as well as by incurred month and benefit category (i.e., categories as defined for URRT Worksheet 1, Section II, plus separate categories for each non-EHB): • Change in reserves between the beginning (i.e., previous year's 3/31) claim reserves and ending (i.e., current year's 3/31) claim reserves. • Total claims. • PMPM (i.e., use monthly membership from #1.b above to calculate claims per member per month (PMPM)). • Paid-to-allowed ratios of paid (incurred) claims to allowed claims. (ii) Explain if EHB allowed claims were obtained from claims records or imputed from paid claims. If amounts were imputed, please elaborate about how they were imputed.	ANH IND OIC Health Exhibits WAC 284-43-6660 Part II Written Description Justifying the Rate Increase	WA Exh 1 – Experience Data Entire Document Page 2

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		(iii) Demonstrate how URRT Worksheet 1, Section II, categories map to WAC 284-43-6660 summary categories. Reconcile data between the two summaries. (iv) Additionally, provide related monthly information in WA Exhibit 1.		
	d	2024 actual and projected: Provide analysis of actual experience versus amounts projected in the plan year 2024 rate filing [45 CFR §154.301(a)(3)(ii)] in WA Exhibit 2. Identify material differences in actual and expected experience, the primary source(s) of deviations, and any action taken in your 2026 projections to address deviations. Additionally, address how the business is or is not impacted by federal income tax.	ANH IND OIC Health Exhibits Part III Rate Filing Documentation and Actuarial Memorandum	WA Exh 2 - Actual vs. Expected WA Exh 11 – Retention "Non-Benefit Expenses / Taxes and Fees" / Section 4.4.7(c)
	e	Split up experience if you are terminating any counties in 2025 and/or 2026: If you are terminating any counties for plan year 2025 and/or 2026, include a table splitting URRT Worksheet 1, Section I experience between continuing and terminated counties. If you are not terminating any counties, respond "N/A."	N/A – we are not terminating any counties	
2		**Manual EHB Allowed Claims:** If credibility is 100%, respond "N/A" for each item. • If you use a credibility-blended estimate, explain the processes in detail (i) per guidance in URR Instructions 4.4.3.3, to establish the Manual EHB Allowed Claims PMPM for WA and (ii) per 4.4.3.4 to establish the credibility percentage for URRT Worksheet 1, Section II. • Note: if the 2024 experience is 0.00% credible, then the trend, morbidity, demographic, plan design, and other factors in URRT Worksheet 1, Section II can be listed as 1.000. In that case, only analyses of the manual trend and adjustment factors are required.		

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	a	Manual data relevance: Explain the relevance of the data used to determine the Manual EHB Allowed Claims PMPM.	Part III Rate Filing Documentation and Actuarial Memorandum	"Manual Rate Adjustments" / Section 4.4.3.3
	b	Manual EHB allowed claims PMPM: • Show the detailed calculation of the Manual EHB Allowed Claims PMPM entered in URRT Worksheet 1, Section II. • Justify any adjustments made to the data, such as adjustments for trend, morbidity, demographics, plan design, and geographic areas. Your response should clearly identify how your estimate considers the cost and utilization characteristics of your individual health plan market service area in the State of Washington. • Note: the manual rate must be developed in a manner consistent with 100% credibility. See #2.c below.	ANH IND Part III Appendix	Part III Appendix: "Exhibit E1: Development of 2026 Index Rate"
	c	Credibility of experience data: Describe the credibility methodology and assumptions used, per Actuarial Standard of Practice (ASOP) No. 25. • Identify the actuarially sound and appropriate credibility procedure used to develop your credibility estimate. • At what level is experience determined to be more than 0% credible? • How is partial credibility determined? • At what level is experience determined to be 100% credible?	Part III Rate Filing Documentation and Actuarial Memorandum	"Credibility of Experience" / Section 4.4.3.4
	d	Show how you estimated credibility of the 2024 allowed claims and member months used in rate development. Use your credibility procedure.	Part III Rate Filing Documentation and Actuarial Memorandum	"Credibility of Experience" / Section 4.4.3.4

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
3		**Experience in WAC 284-43-6660 Summary, and Summary of Pooled Experience with Adjustments:**		
	a	WAC 284-43-6660 summary, experience: Complete the WAC 284-43-6660 summary for Individual and Small Group Contract filings. • Provide data to support WAC 284-43-6660 without adjustments for Risk Adjustment and High-Cost Risk Pool (HCRP) receipts and assessments. • Data should be based on the incurred years 2024, 2023, and 2022.	WAC 284-43-6660	Entire Document
	b	Summary of Pooled Experience with Adjustments: • Create a document or exhibit called "Summary of Pooled Experience with Adjustments" for calendar years 2024, 2023, and 2022. Start with the "Summary of Pooled Experience" table from the WAC 284-43-6660 summary and add the following rows: o Risk Adjustment transfer amounts o HCRP receipts o HCRP assessments o HHS-RADV adjustments: Indicate the source of each RADV amount and specify each applicable Benefit Year (BY) and HHS report date. List amounts from different reports on separate lines. o Commercial reinsurance reimbursements received and expected o Adjusted Gain/Loss, excluding anticipated Medical Loss Ratio (MLR) rebates, as a dollar amount o Adjusted Gain/Loss, excluding anticipated MLR rebates, as a percent of premium o Anticipated MLR rebates o Subsequent adjustments: If necessary, also list any subsequent adjustments for prior years according to when payments were received. Document the amount and incurred year for each adjustment. For example, if a Risk Adjustment transfer amount was received or paid in 2024 for a period prior to 2024 at an	Part II Written Description Justifying the Rate Increase	Page 2

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	amount other than the Risk Adjustment transfer amounts above (i.e., at the top of this list), list the difference as a below-the-line adjustment to 2024 experience. • Add a copy of this table to the Part II Written Description. • Document and justify every estimated amount. • For each federal Risk Adjustment transfer amount, identify either (1) the final federal Risk Adjustment Payments Report used or (2) the interim risk adjustment report used. Note: only use an interim report for periods when a final report is not yet available. • Note: Since the federal Reinsurance and Risk Corridor programs ended in 2016, they should not be included in the summary.		
c	Changes to prior period experience: If applicable, justify and show line-item differences in 2023 and 2022 experience in this rate filing's summary versus the final version of the "Summary of Pooled Experience with Adjustments" in last year's filing. Also, describe any such changes in the WAC 284-43-6660 summary under General Information #5.	N/A	
4	**Plan Level Experience and Current Data:** Document and justify URRT Worksheet 2, Section II Experience Period and Current Plan Level Information. • Explain whether amounts are based on each plan's experience or allocated to plans. If amounts are allocated, demonstrate and justify the allocation method. • Explain any differences between totals in URRT Worksheet 2, Section II and URRT Worksheet 1, Section I.	Part III Rate Filing Documentation and Actuarial Memorandum	"Effective Rate Review Information and Additional Requirements" / Section 4.7.1 "Risk Adjustment Payment/Charge" Section 4.4.3.6(b)

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
TREND FACTORS			
5	**Allowed Claims Trends:** Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more categories of non-EHBs, as applicable. Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data. As indicated in URR Instructions, describe the trend development in the Part III actuarial memorandum.		
a	Allowed claims EHB trend analysis: • In WA Exhibit 3, provide annual EHB trends by benefit category. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • In WA Exhibit 4, provide your retrospective analysis of normalized EHB allowed claim trends. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • In WA Exhibit 5, provide aggregate actual experience (A) EHB trends, projected (i.e., expected; E) EHB trends, and actual-to-expected (a.k.a. A:E) EHB trend analysis. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.	ANH IND OIC Health Exhibits Part I Unified Rate Review Template	WA Exh 3 - Trend Analysis WA Exh 4 - Normalized Trend WA Exh 5 - w1 Pool Factors Worksheet 1 & 2
b	Allowed claims non-EHB trend analysis: If applicable, include an exhibit that develops the non-EHB allowed claims trend.	ANH IND OIC Health Exhibits	WA Exh 1 - Experience Data
c	Projected allowed claims trend development (EHB & non-EHB): • As outlined in URR Instructions 4.4.3.1, describe how you arrived at your allowed claims trend assumptions, including the data used, credibility of the data used, and any adjustments made to the data. • Provide an overall allowed claims trend estimate as well as EHB breakdowns into URRT worksheet 1 benefit categories (or at least medical and prescription drug categories).	Part III Rate Filing Documentation and Actuarial Memorandum	"Trend Factors" / Section 4.4.3.1

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		○ Further break the EHB trends down into utilization, unit cost, and service mix/intensity components. ○ Upload relevant EHB details to **WA Exhibit 3**; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • If your overall trend, indicated in URRT Worksheet 1, Section II, differs materially from the retrospective trend indicated in WA Exhibit 4, provide detailed actuarial support for the difference. Address the following: ○ Actuarial support must provide both qualitative and quantitative bases for the difference. Refer to other WA Exhibits and/or separate issuer-developed actuarial exhibits for support, where appropriate. ○ Prospective trend adjustments should identify all data, assumptions, methods, and models. Note that prospective trend adjustments are NOT exempt from actuarial support requirements. Reliance statements do not exempt carriers from actuarial support requirements. • Address how your estimates reflect trends specific to the State of Washington. Note that nationwide trend analysis is not sufficient support for Washington State unit cost trend projections. ○ Address whether and how unit cost projections reflect projected network and provider contract changes for the projection period. Comment about how much of the provider contracting is already complete for plan year 2026 and how much of the projected reimbursement trend is already locked in for plan year 2026.		
	d	Independence of various utilization changes: • Explain how you separated expected utilization changes due to (i) changes in average health status of the population (a.k.a. morbidity) versus (ii) other projected utilization changes (e.g., change in mix of services). • Clarify how the various utilization and morbidity adjustments in the rate filing are independent (i.e., do not overlap nor depend on one another).	Part III Rate Filing Documentation and Actuarial Memorandum	"Trend Factors" / Section 4.4.3.1

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
6	**Incurred Claims Trends:** • Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more separate non-EHB categories, as applicable. They should also be available for each type of service in the WAC 284-43-6660 trend factor summary. • Incurred claims trends differ from allowed claims trends in that they reflect leveraging of fixed cost-shares. • Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data. • Describe the trend development in the Part III actuarial memorandum.		
a	Incurred claims projected trend (EHB & non-EHB): (see also #32.c of this checklist) • Include an exhibit that develops the incurred claims trend percentages entered in the WAC 284-43-6660 summary. Justify the projected incurred claims trend percentages. • Show how to calculate the Portion of Claim Dollars for trends in the WAC 284-43-6660 summary. Note: the percentages should be based on the 2024 incurred claims dollars by trend category. The total incurred claims used in the calculation should be consistent with the incurred claims PMPM in URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.17. • Demonstrate that the overall incurred claims annual trend (EHB and non-EHB) matches (1) the annualized trend from URRT Worksheet 1, Section I General Product and Plan Information to URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.15 as well as (2) the incurred claims trend listed in Rate Review Details (see also #23.b of this checklist).	ANH IND OIC Health Exhibits ANH IND Part III Appendix Part III Rate Filing Documentation and Actuarial Memorandum	WA Exh 5 - w1 Pool Factors WA Exh 1 – Experience Data "Effective Rate Review Information and Additional Requirements / Section 4.7.1
URRT WORKSHEET 1, SECTION II EXPERIENCE PERIOD and CURRENT PLAN LEVEL INFORMATION, NON-TREND EHB ADJUSTMENT FACTORS			
7	**URRT Worksheet 1, Section II Non-Trend EHB Factors:** Explain and show the detailed calculations for actuarial assumptions underlying each non-trend EHB factor used in URRT Worksheet 1, Section II Experience Period and Current Plan Level Information. Provide actual experience, projections, and actual-to-expected information in WA Exhibit 5; see instructions in the exhibit template. • Morbidity Adjustment	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Morbidity Adjustment" / Section 4.4.3.2(a), "Demographic Shift" Section 4.4.3.2(b) "Plan Design Changes" / Section 4.4.3.2(c)

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	• Demographic Shift • Plan Design Changes • Other If applicable, provide a detailed breakdown of any adjustments made under the "Other" category such as significant provider network or pharmacy rebate changes from the experience period.	ANH IND OIC Health Exhibits	"Other Adjustments" / Section 4.4.3.2(d) "Credibility of Experience" / Section 4.4.3.4, "Risk Adjustment Payment/Charge" Section 4.4.3.6(b) "Non-Benefit Expenses" / Section 4.4.7 Health Exhibits: WA Exh 10 - Risk Adjustment, Health Exhibits: WA Exh 8 - CSR Experience
URRT WORKSHEET 2, SECTION I GENERAL PRODUCT and PLAN INFORMATION, AV METAL VALUES			
8	**AVC Screenshots:** (see also #9 below) • Provide the Actuarial Value Calculator (AVC) screenshots in PDF format showing "Calculation Successful." State the corresponding HIOS Plan ID on each AVC Screenshot. For the 2026 AV Calculator and Methodology, see link: https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html Please do not submit AVC screenshots for every CSR plan variation (i.e., 73%, 87%, and 94%), however, be mindful of the de minimis variation limit of 0/+1 percentage points. NOTE: if you rely on AV Metal Values calculated by the Exchange's actuaries, do not submit your own AVC screenshot copies for standardized plans. Instead, document such reliance in your Part III actuarial memorandum and include in SERFF Supporting Documentation a copy of the Exchange's actuarial certification of AV Metal Values for standardized plans. • MHSUD cost-share: You may list the MHSUD office visit cost-share in the AVC if you include justification in the actuarial memorandum that blending the cost-share with the MHSUD other outpatient cost-share has a negligible impact on the final AV Metal Value.	ANH IND AV Screenshots, Standard Plan Unique Design and AV Screenshots	Entire Documents

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	• Please reformat the "Coinsurance, if different" cells to display the same 4-decimal place accuracy as the default coinsurance for tiers 1 & 2. Also, reformat the tiered utilization percentages to more accurately indicate the weights used in the calculation. • The AV Metal Value of non-standardized silver health plans offered on the Exchange may not be less than the AV Metal Value of the standardized silver health plan with the lowest AV Metal Value. [RCW 43.71.095(2)(b)(iii)] Standardized plan information is available on Exchange's website. • Metal Levels Platinum – 90%, range -2/+2% Gold – 80%, range -2/+2% Silver – 70%, range -2/+2% for non-QHPs and 0/+2% for QHPs Bronze – 60%, range -2/+2% or Expanded Bronze +2/+5% Catastrophic – The AV requirements are not specified by law		
9	**Unique Benefit Design for AVC (Actuarial Value Calculator):** Note: Address this item in conjunction with #8 above. • The actuary would be prudent to attempt to use data and assumptions that are consistent with the calculators as much as possible when adjusting for unique plan designs (https://www.actuary.org/sites/default/files/files/MVPN_042314.pdf). The continuance tables in the AVC should be used, if possible, so that the adjustments are consistent with the AVC calculations. • Do any plans have a unique benefit design? If yes, for each such plan, you must: o Use one of the two methods, 45 CFR §156.135(b)(2) **or** 45 CFR §156.135(b)(3), to certify the Metal Value and provide the exact AV Metal Value for the plan. o You must also provide detailed support for your unique plan design AVs. • Please provide supporting unique AV calculations in your rate filing memorandum and exhibits. o Include enough detail for the reviewer to determine whether the methods, assumptions, and results are appropriate and reasonable. o You must provide justification for AVs when actual plan designs deviate from the AVC's functionality, even if your actuary assumes the impact is immaterial.		

- **Notes About Plan Designs in the AVC:**
  - To be consistent with the requirements in the AVC User Guide (see FAQ Q2 & Q3), all plans with a $0 Rx or a $0 medical deductible should indicate an integrated medical and drug deductible when possible. For illustrative purposes, consider a plan with a non-zero medical deductible and a $0 drug deductible, which is equivalent to saying that none of the drug tiers (i.e., benefits) is subject to any kind of deductible:
    - Case 1: One or more of the drug tiers are subject to coinsurance (which, from our earlier assumption, apply before any deductible).
    - Case 2: Each drug tier is either fully covered or subject to a copay.
    - For Case 1, using a combined deductible would force the drug coinsurance(s) to apply after the medical deductible (given the limitations of the AVC with regards to entering coinsurance before the deductible). For Case 2, an integrated deductible should be used.
  - The reverse situation with $0 medical and non-zero Rx deductibles is similar, however, only coinsurance for the medical benefits listed in the AVC are considered. If, for example, a coinsurance is only applied to the ambulance benefit, which is not part of the AVC, a combined deductible should be applied.
  - *Plans that include Coinsurance During the Deductible Phase or can otherwise be described as having "Services not Subject to Deductible and without a copay":*
    Excel row 72 on the User Guide sheet of the AVC states, "Services not subject to deductible and without a copay are treated as covered at 100 percent by the plan until the deductible is met through enrollee payments for other services." When this occurs, the AVC output is higher than that of the actual plan design; the difference depends on the size of the deductible and impact of the corresponding benefit on the actuarial value. The exact difference, however, is unknown without using an effective copay, which requires a unique benefit design, to approximate the coinsurance in the deductible range. If your plans include this type of cost-sharing design, you are required to show that their AVs are within the acceptable metal level range using unique benefit designs. See the AVC User Guide sheet FAQ Q16 for additional information.
  - *Plans that include "Services not Subject to Deductible and with a copay":*
    Copays paid during the deductible range do not accumulate toward the deductible, regardless of whether the benefit is subject to deductible.
  - *Plans that partition benefit categories into subcategories with different cost-share designs:*
    If the plan has different cost-sharing for subcategories of benefits included in the AVC but the AVC only accepts one cost-sharing structure, you must (1) enter the cost-share variations in the

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		Benefit Components document and (2) account for the differences between the plan design and the AVC functionality in your AV Metal Value calculations. For example, the AVC only accepts one MHSUD (mental health/substance use disorder) outpatient cost-share structure, so if a plan design includes different cost-shares for MHSUD outpatient professional (office) visits versus MHSUD outpatient other-than-professional-visits, the plan design does not align with standard use of the AVC.		
	a	If using the unique benefit design certification method in 45 CFR §156.135(b)(2): • Provide the required actuarial certification language as well as justification and detailed calculations of how you estimated a fit of the plan design into the parameters of the AVC. • Submit one AVC screenshot for each plan to show that the benefit design after the fit is a legal metal plan.	ANH IND CMS Unique Plan Design Documentation and Standard Plan Unique Design and AV Screenshots	Entire document
	b	If using the unique benefit design certification method in 45 CFR §156.135(b)(3): • Provide the required actuarial certification language as well as justification and detailed calculations of (i) how the AVC was used to determine the AV Metal Value for the plan provisions that fit within the calculator parameters while (ii) appropriate adjustments were made to the AVC output(s) for plan design features that deviate substantially from AVC parameters. • Submit two or more AVC screenshots including at least one extreme high AV Metal Value and one extreme low AV Metal Value based on features like those of the plan. • Using the filed AVC screenshot results, explain how adjustments are made to generate each plan's EXACT final AV Metal Value used in the URRT.	ANH IND CMS Unique Plan Design Documentation and Standard Plan Unique Design and AV Screenshots	Entire document
	c	Unique Plan Design Supporting Documentation and Justification: Include a completed Unique Plan Design Supporting Documentation and Justification form (a blank form can be found on the CMS website). Note: You may submit your own version of the official form, to accommodate your complete responses and improve readability.	ANH IND CMS Unique Plan Design Documentation and Standard Plan Unique Design and AV Screenshots	Entire document

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
d	Pharmacy tiers: If your prescription drug tiers do not exactly match those in the AVC and you do not identify the plans as having unique benefits, please add a discussion to the Part III actuarial memorandum. Consider guidance in relevant documents such as the PY2025 QHP Issuer Application Instructions (e.g., 5.8 Suggested Coordination of Drug Data between Templates) and AVC supporting documentation.	N/A	
10	**AV Metal Values:** (URRT Worksheet 2, Section I General Product and Plan Information, Field 1.6) Load the final PY2026 AV Metal Values into URRT Worksheet 2 and WA Exhibit 6. Additionally, load prior AV Metal Values into WA Exhibit 6; see instructions in the exhibit template.	ANH IND OIC Health Exhibits Part I Unified Rate Review Template	WA Exh 6 - Actuarial Values Worksheet 2 / Section I General Product and Plan Information / Field 1.6
URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS			

11	**AV and Cost Sharing Design of Plan Factors:**
	(URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3)
	Document and justify the factors including #11.a through #11.d below.
	Then, address items #11.e through #11.h below. Include aggregate actual experience, projections, and actual-to-expected analysis in WA Exhibit 7; see the instructions in the exhibit template.
	
	URR Instructions Section 2.2.3 and URRT Worksheet 2, Section III include four adjustments directly related to plan-level incurred claims rate development.
	• These adjustments are the "AV and Cost Sharing Design of Plan", "Provider Network Adjustment" (see checklist #12), "Benefits in Addition to EHB" (see checklist #13), and "Catastrophic Adjustment" (see checklist #14).
	• Do not include morbidity of the population expected to enroll in the plan (i.e., differences due to health status) per URR Instructions Section 4.4.4.
	• Each of these adjustments should be normalized to not double count the impact of the other factors.
	
	To derive the "AV and Cost Sharing Design of Plan":
	• There are four subcomponents of the adjustment defined in WAC 284-43-6810(1); they are:
	  o AV pricing value,
	  o Induced demand factor (IDF),
	  o Cost-sharing reduction (CSR) silver load (if applicable), and
	  o Exclusion of funds for abortion services per 45 CFR §156.280(e) (if applicable).
	• Definitions of these terms and related terms can be found in WAC 284-43-6800.
	• Detailed guidance related to each subcomponent of the "AV and Cost Sharing Design of Plan" is provided in this checklist in sections 11 (a)-(h).
	• The formula combining the subcomponents of the "AV and Cost Sharing Design of Plan" is expected to be the following: (AV and Cost Sharing Design of Plan) = (AV Pricing Value) x (Induced Demand Factor, IDF) x (CSR Silver Load and/or AIAN adjustment, as applicable) x (Factor to exclude the cost of abortion services for which public funding is prohibited); where the AV Pricing Value and IDF are on an appropriate relativity basis.
	
	Note the following:
	• For benefit differences relate to EHB-only cost sharing. See #11.a below.	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**

	• For expected utilization adjustments due to differences in cost-sharing (i.e., induced demand). See #11.b below.
	• For CSR silver load and exclusion of funds for abortion services per 45 CFR §156.280(e):
	  o If CSR payments are not funded, a CSR silver load factor should be included for the on-Exchange silver plans; this is an additional step not covered in the URR Instructions. See #11.c below.
	  o For all plans offered on the Exchange, include an adjustment to remove the impact of coverage of abortion services for which public funding is prohibited. See #11.d below.
	• To determine aggregate weighted averages for items covered by this #11, unless otherwise specified, apply each plan's projected membership as weights.		

a	**AV Pricing Value (a.k.a. EHB paid-to-allowed factors) by plan:**
	• Provide the factor for each plan that shows the impact of benefit differences for EHB-only cost sharing.
	• See WAC 284-43-6800(3) for the definition of AV pricing value and WAC 284-43-6800(1) for the definition of AV metal value.
	• Per WAC 284-43-6810(3):
	  o Rate development exhibits should demonstrate compliance with the following:
	  ▪ "The AV pricing value must be within ±2% of a plan's designated AV metal value."
	  ▪ "The allowable range of AV pricing value may be increased or decreased by 1% and must not result in a total adjustment exceeding ±3%, if the plan has significant features that are not considered in the AV metal value calculation. Applicable plan features may include, but are not limited to, an embedded pediatric dental benefit, aggregate family deductible, or significant out-of-network utilization."
	  ▪ If you are requesting the expanded AV Pricing Value range of ±3%, identify this in WA Exhibit 9 and provide supporting documentation for the request. Documentation for this request must show significant plan features impact EHBs, those plan features are excluded from consideration in the federal AV calculator and AV metal value, and those plan features have a material pricing impact supported by actuarial analysis.
		ANH IND OIC Health Exhibits
		
		Part III Rate Filing Documentation and Actuarial Memorandum
			WA Exh 9 - AV and Cost-Share
			
			Part III Appendix: "Exhibit E2: Plan Adjusted Index Rate Development"

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		▪ Note that AV pricing value must be actuarially sound, and the ranges referenced above should not be used as an adjustment (i.e., ceiling or floor) to AV pricing values. ▪ AV pricing values should be normalized for impacts of all other allowable plan-level rating adjustments (including subcomponents of the "AV and Cost Sharing Design of Plan") and for use in the calculations of the "AV and Cost Sharing Design of Plan" factors. o The Part III actuarial memorandum in the rate filing must include the following information related to AV metal value and AV pricing value: ▪ Each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values. ▪ The methodology that was used to develop the AV pricing value including that it is based on a standardized population. The carrier must identify all material changes in the AV pricing value development and their impacts. ▪ Note that if you have a commercial or other (e.g., internal) reinsurance/pooling agreement, consider projected recoverable amounts in the overall AV Pricing Value.		
	b	**Induced demand factors (IDFs) by plan:** • Each plan's IDF can vary by plan design but must be consistent with the federal risk adjustment transfer formula per WAC 284-43-6810(2). Therefore, plan IDFs should be determined by the formula $(\text{AV pricing value})^2 - (\text{AV pricing value}) + 1.24$. • Note the following: o The MAIR reflects average induced demand for the pool. o IDFs adjust average pool-level projected allowed claims to plan-level amounts. IDFs reflect the impact of plan design on plan-level utilization (i.e., induced demand or anti-selection) relative to the average induced demand in the pool. IDFs should not change the overall expected allowed claims nor the paid-to-allowed claims ratio. o Calculate the aggregate impact of your pool's projected induced demand factors. If it is not 1.000, apply an adjustment in URRT worksheet 1's "Other" adjustment. Such an adjustment should equal (1 / (aggregate impact of your pool's projected induced demand factors)). The net impact should be 1.000.	ANH IND OIC Health Exhibits ANH IND Part III Appendix	WA Exh 9 - AV and Cost-Share Part III Appendix: "Exhibit E2: Plan Adjusted Index Rate Development"

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
c	**Cost-sharing reduction (CSR) silver load factors by plan:** • Note: In this case, references to "CSR" subsidies include subsidies for the AIAN population. Include actual experience and the projected CSR silver load factor in WA Exhibit 8; see the instructions in the exhibit template. • Consult WAC 284-43-6820 for guidance on the uniform CSR silver load adjustment factor for plan year 2026.	ANH IND OIC Health Exhibits	WA Exh 8 - CSR Experience (Note all Asuris plans are off exchange)
d	**Exchange plan adjustment for cost of covering certain abortion services:** (see also #13 & #27 of this checklist) For Exchange plans only, include an adjustment factor to remove the impact of coverage of abortion services for which public funding is prohibited. Per 45 CFR §156.280(e)(4)(iii), you may not estimate such a cost at less than one dollar per enrollee, per month (i.e., $1.00 premium PMPM, see https://www.cms.gov/files/document/qhp-abortion-faq.pdf Q3). • Note that you must include abortion services in URRT Worksheet 1, Section II because Washington considers abortion services to be EHBs. • The impact of coverage of abortion services for which public funding is prohibited should be addressed in URRT Worksheet 2, Section II Experience Period and Current Plan Level Information. In other words, related costs should flow through with other claim experience. • For Exchange plans: o Include the impact as part of URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5 Benefits in Addition to EHB. o Remove the impact from URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3 AV and Cost Sharing Design of Plan. The abortion adjustment applied to Field 3.3 is the reciprocal of the abortion adjustment applied to Field 3.5. (URR Instructions Section 2.2.3). This load should be explicitly listed as a separate column in your development exhibit for the AV and Cost Sharing Design of Plan factors. o Explain in the Part III actuarial memorandum that per URR instructions, coverage of abortion services for which public funding is prohibited are included in the URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5 as a non-EHB.	N/A – all plans offered off exchange	

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	e	**AV and Cost Sharing Design of Plan factors:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3) Discuss and demonstrate the calculation of the final plan adjustment factors used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3, AV and Cost Sharing Design of Plan. See the introduction to this checklist #11 for the AV and Cost Sharing Design of Plan formula using the four subcomponents addressed in WAC 284-43-6810(1).	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Plan Adjusted Index Rate" / Section 4.4.4 Part III Appendix: "Exhibit E2: Plan Adjusted Index Rate Development"
	f	**Compare the AV Metal Value and the AV Pricing Value:** Provide the comparison of the AV Metal Values and AV Pricing Values in WA Exhibits 6 and 9.	ANH IND OIC Health Exhibits	WA Exh 6 - Actuarial Values WA Exh 9 - AV and Cost-Share
	g	**Base premium rates versus CPAIR:** Calculate the difference between the 1.0000 premium rates (i.e., age factor 1.0000 such as for age 21; area factor 1.0000; tobacco factor 1.0000 for non-smoker) for each plan in the Rate Schedule and the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.14. The differences should be within a few cents at most. (see also #36 of this checklist)	ANH IND Part III Appendix	"Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping"
	h	**Experience period incurred claims, allowed claims, and paid-to-allowed ratios:** Include a table that shows by metal level the 2024 paid (incurred) claims and allowed claims experience and calculates the paid-to-allowed ratios. See also #1.c and #1.d of this checklist.	ANH IND OIC Health Exhibits	WA Exh 8 - CSR Experience
12		**Provider Network Adjustment Factors:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.4) Demonstrate the build-up of the provider network factors. If you only have one network, please respond "N/A," and use a factor of 1.0000. The network factors should be normalized so that there is no change to the overall weighted average of the claim costs after the Provider Network Adjustment factors are applied. Include an exhibit demonstrating the normalization (i.e., normalize the network factors such that the following amounts match): • Average incurred claims with risk adjustment and Exchange user fee:	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Other Adjustments" / Section 4.4.3.2(d); Part III Appendix: "Exhibit E2: Plan Adjusted Index Rate Development"

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	Sum product of the projected membership x MAIR x (AV and Cost Sharing Design of Plan) x (Benefits in Addition to EHB) x (Catastrophic Adjustment) divided by the total projected membership. • Average incurred claims with risk adjustment and Exchange fee as well as provider network adjustment factors: Sum product as described above with Provider Network Adjustment factors also incorporated. If applicable, include a discussion of the network for the public option plans (i.e., Cascade Select plans).		
13	**Benefits in Addition to EHB Factors:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5) Document and justify these factors. Note that they should be developed as loads on EHB incurred claims. See URR Instructions and 45 CFR §156.115(d) for additional information. Include aggregate actual experience, projections, and actual-to-expected analysis in WA Exhibit 7; see the instructions in the exhibit template. If plans do not include non-EHBs (non-essential health benefits) and all plans are outside the Exchange, please respond "N/A." Notes about abortion services for URRT purposes (see also #11.d & #27 of this checklist): • Exchange plans that include coverage of abortion services for which public funding is prohibited must calculate such abortion services as non-EHBs. • For plans offered Outside Market Only, such abortion services must be calculated as EHBs. Then, only non-EHBs, if applicable, should be addressed as part of Benefits in Addition to EHB.	Part III Rate Filing Documentation and Actuarial Memorandum ANH IND OIC Health Exhibits	"Establishing the Index Rate" / Section 4.4.3.5 WA Exh 7 - w2AggregateFactors
14	**Catastrophic Adjustment Factors:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.9) Document and justify any such factor(s). Include aggregate actual experience, projections, and actual-to-expected analysis in WA Exhibit 7; see the instructions in the exhibit template.	N/A, no catastrophic plans offered	

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS, CALIBRATION FACTORS				
15		**Age Factors and Age Calibration Factors:**		
	a	Age calibration factor development: Provide the 2026 age factors and the calculation of the age calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.11. Note: each calibration factor (age, geographic, and tobacco) must be calculated independently.	ANH IND Part III Appendix	"Exhibit C1: Age Curve And Tobacco Calibration Factors"
	b	Age calibration factors, projected versus prior: Compare the 2026 age calibration factor to the 2023, 2024, and 2025 factors.	ANH IND Part III Appendix	"Exhibit C3: Demographic Factor Comparison"
	c	Average age: Show the average age and provide actuarial justification for the methodology employed to calculate the average age.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Calibration" / Section 4.4.5 Part III Appendix: "Exhibit C1: Age Curve and Tobacco Calibration Factors"
16		**Area Factors and Geographic Calibration Factors:** See WAC 284-43-6701 for geographic rating areas effective on or after January 1, 2019. Note, if Area 1 (King County) is in your service area, its factor must be set at 1.0000. If Area 1 (King County) is **not** in your service area, the geographic rating area of the county with the largest enrollment in your service area must be set at 1.0000. If you are an insurer new to the Washington state market, the geographic area with the greatest number of counties must be set at 1.0000.		
	a	Area factor development: Note: if your service area is limited to a single area, please respond "N/A," since the area factor is 1.0000. Demonstrate the build-up of the geographic rating area factors. Document and justify the 2026 factors with details including, but not limited to, the following: • Certify that the following items were not used to establish any geographic rating area factor: o Health status of enrollees or the population in an area.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Rate Factors	Part III: "Factor Changes" / Section 4.3 Rate Factors: "Summary of Current and Prior Year Factors" / Page 2 "Exhibit C2: Geographic Factors"

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		○ Medical condition of enrollees or the population in an area including physical, mental, and behavioral health illnesses. ○ Claims experience. ○ Health services utilization in the area. ○ Medical history of enrollees or the population in an area. ○ Genetic information of enrollees or the population in an area. ○ Disability status of enrollees or the population in an area. ○ Other evidence of insurability applicable in the area. • Clarify how projected unit cost changes were considered for each area. Also, clarify how credibility was considered. Like trends, you should not solely rely on historical information, especially if it is not considered to be 100% credible or if significant changes are projected in the future.		
	b	Area factors, highest versus lowest: Demonstrate that your geographic rating area factors comply with WAC 284-43-6681 highest to lowest cost ratio requirements of • 1.40 if offering an Exchange QHP in every county, • 1.22 if offering an Exchange QHP in every county in six or more rating areas, or • 1.15 in all other cases.	ANH IND Rate Factors	Rate Factors: "Summary of Current and Prior Year Factors" / Page 2
	c	Area factors, projected versus prior: Compare the 2026 area factors and calibration factor to the 2023, 2024, and 2025 factors. If the 2026 factors did not change from those in the prior filing, indicate why the factors did not change; indicate when the factors were last evaluated and what data was used in that evaluation. Note: Our opinion is that the geographic area factors should be regularly evaluated.	ANH IND Part III Appendix	"Exhibit C3: Demographic Factor Comparison"
	d	URRT geographic calibration factor: Provide the calculation of the geographic calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.12. Note: each calibration factor (age, geographic, and tobacco) must be calculated independently.	ANH IND Part III Appendix	"Exhibit C2: Geographic Factors"

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	e	Load area factors into URRT: Provide the geographic rating areas and rating factors in URRT Worksheet 3.	ANH IND Rate Factors	Rate Factors: "Summary of Current and Prior Year Factors" / Page 2
17		**Tobacco Use Factor and Tobacco Calibration Factor:**		
	a	Tobacco use factor development: Document and justify the 2026 Tobacco Use factor. • The maximum factor is 1.500 (see 45 CFR §147.102(a)(1)(iv)). • If the factor did not change from the prior filing, indicate when the factor was last evaluated and what data was used in that evaluation. Note: Our opinion is that the factor should be re-evaluated periodically.	Part III Rate Filing Documentation and Actuarial Memorandum	"Effective Rate Review Information and Additional Requirements" / Section 4.7.1 "Consumer Adjusted Premium Rate Development" / Section 4.4.6 Note: OIC and WAHBE requested that companies remove the tobacco rating factor. Asuris removed the factor.
	b	URRT tobacco calibration factor: Provide the calculation of the tobacco calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.13. Note: each calibration factor (age, geographic, and tobacco) must be calculated independently.	ANH IND Part III Appendix	"Exhibit C1: Age Curve and Tobacco Calibration Factors"
	c	Tobacco factors, projected versus prior: Compare the 2026 tobacco use factor and calibration factor to amounts for 2023, 2024, and 2025.	ANH IND Part III Appendix	"Exhibit C3: Demographic Factor Comparison"
RISK ADJUSTMENT AND HIGH-COST RISK POOL (HCRP)				
18		**Experience Period Risk Adjustment & HCRP:**		
	a	Experience period risk adjustment formula details: Provide the actual 2024 risk adjustment experience and projections in WA Exhibit 10; see the instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.	ANH IND OIC Health Exhibits	WA Exh 10 - Risk Adjustment

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		REMINDER: Do **NOT** revise the sign (receivables positive; payables negative) of the actual or projected risk adjustment transfer and HCRP amounts in any exhibit unless specifically instructed to do so. Clearly document the instances when the instructions specify a change in sign.		
	b	Experience period risk adjustment & HCRP by plan: (URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.7) Using formulae, please address 2024 risk adjustment transfer amounts, HCRP assessments, and HCRP receipts.	Part I Unified Rate Review Template	Worksheet 2 / Section II Risk Adjustment Transfer Amount / Field 2.7
19		**Projection Period Risk Adjustment & HCRP:**		
	a	Projection period incurred risk adjustment & HCRP development: (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16) Provide the projected plan year 2026 risk adjustment information in WA Exhibit 10; see the instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.	ANH IND OIC Health Exhibits	WA Exh 10 - Risk Adjustment
	b	Projection period risk adjustment & HCRP for URRT Worksheet 2 (on incurred claims basis), Development and justification: (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16) • Explain in detail in the Part III actuarial memorandum how you estimated the 2026 risk adjustment factors (e.g., PLRS, IDF, GCF, AV, and ARF), including the four membership groupings in (a), as applicable. (See URR Instructions regarding the requirements to provide detailed information and justification for risk adjustment.) • Provide detailed support and rationale for each assumption, including persisting membership, stating the most current data used, its "as of" date, and its source (e.g., internal, CMS, etc.). • Describe how your projections considered the 2026 risk adjustment model changes. • Explain 2026 HCRP estimated assessments and receipts.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix ANH IND OIC Health Exhibits	Part III: "Risk Adjustment Payment/Charge" / Section 4.4.3.6(b); Health Exhibits: WA Exh 10 - Risk Adjustment

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		• We expect the following: o Since the URRT applies total pool-level projected risk adjustment in Worksheet 1, Section II, the projected risk adjustment loaded into Worksheet 2, Section IV can use total pool-level projections rather than metal/catastrophic or plan projections. o Applicable risk adjustment transfer amount parameters projected for your own risk pool will be consistent with assumptions in the rate development (e.g., population and other factors in URRT, age and geographic calibration factors, etc.). Please explain any deviations.		
	c	Projection period risk adjustment & HCRP for URRT Worksheet 1 (on allowed claims basis): (URRT Worksheet 1, Section II Projections) Provide the calculation of the projected Risk Adjustment Payment/Charge, on an allowed claim dollar basis, as entered in URRT Worksheet 1, Section II. For additional details, see #28 of this checklist.	ANH IND OIC Health Exhibits ANH IND Part III Appendix	Health Exhibits: WA Exh 10 - Risk Adjustment; WA Exh 8 - CSR Experience "Exhibit E1: Development of 2026 Index Rate"
	d	Projected 2026 RADV impacts: Explain in the Part III actuarial memorandum any impacts due to Risk Adjustment Data Validation (RADV) audits. For example, explain any impact to the company or statewide 2026 PLRS projections due to the 2022 RADV audit report.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Risk Adjustment Payment/Charge" / Section 4.4.3.6(b);
	e	HCRP, projected versus prior: Compare (i) actual HCRP receipts and assessments for 2022, 2023, and 2024 versus (ii) projected HCRP receipts and assessments for 2022, 2023, 2024, 2025, and 2026. Explain differences.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix ANH IND OIC Health Exhibits	Part III: "Risk Adjustment Payment/Charge" / Section 4.4.3.6(b); Part III Appendix: "Exhibit A1: Development of 2026 Rate Change" Health Exhibits: WA Exh 10 - Risk Adjustment

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	f	Projection period risk adjustment transfers & HCRP by plan: Using formulae, please address 2026 projected risk adjustment transfer amounts, HCRP assessments, and HCRP receipts on an incurred basis.	ANH IND OIC Health Exhibits ANH IND Part III Appendix	Health Exhibits: WA Exh 10 - Risk Adjustment "Exhibit E1: Development of 2026 Index Rate" "Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping"

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
RETENTION LOADS **URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS, ADMINISTRATIVE COSTS**			
20	**Administrative Expense:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6) Provide the requested information in WA Exhibit 11; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. Projection period administrative expense development: • In the Part III actuarial memorandum and supporting exhibits, justify the 2026 PMPM and/or percent of premium load for each item, and comment why various amounts do or do not vary by plan. • In the Part III actuarial memorandum, justify any item with a $0.00 load. For example, if no offset is projected for investment income, please explain why. Note: it is insufficient to simply state that an amount is considered immaterial. • In the Part III actuarial memorandum, describe planned quality improvement initiatives. • At a minimum, include detailed calculations of the following projected amounts: o Quality improvement (QI) expenses o Commissions o Commercial reinsurance premium (if applicable) o Offset for anticipated investment income (if applicable) o General administrative expenses • Note that the commissions load should be consistent with the submitted commission certification (see also #35 of this checklist). The load may include adjustments for bonuses which are not specific to the individual line of business and, therefore, not covered in the certification. Any such bonuses should be explained in the Part III actuarial memorandum and exhibits. Combine these amounts with actual taxes and fees to reconcile to Expenses shown in the WAC 284-43-6660 summary (see also #21 of this checklist).		

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
21	**Taxes and Fees:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7) Provide the requested information in WA Exhibit 11; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. Projection period taxes and fees' development: • In the Part III actuarial memorandum and supporting exhibits, justify the 2026 PMPM and/or percent of premium load for each item, and explain why various amounts do or do not vary by plan. • In the Part III actuarial memorandum, justify any item with a $0.00 load. Note: it is insufficient to simply state that an amount is considered immaterial. • At a minimum, include detailed calculations of the following projected amounts: o Premium Tax [RCW 48.14.020 or 0201] o Federal Income Tax o Regulatory Surcharge [RCW 48.02.190] Include a discussion of the current information available at https://www.insurance.wa.gov/regulatory-surcharge-calculation. o Insurance Fraud Surcharge [RCW 48.02.190] Include a discussion of the current information available at https://www.insurance.wa.gov/fraud-surcharge-calculation. o Risk Adjustment user fee The 2026 per capita risk adjustment user fee is set at $0.20 PMPM. o PCORI Patient-Centered Outcomes Research Institute (PCORI) Fee (Internal Revenue Code sections 4375 and 4376). Include a discussion of the latest information on the IRS website and the National Health Expenditure (NHE) trend projections. Note that the fee changes annually by policy end date; for this Individual market rate filing, assume all plans end 12/31/2026. o Mitigating Inequity Fee [WAC 284-43-6590], if applicable (see also #38 of this checklist).		

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	○ WSHIP assessment [RCW 48.41.090] Include a discussion of the current and projected assessment information in annual or other reports available at https://www.wship.org/ as well as the WSHIP information separately sent to you as a member plan. Note: WSHIP = Washington State Health Insurance Pool. ○ Washington Partnership Access Line (WAPAL) assessment [WAC 182-110-0500] Include a discussion of the historical assessments paid and the current information available at https://wapalfund.org. Combine these amounts with actual administrative expenses to reconcile to Expenses shown in the WAC 284-43-6660 summary. (see also #20 of this checklist)		
22	**Profit & Risk Load:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8) Provide the information in WA Exhibit 11; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • Profit & Risk load is the portion of the projected earned premium that is not directly associated with claims or expenses. • The amount must be the same across all plans. Projection period profit & risk load development: Justify that your Profit & Risk load is reasonable [RCW 48.43.734] in relation to your company's surplus, capital, and profit levels. • Discuss in detail how you established your 2026 plan year load. • Clarify whether your experience unpaid claims liability estimate also includes any margin or if the estimate reflects your best estimate. • Explain whether other plan year 2026 rating assumptions include their own margin provisions.		
DOCUMENTATION AND EXHIBITS			

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
23		**Company Rate Information and Rate Review Detail:** For the "Company Rate Information" and "View Rate Review Detail" on the Rate/Rule Schedule tab of the SERFF rate filing, provide an exhibit with the following information. • The information should represent your **initial requested rate change**. • Note: If post submission updates are necessary to correct any information, update the exhibit to indicate what was updated and the reason for the update(s). • Issuers with renewal plans must address the items below. For more information related to "Company Rate Information" and "View Rate Review Detail," see SERFF and Rate Filing Instructions.		
	a	SERFF Company Rate Information: Provide the calculation, explanation, and/or source of the information. Note the following: • Number of policy holders affected for this program: The number of subscribers as of March 2025. • Minimum and Maximum % changes: From the initial Uniform Product Modification Justification (UPMJ) Q5 rate changes by plan. • Overall % rate impact: The calculated overall average rate change in UPMJ Q5. • Written Premium for this Program and Written Premium Change for this Program: Annual amounts; see Written Premium in the NAIC glossary.	ANH IND Part III Appendix	"Checklist Value Comparison" / Exhibit F1
	b	SERFF Rate Review Detail (RRD): Provide the calculation, explanation, and/or source of the information. (i) Products, Number of Covered Lives: The number of covered lives (members) as of March 2025. If applicable, differentiate renewing products which list current lives versus new products which list projected lives (see instructions in the RRD in SERFF). (ii) Trend Factors: Annual incurred claims trend factor, including leveraging, which matches the weighted average of the trends by category in the initial 2026 WAC 284-43-6660 summary. (see also #6.b of this checklist)	Part I Unified Rate Review Template, Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix, Rate Schedule, ANH IND Uniform Product	Rate Review Detail: (i) Covered Lives as of March 2025: Part I, Worksheet 2, Section II, row 2.10; Projected Lives on New Products: Part I, Worksheet 2, Section IV, row 4.9. Note: please divide row 4.9 by 12 to convert from months to lives.

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(iii) Forms: List all forms for the rate filing in the applicable categories. If a category does not apply to any form in the filing, leave it blank. (see SERFF instructions) Note: since the ACA requires that all non-grandfathered individual and small group health plans be guaranteed issue, the "Affected Forms for Closed Blocks" in the Forms Section should be left blank. (iv) Requested Rate Change Information: • Change period: Annual. • Member months: Membership for the 2024 experience period. • Min, Max, and weighted average rate change: Match the initial UPMJ Q5. (v) Prior Rate: • Total earned premium & total incurred claims: Projected earned premiums and incurred claims, respectively, for 2025. • Minimum and maximum per member per month (PMPM): Be consistent with the rates in the 2025 final Rate Schedule. • Weighted average PMPM: Be consistent with the current community rate in the initial WAC 284-43-6660 summary. (vi) Requested Rate: • Projected earned premium & projected incurred claims: For 2026, be consistent with the initial URRT Worksheet 2. • Minimum and maximum PMPM: From the initial 2026 Rate Schedule. • Weighted average PMPM: Be consistent with the weighted average PMPM premium rate consistent in the initial URRT Worksheet 2.	Modification Justification ANH IND OIC Health Exhibits	(ii) 2024 Member Months: Part III Appendix: "Development of 2026 Rate Change" / Exhibit A1 Rate Change Data: UPMJ Q5 (iii) Prior Rate: Requested rate less requested rate change, and using current enrollment Min and Max: Rate Schedule (iv) Projected premium and claims: Part III Appendix: "Development of 2026 Rate Change" / Exhibit A1 Min and Max: Rate Schedule Average Rate: Part I, Worksheet 1 (v) Trend: Part III: Trend Factors; Part III Appendix: "Part I URRT, Worksheet 1, Factor Comparison" / WA Exh 3 - Trend Analysis

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
c	Current enrollment: Compare current enrollment information across the various rate filing exhibits, including, but not limited to the following: • RRD Number of Covered Lives • URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.10 Current Enrollment • UPMJ Q1 Enrollment as of 3/31/2025 • Part III supporting exhibits' current enrollment Explain any inconsistencies.	ANH IND Part III Appendix	"Checklist Value Comparison" / Exhibit F1
d	Projected enrollment: Compare projected enrollment information across the various rate filing exhibits, including, but not limited to the following: • RRD (Projected Earned Premium) / (Requested Rate Weighted Avg. PMPM) • URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.9 Projected Member Months • Part II written explanation projected enrollment • Part III supporting exhibits' projected enrollment Explain any inconsistencies.	ANH IND Part III Appendix	"Checklist Value Comparison" / Exhibit F1
24	**Impacts of Changes 45 CFR §154.301(a)(4):** • Document the methodology, justification, and calculations used to determine the impacts of the changes outlined in the Effective Rate Review Program under 45 CFR §154.301(a)(4) (i) through (xv). • Note that if you change the contribution to surplus from the prior submission, you must provide additional support for why the change is warranted. • *To add context to the factors listed below, please also summarize in the Part III actuarial memorandum the approximate percent impact of the most significant contributors* ***to the proposed aggregate rate change*** *(see URR Instructions section 4.3, for example).*		

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(i) The impact of medical cost trend ***changes by major service category***. Include a discussion of the cost trend change for each specific benefit category listed in URRT Worksheet 1, Section II.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix ANH IND OIC Health Exhibits	Part III: "Proposed Rate Changes" / Section 4.3, "Trend Factors" / Section 4.4.3.1; WA Exh 3 - Trend Analysis
	(ii) The impact of utilization ***changes by major service category***. Include a discussion of the utilization trend change for each specific benefit category listed in URRT Worksheet 1, Section II.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix ANH IND OIC Health Exhibits	Part III: "Proposed Rate Changes" / Section 4.3, "Trend Factors" / Section 4.4.3.1; WA Exh 3 - Trend Analysis
	(iii) The impact of cost-sharing ***changes by major service category***, including actuarial values. Include a discussion of the cost-share changes for each specific benefit category listed in URRT Worksheet 1, Section II.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Plan Design Changes" / Section 4.4.3.2(c)
	(iv) The impact of benefit *changes*, including essential health benefits (EHBs) and non-essential health benefits (non-EHBs). Address the new essential health benefits for non-grandfathered individual and small group health insurance coverage in the State of Washington for plan years beginning on or after January 1, 2026. For each new EHB, describe whether your plan designs already covered the benefit or describe what plan design changes were required. Clearly demonstrate and justify any rate changes due to these new EHBs.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Plan Design Changes" / Section 4.4.3.2(c)

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(v) The impact of *changes in* enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Morbidity Adjustment" / Section 4.4.3.2(a)
	(vi) The impact of any *overestimate or underestimate* of medical trend for prior year periods related to the rate increase. Include a discussion and analysis of actual to expected medical trends.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Trend Factors" / Section 4.4.3.1
	(vii) The impact of *changes in* reserve needs. Include a discussion of any change in reserve needs.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Experience Period Premium and Claims" / Section 4.4.1
	(viii) The impact of *changes in* administrative costs related to programs that improve health care quality. Include a discussion of any such changes.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Trend Factors" / Section 4.4.3.1, "Non-Benefit Expenses" / Section 4.4.7
	(ix) The impact of *changes in* other administrative costs. Include a discussion of any such changes.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Non-Benefit Expenses" / Section 4.4.7
	(x) The impact of *changes in* applicable taxes, licensing, or regulatory fees. Include a discussion of any such changes.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Non-Benefit Expenses" / Section 4.4.7

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(xi) Medical loss ratio (MLR). Include a projected federal MLR calculation [45 CFR §158.221; see also CMS MLR Filing Instructions]. Note: This is one of only two 45 CFR §154.301(a)(4) items not written in terms of the impact of changes; the other is (xii) for the issuer's capital and surplus. Note: As stated in the Final 2026 NBPP, determination of a "qualifying issuer" is "based on an issuer's 3-year aggregate ratio of net payments related to the risk adjustment program…to earned premiums." See 45 CFR §158.103 for full definition details. • *Issuers who (a)* ***are NOT projected to be qualifying issuers*** *or (b)* ***are projected to be qualifying issuers but opt to follow the unadjusted MLR formula****, as defined in the Final 2026 Notice of Benefit and Payment Parameters (NBPP)*: ○ Numerator: Incurred claims [45 CFR §158.140(a)] – Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that payables subtract negative amounts) + Quality Improvement Expenses [45 CFR §158.150(a)] ○ Denominator: Earned Premiums [45 CFR §158.130] – Taxes & Fees [45 CFR §§ 158.161(a) and 158.162(a)(1) and (b)(1)] – Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR Filing Instructions] • *Issuers who* ***are projected to be qualifying issuers and opt to follow the adjusted MLR formula****, as defined in the Final 2026 Notice of Benefit and Payment Parameters (NBPP)*: (See also the formula below written with variables, copied from the Final 2026 NBPP.) ○ Numerator: Incurred claims [45 CFR §158.140(a)] + Quality Improvement Expenses [45 CFR §158.150(a)] ○ Denominator: Earned Premiums [45 CFR §158.130] – Taxes & Fees [45 CFR §§ 158.161(a) and 158.162(a)(1) and (b)(1)]	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Projected Loss Ratio" / Section 4.5

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	+ Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that payables add negative amounts) – Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR filing instructions] • If CBE are included, provide justification that includes the following details: o How total CBE are allocated to lines of business (e.g., individual, small group, and large group) o For federal tax-exempt issuers: ▪ CBE are limited to the highest of either: • Three percent of earned premium; or • The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market. ▪ Please address the impact, if any, of capping CBE for MLR purposes. ▪ MLR reporting instructions say federal tax-exempt issuers may report a value for both state premium taxes and CBE if reported CBE do not exceed the allowable capped amount (as outlined above). If you are a federal tax-exempt issuer, please confirm this requirement has been met. o For non-federal tax-exempt issuers: ▪ CBE are limited to: The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market. ▪ Please address the impact, if any, of capping CBE for MLR purposes. ▪ MLR reporting instructions say non-federal tax-exempt issuers may report a value for state premium taxes or CBE but not both. Issuers may not report zero ($0) CBE in lieu of negative State premium taxes and may not enter CBE more than the allowable capped		

amount. If you are a non-federal tax-exempt issuer, please confirm this requirement has been met.

- Credibility adjustment, if any [45 CFR §158.232]
- Comment about how the following recent MLR reporting regulation changes were considered: [See, for example: 45 CFR §158 and related sections as well as various Final plan year NBPPs]
  - Adjustments to the numerator:
    - Deduct from incurred claims not only prescription drug rebates received by the issuer, but also any price concessions received and retained by the issuer, and any prescription drug rebates, and other price concessions received and retained by an entity providing pharmacy benefit management services to the issuer. [45 CFR 158.140(b) and 2022 NBPP]
    - Beginning with the 2020 MLR reporting year, an issuer may include in the numerator of the MLR any shared savings payments the issuer has made to an enrollee as a result of the enrollee choosing to obtain health care from a lower-cost, higher-value provider. [45 CFR §158.221(b)(8)]
  - Report expenses for services outsourced to or provided by other entities in the same manner as expenses for non-outsourced (i.e., incurred directly by the issuer) services. [45 CFR §158.110(a) and 2021 NBPP]
  - Quality Improvement Activity (QIA) expenses:
    - Allowance for the Individual market to report certain wellness incentives described in 45 CFR §158.150(b)(2)(iv)(A)(5)(ii) (see also 2021 NBPP) as QIA expenses.
    - Only those provider incentives and bonuses that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes. (e.g., see 2023 NBPP)
    - Only expenditures directly related to activities that improve health care quality may be included in QIA (Quality Improvement Activity) expenses for MLR reporting and rebate calculation purposes. [45 CFR §158.150(a) and 2023 NBPP]
    - ***Removing*** the option for issuers to report an amount equal to 0.8 percent of earned premium in the relevant State and market in lieu of reporting the issuer's actual expenditures for activities that improve health care quality (e.g., see 2022 NBPP).
  - MLR rebate prepayment and safe harbor [45 CFR §158.240(g)]:

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	Allowance to prepay a portion or 100% of an estimated MLR rebate for a given MLR reporting year, and establishing a safe harbor allowing such issuers, under certain conditions, to defer the payment of rebates remaining after prepayment until the following MLR reporting year (e.g., see 2022 NBPP). ○ Replacement formula for qualifying issuers (e.g., see 45 CFR §158.103 for definition of qualifying issuer), written with variables: If (ra / p) > or = 50%, then: Adjusted MLR = [(i + q – s + nc – rc) / {(p + s – nc + rc) – t – f – (s – nc + rc) – na + ra}] + c where i = incurred claims q = expenditures on quality improving activities p = earned premiums t = Federal and State taxes f = licensing and regulatory fees including $0 for transitional reinsurance contributions s = issuer's transitional reinsurance receipts (=$0) na = issuer's risk adjustment related payments nc = issuer's risk corridors related payments (=$0) ra = issuer's risk adjustment related receipts rc = issuer's risk corridors related receipts (= $0) c = credibility adjustment, if any		
	(xii) The health insurance issuer's capital and surplus (i.e., if and how rate development considered your issuer's current capital and surplus levels). For example, are changes required to your issuer's premium to surplus ratio? Include a discussion in the Part III actuarial memorandum. Note: This is one of only two 45 CFR §154.301(a)(4) items not written in terms of the impact of changes; the other is (xi) for MLR.	ANH IND Supp Exhibits Part III Rate Filing Documentation and Actuarial Memorandum	Supp Exhibits: "Months of Surplus"; Part III: "Proposed Rate Changes" / Section 4.3, "Contribution to Surplus & Risk Margin" / Section 4.4.7(b)

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(xiii) The impacts of geographic factors and variations.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Proposed Rate Changes" / Section 4.3, "Calibration" / Section 4.4.5; Part III Appendix: "Exhibit C2: Geographic Factors"
	(xiv) The impact of ***changes within*** a single risk pool to all products or plans within the risk pool.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Uniform Product Modification Justification	Part III: "Proposed Rate Changes" / Section 4.3, "Morbidity Adjustment" / Section 4.4.3.2(a); UPMJ Q5
	(xv) The impact of reinsurance (which is N/A for Washington) and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.	Part III Rate Filing Documentation and Actuarial Memorandum	"Proposed Rate Changes" / Section 4.3, "Development of the Market-wide Adjusted Index Rate" / Section 4.4.3.6 and all subsections
25	**Drug Manufacturer Support of Member Out-of-Pocket Costs:** Per revised 45 CFR §156.130(h), for plan years beginning on or after January 1, 2020, amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs are permitted, but not required, to be counted toward the annual limitation on cost sharing. RCW 48.43.435 further outlines requirements for plans issued or renewed on or after January 1, 2024. Indicate what you implemented related to these requirements and justify any impact to your rate development.	Part III Rate Filing Documentation and Actuarial Memorandum	Part III: "Other Adjustments" / Section 4.4.3.2(d)

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
26		**Financial Statement Analysis:**		
	a	Reconcile to Additional Data Statement (ADS) for the year ending December 31, 2024: • For carriers not required to file an ADS, please respond "N/A." For ease of review for carriers who file an ADS, please include with the rate filing a copy of the ADS pages. • For HMOs and HCSCs, show ADS amounts total revenues (line 7), total hospital and medical claims (line 17), and administrative expenses (line 19 + line 20). • Please include a detailed list of adjustments required to reconcile between ADS amounts and amounts in the Summary of Pooled Experience in the WAC 284-43-6660 summary and in URRT Worksheet 1, Section I. Calculate the amount and percentage unreconciled, and explain any significant unreconciled amounts. • Explain any difference in the projected risk adjustment amount included in the ADS premium amount versus the experience period risk adjustment amount entered in URRT Worksheet 1, Section I. • Also, compare the average monthly membership from the WAC 284-43-6660 summary's 2024 experience period with the average monthly membership calculated from the quarter ending enrollment listed in the ADS. Explain any significant differences.	ANH IND Additional Data Reconciliation	Entire Document
	b	Months of surplus: For all issuers, please provide a calculation of your company's Months of Surplus using information in the 2024 annual statement and one of the following formulas, with one decimal place of accuracy. Health Statement: Months of Surplus = [(Annual Statement Page 3, Line 33: Total capital and surplus) / (Page 4, Line 18: Total hospital and medical (Lines 16 minus 17))] * 12. Life Statement: Months of Surplus = [(Annual Statement Page 3, Line 38: Total (Lines 29, 30, & 37)) / (Page 4, Line 20: Total (Lines 10 to 19))] * 12.	Part III Rate Filing Documentation and ANH IND Supp Exhibits	Part III: "Contribution to Surplus & Risk Margin" / Section 4.4.7(b) "Reliance" / Section 4.7.2; Supp Exhibits: "Months of Surplus"
27		**Abortion Services for Which Public Funding is Prohibited:** (see also #11.d & #13 of this checklist) For Exchange filings, document the pricing per member per month (PMPM) for voluntary abortion services and the "EHB Percent of Total Premium" to be listed in the Plans & Benefit Template (PBT) in the	Part III Actuarial Memorandum No plans offered on exchange.	"Effective Rate Review Information and Additional Requirements" / Section 4.7.1

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	binder filing [45 CFR §156.280(e)(4)]. See also QHP Application Instructions for EHB Percent of Total Premium calculation guidance. Note: The Index Rates in URRT Worksheet 1, Section II must include allowed claims for abortion services even for Exchange plans. Voluntary abortion services are *only* considered a non-EHB for Exchange plans in the percentages listed in the PBT and in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5. Otherwise, the State of Washington considers voluntary abortion services as EHBs for Exchange plans. Additionally, non-Exchange plans will consistently consider voluntary abortion services as EHBs.		
SEPARATE DOCUMENTS Address the following items together with other relevant items covered elsewhere in this checklist.			
28	**Part I Unified Rate Review Template (URRT):** Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the Exchange User Fee input for URRT Worksheet 1 Section II, please use and reference the applicable amount(s) calculated in the URRT. Please do not disable the macros in the Excel version of the URRT; please submit a macro-enabled URRT workbook. The URRT worksheets allow up to 16 characters including decimal places. Only apply rounding to amounts directly loaded into the URRT and only to the extent necessary to meet the 16-character limitation. Do not round any intermediate amounts.		
a	URRT Exchange User Fees: (URRT Worksheet 1, Section II Projections) If the issuer is only outside the exchange, please respond "N/A." The Exchange user fee for 2026 is $5.11 PMPM. • For issuers marketing both inside and outside the Exchange, confirm that the Exchange user fees, or Exchange assessment fees, are spread across the entire pool.	N/A No plans offered on exchange	

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
		• For issuers only marketing inside the Exchange: The default expectation is that 100% of membership will be on the Exchange. If your project less than 100% Exchange membership, include an explanation in the Part III actuarial memorandum. • Justify the Exchange User Fees' percentage load entered in URRT Worksheet 1, Section II. Compare the result against the required amount per member per month (PMPM). There should be a reasonable assumption for the distribution of enrollees inside and outside the Exchange. • If any Exchange membership is projected for plan year 2026, please check that a nonzero dollar amount flows through to URRT Worksheet 1, Section II Exchange User Fees. • Ensure the amount is adjusted to reflect an allowed dollar basis as discussed in #28.b of this checklist.		
	b	URRT factor to toggle between worksheet 1 and worksheet 2 amounts for risk adjustment transfers and Exchange user fees: Justify the factor used to develop Risk Adjustment Payment/Charge and Exchange User Fees for URRT Worksheet 1, Section II. The adjustment should be the aggregate impact of the four plan factors from URRT Worksheet 2, Section III Plan Adjustment Factors (i.e., Fields 3.3, 3.4, 3.5, and 3.9). Later URRT steps apply the plan factors through multiplication; to neutralize the overall impact, URRT Worksheet 1 needs to divide by their aggregate impact.	ANH IND OIC Health Exhibits ANH IND Part III Appendix	WA Exh 8 - CSR Experience Exhibit E4: Plan Variation From Market Adjusted Index Rate For Renewal Plans
	c	URRT Worksheet 1, Section II, 2026 versus 2025: Compare the projections in URRT Worksheet 1, Section II in this year's filing for 2026 versus those in last year's filing for 2025.	ANH IND OIC Health Exhibits	WA Exh 3 - Trend Analysis
	d	URRT Worksheet 2 terminated plan mapping: Document and justify URRT Worksheet 2 product and plan mapping for terminated plans, in accordance with the following: • For the inside Exchange plans and plans that are both inside and outside Exchange, follow the mapping information you (the issuer) provided to WAHBE and as required by 45 CFR §155.335(j). • For the outside Exchange plans, follow your procedure as indicated in the letter(s) provided to the policyholder(s) and consistent with Uniform Product Modification Justification (UPMJ).	ANH IND Part III Appendix	"Exhibit D2: Terminated Plan Mapping"

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		Note: each 2025 plan should map all members in the plan to the same 2026 plan. Respond "N/A" if no 2025 plans are terminating.		
	e	URRT Worksheet 2, Section I, general product and plan information, Cumulative rate change % for composite plans: For any plan in URRT Worksheet 2 which is the composite of more than one plan in UPMJ Q5, include an exhibit detailing the calculation of the Cumulative Rate Change % (over 12 mos. prior) based on the overall average rate change by plan in UPMJ Q5. If there are no composite plan rate changes, respond as "N/A."	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Effective Rate Review Information and Additional Requirements" / Section 4.7.1; Part III Appendix: "Exhibit D1: 2026 Average Change in Plan Base Rates"
	f	URRT Worksheet 2, Section IV Projected Plan Level Information Projected allowed claims, incurred claims & premiums: • Include an exhibit that calculates the projected dollar amounts by plan for URRT Worksheet 2, Section IV Projected Plan Level Information. • For clarity, please also show calculations of the plan-specific and aggregate projected PMPM amounts for Fields 4.11 through 4.17. • Aggregate amounts should reconcile as demonstrated in WA Exhibit 12; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. Note that although reconciliation is expected in aggregate, differences may be reasonable for specific plans. • Note that the following results are expected: o The Total Allowed Claims PMPM in Field 4.11 should be consistent with the [Projected Index Rate] + [average PMPM of the CSR load (on an allowed basis)] + [average PMPM for non-EHB, excluding abortion services reported as non-EHB (on an allowed basis)]. o The Allowed Claims PMPM by plan in Field 4.11 should only differ from the Total Allowed Claims PMPM due to URRT Worksheet 2, Section III Plan Adjustment Factors, Fields 3.3 AV and Cost Sharing Design of Plan (a.k.a. Pricing AV), 3.4 Provider Network Adjustment, 3.5 Benefits in Addition to EHB, and 3.9 Catastrophic Adjustment.	ANH IND Part III Appendix ANH IND OIC Health Exhibits	"Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping " WA Exh 12 - w2 Proj Recon

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
g	URRT projected members by plan: Please document the following in the Part III actuarial memorandum: • Explain how member months were projected by plan. • Explain how URRT membership projections align with 2026 company expectations for the product line. • Justify any new or renewing plans with zero projected enrollment. • If the opining actuary relied on membership projections from another area of your company, please indicate as such in the reliance section of the actuarial certification.	Part III Rate Filing Documentation and Actuarial Memorandum, ANH IND Part III Appendix	Part III: "Membership Projections" / Section 4.6.2 Part III Appendix: "Exhibit E2: Plan Adjusted Index Rate Development "
h	URRT projected PAIR versus premium PMPM: Compare the weighted-average Plan Adjusted Index Rate (PAIR; URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.10) to the aggregate premium PMPM projected in Field 4.17. Weight the PAIR amounts by projected member months. Explain any differences.	ANH IND Part III Appendix	"Checklist Value Comparison" / Exhibit F1
i	URRT controlled group renewal clarification: Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #30.b and #31.c of this checklist). If not applicable, indicate "N/A." In URRT Worksheet 2 Section I General Product and Plan Information and Section II Experience Period and Current Plan Level Information, for the current and new issuers: • The Plan Name (Field 1.3) and Plan ID (Field 1.4) will be unique to each issuer. • Indicate the plan as a renewing plan (Field 1.7). • Include the current rate from the current issuer (Field 2.11) in the new issuer's URRT. • Use the current rate in the calculation of the rate increase (Field 1.11) in the new issuer's URRT. • For consistency across the worksheets, only include experience in the current issuer's URRT Worksheets 1 and 2.	N/A	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
29	**Part II Written Description Justifying the Rate Increase:** (a) Follow content guidance outlined in URR Instructions. (b) Include key drivers of the risk pool's rate increase as well as relevant plan details such as those described below. • Changes in Benefits: Consumers tend to view cost-share changes as "benefit changes," so a summary of the cost-share changes should be included in this section along with other significant benefit changes. Note: the cost-share changes in this document should just be an overview of major changes, such as general discussion of the range of deductibles or changes in copays, rather than a repeat of the detailed list in UPMJ Q4a & 4b. • Administrative Costs and Anticipated Margins: Consumers tend to view all retention loads, other than profit, as "administrative costs," so taxes and fees should be included in this section along with other administrative expenses. • Please also note the pool's projected profit & risk load.	Part II Written Description Justifying the Rate Increase	Page 1
30	**Part III Actuarial Memorandum and Certification:** • Submit the actuarial memorandum exhibits in a separate Excel spreadsheet and corresponding PDF. Note: the PDF version of the actuarial memorandum exhibits can be submitted on the URRT tab rather than the Supporting Documentation tab in SERFF so that it will be uploaded to CMS. The Excel spreadsheet, however, must be submitted on the Supporting Documentation tab. • Note: to reduce the review time required to sift through duplicate file versions, please do NOT submit additional complete copies of the URRT worksheets, the WAC 284-43-6660 summary, or the Rate Schedules with the actuarial memorandum exhibits. • Note: The State of Washington requires that the redacted actuarial memorandum must match the unredacted actuarial memorandum.		
a	Actuarial certification: Include an actuarial certification as prescribed in the Part III Actuarial Memorandum and Certification Instructions found in the URR Instructions. Include the signature date in the signatory block of the	Part III Rate Filing Documentation and Actuarial Memorandum	"Actuarial Certification" / Section 4.7.3

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	certification and update the date throughout the filing review season, as needed, if assumptions or rates change.		
b	Controlled group renewal clarification for Part III: Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #28.i and #31.c of this checklist). If not applicable, indicate "N/A." In both the current and new issuers' Part III actuarial memorandums, add a crosswalk detailing the current and renewing plan information. Include: • The name of the current and new issuers offering the plan. • A comparison of the 2025 and 2026 HIOS Plan IDs and plan names. • A comparison of the 2025 counties in the service area for the renewing plan and the 2026 counties offered by the new issuer to demonstrate meeting the requirement to cover a majority of the same service area. • Discuss the cost-share changes to the plan and confirm that the product network type and covered benefits remain the same.	N/A	
c	UPMJ versus URRT rate changes: Rate changes by plan in URRT Worksheet 2, Section I General Product and Plan Information, Field 1.11 should match rate changes by plan in UPMJ Q5. For clarity, discuss in the Part III actuarial memorandum the differences in the calculation of the official aggregate rate change in UPMJ Q5 and the rate change amounts in URRT Worksheet 2, Section I General Product and Plan Information, Fields 1.12 and 1.13.	Part III Rate Filing Documentation and Actuarial Memorandum	Part III: "Effective Rate Review Information and Additional Requirements" / Section 4.7.1
31	**Uniform Product Modification Justification (UPMJ):** Review and follow the general instructions as well as the UPMJ instructions for each question. The UPMJ template can be found on the Washington State OIC website.		

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	a	UPMJ Q4a & 4b: • For UPMJ Q4a, keep in mind that the content will ultimately be included in our decision memorandum that is posted for public consumption, so explain the cost-share changes as you would to an existing or prospective member. • For each cost-share amount listed in UPMJ Q4a, include dollar, comma, and percent symbols as well as numeric amounts. • Spell out the first occurrence of each acronym in Q4a and Q4b. For example, "Maximum Out-of-Pocket (MOOP)." • Note: For plans that add or remove out-of-network (OON) coverage, the change should be listed as a member cost-share change rather than a benefit change.	ANH IND Uniform Product Modification Justification	UPMJ Q4a, UPMJ Q4b
	b	UPMJ Q5: (i) Column 5(d): • Only include enrollment from renewing counties. • If you are exiting any counties, please address the following: Since you are exiting counties, total enrollment in Q5 may not match the UPMJ Q1 total, so include an exhibit in the filing with current enrollment by plan split between renewing and terminating counties. Note that UPMJ Q1 should include all enrollment before reductions for terminating counties. (ii) Display rate changes for every renewing and terminated plan, even if the 03/31/2025 enrollment is 0. A plan should only reflect 0.00% across columns 5(g), 5(h), 5(i), and 5(j) if there are no experience, benefit, and cost-share rate changes for the plan. (iii) Submit an exhibit supporting rate changes for each UPMJ Q5 column. • Ensure UPMJ Q5 rate changes are consistent with the benefit and cost-share changes in UPMJ Q4a and Q4b. • Justify each rate change by showing the calculation or explaining how the percentages were determined and ensure rate filing documents consistently support the rate changes. • Explain how plan-specific rate changes disregard the morbidity of the population expected to enroll in each plan.	ANH IND Uniform Product Modification Justification	UPMJ Q5

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		• Note that it is acceptable to back into column 5(g), Experience Rate Change for Plan, using justified amounts for 5(j), Overall Average Rate Change for Plan; 5(i), Cost-Share Rate Change for Plan; and 5(h), Benefit Rate Change for Plan. • Explain any large plan variations in 5(g), Experience Rate Change for Plan. We expect that there should be little variability due to the single risk pool requirement. • Specify the source of the 2025 and 2026 rates used to calculate the overall increase for each plan. The changes should be consistent with the changes to the Rate Schedule. They should be weighted by the plan's current enrollment distribution for age, geographic area, and tobacco status (see URR Instructions 2.2.1 and 4.3).		
	c	Controlled group renewal clarification for UPMJ: Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #28.i and #30.b of this checklist). If not applicable, indicate "N/A." • *Current issuer*: UPMJ Q4a and Q5 will be blank. • *New issuer*: UPMJ Q4a must include the benefit changes from the current issuer's plan to the new issuer's plan. Q5 should include a line with the new plan's rate change percentage with zero members.	N/A	
32		**WAC 284-43-6660 summary:** Complete and submit the template "Format – Rates – WAC 284-43-6660 Summary Duplicate" provided on the Washington State OIC website. See below for additional information.		
	a	Proposed rate summary: • Proposed Community Rate must be consistent with the aggregate projected premium PMPM in URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.17. • Percentage Change must be consistent with the overall average rate change in UPMJ Q5. • Current Community Rate = (Proposed Community Rate) / (1 + Percentage Change).	WAC 284-43-6660	Entire Document

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	b	Components of proposed community rate: • Component (a) Claims should match (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.15 Incurred Claims PMPM) minus (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.16 Risk Adjustment Transfer Amount PMPM). • Component (b) Expenses combined with component (d) Investment Earnings must be consistent with the combined values of (Exchange User Fees in URRT Worksheet 1, Section II) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6 Administrative Expense) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7 Taxes and Fees). • Component (c) Contribution to Surplus Contingency Charges, or Risk Charges must be consistent with (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8 Profit & Risk Load). • Total row (e) must match the Proposed Community Rate from #32.a above (i.e., Proposed rate summary) in the WAC 284-43-6660 summary.	WAC 284-43-6660	Entire Document
	c	Trend factor summary: (see also #6.b of this checklist) • If the WAC 284-43-6660 summary shows the same trend for each type of service, please explain whether you expect any variation by type of service. If variation is expected, please explain the choice of a single trend factor for this summary. • For plans with embedded dental (pediatric or adult), ensure the embedded dental trend is included in the Other trend category, and then add a note to the General Information section #5 that the embedded dental trend is included in the Other trend category. This is to be consistent with the URR Instructions, section 2.1.3.1.	WAC 284-43-6660	Entire Document
	d	General Information section #4: Respond with "See Rate Schedule."	WAC 284-43-6660	General Information Section #4

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
33	**Benefit Components:** Provide a completed Benefit Components Speed-to-Market Tool. • The file "Format - Rates - 2026 Med Benefit Components" is provided on the Washington State OIC website. • The cost-shares for all embedded benefits, including pediatric dental, must have every different cost-share visible such as for different kinds of pediatric dental care (e.g., cleaning versus extensive surgeries, or as preventive, basic, major services), if applicable. • Note: the information you provide in this file should be consistent with the other documents in your binder, rate, and form filings (e.g., PBT, AVC Screenshots, MH/SUD Certification). • Include the benefit components for the Exchange silver plan CSR variations. • The plans should indicate integrated or separate medical and drug deductibles consistent with the AVC screenshots (see also #9 of this checklist).	Benefit Components	Entire Document
34	**Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity:**		
a	MH/SUD financial requirement parity certification: Complete the "Mental Health and Substance Use Disorder Financial Requirement Parity Certification" Speed-to-Market Tool. See file "Certification – Rates – 2026 Mental Health and Substance Use Disorder Financial Req Parity" on the Washington State OIC website.	ANH IND MHSUD Certification	Entire Document
b	MH/SUD parity calculations: Complete an MH/SUD Parity Speed-to-Market Tool that documents MHSUD financial requirement parity testing calculations. See file template "Certification - Rates - 2026 Mental Health and Substance Use Disorder Financial Req Parity Calculations" on the Washington State OIC website. • In the Mapping Information and each MHSUD Parity Testing Worksheet, please use the same benefit descriptions listed (both EHB and non-EHB) in the Benefit Components. The list should include all benefits, including inpatient, emergency care and prescription drugs.	ANH IND MHSUD Certification	Entire Document

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	• Carriers must either test all outpatient services in one category or test both outpatient office visits and all other outpatient services separately. • Categories can be split in some cases if, for example, you want to split services between office visits and all other outpatient services. If you combine categories, indicate in the notes which categories are included. For example, a therapies category in the testing can combine rehabilitative speech therapy and rehabilitative occupational and physical therapies from the Benefit Components. • For easy comparison, enter the plans in the same order and use the same tab names in the MHSUD Parity and Benefit Components workbooks. It would also be helpful if the Service Descriptions in the worksheets are in the same order as the Benefit Components. • Plan projected allowed amounts should be annual dollar amounts which reflect a reasonable projected dollar amount [WAC 284-43-7040(1)(c)(ii)] as attested to in the MH/SUD Financial Requirement Parity Certification (section II.B.2). The amounts should be consistent with the allowed claims projected in URRT Worksheet 2, Section IV Projected Plan Level Information. • The cost-shares for all embedded benefits, including dental and vision, must have every different cost-share visible, such as for different kinds of pediatric dental care, in the list of medical/surgical benefits. • Include the parity calculations for the Exchange silver plan CSR variations. • As noted in WAC 284-43-7020(5)(a), a plan or issuer must treat the least restrictive level of the financial requirement limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification. In the case of multiple cost shares across provider tiers, we recommend demonstrating parity by comparing each tier's MH/SUD cost shares versus the least restrictive level of medical/surgical benefit cost shares across all provider tiers in the classification.		
35	**Commission Certification:** (see also #20.a of this checklist) Provide detailed proposed commission schedules, even if no commissions are expected to be paid for this block of business for plan year 2026. They should be signed and dated by an officer or a senior manager of your company who oversees commission schedule implementation. The officer or senior	Commission Information and Officer Certification	Entire Document

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	manager should certify that the information is accurate to the best of their knowledge at the time of the rate submission. The commission schedule must comply with CMS guidance below and 45 CFR §147.104(e) and §156.225(b). https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term= Commission schedules should not differ for special enrollment periods. Broker bonus programs determined across multiple lines of business are not part of this certification, but they should be noted and accounted for in the rate development. Note: Commission schedules filed in individual and small group rate filings must be finalized prior to the final disposition. The commission schedule will not be allowed to change after the rate filing is approved.		
36	**Rate Schedule:** Provide a complete rate schedule using the "Format - Rates - 2026 Individual Non-grandfathered Health Plan Rate Schedule template." Be mindful of the following: • Use the most current version of the template. • The 1.0000 premium rates (age factor 1.0000 such as for age 21; tobacco factor 1.0000 for non-smoker; area factor 1.0000) should be consistent with the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.14. (see also #11.g of this checklist) • Submit on the Rate/Rule Schedule tab in SERFF.	Rate Schedule	Entire Document
37	**Rate Example:** Submit a rate calculation example on the Rate/Rule Schedule tab in SERFF. Address the following: • Use the rates in the Rate Schedule. • Include a statement that rates are charged to no more than the three **oldest** covered children under 21 for family coverage [45 CFR §147.102(c)(1)]. • If your premium rates adjust for tobacco use, please include in the example at least one family member who uses tobacco and would then be subject to the adjustment.	ANH IND Rating Example	Entire Document

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
38	**Requirements for Mitigating Inequity in the Health Insurance Market [WAC 284-43-6590]:** If applicable, submit a separate certification detailing the calculation of a fee for excluding any benefit mandated or required by Title 48 RCW or rules adopted by the commissioner. A member of the American Academy of Actuaries (MAAA) must sign the certification. (see also #21.a of this checklist)	N/A	
39	**Use of Artificial Intelligence, Machine Learning, and/or Predictive Modeling:** In preparing assumptions and premium rates for this rate filing, did your company rely on artificial intelligence techniques, machine learning techniques, and/or other predictive modeling methods? Please explain any such reliance including the models and where the results applied to the rate filing. Please explain how your actuary fulfilled professionalism requirements including those in the Code of Professional Conduct and Actuarial Standards of Practice (ASOPs), such as ASOP No. 56, *Modeling*. Include comments about how you evaluated results for reasonableness. Consider, for example, the September 2024 professionalism discussion paper, "Actuarial Professionalism Considerations for Generative AI," published by the American Academy of Actuaries.	N/A	Asuris did not rely on Artificial Intelligence, Machine Learning, and/or Predictive Modeling for this filing.
40	**1332 waiver checklist:** Complete and submit the file "Checklist – Rates – 2026 Individual Supplemental Checklist for 1332 Waiver Reporting."	ANH IND 1332 Checklist	Entire Document

2026 Plan Year (PY)
Individual Nongrandfathered Health Plan
Supplemental Checklist for 1332 Waiver Reporting

Instructions:

This supplemental checklist is requested by the Washington Health Benefit Exchange (HBE) regarding the 1332 waiver reporting requirements. This form (i.e., supplemental checklist) applies to **all individual health plan market issuers** including those with only off-Exchange plans.

The OIC helps the HBE gather the following information when issuers submit their initial and final rate filing documents. The OIC will check the consistency of data reported in this form versus data reported elsewhere in the rate filing. If the information reported in this form is inconsistent with other rate filing information, the OIC may send out an objection requesting a reporting issuer to update this form.

The purpose of this form is to collect with-waiver versus without-waiver differences in assumptions, methodologies, and projections used for individual market rate filings for PY 2026. This information will be used for reporting purposes associated with the guidelines stated in the 1332 Waiver. The federal government requires the State of Washington to report on elements related to health insurance rates, spending, and enrollment as if the waiver were not in effect. The following information is needed to create that report. Details on the waiver can be found here.

Response Information:

General Information	
Issuer Name:	Asuris Northwest Health
Applicable Market:	Individual Medical
Plan Year:	2026

Section I – Please provide a response for each item.

General Assumptions

1. Are the reporting issuer's PY 2026 premium rates impacted?

    a. If the waiver were not in effect, would the reporting issuer's premium rates differ by rating cell (i.e., by plan, smoker/non-smoker, geographic rating area, age band) in the Rate Schedule?

    ☐ Yes ☒ No

    b. If the waiver were not in effect, would the reporting issuer's total projected earned premiums be different?

    ☐ Yes ☒ No

2. If yes for #1a and/or #1b, how are the reporting issuer's PY 2026 premium rates impacted?

    a. If yes for #1a, please describe the projected impact by rating cell (i.e., by plan, smoker/non-smoker, geographic rating area, age band), including any quantitative factors used to differentiate premium rates with-waiver versus without-waiver. Note that the purpose of this item is to identify any potential population acuity factors due to the waiver.

    b. If yes for #1b, please describe the projected impact to total premiums. Please describe any other differences that apply beyond those by rating cell already described above under #2a. If differences are only due to factors described above in #2a, please explain.

Enrollment

Note that "average annual members" is equal to total member months for the year divided by 12.

3. What is the reporting issuer's projected with-waiver enrollment for PY 2026?
   Provide the reporting issuer's average annual members by rating area as well as summed across the issuer's rating areas. The total number summed across the rating areas and multiplied by 12 months should reconcile to the value reported in the Unified Rate Review Template (URRT), Worksheet 2 – Product-Plan Data, Section IV: Projected Plan Level Information, field **4.9 Projected Member Months**.

Rating Area	**PY 2026 Enrollment**
Area 4	128
Area 6	357
Area 7	321
Area 9	158
Whole State	964

4. What is the reporting issuer's projected without-waiver enrollment for PY 2026?
   Provide the reporting issuer's average annual members by rating area as well as summed across the issuer's rating areas.

Rating Area	**PY 2026 Enrollment**
Area 4	128
Area 6	357
Area 7	321
Area 9	158
Whole State	964

5. For the reporting issuer's PY 2026 projected enrollment, please provide enrollment projections by plan. Provide both with-waiver and without-waiver projected enrollment. Describe how with-waiver and without-waiver assumptions differ. If no plan mix differences are expected, please explain.

PY 2026 projected enrollment by plan does not differ between with-waiver and without-waiver assumptions.

Plan ID	PY 2026 Projected Enrollment
69364WA1220004	235
69364WA1220006	305
69364WA1220008	263
69364WA1220014	158
69364WA1220016	3

Total Premiums

6. What is the reporting issuer's projected with-waiver total premium for PY 2026?
   Provide the reporting issuer's projected premium by rating area as well as summed across the issuer's rating areas. The total amount summed across the rating areas should reconcile to the value reported in the Unified Rate Review Template (URRT), Worksheet 2 – Product-Plan Data, Section IV: Projected Plan Level Information, field **4.8 Premium**.
   Round to the nearest cent.
   Use enrollment reported above in #3.

Rating Area	PY 2026 Premium
Area 4	$1,174,310.80
Area 6	$3,275,226.22
Area 7	$2,944,951.31
Area 9	$1,449,539.90
Whole State	$8,844,028.23

7. What is the reporting issuer's projected without-waiver total premium for PY 2026?
   Provide the reporting issuer's projected premium by rating area as well as summed across the issuer's rating areas.
   Round to the nearest cent.
   Use enrollment reported above in #4.

Rating Area	**PY 2026 Premium**
Area 4	$1,174,310.80
Area 6	$3,275,226.22
Area 7	$2,944,951.31
Area 9	$1,449,539.90
Whole State	$8,844,028.23

8. For the reporting issuer's PY 2026 projected premiums, please describe how with-waiver and without-waiver assumptions and methodologies differ.
   Discuss impacts to individual rating cell premium rates, premium PMPM, and total premium.
   Discuss how assumed plan enrollment differences discussed above in #5 impact projected premiums.
   See also #13 below related to projected medical spending.
   If no differences are expected, please explain.

None.

Service Area

9. For PY 2026, would the service area offered by the reporting issuer have differed if the waiver were not in effect?

   ☐ Yes ☒ No

10. If yes for #9, please describe how the reporting issuer's PY 2026 service area participation would have differed without the waiver.

Medical Spending (a.k.a. Claims or Costs)

11. What is the reporting issuer's PY 2026 with-waiver total projected medical allowed claims spending (i.e., the sum of incurred claims and member cost shares)?
    Provide the reporting issuer's projected medical allowed claims spending by rating area as well as summed across the issuer's rating areas. The total amount summed across the rating areas should reconcile to the value reported in the Unified Rate Review Template (URRT), Worksheet 2 – Product-Plan Data, Section IV: Projected Plan Level Information, field **4.2 Allowed Claims**.
    Round to the nearest cent.
    Use enrollment reported above in #3.

Rating Area	**PY 2026 Allowed Claims**
Area 4	$1,421,240.10
Area 6	$3,963,927.48
Area 7	$3,564,203.70
Area 9	$1,754,343.25
Whole State	$10,703,714.54

12. What is the reporting issuer's PY 2026 without-waiver total projected medical allowed claims spending (i.e., the sum of incurred claims and member cost shares)?
    Provide the reporting issuer's projected medical spending by rating area as well as summed across the issuer's rating areas.
    Round to the nearest cent.

Use enrollment reported above in #4.

Rating Area	PY 2026 Allowed Claims
Area 4	$1,421,240.10
Area 6	$3,963,927.48
Area 7	$3,564,203.70
Area 9	$1,754,343.25
Whole State	$10,703,714.54

13. For the reporting issuer's PY 2026 medical allowed claims spending projections, please describe how with-waiver and without-waiver assumptions and methodologies differ.
    For example, address changes to adjustment factors for URRT Worksheet 1, Section II: Projections.
    Discuss impacts to both PMPM and total costs.
    Discuss how assumed plan enrollment differences discussed above in #5 impact projected medical allowed claims spending.
    See also #8 above related to projected premiums.
    If differences are not expected, please explain.

Asuris does not anticipate any substantive impact from the inclusion of the 1332 wavier and no adjustments were made in the development of medical spending to account for it.

14. For the reporting issuer's PY 2026 Risk Adjustment projections, please describe how with-waiver and without-waiver assumptions differ. Please also describe expected impacts.
    If differences are not expected, please explain.

Asuris does not anticipate any substantive impact from the inclusion of the 1332 wavier and no adjustments to risk adjustment projections were made to account for it.

15. For the reporting issuer's PY 2026 Administrative Expense projections, please describe how with-waiver and without-waiver assumptions and methodologies differ.
    Please also describe expected impacts.
    If differences are not expected, please explain.

    Asuris does not anticipate any substantive impact from the inclusion of the 1332 wavier and no adjustments to administrative expenses were made to account for it.

Section II - For Informational Purposes as Background Information

The state is required to submit the following information to CMS on an annual basis.

(a) The final Second Lowest Cost Silver Plan (SLCSP) rates for individual health insurance coverage for a representative individual (e.g., a 21-year-old non-smoker) in each rating area or service area (if premiums vary by geographies smaller than rating areas) for the applicable plan year that are actuarially certified. Also include the actuarial memoranda;
(b) The estimate of what the final SLCSP rates for individual health insurance coverage for a representative individual in each rating area or service area (if premiums vary by geographies smaller than rating areas) would have been absent approval of this waiver for the applicable plan year, that are actuarially certified. The state must include with this information the methods and assumptions the state used to estimate the final SLCSP rates and state's estimate of what the final SLCSP rates would have been absent approval of the waiver for each rating area or service area absent approval of this waiver. Also include the actuarial memoranda;
(c) From each issuer, the estimate of the total amount of all premiums expected to be paid for individual health insurance coverage for the applicable plan year;
(d) From each issuer, the estimate of the total premiums that would have been expected to be paid for individual health insurance coverage for the applicable plan year without the waiver;
(e) From each issuer, the estimate of the total amount of all medical spending expected to be paid for individual health insurance enrollees for the applicable plan year, along with any underlying analyses;
(f) From each issuer, the estimate of the total amount of all medical spending that would have been expected to be paid for individual health insurance enrollees for applicable plan year without the waiver, along with any underlying analyses;

(g) The state specific age curve premium variation for the current and upcoming plan year;
(h) Reports of the estimated total state subsidy program reimbursements for the upcoming plan year;
(i) Reports of the total enrollment estimates for individual health insurance coverage, both with and without the waiver for the upcoming plan year;
(j) An explanation of why the experience for the upcoming plan year may vary from previous estimates and how assumptions used to estimate the impact have changed. This includes an explanation of changes in the estimated impact of the waiver on aggregate premiums, the estimated impact to the SLCSP rates, and the estimated impact on enrollment. The state should also explain changes to the estimated state subsidy program estimates relative to prior estimates.

Asuris Northwest Health
Individual
Claims

Incurred 01/01/2024 - 12/31/2024
Run-out through 03/31/2025

Additional Data Statement (ADS) Paid Claims	**$**	**8,146,034**
Change In UCL[a]	$	(699,000)
Risk Sharing Expense[b]	$	(29,333)
Miscellaneous Claims Exp.[c]	$	(45,458)
Ceded Dental[d]	$	101,643
Legal Settlements[e]	$	424
Total Claims Adjustments	**$**	**(671,724)**
Difference between Actuarial and ADS due to incurred dates[1]	$	(983,054)
Difference between Actuarial and ADS due to pharmacy rebates	$	(8,176)
Difference between Actuarial and ADS due to paid dates[2]	$	1,364,462
Incurred Claims UCL[3]	$	84,355
Total Other Adjustments	**$**	**457,587**
Additional Data Statement Paid Claims	$	8,146,034
Total Claims Adjustments	$	(671,724)
Total Other Adjustments	$	457,587
Adjusted Additional Data Statement Incurred Claims	**$**	**7,931,897**
Total Actuarial Incurred Claims in Experience Period		**7,930,833**
Unexplained difference between ADS and Actuarial Incurred Claims	**$**	**1,064**
% Unexplained difference between ADS and Actuarial Incurred Claims		**0.01%**

(a) Year over year change from 12/31/2023 to 12/31/2024 in Unpaid Claims Liability estimate.
Actuarial claims are incurred date basis whereas the ADS claims are calculated on an accounting basis (claims + change in reserves)
(b) Adjustment for provider risk sharing agreements that are not reflected in actuarial claims
(c) Claim recoveries and removal of standalone dental/vision claims that is not ACA
(d) Pediatric Dental claims that are recognized as ceded in the ADS but are included in the actuarial claims
(e) Items related to legal matters recognized as claims in the ADS and are not included in actuarial claims
(1) Actuarial claims paid 01/01/2024 - 12/31/2024 and incurred 01/01/2021 - 12/31/2023
(2) Actuarial claims paid 01/01/2025 - 03/31/2025 and incurred 01/01/2024 - 12/31/2024
(3) Actuarial claims incurred 01/01/2024 - 12/31/2024 and paid after 03/31/2025

Asuris Northwest Health
Individual
Premium

Incurred 01/01/2024 - 12/31/2024
Run-out through 03/31/2025

Additional Data Statement (ADS) Premium	**$**	**8,296,760**
ACA 3Rs Programs[a]	$	(1,762,993)
Premium Ceded/Assumed[b]	$	5,062
Ceded Dental[c]	$	59,635
Misc Premium[d]	$	7,109
Total Premium Adjustments	**$**	**(1,691,187)**
Difference between Actuarial and ADS due to incurred dates[1]	$	2,470
Difference between Actuarial and ADS due to paid dates[2]	$	(17,331)
Total Other Adjustments	**$**	**(14,861)**
Additional Data Statement Premium	$	8,296,760
Total Premium Adjustments	$	(1,691,187)
Total Other Adjustments	$	(14,861)
Total Adjusted Additional Data Statement Premium	**$**	**6,590,712**
Total Actuarial Premium	**$**	**6,589,078**
Unexplained difference between ADS and Actuarial Premium[3]	**$**	**1,634**
% Unexplained difference between ADS and Actuarial Premium[3]		**0.02%**

(a) ACA risk adjustment, including HCRP, included in the ADS premium that is not included in actuarial premium

(b) Excess Loss premium that is recognized as ceded in the ADS premium, but is included in actuarial premium

(c) Pediatric Dental premiums that are recognized as ceded in the ADS but are included in the actuarial premiums

(d) Retroactive premium and member write off adjustments

(1) Actuarial premium earned 01/01/2024 - 12/31/2024 and incurred 01/01/2021 - 12/31/2023

(2) Actuarial premium earned 01/01/2025 - 03/31/2025 and incurred 01/01/2024 - 12/31/2024

(3) Actuarial premium is not used in rate development

Asuris Northwest Health
Individual
Enrollment

Incurred 01/01/2024 - 12/31/2024
Run-out through 03/31/2025

Additional Data Statement (ADS)	
First Quarter	1,002
Second Quarter	988
Third Quarter	976
Fourth Quarter	941
Average	977
Actuarial Unadjusted Average Enrollment	
Average 2024 Enrollment	976
% Unexplained difference between ADS and Actuarial Enrollment[1,2]	**0.04%**

(1) There is no difference due to incurred dates; ADS only uses lag 0 enrollment

(2) Actuarial enrollment is adjusted through 3/31/2025, creating small differences to the ADS

Asuris Northwest Health
Individual
Expenses

Incurred 01/01/2024 - 12/31/2024
Run-out through 03/31/2025

Additional Data Statement (ADS)		
Claims adjustment and general administrative expenses	$	837,275
Ceded reinsurance premium adjustment		60,961
Adjusted Additional Data Statement Expenses	**$**	**898,236**
Actuarial Expenses	$	904,373
% Unexplained difference between ADS and Actuarial Expenses		**-0.68%**

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$50.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$20.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	80%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name:	Gold 2000
Plan HIOS ID:	69364WA1220014
Issuer HIOS ID:	69364
AVC Version:	2026_1b
AV Iteration:	G_2000

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.63%
Metal Tier:	Gold
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.0195 seconds

Final 2026 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$70.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$20.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name:	Silver 5000
Plan HIOS ID:	69364WA1220008
Issuer HIOS ID:	69364
AVC Version:	2026_1b
AV Iteration:	S_5000

Output

Calculate

Status/Error Messages:	Standard On-Exchange Individual Silver Plans must meet a [0, +2] percent de minimis range; Calculation Successful.
Actuarial Value:	69.99%
Metal Tier:	Silver Off-Exchange and Small Group Market
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.0898 seconds

Final 2026 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,750.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
MOOP ($)			$8,300.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☑	80%		☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name:	Bronze HSA 7750
Plan HIOS ID:	69364WA1220006
Issuer HIOS ID:	69364
AVC Version:	2026_1b
AV Iteration:	BHSA_7750

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	62.61%
Metal Tier:	Bronze
Additional Notes:	
Calculation Time:	0.0898 seconds

Final 2026 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$8,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$60.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$120.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$60.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$60.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$60.00	☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$20.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name:	Bronze 8000
Plan HIOS ID:	69364WA1220016
Issuer HIOS ID:	69364
AVC Version:	2026_1b
AV Iteration:	B_8000

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	64.42%
Metal Tier:	Bronze
Additional Notes:	
Calculation Time:	0.2578 seconds

Final 2026 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$9,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐			☐	☐
Specialist Visit	☐	☐		$60.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name:	Bronze Essential 9000
Plan HIOS ID:	69364WA1220004
Issuer HIOS ID:	69364
AVC Version:	2026_1b
AV Iteration:	BE_9000_SP

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	63.20%
Metal Tier:	Bronze
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.25 seconds

Final 2026 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$9,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$60.00	☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	4

Plan Description:

Name:	Bronze Essential 9000
Plan HIOS ID:	69364WA1220004
Issuer HIOS ID:	69364
AVC Version:	2026_1b
AV Iteration:	BE_9000_PCP

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	61.41%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.0195 seconds

Final 2026 AV Calculator

Exhibit A - Modeled Plan Design Differences **Appendix**
Asuris Northwest Health - Individual

Using Method 45 CFR 156.135(b)(3)

Plan Name	HHS Plan ID	Modeled Plan Design Differences
Bronze Essential 9000	69364WA1220004	Upfront Primary/Specialist/Urgent Care Office Visits

Exhibit B - Description of AV Iterations for Plans using Method 45 CFR 156.135(b)(3) **Appendix**
Asuris Northwest Health - Individual

Plan Name	HHS Plan ID	Unique Benefits Description	AV Iteration 1 Description	AV Iteration 2 Description
Bronze Essential 9000	69364WA1220004	**Upfront Office Visits** $60 w/deductible waived for 4 upfront visit limit then Deductible & Coinsurance (Upfront visit limit applies to combined Primary/Specialist/Urgent Care visits)	**Iteration Name**: BE_9000_SP **Unique Benefits Modeled:** $60 Unlimited Upfront Specialist Office Visits **Iteration Description:** Reflects maximum member cost share scenario on unique benefits.	**Iteration Name**: BE_9000_PCP **Unique Benefits Modeled:** Four $60 Upfront PCP Visits **Iteration Description:** Reflects minimum member cost share scenario on four upfront PCP visits.

Exhibit C - Actuarial Values for Plans using Method 45 CFR 156.135(b)(3) **Appendix**
Asuris Northwest Health - Individual

Plan Name	HHS Plan ID	AV Iteration 1	AV Iteration 2	Weight Iteration 1	Weight Iteration 2	AV Screenshot Page(s)	Final AV
Bronze Essential 9000	69364WA1220004	63.20%	61.41%	63.97%	36.03%	5-6	62.56%

Unique Plan Design—Supporting Documentation and Justification

Fill in the following information.

Health Insurance Oversight System (HIOS) Issuer ID:
69364

HIOS Product IDs:
69364WA122

Applicable HIOS Plan IDs (Standard Component):
69364WA1220004, 69364WA1220008, 69364WA1220014, 69364WA1220016

Reasons the plan design is unique, that is, the reason benefits are incompatible with the parameters of the Actuarial Value Calculator (AVC) and their materiality:
For modeled plan design differences that were incompatible with the AVC, please see “Exhibit A- Modeled Plan Design Differences”, that is included in the Appendix.

Acceptable alternate method used per *Code of Federal Regulation* (CFR) 156.135(b)(2) or 156.135(b)(3):
Alternate method 45 CFR 156.135(b)(3) was used for AV determinations. Please see “Exhibit A- Modeled Plan Design Differences” for a list of plans and plan IDs modeled.

In addition, the deductible is waived for medications on the Optimum Value Medication List for plans 69364WA1220004, 69364WA1220006, 69364WA1220008, 69364WA1220014 and 69364WA1220016. The impact is immaterial to the AVC.

Plan IDs 69364WA1220008, 69364WA1220014 and 69364WA1220016 have different cost shares for Mental Health & Substance Use Disorder (MHSUD) Office Visits and MHSUD All Other OP Services. They are subject to copays for MHSUD Office Visits and are subject to deductible and coinsurance for MHSUD All Other OP Services. MHSUD office visits represent majority of the outpatient MHSUD services. Cost share design entered in the AVC is the predominant cost share. Having different cost shares for MHSUD Office Visits and MHSUD All Other OP Services is immaterial to the AVC.

Confirmation that only in-network cost sharing, including multitier networks, was considered:
Only in-network cost sharing, including multitier networks, was considered.

Description of the standardized plan population data used:
Population data contained within the AVC was used to the maximum extent possible to generate scenarios and adjusted input for unique plan design features. In situations where AVC data was not available or practical to use, adjustments were calculated using data from a proprietary benefit relativity model constructed from historical claims information from Asuris and its affiliated companies.

If the method described in CFR 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AVC:
N/A

If the method described in CFR 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:
For the plans modeled under alternate method 45 CFR 156.135(b)(3), upfront PCP and Specialist office visits were considered both unique and material for AV determination purposes.
The AVC was used to estimate minimum and maximum member cost sharing iteration AVs for the unique benefits of each plan. Please see "Exhibit B - Description of AV Iterations for Plans using Method 45 CFR 156.135(b)(3)" for a description of each AV iteration modeled.

The iteration weights are calculated in the following table.

(A) Metal Tier	**Bronze**
Primary vs Specialty Iteration Weights	
(B) Avg. Primary Care Freq [(1)]	1.155
(C) Avg. Specialist Freq [(2)]	2.051
(D) % Primary Care ((B) / ((B) + (C)))	36.03%
(E) % Specialist ((C) / ((B) + (C)))	63.97%
(J) Iteration 1 Weight	63.97%
(K) Iteration 2 Weight	36.03%

Notes:

(1) AV calculator Cont. Table Combined cell J170

(2) AV calculator Cont. Table Combined cell L170

In addition, please see "Exhibit C - Actuarial Values for Plans using Method 45 CFR 156.135(b)(3)" for AVs for each iteration, iteration weights, AV screenshot page numbers and final AV determinations for each plan.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in CFR 156.135(b)(2) or 156.135(b)(3) for benefits that deviate substantially from the parameters of the AVC and have a material impact on the actuarial value.

The analysis was

(i) conducted by a member of the American Academy of Actuaries and

(ii) performed in accordance with generally accepted actuarial principles and methods.

Actuary Signature:

Actuary Printed Name:

Daniel Boeder, FSA, MAAA

Date: 5/15/2025

Asuris Northwest Health
Individual Plans

Commissions are paid to licensed producers supporting enrollment for eligible individual members. Standard commissions are paid as per member per month (PMPM) to provide transparency and better cost control.

The standard commissions schedule effective 1/1/2026 for the Individual block of business is as follows:

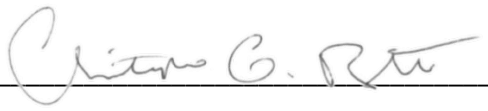
Asuris Northwest Health (ANH) will employ a tiered commission structure, with per-member, per-month commissions increasing based on the producer's production and level of knowledge of ANH's offering. The tiers will be as follows

- Tier 0 Producer: Independent producers who are not appointed with ANH
- Tier 1 Producer: Producers who are appointed with ANH
- Tier 2 Producer: Producers who are appointed with ANH and have passed a test designed to demonstrate knowledge of ANH's individual product offerings
- Tier 3 Producer: Producers who are appointed, have passed the knowledge test, and have sold or renewed at least 75 enrollees.

The commission structure for each tier is provided in the chart below.

Tier	**Commission PMPM**
Tier 0	$0
Tier 1	$20
Tier 2	$21
Tier 3	$28

I, Christopher Blanton, am an officer of Asuris Northwest Health and responsible for implementing the commissions schedule for the Individual line of business. I certify, that to the best of my knowledge, the provided schedule will be implemented effective 1/1/2026.



05/02/2025

Christopher G. Blanton — Date

Senior Vice-President, Asuris Northwest Health

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

Mental Health and Substance Use Disorder (MHSUD) Financial Requirement Parity Certification

Required to be submitted with Plan Year (PY) 2026
ACA Individual and Small Group Market Rate Filings

I. Purpose

Issuers are required to comply with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations and guidance, such as Chapter 284-43 WAC Subchapter K, Mental Health and Substance Use Disorder. Financial requirements and treatment limitations applicable to mental health/substance use disorder (MHSUD) benefits cannot be more restrictive than those applicable to medical/surgical benefits.

This document focuses on financial parity requirements [MHPAEA and WAC 284-43-7040]. For quantitative treatment limitations (QTL) and non-quantitative treatment limitations (NQTL), see the checklist under the form filing instructions; for QTL and NQTL definitions, see MHPAEA and WAC 284-43-7010.

Financial requirements are defined in MHPAEA and WAC 284-43-7010 as cost sharing measures, such as deductibles, copayments, coinsurance, and out-of-pocket maximums; note that the definition explicitly excludes aggregate lifetime and annual dollar limits.

See WAC 284-43-7010 for additional relevant definitions (e.g., classification of benefits, medical/surgical benefits, mental health benefits, predominant level, substance use disorder benefits, and substantially all).

II. Key Points

A. Required level of review

Attest/certify in section III below.

1. Parity review must be done separately by plan, for each type of financial requirement and each benefit classification.
2. Parity review also must be done separately by coverage unit, if a plan or issuer applies different levels of financial requirement (i.e., different cost shares) to different coverage units. [WAC 284-43-7020(6)(e), WAC 284-43-7040(2) and WAC 284-43-7040(4)]

   WAC 284-43-7010 defines a coverage unit as the way in which a plan or issuer groups individuals for purposes of determining benefits, premiums, or contributions. For example, different coverage units could be self-only, family, or employee-plus-spouse.

B. Classifying Benefits

[Note especially WAC 284-43-7020.]

Attest/certify in section III below.

1. All medical/surgical and MHSUD benefits are subject to parity review. Each medical/surgical and MHSUD benefit must be assigned to a benefit classification.

2. Permitted classifications of benefits:
   (1) Inpatient, In-Network
   (2) Inpatient, Out-of-Network
   (3) Outpatient, In-Network
      (3a) Outpatient, In-Network – Office Visits
      (3b) Outpatient, In-Network – All Other Outpatient
   (4) Outpatient, Out-of-Network
      (4a) Outpatient, Out-of-Network – Office Visits
      (4b) Outpatient, Out-of-Network – All Other Outpatient
   (5) Emergency Care
   (6) Prescription Drugs

   Per WAC 284-43-7020(6)(a), plans and issuers may split outpatient into "office visits" and "all other outpatient items and services." A particular plan should address (3) **or** both (3a)+(3b), not all three; similarly, a particular plan should address (4) **or** both (4a)+(4b), not all three.

3. When classifying benefits, the same standards must apply to both medical/surgical and MHSUD benefits.

   For example, assign covered intermediate MHSUD benefits (e.g., residential treatment, partial hospitalization, and intensive outpatient treatment) in the same way comparable intermediate medical/surgical benefits are assigned. Additionally, if home health care is classified as outpatient, then any covered MHSUD intensive outpatient services and partial hospitalizations must also be classified as outpatient. [WAC 284-43-7020(3)]

C. Financial requirement parity details

[Note especially WAC 284-43-7020, WAC 284-43-7020(4), and WAC 284-43-7040.]

Attest/certify in section III below.

1. Financial requirement parity analysis considers both type and level.

   a) Financial requirement cost share *types* include deductibles, copayments, coinsurance, and out-of-pocket maximums but not aggregate lifetime and annual dollar limits.

   b) A financial requirement cost share *level* is the amount of the financial requirement type. For example, coinsurance levels might include 20% and 25%; copayment levels might include $15 and $20; and deductible levels might include $250 and $500.

2. Financial requirement parity methodology:
   Within each benefit classification [WAC 284-43-7020], a plan or issuer may not apply any financial requirement to MHSUD benefits that is more restrictive than the corresponding predominant level applied to medical/surgical benefits.

   a) WAC 284-43-7010 indicates that a type of financial requirement is considered to apply to "*substantially all*" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification as determined by WAC 284-43-7040(2)(a).

   b) WAC 284-43-7010 indicates if a type of financial requirement applies to substantially all medical/surgical benefits in a classification, the "*predominant level*" is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement.

   c) Review projected plan payments for medical/surgical benefits for the upcoming plan year.

      Dollar amounts should be stated as allowed claim amounts (i.e., the amount the plan allows) before enrollee cost sharing because payments based on the allowed amounts cover the full scope of benefits being provided. A reasonable actuarial method must be used to project the dollar amounts. [WAC 284-43-7040(1)(c)]

   d) Note that WAC 284-43-7040(1)(d) clarifies how to handle certain plan dollar thresholds.

3. Rate filing documentation of financial requirement parity:
   In the rate filing, address the following for each plan, classification, and coverage unit (if applicable).

   a) For medical/surgical benefits, show every different cost share type and level. Then, demonstrate what meets the "substantially all" requirements and what qualifies as the "predominant level."

   b) Compare MHSUD benefit cost shares to medical/surgical benefits' substantially all and predominant level cost shares.

   c) As noted under section B above, WAC 284-43-7020(6)(a) allows, but does not require, subclassifications within outpatient – (a) office visits versus (b) all other outpatient items and services.

      For each plan, please indicate whether outpatient parity testing was conducted in aggregate (i.e., one outpatient benefit classification) or using the outpatient subclassifications. Provide information and results accordingly.

4. Actuarial memorandum discussion of projected plan dollar amounts:
   In the Part III Actuarial Memorandum, please describe how the 2026 annual projected plan and benefit dollar amounts were determined.

   Address the following:

   a) Describe the underlying claims data source and characteristics as well as any adjustments made. Explain any differences versus the data used to project PY2026 claims and premium rates.

   b) Ensure claim amounts reflect what the plan allows before reductions for enrollee cost sharing.

c) How does plan-level data compare to data for the book of business?
The underlying data set will *not* usually be your issuer's entire projected book of business; additionally, the projections will reflect plan-level assumptions as opposed to product-level assumptions. For example, see the (*) CMS FAQs listed below.

d) Certify that a reasonable actuarial method was used to project amounts for each plan in accordance with WAC 284-43-7040(1)(c)(ii) and applicable Actuarial Standards of Practice.

e) Provide additional requested data details on the 'Data Information' tab in your complementary Excel workbook of MHSUD financial requirement parity calculations.

(*) CMS/CCIIO ACA FAQ 31; April 20, 2016; Q8. CMS/CCIIO ACA FAQ 34; October 27, 2016; Q3.

D. Cumulative financial requirements

[Note especially WAC 284-43-7040(3).]

Attest/certify in section III below.

A plan or issuer may not apply cumulative financial requirements (e.g., deductibles and out-of-pocket maximums) for MHSUD benefits in a classification that accumulate separately from any cumulative requirement established for medical/surgical benefits in the same classification. Note that cumulative requirements must also satisfy the quantitative parity analysis.

E. Prohibited exclusions

[Note especially WAC 284-43-7080.]

Attest/certify in section III below.

A plan may not exclude MHSUD treatments or services for any of the reasons documented in WAC 284-43-7080.

III. Documentation & Attestation

General Information	
Issuer Name:	Asuris Northwest Health
Applicable Market:	Individual
Plan Year:	2026

1. Please complete and submit one set of MHSUD financial requirement parity certification documents for each rate filing.
   - Certification: PDF version of this certification document.
   - Calculations: Excel file (and its corresponding PDF file) demonstrating financial requirement parity testing results. See below for details.

2. For the calculations, use the OIC-developed Excel template found on our website (Certification - Rates - 2026 Mental Health and Substance Use Disorder Financial Req Parity Calculations).
   a) Review instructions on the first worksheet tab.
   b) Create and populate a separate detailed worksheet for each plan.
   c) After fully populating the Excel file, create a PDF version of the file. In SERFF, submit both the Excel and PDF file formats. Remember the Excel and PDF file contents and file names should exactly match with the only exception being that the Excel file name will end in "DUPLICATE."
3. Actuarial certification:
   a) Complete the actuarial certification below.
   b) Enter requested information, as needed.
   c) Check attestation boxes, where appropriate, to indicate your agreement.
   d) Then, complete the signature block.
   e) Create a PDF version of the file, and upload the PDF version to SERFF.
4. List below the names of the supporting files:

ANH IND MHSUD Exhibit Duplicate.xlsx
ANH IND MHSUD Exhibit.pdf

Actuarial Certification
of MHSUD Financial Requirement Parity
for the PY2026 ACA Rate Filing:

I, Janessa Sanchez, FSA, MAAA, certify the following:
☒ I am an employee of Asuris Northwest Health or
☐ I am a consultant associated with the firm of N/A;

☒ I am a qualified actuary as outlined in Chapter 284-05 WAC. I am a member of the American Academy of Actuaries, and I am acting within the scope of my training, experience, and qualifications.

☒ Level of review:
I attest to conducting MHSUD financial requirement parity analysis at the appropriate level, as noted below:
☒ Parity review was done separately by plan, for each type of financial requirement and each benefit classification. Parity analysis does not vary by coverage unit because financial requirements do not vary by coverage unit.

☐ Parity review was done separately by plan and coverage unit, for each type of financial requirement and each benefit classification. Parity analysis varies by coverage unit because financial requirements vary by coverage unit.

☒ Benefit classifications:
I attest that all medical/surgical and MHSUD benefits were assigned to benefit classifications.

I attest that the issuer (1) has criteria documented as to how medical/surgical benefits were assigned to each permitted classification and (2) the same standards apply for both medical/surgical and MHSUD benefits.

Upon request, the documentation can be made available to the Washington OIC within 10 business days.

☒ Cost-share accuracy:
For the 2026 plan year, I certify the accuracy of the cost shares for both medical/surgical and MHSUD benefits that are used to evaluate parity of MHSUD financial requirements as loaded into the calculation workbook (*ANH IND MHSUD Exhibit Duplicate.xlsx*) and as otherwise discussed in this rate filing.

☒ Projected plan dollar amounts:
I attest to the following related to dollar amounts used to test MHSUD financial requirement parity:
- ☒ Projected dollar amounts are consistent with plan-specific projected allowed amounts used elsewhere in this rate filing, or
  - ☐ Projected dollar amounts differ from plan-specific projected allowed amounts used elsewhere in this rate filing as explained in the Part III actuarial memorandum.
- ☒ Projected dollar amounts reflect what the plan allows before reductions for enrollee cost sharing.
- ☒ Plan-level dollar amounts do not reflect aggregate data for the book of business.
- ☒ A reasonable actuarial method was used to project amounts for each plan in accordance with WAC 284-43-7040(1)(c)(ii) and applicable Actuarial Standards of Practice (ASOPs).
- ☒ Additional data details are available on the 'Data Information' tab in the Excel workbook of MHSUD financial requirement parity calculations.

☒ Financial requirement parity:
I attest to parity between MHSUD benefits and medical/surgical benefits in
- ☒ Financial requirements as outlined in Chapter 284-43 WAC Subchapter K Mental Health and Substance Use Disorder and
- ☒ Financial accumulators, such as deductibles and out-of-pocket maximums, by plan and classification. [Note especially WAC 284-43-7040(3).]

☒ Substantially all and predominance:
I certify that each plan submitted in this rate filing meets the "substantially all" and "predominant" / "predominant level" financial requirement parity testing requirements under MHPAEA and Chapter 284-43 WAC, Subchapter K Mental Health and Substance Use Disorder.
- ☒ Type: I attest that for each plan, the type of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) applies to at least two-thirds of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).
- ☒ Level: I attest that for each plan, the level of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) is no more restrictive than the level of financial

requirement imposed upon more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).

☒ I attest that if a single financial requirement did not meet the one-half threshold for a particular plan and classification (or applicable subclassification), then the level of financial requirement imposed upon MHSUD benefits was determined after combining levels until the combination of levels covered more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification), as described in WAC 284-43-7040(2)(b)(ii) and (iii).

☒ I attest that the above statements are supported by details in the complementary MHSUD financial requirement calculation workbook (cited above) and submitted as part of this rate filing.

☒ Parity across tiers:

- WAC 284-43-7020(5)(a): A plan or issuer must treat the least restrictive level of the financial requirement that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to MHSUD benefits in the same classification.
  - ☒ I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the financial requirements do not vary by provider tier.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(5)(b): If a plan or issuer classifies providers into tiers and varies cost-sharing by tier, the criteria for classification must be applied to generalists and specialists providing MHSUD services no more restrictively than such criteria are applied to medical/surgical benefit providers.
  - ☒ I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the cost-sharing does not vary by provider tier.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(6)(b): A plan or issuer may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers if the tiering is based on reasonable factors and without regard to whether a provider is an MHSUD provider or a medical/surgical provider.
  - ☒ I certify that this does not apply to plans in this rate filing. The plans do not use network tiers.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(6)(c): After network tiers are established, the plan or issuer may not impose any financial requirement on MHSUD benefits in any tier that is more restrictive than the predominant financial requirement that applies to substantially all medical/surgical benefits in that tier.
  - ☒ I certify that this does not apply to any plans in this rate filing. The plans do not use network tiers.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(6)(d): If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to MHSUD benefits, the plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.
  ☒ I certify that none of the plans in this rate filing use prohibited prescription drug tiers. Prescription drug tiers are based only on the reasonable factors listed above and without regard to whether a drug is prescribed for medical/surgical or MHSUD benefits.

☒ No prohibited exclusions:
WAC 284-43-7080 (*including rule updates effective January 1, 2022, for gender affirming treatment*): A plan may not exclude MHSUD treatments or services for any of the reasons documented in WAC 284-43-7080.
☒ I certify that none of the plans in this rate filing apply exclusions prohibited by WAC 284-43-7080.

☒ I attest that, to the best of my knowledge, each of the plans otherwise satisfy the requirements under MHPAEA and Chapter 284-43 WAC, Subchapter K.

Actuary's Name & Designations: Janessa Sanchez, FSA, MAAA

Signature: Janessa Sanchez Digitally signed by Janessa Sanchez Date: 2025.05.14 10:25:36 -07'00'

Title: Manager, Actuarial Pricing

Contact Information: Janessa.sanchez@cambiahealth.com, (206) 332-5272

Date of Attestation: 5/14/2025

MHSUD Financial Requirement Parity Testing -- Summary

Issuer and Filing Information

Issuer Name:	Asuris Northwest Health
HIOS Issuer ID:	69364
Market:	Individual
Plan Year:	2026

Worksheet Instructions

Step 1) In your Excel application, ensure macros are enabled and calculations are set to automatic.
Step 2) Enter Plans.
- *List HIOS Plan IDs and Plan Names in the first two columns of the table below. Include silver base and CSR plan variants.*
- *When a plan has multiple in-network tiers, load information for each tier. Enter each in-network tier here in this file as a separate "plan" record with the plan ID formatted as "12345WA0010001_INN-T1." This will create a separate worksheet for each in-network tier and allows for parity to be analyzed for each tier.*
- *Confirm all HIOS Plan IDs are included in the table-object and then remove any extra rows in the table.*
- *For ease of review, we request that plans in this file be in the same order as they are in the Benefit Components' file.*

Step 3) Click the button below to start the macro that generates the testing worksheets.

Note: The macro creates a testing template for each Plan ID listed in the table below. It also links the IDs in the table to its worksheet.

Step 4) Populate each testing worksheet with the corresponding plan's information.

This format is used for cells that need user input

Step 5) Prior to submitting this file as part of the rate filing, remove the "Example" sheet from the workbook.
Step 6) After completing all plan testing worksheets, save a copy of the workbook in Excel and PDF formats and include both as part of your rate filing submission.

Testing Summary

HIOS Plan ID	Plan Name	Test Results	Notes
69364WA1220004	Bronze Essential 9000	Pass	
69364WA1220006	Bronze HSA 7750	Pass	
69364WA1220008	Silver 5000	Pass	
69364WA1220014	Gold 2000	Pass	
69364WA1220016	Bronze 8000	Pass	

MHSUD Financial Requirement Parity Testing Testing Data Information

Instructions: Provide information about the data used to test parity.

Item #	Task
1	Identify the data source used to estimate allowed claims for the purpose of MHSUD financial requirement parity testing. This refers to the allowed amounts by service entered in Part 1 of each plan's testing worksheet.
	Cambia Washington individual market claims data.
2	Identify the period (i.e., date range) represented in the data.
	Incurred from 1/1/2024 to 12/31/2024, paid through 3/31/2025
3	Address the credibility of the data used in your MHSUD financial requirement parity testing.
	Cambia Washington individual market claims data are considered fully credible for MHSUD parity testing.
4	Identify whether the data is consistent with the data in your URRT. If not, explain why the data is not consistent, why the data is appropriate, and summarize material adjustments made to the data.
	The data is consistant with the data used in the rate development and URRT.
5	If data other than State of Washington plan data was used, what is the source, and why is it appropriate for MHSUD financial requirement parity testing purposes?
	Only Washington plan data was used.

MHSUD Financial Requirement Parity Testing
Mapping Medical/Surgical Services to Benefit Classifications

Instructions

Purpose: Show how medical/surgical services map to benefit classifications used in PART 1 of the testing worksheets.

A. Service Description column:
List all services used to test parity. If additional rows are needed, add rows to the table.
Enter descriptions exactly as they are entered in PART 1 of the testing worksheets.

B. Mapped Benefit Classification for MHSUD Parity Testing column:
Select the parity testing benefit classification assigned to each medical/surgical service:
Inpatient, Outpatient - Office Visits*, Outpatient - All Other*, Emergency Care, or Prescription Drugs.
*Note 1: If **ALL** plans test parity with the combined Outpatient classification,
you may enter "Outpatient" instead of "Outpatient - Office Visits" and "Outpatient - All Other".
*Note 2: If **ANY** plan tests parity using Outpatient subclassifications,
choose either "Outpatient - Office Visits" or "Outpatient - All Other" for each outpatient medical/surgical service.

C. Mapped Benefit in corresponding Benefit Components document (If applicable) column:
Select the benefit from the Benefit Components document that is assigned to each Benefit Classification for MHSUD parity testing.
*Note 1: Click on the "Import Benefit Components Into Column C" button and select the matching benefit components to expand the list of options in column C.
*Note 2: To assign multiple benefits from the Benefit Components document to a single Benefit Classification for MHSUD parity testing, create two separate rows with the same entry in column B, but different entries in column C.

Notes column: Explain any differences by plan.

Mapping Table

A. Service Description	B. Mapped Benefit Classification for MHSUD Parity Testing	C. Mapped Benefit in corresponding Benefit Components document (If applicable)	Notes
Primary Care Visit to Treat an Injury or Illness	Outpatient - Office Visits	Primary Care Visit to Treat an Injury or Illness	Some plans do not use the outpatient office visit subclassification.
Specialist Visit	Outpatient - Office Visits	Specialist Visit	Some plans do not use the outpatient office visit subclassification.
Urgent Care	Outpatient - Office Visits	Urgent Care	Some plans do not use the outpatient office visit subclassification.
Preventive Care/Screening/Immunization (OV)	Outpatient - Office Visits	Preventive Care/Screening/Immunization	Some plans do not use the outpatient office visit subclassification.
Virtual Visits	Outpatient - Office Visits	Virtural Care - Telehealth	Some plans do not use the outpatient office visit subclassification.
Hospital / Surgery OP	Outpatient - All Other	Outpatient Surgery Physician/Surgical Services	
Imaging (CT/PET Scans, MRIs)	Outpatient - All Other	Imaging (CT/PET Scans, MRIs)	
X-rays and Diagnostic Imaging	Outpatient - All Other	X-rays and Diagnostic Imaging	
	Outpatient - All Other	Laboratory Outpatient and Professional Services	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient - All Other	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Acupunture/Spinal Manipulations	Outpatient - All Other	Acupunture	
	Outpatient - All Other	Chiropractic Care	
Emergency Transportation	Outpatient - All Other	Emergency Transportation	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Outpatient - All Other	Rehabilitative Occupational and Rehabilitative Physical Therapy	
	Outpatient - All Other	Rehabilitative Speech Therapy	
Reproductive Healthcare	Outpatient - All Other	Reproductive Health Care	Includes Diagnostic and Supplemental Breast Examinations
Virtual Care (Store and Forward)	Outpatient - All Other	Virtual Care - Store & Forward	
Hearing Aids	Outpatient - All Other	Hearing Aids	
Preventive Care for Specified Chronic Conditions	Outpatient - All Other	Preventive Care for Specified Chronic Conditions	Not applicable for Cascade Plans
Pediatric Dental - Class 1 Preventive	Outpatient - All Other	Dental Check-Up for Children	Broken out for plans that include Pediatric Dental
Pediatric Dental - Class 2 Basic	Outpatient - All Other	Basic Dental Care – Child	Broken out for plans that include Pediatric Dental
Pediatric Dental - Class 3 Major	Outpatient - All Other	Major Dental Care – Child	Broken out for plans that include Pediatric Dental
	Outpatient - All Other	Orthodontia – Child	
Preventive Care/Screening/Immunization (Other)	Outpatient - All Other	Routine Eye Exam for Children	
	Outpatient - All Other	Eye Glasses for Children	
	Outpatient - All Other	Well Baby Visits and Care	
	Outpatient - All Other	Diabetes Education	
	Outpatient - All Other	Embedded IAP	
	Outpatient - All Other	Abortion for Which Public Funding is Prohibited	
Other	Outpatient - All Other	Skilled Nursing Facility	
	Outpatient - All Other	Infertility Treatment	
	Outpatient - All Other	Cosmetic Surgery	
	Outpatient - All Other	Routine Foot Care	
	Outpatient - All Other	Diabetes Care Management	
	Outpatient - All Other	Inherited Metabolic Disorder - PKU	
	Outpatient - All Other	Gender Affirming Care	
	Outpatient - All Other	Travel Immunizations	
	Outpatient - All Other	Orthognathic Surgery	
	Outpatient - All Other	Palliative Care (Home Health Aide Care)	
	Outpatient - All Other	Repair of Teeth Due to Injury	

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Asuris Northwest Health
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Bronze Essential 9000 — *<<<<This will auto populate from summary sheet macro*
Plan ID: 69364WA1220004 — *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: — *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: **Pass**

Links only work for sections that are not already hidden>>>>>

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	All Combined

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier: D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Se	No	Yes			Pass		Pass
Outpatient - Office Visits Separate							

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (3) Outpatient, In-Network (OP INN)

Click>>>>> Home — **Errors found:** 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3) Outpatient, In-Network (OP INN)
Notes: *Use this table if you are testing all outpatient services combined.*

Classification	Outpatient	OP
Network (In/Out)	In-Network	INN
Classification Code	3	OP INN
Table Name		tbl_OPINN_P1

Number of Rows: 21

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share (If true, enter "x")
Primary Care Visit to Treat an Injury or Illness	$60 Deductible waived, 4 upfront visit limit shared for Primary Care, Specialist & Urgent Care, Deductible and Coinsurance after limit is met	$165,847.58	$0.00	$60.00	N/A	$10,150.00	
Specialist Visit	$60 Deductible waived, 4 upfront visit limit shared for Primary Care, Specialist & Urgent Care, Deductible and Coinsurance after limit is met	$128,083.27	$0.00	$60.00	N/A	$10,150.00	
Urgent Care	$60 Deductible waived, 4 upfront visit limit shared for Primary Care, Specialist & Urgent Care, Deductible and Coinsurance after limit is met	$8,906.41	$0.00	$60.00	N/A	$10,150.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$29,154.57	$0.00	N/A	N/A	$10,150.00	x
Virtual Visits	Covered in Full	$38,448.73	$0.00	N/A	N/A	$10,150.00	x
Hospital / Surgery OP	Deductible and Coinsurance	$604,723.62	$9,000.00	N/A	10%	$10,150.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$41,689.75	$9,000.00	N/A	10%	$10,150.00	
X-rays and Diagnostic Imaging	Deductible and Coinsurance	$114,007.24	$9,000.00	N/A	10%	$10,150.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Deductible and Coinsurance	$292,387.47	$9,000.00	N/A	10%	$10,150.00	
Hearing Aids	Coinsurance	$3.67	$0.00	N/A	10%	$10,150.00	
Acupunture/Spinal Manipulations	Deductible and Coinsurance	$10,228.99	$9,000.00	N/A	10%	$10,150.00	
Emergency Transportation	Deductible and Coinsurance	$7,838.75	$9,000.00	N/A	10%	$10,150.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Deductible and Coinsurance	$48,683.07	$9,000.00	N/A	10%	$10,150.00	x
Reproductive Healthcare	Covered in Full	$6,614.31	$0.00	N/A	N/A	$10,150.00	x
Virtual Care (Store and Forward)	Covered in Full	$69.09	$0.00	N/A	N/A	$10,150.00	x
Preventive Care/Screening/Immunization (Other)	Covered in Full	$77,995.56	$0.00	N/A	N/A	$10,150.00	
Preventive Care for Specified Chronic Conditions	Deductible Waived, Coinsurance Applies	$11,144.64	$0.00	N/A	10%	$10,150.00	
Pediatric Dental - Class 1 Preventive	Covered in Full	$511.83	$0.00	N/A	N/A	$10,150.00	x
Pediatric Dental - Class 2 Basic	Coinsurance	$394.80	$0.00	N/A	20%	$10,150.00	
Pediatric Dental - Class 3 Major	Coinsurance	$45.12	$0.00	N/A	50%	$10,150.00	
Other	Deductible and Coinsurance	$507,120.32	$9,000.00	N/A	10%	$10,150.00	
Total Row		$2,093,898.79					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3) Outpatient, In-Network (OP INN)

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	$9,000.00	$9,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	10%	10%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			Pass

**If not applicable, enter "N/A"*

Enter Footnotes
xx

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$1,626,679.21	77.69%	OP INN Deductible
Copayment	$302,837.26	14.46%	Fail
Coinsurance	$1,638,267.44	78.24%	OP INN Coinsurance
OOPM	$2,093,898.79	100.00%	OP INN OOPM
Total Projected	$2,093,898.79		

Step 2 Predominant Level

Deductible ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$9,000.00	$1,626,679.21	77.69%	$9,000.00	
	$467,219.57	22.31%		
Total	$2,093,898.79	100.00%		

Copayment ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
10%	$1,637,827.52	99.97%	10%	
20%	$394.80	0.02%		
50%	$45.12	0.00%		
	$0.00			
Total	$1,638,267.44	100.00%		

OOPM ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$2,093,898.79	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$2,093,898.79	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Asuris Northwest Health
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

Benefit Classification: (3) Outpatient, In-Network (OP INN)

PLAN INFORMATION

Plan Name: Bronze HSA 7750 <<<This will auto populate from summary sheet macro
Plan ID: 69364WA1220006 <<<This will auto populate from summary sheet macro
CSR Variant Description: <<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.

Click>>>> Home

Errors found: 0

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: Pass

<<<Click the links in the cells below to scroll directly to the stated section>>>>

Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN	
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX	

Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN	
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX	

Links only work for sections that are not already hidden>>>>>

Testing Options

Option	Selection
Out-of-Network Test?	No
Outpatient Benefit Testing	All Combined

Column Options
Explore Columns
Auto-Fit/Hide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. Rx Network Test		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Svcs	No	Yes			Pass		Pass
Outpatient - Office Visits Separate							

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification: (3) Outpatient, In-Network (OP INN)
Notes: Use this table if you are testing all outpatient services combined.

Classification	Outpatient	OP
Network (In/Out)	In-Network	INN
Classification Code	3	OP INN
Table Name		OP_Comps_P1

Number of Rows: 21

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (Optional)	No Cost-Share (If True, enter "X")
Primary Care Visit to Treat an Injury or Illness	Deductible and Coinsurance	$231,288.00	$7,750.00	N/A	50%	$6,300.00	
Specialist Visit	Deductible and Coinsurance	$166,215.75	$7,750.00	N/A	50%	$6,300.00	
Urgent Care	Deductible and Coinsurance	$11,168.00	$7,750.00	N/A	50%	$6,300.00	
Preventive Care/Screening/Immunization	Covered in Full	$17,869.00	$0.00	N/A	N/A	$6,300.00	
Virtual Visits	Deductible and Coinsurance	$48,301.50	$7,750.00	N/A	50%	$6,300.00	
Hospital / Surgery OP	Deductible and Coinsurance	$784,854.00	$7,750.00	N/A	50%	$6,300.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$54,107.00	$7,750.00	N/A	50%	$6,300.00	
X-rays and Diagnostic Imaging	Deductible and Coinsurance	$147,964.00	$7,750.00	N/A	50%	$6,300.00	
Outpatient Facility fee (e.g., Ambulatory Surgery Center)	Deductible and Coinsurance	$379,485.00	$7,750.00	N/A	50%	$6,300.00	
Hearing Aids	0% after the defined NO Minimum Required Deductible amount is met	$6.25	$4,650.00	N/A	0%	$6,300.00	
Acupuncture/Spinal Manipulation	Deductible and Coinsurance	$33,275.00	$7,750.00	N/A	50%	$6,300.00	
Emergency Transportation/Ambulance	Deductible and Coinsurance	$10,379.75	$7,750.00	N/A	50%	$6,300.00	
Rehabilitative and Occupational and Rehabilitative Physical Therapy	Deductible and Coinsurance	$63,384.00	$7,750.00	N/A	50%	$6,300.00	
Reproductive Healthcare	0% after the defined NO Minimum Required Deductible amount is met	$8,384.00	$4,650.00	N/A	0%	$6,300.00	
Virtual Care (Store and Forward)	0%	$84.00	$7,750.00	N/A	0%	$6,300.00	
Preventive Care/Screening/Immunization	Covered in Full	$101,228.00	$0.00	N/A	N/A	$6,300.00	
Preventive Care for Specified Chronic Conditions	Deductible Waived, Coinsurance Applies	$14,469.00	$0.00	N/A	50%	$6,300.00	
Pediatric Dental - Core & Basic Care	Deductible	$464.00	$7,750.00	N/A	N/A	$6,300.00	
Pediatric Dental - Comprehensive Care	Deductible and Coinsurance	$512.00	$7,750.00	N/A	20%	$6,300.00	
Pediatric Dental - Cosmetic Care	Deductible and Coinsurance	$18.00	$7,750.00	N/A	50%	$6,300.00	
Other	Deductible and Coinsurance	$419,177.00	$7,750.00	N/A	50%	$6,300.00	
Total Row		$2,717,613.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3) Outpatient, In-Network (OP INN)

Cost-Share Type	MHSUD Cost-Shares	Predominant Level for Parity	MHSUD Financial Parity Result
Deductible	$7,750.00	$7,750.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	50%	50%	Pass
OOPM	$6,300.00	$6,300.00	Pass
Overall			Pass

*If not applicable, enter "N/A"

Errors Footnotes
na

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$2,564,081.63	94.35%	OP INN Deductible
Copayment	$0.00	0.00%	Fail
Coinsurance	$153,200.38	5.64%	OP INN Coinsurance
OOPM	$2,717,613.01	100.00%	OP INN OOPM
Total Projected	$2,717,613.01		

Step 2 Predominant Level

Deductible — (3) Outpatient, In-Network (OP INN) Errors found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$1,650.00	$8,589.25	0.32%	$1,650.00	
$7,750.00	$2,551,492.38	99.67%	$7,750.00	
Total	$2,564,081.63	100.00%		

Copayment — (3) Outpatient, In-Network (OP INN) Errors found: 0

Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance — (3) Outpatient, In-Network (OP INN) Errors found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
20%	$0.00	0.00%	20%	
50%	$2,568,845.63	99.35%	50%	
	$9,678.56	0.34%		
	$9,678.56	0.34%		
Total	$2,568,524.19	100.00%		

OOPM — (3) Outpatient, In-Network (OP INN) Errors found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$6,300.00	$2,717,613.01	100.00%	$6,300.00	
	$0.00			
	$0.00			
	$0.00			
Total	$2,717,613.01	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Asuris Northwest Health
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Silver 5000 *<<<<This will auto populate from summary sheet macro*
Plan ID: 69364WA1220008 *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: Pass

Links only work for sections that are not already hidden>>>>>

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	Office Visits Separate

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier: D1. In-Network	D. By Network Tier: D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Servic							
Outpatient - Office Visits Separate							
Outp	No	Yes			Pass		Pass
Outp	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Click>>>>> Home **Errors found:** 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV IN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OO	Move to ER	Move to RX

PART 1
COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3a) Outpatient - Office Visits, In-Network (OP-OV INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - Office Vis	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 6

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Primary Care Visit to Treat an Injury or Illness	Copay	$185,608.15	$0.00	$20.00	N/A	$10,150.00	
Specialist Visit	Copay	$143,344.26	$0.00	$70.00	N/A	$10,150.00	
Urgent Care	Copay	$9,967.59	$0.00	$70.00	N/A	$10,150.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$32,628.31	$0.00	N/A	N/A	$10,150.00	x
Virtual Visits	Copay	$43,029.85	$0.00	$10.00	N/A	$10,150.00	
Total Row		$414,578.16					

PART 2
ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$20.00	$20.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			Pass

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
xx

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$381,949.85	92.13%	OP-OV INN
Coinsurance	$0.00	0.00%	Fail
OOPM	$414,578.16	100.00%	OP-OV INN OOPM
Total Projected	$414,578.16		

Step 2 Predominant Level

Deductible ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Deductible	Allowed Claims	Portion	Predominant &	Error Checking
	$414,578.16	100.00%		
Total	$414,578.16	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10.00	$43,029.85	11.27%	$10.00	
$20.00	$185,608.15	48.59%	$20.00	
$70.00	$153,311.85	40.14%		
	$0.00			
Total	$381,949.85	100.00%		

Coinsurance ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant &	Error Checking
$10,150.00	$414,578.16	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$414,578.16	100.00%		

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)

Click>>>>> Home **Errors found:** 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

PART 1
COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 16

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Hospital / Surgery OP	Deductible and Coinsurance	$676,775.80	$5,000.00	N/A	10%	$10,150.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$46,657.04	$5,000.00	N/A	10%	$10,150.00	
X-rays and Diagnostic Imaging	Deductible and Coinsurance	$127,591.08	$5,000.00	N/A	10%	$10,150.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Deductible and Coinsurance	$327,225.13	$5,000.00	N/A	10%	$10,150.00	
Hearing Aids	Coinsurance	$4.10	$0.00	N/A	10%	$10,150.00	
Acupunture/Spinal Manipulations	Copay	$11,447.76	$0.00	$20.00	N/A	$10,150.00	
Emergency Transportation	Deductible and Coinsurance	$8,772.73	$5,000.00	N/A	10%	$10,150.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Deductible and Coinsurance	$54,483.61	$5,000.00	N/A	10%	$10,150.00	
Reproductive Healthcare	Covered in Full	$7,402.40	$0.00	N/A	N/A	$10,150.00	x
Virtual Care (Store and Forward)	Covered in Full	$77.32	$0.00	N/A	N/A	$10,150.00	x
Preventive Care/Screening/Immunization (Other)	Covered in Full	$87,288.65	$0.00	N/A	N/A	$10,150.00	x
Preventive Care for Specified Chronic Conditions	Deductible Waived, Coinsurance Applies	$12,472.51	$0.00	N/A	10%	$10,150.00	
Pediatric Dental - Class 1 Preventive	Covered in Full	$572.81	$0.00	N/A	N/A	$10,150.00	x
Pediatric Dental - Class 2 Basic	Coinsurance	$441.84	$0.00	N/A	20%	$10,150.00	
Pediatric Dental - Class 3 Major	Coinsurance	$50.50	$0.00	N/A	50%	$10,150.00	
Other	Deductible and Coinsurance	$567,543.16	$5,000.00	N/A	10%	$10,150.00	
Total Row		$1,928,806.44					

PART 2
ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3b) Outpatient - All Other, In-Network (OP-AO INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$5,000.00	$5,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	10%	10%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			Pass

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
xx

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$1,809,048.55	93.79%	OP-AO INN Deductible
Copayment	$11,447.76	0.59%	Fail
Coinsurance	$1,822,017.50	94.46%	OP-AO INN Coinsurance
OOPM	$1,928,806.44	100.00%	OP-AO INN OOPM
Total Projected	$1,928,806.44		

Step 2 Predominant Level

Deductible ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$5,000.00	$1,809,048.55	93.79%	$5,000.00	
	$119,757.89	6.21%		
Total	$1,928,806.44	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
10%	$1,821,525.17	99.97%	10%	
20%	$441.84	0.02%		
50%	$50.50	0.00%		
	$0.00			
Total	$1,822,017.50	100.00%		

OOPM ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$1,928,806.44	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,928,806.44	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Asuris Northwest Health
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Gold 2000 — *<<<<This will auto populate from summary sheet macro*
Plan ID: 69364WA1220014 — *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: — *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: **Pass**

Links only work for sections that are not already hidden>>>>>

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	Office Visits Separate

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier: D1. In-Network	D. By Network Tier: D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Service							
Outpatient - Office Visits Separate							
Outp	No	Yes			Pass		Pass
Outp	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Click>>>>> Home — Errors found: 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OO	Move to ER	Move to RX

PART 1
COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3a) Outpatient - Office Visits, In-Network (OP-OV INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - Office Vis	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 6

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Primary Care Visit to Treat an Injury or Illness	Copay	$111,506.04	$0.00	$20.00	N/A	$10,150.00	
Specialist Visit	Copay	$86,115.56	$0.00	$50.00	N/A	$10,150.00	
Urgent Care	Copay	$5,988.14	$0.00	$50.00	N/A	$10,150.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$19,601.80	$0.00	N/A	N/A	$10,150.00	x
Virtual Visits	Copay	$25,850.63	$0.00	$10.00	N/A	$10,150.00	
Total Row		$249,062.16					

PART 2
ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$20.00	$20.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			**Pass**

Enter Footnotes (as needed) about
xx

**If not applicable, enter "N/A"*

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$229,460.37	92.13%	OP-OV INN
Coinsurance	$0.00	0.00%	Fail
OOPM	$249,062.16	100.00%	OP-OV INN OOPM
Total Projected	$249,062.16		

Step 2 Predominant Level

Deductible ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Deductible	Allowed Claims	Portion	Predominant &	Error Checking
	$249,062.16	100.00%		
Total	$249,062.16	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10.00	$25,850.63	11.27%	$10.00	
$20.00	$111,506.04	48.59%	$20.00	
$50.00	$92,103.70	40.14%		
	$0.00			
Total	$229,460.37	100.00%		

Coinsurance ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant &	Error Checking
$10,150.00	$249,062.16	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$249,062.16	100.00%		

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)

Click>>>>> Home — Errors found: 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

PART 1
COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 16

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Hospital / Surgery OP	Deductible and Coinsurance	$406,580.14	$2,000.00	N/A	10%	$10,150.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$28,029.71	$2,000.00	N/A	10%	$10,150.00	
X-rays and Diagnostic Imaging	Deductible and Coinsurance	$76,651.68	$2,000.00	N/A	10%	$10,150.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Deductible and Coinsurance	$196,583.92	$2,000.00	N/A	10%	$10,150.00	
Hearing Aids	Coinsurance	$2.46	$0.00	N/A	10%	$10,150.00	
Acupunture/Spinal Manipulations	Copay	$6,877.36	$0.00	$20.00	N/A	$10,150.00	
Emergency Transportation	Deductible and Coinsurance	$5,270.31	$2,000.00	N/A	10%	$10,150.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Deductible and Coinsurance	$32,731.60	$2,000.00	N/A	10%	$10,150.00	
Reproductive Healthcare	Covered in Full	$4,447.07	$0.00	N/A	N/A	$10,150.00	x
Virtual Care (Store and Forward)	Covered in Full	$46.45	$0.00	N/A	N/A	$10,150.00	x
Preventive Care/Screening/Immunization (Other)	Covered in Full	$52,439.57	$0.00	N/A	N/A	$10,150.00	x
Preventive Care for Specified Chronic Conditions	Deductible Waived, Coinsurance Applies	$7,492.99	$0.00	N/A	10%	$10,150.00	
Pediatric Dental - Class 1 Preventive	Covered in Full	$344.12	$0.00	N/A	N/A	$10,150.00	x
Pediatric Dental - Class 2 Basic	Coinsurance	$265.44	$0.00	N/A	20%	$10,150.00	
Pediatric Dental - Class 3 Major	Coinsurance	$30.34	$0.00	N/A	50%	$10,150.00	
Other	Deductible and Coinsurance	$340,957.49	$2,000.00	N/A	10%	$10,150.00	
Total Row		$1,158,750.64					

PART 2
ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3b) Outpatient - All Other, In-Network (OP-AO INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$2,000.00	$2,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	10%	10%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			**Pass**

Enter Footnotes (as needed) about
xx

**If not applicable, enter "N/A"*

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$1,086,804.83	93.79%	OP-AO INN Deductible
Copayment	$6,877.36	0.59%	Fail
Coinsurance	$1,094,596.07	94.46%	OP-AO INN Coinsurance
OOPM	$1,158,750.64	100.00%	OP-AO INN OOPM
Total Projected	$1,158,750.64		

Step 2 Predominant Level

Deductible ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,000.00	$1,086,804.83	93.79%	$2,000.00	
	$71,945.81	6.21%		
Total	$1,158,750.64	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
10%	$1,094,300.29	99.97%	10%	
20%	$265.44	0.02%		
50%	$30.34	0.00%		
	$0.00			
Total	$1,094,596.07	100.00%		

OOPM ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$1,158,750.64	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,158,750.64	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Asuris Northwest Health
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Bronze 8000 — *<<<<This will auto populate from summary sheet macro*
Plan ID: 69364WA1220016 — *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: — *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: **Pass**

Links only work for sections that are not already hidden>>>>>

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	Office Visits Separate

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier: D1. In-Network	D. By Network Tier: D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Servic							
Outpatient - Office Visits Separate							
Outp	No	Yes			Pass		Pass
Outp	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Click>>>>> Home — **Errors found:** 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV IN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OO	Move to ER	Move to RX

PART 1
COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3a) Outpatient - Office Visits, In-Network (OP-OV INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - Office Vis	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 6

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Primary Care Visit to Treat an Injury or Illness	Copay	$2,117.20	$0.00	$60.00	N/A	$10,150.00	
Specialist Visit	Copay	$1,635.11	$0.00	$120.00	N/A	$10,150.00	
Urgent Care	Copay	$113.70	$0.00	$120.00	N/A	$10,150.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$372.19	$0.00	N/A	N/A	$10,150.00	x
Virtual Visits	Copay	$490.83	$0.00	$10.00	N/A	$10,150.00	
Total Row		$4,729.03					

PART 2
ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$60.00	$60.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			**Pass**

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
xx

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$4,356.84	92.13%	OP-OV INN
Coinsurance	$0.00	0.00%	Fail
OOPM	$4,729.03	100.00%	OP-OV INN OOPM
Total Projected	$4,729.03		

Step 2 Predominant Level

Deductible ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — **Errors found:** 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Deductible	Allowed Claims	Portion	Predominant &	Error Checking
	$4,729.03	100.00%		
Total	$4,729.03	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — **Errors found:** 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10.00	$490.83	11.27%	$10.00	
$60.00	$2,117.20	48.59%	$60.00	
$120.00	$1,748.80	40.14%		
	$0.00			
Total	$4,356.84	100.00%		

Coinsurance ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — **Errors found:** 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — **Errors found:** 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant &	Error Checking
$10,150.00	$4,729.03	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$4,729.03	100.00%		

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)

Click>>>>> Home — **Errors found:** 0

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

PART 1
COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 16

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Hospital / Surgery OP	Deductible and Coinsurance	$7,719.88	$8,000.00	N/A	50%	$10,150.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$532.21	$8,000.00	N/A	50%	$10,150.00	
X-rays and Diagnostic Imaging	Copay	$1,455.41	$0.00	$60.00	N/A	$10,150.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Deductible and Coinsurance	$3,732.61	$8,000.00	N/A	50%	$10,150.00	
Hearing Aids	Coinsurance	$0.05	$0.00	N/A	50%	$10,150.00	
Acupunture/Spinal Manipulations	Copay	$130.58	$0.00	$60.00	N/A	$10,150.00	
Emergency Transportation	Deductible and Coinsurance	$100.07	$8,000.00	N/A	50%	$10,150.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Deductible and Coinsurance	$621.49	$8,000.00	N/A	50%	$10,150.00	
Reproductive Healthcare	Covered in Full	$84.44	$0.00	N/A	N/A	$10,150.00	x
Virtual Care (Store and Forward)	Covered in Full	$0.88	$0.00	N/A	N/A	$10,150.00	x
Preventive Care/Screening/Immunization (Other)	Covered in Full	$995.69	$0.00	N/A	N/A	$10,150.00	x
Preventive Care for Specified Chronic Conditions	Deductible Waived, Coinsurance Applies	$142.27	$0.00	N/A	50%	$10,150.00	
Pediatric Dental - Class 1 Preventive	Covered in Full	$6.53	$0.00	N/A	N/A	$10,150.00	x
Pediatric Dental - Class 2 Basic	Coinsurance	$5.04	$0.00	N/A	20%	$10,150.00	
Pediatric Dental - Class 3 Major	Coinsurance	$0.58	$0.00	N/A	50%	$10,150.00	
Other	Deductible and Coinsurance	$6,473.88	$8,000.00	N/A	50%	$10,150.00	
Total Row		$22,001.59					

PART 2
ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3b) Outpatient - All Other, In-Network (OP-AO INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/Surgical	MHSUD Financial Parity Result
Deductible	$8,000.00	$8,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	50%	50%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			**Pass**

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
xx

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$19,180.12	87.18%	OP-AO INN Deductible
Copayment	$1,585.99	7.21%	Fail
Coinsurance	$19,328.06	87.85%	OP-AO INN Coinsurance
OOPM	$22,001.59	100.00%	OP-AO INN OOPM
Total Projected	$22,001.59		

Step 2 Predominant Level

Deductible ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — **Errors found:** 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$8,000.00	$19,180.12	87.18%	$8,000.00	
	$2,821.47	12.82%		
Total	$22,001.59	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — **Errors found:** 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — **Errors found:** 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
20%	$5.04	0.03%	20%	
50%	$19,323.02	99.97%	50%	
	$0.00			
	$0.00			
Total	$19,328.06	100.00%		

OOPM ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) — **Errors found:** 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$22,001.59	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$22,001.59	100.00%		

WA Exhibit 1: Experience Data

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

2024 CLAIMS BUILD-UP, TOTAL

Incurred Month yyyymm	Member Months	Incurred & Paid Claims	IBNP for Incurred Claims	Ultimate Incurred Claims	Allowed Claims (without IBNP)	IBNP for Allowed Claims	Ultimate Allowed Claims
202401	999	$432,713	$7,030	$439,742	$513,934	$8,504	$522,438
202402	1,005	$798,527	$7,030	$805,557	$948,412	$8,504	$956,916
202403	994	$449,975	$7,030	$457,004	$534,436	$8,504	$542,939
202404	987	$1,108,461	$7,030	$1,115,491	$1,316,521	$8,504	$1,325,025
202405	994	$552,499	$7,030	$559,528	$656,204	$8,504	$664,708
202406	980	$611,477	$7,030	$618,506	$726,252	$8,504	$734,756
202407	981	$843,000	$7,030	$850,029	$1,001,232	$8,504	$1,009,736
202408	974	$733,457	$7,030	$740,486	$871,127	$8,504	$879,631
202409	962	$530,910	$7,030	$537,940	$630,563	$8,504	$639,067
202410	959	$591,046	$7,030	$598,076	$701,986	$8,504	$710,490
202411	957	$1,226,713	$7,030	$1,233,743	$1,456,969	$8,504	$1,465,473
202412	924	$715,246	$7,030	$722,276	$849,499	$8,504	$858,003
CY2024	11,716	$8,594,024	$84,355	$8,678,379	$10,207,134	$102,046	$10,309,181

2024 ULTIMATE ALLOWED CLAIMS, TOTAL

Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Capitation	Prescription Drug before Drug Rebates	Prescription Drug Rebates (Negative $)	Non-EHBs	Total EHB Allowed	Total Allowed (EHB + non-EHB)	Check Total Allowed (should be $0)
$135,798	$152,060	$101,658	$21,612	$0	$110,267	($62,297)	$1,043	$459,098	$460,141	$62,297
$248,732	$278,518	$186,201	$39,585	$0	$201,970	($62,297)	$1,910	$892,709	$894,619	$62,297
$141,127	$158,027	$105,648	$22,460	$0	$114,594	($62,297)	$1,084	$479,559	$480,643	$62,297
$344,415	$385,660	$257,829	$54,812	$0	$279,664	($62,297)	$2,645	$1,260,083	$1,262,728	$62,297
$172,778	$193,469	$129,342	$27,497	$0	$140,295	($62,297)	$1,327	$601,084	$602,411	$62,297
$190,986	$213,857	$142,972	$30,395	$0	$155,080	($62,297)	$1,467	$670,992	$672,459	$62,297
$262,462	$293,892	$196,479	$41,770	$0	$213,118	($62,297)	$2,015	$945,424	$947,439	$62,297
$228,643	$256,024	$171,163	$36,388	$0	$185,658	($62,297)	$1,756	$815,579	$817,335	$62,297
$166,113	$186,006	$124,352	$26,436	$0	$134,883	($62,297)	$1,276	$575,494	$576,770	$62,297
$184,678	$206,794	$138,250	$29,391	$0	$149,958	($62,297)	$1,418	$646,775	$648,194	$62,297
$380,922	$426,538	$285,158	$60,622	$0	$309,307	($62,297)	$2,925	$1,400,251	$1,403,176	$62,297
$223,021	$249,729	$166,954	$35,493	$0	$181,093	($62,297)	$1,713	$793,994	$795,706	$62,297
$2,679,674	$3,000,574	$2,006,006	$426,461	$0	$2,175,888	($747,560)	$20,577	$9,541,043	$9,561,620	$747,560

2024 CLAIMS BUILD-UP, PMPM

Incurred Month yyyymm	Member Months	Incurred & Paid Claims	IBNP for Incurred Claims	Ultimate Incurred Claims	Allowed Claims (without IBNP)	IBNP for Allowed Claims	Ultimate Allowed Claims
202401		$433.15	$7.04	$440.18	$514.45	$8.51	$522.96
202402		$794.55	$6.99	$801.55	$943.69	$8.46	$952.15
202403		$452.69	$7.07	$459.76	$537.66	$8.56	$546.22
202404		$1,123.06	$7.12	$1,130.18	$1,333.86	$8.62	$1,342.48
202405		$555.83	$7.07	$562.91	$660.16	$8.56	$668.72
202406		$623.96	$7.17	$631.13	$741.07	$8.68	$749.75
202407		$859.33	$7.17	$866.49	$1,020.62	$8.67	$1,029.29
202408		$753.04	$7.22	$760.25	$894.38	$8.73	$903.11
202409		$551.88	$7.31	$559.19	$655.47	$8.84	$664.31
202410		$616.32	$7.33	$623.65	$732.00	$8.87	$740.87
202411		$1,281.83	$7.35	$1,289.18	$1,522.43	$8.89	$1,531.32
202412		$774.08	$7.61	$781.68	$919.37	$9.20	$928.57
CY2024		$733.53	$7.20	$740.73	$871.21	$8.71	$879.92

2024 ULTIMATE ALLOWED CLAIMS, PMPM

Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Capitation	Prescription Drug before Drug Rebates	Prescription Drug Rebates (Negative $)	Non-EHBs	Total EHB Allowed	Total Allowed (EHB + non-EHB)	Check Total Allowed (should be $0)
$135.93	$152.21	$101.76	$21.63	$0.00	$110.38	($62.36)	$1.04	$459.56	$460.60	$62.36
$247.49	$277.13	$185.27	$39.39	$0.00	$200.96	($61.99)	$1.90	$888.27	$890.17	$61.99
$141.98	$158.98	$106.29	$22.60	$0.00	$115.29	($62.67)	$1.09	$482.45	$483.54	$62.67
$348.95	$390.74	$261.23	$55.53	$0.00	$283.35	($63.12)	$2.68	$1,276.68	$1,279.36	$63.12
$173.82	$194.64	$130.12	$27.66	$0.00	$141.14	($62.67)	$1.33	$604.71	$606.05	$62.67
$194.88	$218.22	$145.89	$31.02	$0.00	$158.24	($63.57)	$1.50	$684.69	$686.18	$63.57
$267.54	$299.58	$200.28	$42.58	$0.00	$217.25	($63.50)	$2.05	$963.73	$965.79	$63.50
$234.75	$262.86	$175.73	$37.36	$0.00	$190.61	($63.96)	$1.80	$837.35	$839.15	$63.96
$172.67	$193.35	$129.26	$27.48	$0.00	$140.21	($64.76)	$1.33	$598.23	$599.55	$64.76
$192.57	$215.64	$144.16	$30.65	$0.00	$156.37	($64.96)	$1.48	$674.43	$675.91	$64.96
$398.04	$445.70	$297.97	$63.35	$0.00	$323.21	($65.10)	$3.06	$1,463.17	$1,466.22	$65.10
$241.37	$270.27	$180.69	$38.41	$0.00	$195.99	($67.42)	$1.85	$859.30	$861.15	$67.42
$228.72	$256.11	$171.22	$36.40	$0.00	$185.72	($63.81)	$1.76	$814.36	$816.12	$63.81

Comments

The formulas above do not allow for the proper treatment of rebates. In order for column T to be 0, column S would have to exclude rebates. We have left the original formulas in tact.

WA Exhibit 2: Overall Actual to Expected Experience Reporting and Analysis

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Actual-to-Expected Experience

		2024, TOTAL				2024, PMPM			2024, % of PREMIUM		
Line Item	Description	ACTUAL EXPERIENCE (A)	PROJECTED (i.e., Expected; E)	A:E - 1	A - E	ACTUAL EXPERIENCE (A)	PROJECTED (i.e., Expected; E)	A:E - 1	ACTUAL EXPERIENCE (A)	PROJECTED (i.e., Expected; E)	A - E
a	Member Months (MM)	11,716	12,684	-7.6%							
b	Premium	$6,589,078	$7,281,790	-9.5%		$562.40	$574.09	-2.0%			
c	Allowed Claims	$10,309,181	$10,369,446	-0.6%		$879.92	$817.52	7.6%	156.5%	142.4%	14.1%
d	Incurred Claims	$7,930,833	$7,766,413	2.1%		$676.92	$612.30	10.6%	120.4%	106.7%	13.7%
e	Cost Sharing Reduction (CSR) Amounts	$0	$0	#DIV/0!		$0.00	$0.00	#DIV/0!	0.0%	0.0%	0.0%
f	Risk Adjustment Transfer Amounts	$960,505	$1,581,059	-39.2%		$81.98	$124.65	-34.2%	14.6%	21.7%	-7.1%
g	Administrative Expense	$716,590	$677,935	5.7%		$61.16	$53.45	14.4%	10.9%	9.3%	1.6%
h	Taxes and Fees	$140,637	$163,112	-13.8%		$12.00	$12.86	-6.7%	2.1%	2.2%	-0.1%
i	Profit Margin (a.k.a. Profit & Risk Load)	($1,238,476)	$254,863	-585.9%		($105.71)	$20.09	-626.1%	-18.8%	3.5%	-22.3%
j	Paid-to-Allowed Ratios	76.9%	74.9%	2.7%	2.0%						

Profit Reconciliation

Calculate profit using PMPMs from the table above	($105.71)	$20.13
Difference (should be close to $0)	$0.00	$0.04

Loss Ratios

Simple Loss Ratio (=Incurred Claims / Premium)	120.4%	106.7%	13.7%
Indicated Rate Change Required, if only based on A:E simple loss ratio	12.9%		
Risk Adjusted Loss Ratio (=Incurred Claims / (Premium + Risk Adjustment Transfer))	105.0%	87.6%	17.4%
Indicated Rate Change Required, if only based on A:E risk adjusted loss ratio	19.9%		

Comments

Line Item	Comments

WA Exhibit 3: Essential Health Benefit (EHB) Trend Reporting and Analysis by Benefit Category, Frequency and Unit Cost

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

DATA -- EHB Allowed Claims

EXPERIENCE -- 2022

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	181.09	$6,694.31	$101.02
Outpatient Hospital	Services	6,296.41	$396.97	$208.29
Professional	Services	14,417.70	$117.91	$141.66
Prescription Drug	Days Filled	435,539.58	$5.42	$196.81
Total				$647.79

EXPERIENCE -- 2023

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	230.60	$7,326.07	$140.78
Outpatient Hospital	Services	7,342.96	$491.76	$300.92
Professional	Services	15,447.40	$131.56	$169.35
Prescription Drug	Days Filled	441,687.73	$6.59	$242.62
Total				$853.67

EXPERIENCE -- 2024

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	370.32	$7,411.53	$228.72
Outpatient Hospital	Services	6,961.33	$441.48	$256.11
Professional	Services	14,672.26	$140.04	$171.22
Prescription Drug	Days Filled	447,492.18	$4.98	$185.72
Total				$841.77

PROJECTED (i.e., EXPECTED) -- 2026

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	392.25	$8,186.78	$267.60
Outpatient Hospital	Services	7,373.52	$487.66	$299.65
Professional	Services	15,541.02	$154.68	$200.33
Prescription Drug	Days Filled	473,988.85	$5.50	$217.29
Total				$984.88

TRENDS -- EHB Allowed Claims

EXPERIENCE TREND -- 2022 to 2023

				Unit Cost Components			
Service	Total EHB Cost	Utilization	Unit Cost	Service Mix / Intensity	Reimbursement	Unit Cost	Check
Inpatient Hospital	39.36%	27.34%	9.44%	5.56%	3.67%	9.44%	TRUE
Outpatient Hospital	44.47%	16.62%	23.88%	19.81%	3.40%	23.88%	TRUE
Professional	19.55%	7.14%	11.58%	9.57%	1.83%	11.58%	TRUE
Prescription Drug	23.27%	1.41%	21.56%	4.10%	16.77%	21.56%	TRUE
Total	**31.782%**						

EXPERIENCE TREND -- 2023 to 2024

				Unit Cost Components			
Service	Total EHB Cost	Utilization	Unit Cost	Service Mix / Intensity	Reimbursement	Unit Cost	Check
Inpatient Hospital	62.47%	60.59%	1.17%	-6.66%	8.39%	1.17%	TRUE
Outpatient Hospital	-14.89%	-5.20%	-10.22%	-16.44%	7.44%	-10.22%	TRUE
Professional	1.10%	-5.02%	6.45%	2.99%	3.35%	6.45%	TRUE
Prescription Drug	-23.45%	1.31%	-24.44%	-0.62%	-23.98%	-24.44%	TRUE
Total	**-1.393%**						

ANNUALIZED PROJECTED TREND -- 2024 to 2026

				Unit Cost Components			
Service	Total EHB Cost	Utilization	Unit Cost	Service Mix / Intensity	Reimbursement	Unit Cost	Check
Inpatient Hospital	8.17%	2.92%	5.10%	-0.30%	5.42%	5.10%	TRUE
Outpatient Hospital	8.17%	2.92%	5.10%	-0.31%	5.43%	5.10%	TRUE
Professional	8.17%	2.92%	5.10%	1.82%	3.23%	5.10%	TRUE
Prescription Drug	8.17%	2.92%	5.10%	-0.38%	5.50%	5.10%	TRUE
Total	**8.167%**						

Comments

There is no "Other" category, so this won't match up to the URRT PMPMs. For our development of the URRT, we have historically usedifferent frequency units.

WA Exhibit 4: Normalized Allowed Claims Analysis

Carrier Name:	**Asuris Northwest Health**
Market:	**Individual**
Rate Filing Plan Year:	**2026**
Experience Period Year:	**2024**

Table 3.1

										Allowable Rating Adjustments									
Incurred Date (YYYYMM)	Member Months	Allowed Claims (as of 3/31/2025)	Allowed Claims Completion factor (based on IBNP estimates)	Ultimate Allowed Claims	One-Time Adjustment for High Claims (Non-Predictive Claims)	One-Time Adjustment for HCRP Receipts	Non-EHB Allowed Claims	Predictive Ultimate Allowed EHB Claims	Predictive Ultimate Allowed EHB Claims PMPM	Morbidity Adjustment	Demographic Shift	Plan Design Changes	Other Adjustments	Combined Adjustment	Accumulated Adjustments	Allowable Rating Adjustment Normalization Factor	Normalized Allowed Claims PMPM (to Experience Period)	Unadjusted 12-Month Rolling Allowed Claims Trend	Normalized 12-Month Rolling Allowed Claims Trend
202201	1,203	$788,048	1.0000	$788,048	-		$1,573	$786,475	$653.76	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$729.82		
202202	1,197	$644,547	1.0000	$644,547	-		$1,287	$643,261	$537.39	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$599.92		
202203	1,188	$917,558	1.0000	$917,558	-		$1,831	$915,727	$770.81	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$860.49		
202204	1,179	$691,819	1.0000	$691,819	-		$1,381	$690,438	$585.61	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$653.74		
202205	1,175	$648,075	1.0000	$648,075	-		$1,294	$646,781	$550.45	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$614.49		
202206	1,163	$591,085	1.0000	$591,085	-		$1,180	$589,905	$507.23	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$566.24		
202207	1,150	$695,919	1.0000	$695,919	-		$1,389	$694,530	$603.94	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$674.20		
202208	1,139	$736,913	1.0000	$736,913	-		$1,471	$735,442	$645.69	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$720.81		
202209	1,136	$930,073	1.0000	$930,073	-		$1,856	$928,216	$817.09	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$912.15		
202210	1,119	$1,045,257	1.0000	$1,045,257	$2,866		$2,086	$1,040,304	$929.67	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$1,037.83		
202211	1,108	$994,859	1.0000	$994,859	-		$1,986	$992,873	$896.09	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$1,000.35		
202212	1,101	$1,132,912	1.0000	$1,132,912	$225,588		$2,261	$905,063	$822.04	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.1163	$917.67		
202301	1,074	$982,917	1.0000	$982,917	-		$1,962	$980,955	$913.37	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$822.79		
202302	1,063	$999,065	1.0000	$999,065	-		$1,994	$997,070	$937.98	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$844.96		
202303	1,058	$942,150	1.0000	$942,150	-		$1,881	$940,270	$888.72	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$800.59		
202304	1,045	$854,039	1.0000	$854,039	-		$1,705	$852,334	$815.63	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$734.75		
202305	1,038	$1,018,200	1.0000	$1,018,200	-		$2,032	$1,016,168	$978.97	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$881.89		
202306	1,029	$1,157,537	1.0000	$1,157,537	-		$2,310	$1,155,226	$1,122.67	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$1,011.34		
202307	1,017	$1,312,449	1.0000	$1,312,449	$193,435		$2,620	$1,116,394	$1,097.73	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$988.87		
202308	995	$812,489	1.0000	$812,489	-		$1,622	$810,867	$814.94	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$734.13		
202309	988	$773,759	1.0000	$773,759	-		$1,544	$772,215	$781.59	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$704.09		
202310	978	$798,755	1.0000	$798,755	-		$1,594	$797,161	$815.09	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$734.26		
202311	959	$796,214	1.0000	$796,214	-		$1,589	$794,625	$828.60	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$746.43		
202312	956	$934,234	1.0000	$934,234	-		$1,865	$932,369	$975.28	1.2316	1.0043	1.0000	1.0019	1.2392	1.2392	0.9008	$878.57	32.54%	6.96%
202401	999	$772,192	1.0000	$772,192	-		$1,541	$770,651	$771.42	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$771.42	27.05%	5.36%
202402	1,005	$1,073,905	1.0000	$1,073,905	$153,565		$2,144	$918,196	$913.63	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$913.63	21.12%	3.30%
202403	994	$722,207	1.0000	$722,207	-		$1,442	$720,766	$725.12	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$725.12	17.88%	3.22%
202404	987	$1,342,953	0.9982	$1,345,377	$157,369		$2,685	$1,185,323	$1,200.93	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$1,200.93	19.04%	7.08%
202405	994	$752,169	0.9982	$753,530	-		$1,504	$752,026	$756.57	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$756.57	11.41%	2.82%
202406	980	$779,447	0.9984	$780,712	-		$1,558	$779,154	$795.05	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$795.05	1.48%	-3.83%
202407	981	$991,170	0.9953	$995,805	-		$1,988	$993,818	$1,013.07	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$1,013.07	-4.04%	-6.55%
202408	974	$860,531	0.9945	$865,253	-		$1,727	$863,526	$886.58	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$886.58	-5.07%	-5.42%
202409	962	$632,077	0.9942	$635,761	-		$1,269	$634,492	$659.55	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$659.55	-5.97%	-4.02%
202410	959	$806,171	0.9858	$817,785	-		$1,632	$816,153	$851.05	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$851.05	-4.69%	0.01%
202411	957	$1,381,350	0.9807	$1,408,572	$276,767		$2,812	$1,128,994	$1,179.72	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$1,179.72	-0.98%	6.87%
202412	924	$840,491	0.9490	$885,656	-		$1,768	$883,889	$956.59	0.9169	0.9872	1.0000	0.9952	0.9008	1.1163	1.0000	$956.59	-2.57%	8.15%

Table 3.2

Plan Year	Total Member Months	Total Allowed Claims (as of 3/31/2025)	-	Total Ultimate Allowed Claims	Total One-Time Adjustment for High Claims (Non-Predictive Claims)	Total One-Time Adjustment for HCRP Receipts	Total Non-EHB Allowed Claims	Total Predictive Ultimate Allowed EHB Claims	Total Predictive Ultimate Allowed EHB Claims PMPM
2022	13,858	$9,817,064		$9,817,064	$228,454	-	$19,595	$9,569,014	$690.50
2023	12,200	$11,381,807		$11,381,807	$193,435	-	$22,718	$11,165,654	$915.22
2024	11,716	$10,954,663		$11,056,755	$587,700	-	$22,069	$10,446,985	$891.69

Comments

Allowed claims in this exhibit are before adjustments for rx rebates. This will not match Exhibit 1 or the URRT as a result.
Large Claims adjusts for individuals with more than 200k in claims within a single month. Allowed claims are before cost sharing is applied, so no plan design adjustments are applied.
Other adjustmenst consists of Network normalizations.

WA Exhibit 5: URRT Worksheet 1 (w1) EHB Pool-Level Adjustment Factors

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table 1

Component	ACTUAL EXPERIENCE (A)		PROJECTED (i.e., EXPECTED; E)				A:E	
	2021 to 2023	2022 to 2024	2021 to 2023	2022 to 2024	2023 to 2025	2024 to 2026	2021 to 2023	2022 to 2024
	(2)	(3)	(4)	(5)	(6)	(7)	(8) (2) vs. (4)	(9) (3) vs. (5)
URRT Worksheet 1								
Annualized Cost Trend Factor	1.110	1.134	1.037	1.043	1.059	1.051	1.070	1.087
Annualized Utilization Trend Factor	1.000	1.003	1.017	1.029	1.029	1.029	0.983	0.975
Morbidity Adjustment	1.142	0.923	1.053	1.004	0.862	0.998	1.085	0.919
Demographic Shift	1.021	0.991	1.008	1.003	0.985	1.007	1.013	0.989
Plan Design Changes	0.992	0.983	0.991	0.989	0.993	0.998	1.001	0.994
Other	0.996	0.966	1.012	1.048	0.982	0.900	0.984	0.922

[1] Ratios for factors. Subtraction for percents.

Comments

WA Exhibit 6: URRT Worksheet 2 (w2) Actuarial Values by Plan

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table 8.1

					Projections			Difference of Pricing Value and Metal Value		
HIOS Plan ID	Metal Level	AV Metal Value 2024	AV Metal Value 2025	AV Metal Value 2026	AV Pricing Value 2024	AV Pricing Value 2025	AV Pricing Value 2026	2024	2025	2026
69364WA1220014	Gold	0.7807	0.7803	0.7863	0.8057	0.8170	0.8102	0.0251	0.0367	0.0239
69364WA1220008	Silver	0.7014	0.7012	0.6999	0.6953	0.6963	0.6928	-0.0061	-0.0049	-0.0071
69364WA1220016	Bronze		0.6481	0.6442		0.6274	0.6235	#VALUE!	-0.0207	-0.0207
69364WA1220006	Bronze	0.6401	0.6201	0.6261	0.6306	0.6240	0.6224	-0.0095	0.0039	-0.0037
69364WA1220004	Bronze	0.6294	0.6230	0.6256	0.6027	0.6049	0.5986	-0.0268	-0.0181	-0.0270

Overall AV Metal Value			Overall AV Pricing Value			Difference of Pricing Value and Metal Value		
2024	2025	2026	2024	2025	2026	2024	2025	2026
0.6779	0.6692	0.6724	0.6708	0.6707	0.6666	-0.0071	0.0014	-0.0058

Comments

The AV Pricing Values shown in this exhibit are net of the Induced Demand Factor and Above EHB Factor and therefore will not match the AV Pricing Values shown in other exhibits such as Exhibit E2.

WA Exhibit 7: URRT Worksheet 2 (w2) Plan Adjustment Factors, in Aggregate

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table

Component	ACTUAL EXPERIENCE (A) 2022	2023	2024	PROJECTED (i.e., EXPECTED; E) 2022	2023	2024	2025	2026	YEAR-TO-YEAR CHANGE in PROJECTED AMOUNTS 2022 to 2023	2023 to 2024	2024 to 2025	2025 to 2026	2024 EXPERIENCE to 2026 PROJECTED	A:E 2022	2023	2024
Paid-to-Allowed Ratio (All, Unadjusted)	0.7243	0.7709	0.7693	0.7661	0.7982	0.7490	0.7764	0.7940	1.042	0.938	1.037	1.023	1.032	0.945	0.966	1.027
Paid-to-Allowed Ratio (Catastrophic, Unadjusted)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Paid-to-Allowed Ratio (Bronze, Unadjusted)	0.6551	0.7337	0.7343	0.7575	0.7906	0.7361	0.7531	0.7753	1.044	0.931	1.023	1.029	1.056	0.865	0.928	0.998
Paid-to-Allowed Ratio (Silver, Unadjusted)	0.7242	0.8030	0.7879	0.7770	0.7984	0.7540	0.7832	0.8007	1.027	0.944	1.039	1.022	1.016	0.932	1.006	1.045
Paid-to-Allowed Ratio (Gold, Unadjusted)	0.7943	0.7945	0.8015	0.7818	0.8244	0.7842	0.8359	0.8432	1.054	0.951	1.066	1.009	1.052	1.016	0.964	1.022
Paid-to-Allowed Ratio (Platinum, Unadjusted)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV and Cost Sharing Design of Plan Development Components																
AV Pricing Value	0.5464	0.5476	0.5358	0.5434	0.5439	0.5346	0.5393	0.6859	1.001	0.983	1.009	1.272	1.280	1.005	1.007	1.002
Induced Demand Factor (IDF)	1.4021	1.4586	1.3985	1.4098	1.4685	1.4019	1.4406	1.1578	1.042	0.955	1.028	0.804	0.828	0.995	0.993	0.998
CSR Silver Load	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Factor for cost of abortion services for which public funding is prohibited	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV and Cost Sharing Design of Plan	0.7661	0.7987	0.7494	0.7661	0.7987	0.7494	0.7769	0.7941	1.043	0.938	1.037	1.022	1.060	1.000	1.000	1.000
Benefits in Addition to EHB	1.0020	1.0020	1.0020	1.0020	1.0020	1.0020	1.0020	1.0012	1.000	1.000	1.000	0.999	0.999	1.000	1.000	1.000
Catastrophic Adjustment	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Comments

Pricing AVs were re-scaled for 2026 to accommodate the requirements of emergency rule CR-103E, hence the change in the AV Pricing Value and Induced Demand Factor from 2025 to 2026.

WA Exhibit 8: CSR Related Experience

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table

					Plan Year 2024 Actual Experience							
HIOS Plan ID	Metal Level	CSR Plan Variant	2026 Plan Category (New, Renewing, Terminated)	CSR Silver Load (Projected)	Member Months	Allowed Claims	Paid Claims	Paid-to-Allowed Ratio	CSR Paid Claims	CSR-Adjusted Paid-to-Allowed Ratio	APTC Payments	Net CSR Funds
69364WA1220004	Bronze	NA	Renewing	1.0000	2,970	$1,216,039	$795,809	0.65442721	$0	0.65442721	$0	
69364WA1220006	Bronze	NA	Renewing	1.0000	3,563	$3,201,172	$2,447,649	0.764610367	$0	0.764610367	$0	
69364WA1220008	Silver	NA	Renewing	1.0000	3,206	$2,583,087	$2,035,173	0.787883998	$0	0.787883998	$0	
69364WA1220014	Gold	NA	Renewing	1.0000	1,977	$3,308,882	$2,652,201	0.801539894	$0	0.801539894	$0	
69364WA1220016	Bronze	NA	Renewing	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	

Comments

WA Exhibit 9: URRT Worksheet 2 (w2) AV and Cost Sharing Design Factors

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

HIOS Plan ID	Metal Level	2026 Plan Category (New, Renewing, Terminated)	Exchange Plan?	Requesting Expanded AV Pricing Value Range	AV Metal Value	AV Pricing Value	Induced Demand Factor (IDF)	CSR Silver Load	Check AV Pricing Value within 2% (or 3%) of AV Metal Value	Check Expected Risk Adjustment IDF	Check CSR Silver Load
69364WA1220014	Gold	Renewing	No	Yes	0.7863	0.8102	1.0860	1.0000	2.39%	1.0860	
69364WA1220008	Silver	Renewing	No	No	0.6999	0.6928	1.0270	1.0000	-0.71%	1.0270	
69364WA1220016	Bronze	Renewing	No	Yes	0.6442	0.6235	1.0050	1.0000	-2.07%	1.0050	
69364WA1220006	Bronze	Renewing	No	No	0.6261	0.6224	1.0050	1.0000	-0.37%	1.0050	
69364WA1220004	Bronze	Renewing	No	Yes	0.6256	0.5986	1.0000	1.0000	-2.70%	1.0000	

Comments

1. Induced demand factors and expected induced demand factors have both been rounded to three decimal places.
2. Expanded AV Pricing Value range requested for certain plans which are HSAs or include embedded pediatric dental.

WA Exhibit 10: Summarized Risk Adjustment (RA)

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

ACTUAL EXPERIENCE, 2024

Description	Statewide Metal Plans	Total for Metal + Catastrophic	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Cata-strophic
Billable Member Months (MM)		11,669	11,669	-	1,999	3,121	6,549		-
Actuarial Value (AV)	0.686		0.661010446	0.900	0.800	0.700	0.600	0.570	0.570
Plan Liability Risk Score (PLRS)	1.292		1.424	0.000	3.054	1.288	0.991	0.000	0.000
Allowable Rating Factor (ARF)	1.711		1.677	0.000	1.567	1.571	1.762	0.000	0.000
Induced Demand Factor (IDF)	1.030		1.022	0.000	1.080	1.030	1.000	0.000	0.000
Geographic Cost Factor (GCF)	1.000		0.948	0.000	0.944	0.944	0.952	0.000	0.000
Final SWAP PMPM (before 86% adjustment is applied)	$590.07							$0.00	
Plan Liability Component approximation = PLRS * IDF * GCF	1.331		1.380	0.000	3.112	1.252	0.944	0.000	0.000
Normalized PLRS * IDF * GCF (N1)			1.037	0.000	2.338	0.941	0.709		TBD
Allowable Rating Component approximation = AV * ARF * IDF * GCF	1.210		1.074	0.000	1.278	1.070	1.006	0.000	0.000
Normalized AV * PLRS * IDF * GCF (N2)			0.888	0.000	1.056	0.884	0.832		TBD
Approximate Transfer PMPM (P * [N1 - N2] * 0.86)			**$75.49**	$0.00	$650.79	$28.95	($62.24)		TBD
Approximate Aggregate Transfer (Transfer PMPM * MM)			**$880,906**	$0	$1,301,176	$90,353	($407,596)		TBD
Aggregate Experience RA Transfer PMPM		84.31658201	$84.32	$0.00	$650.79	$28.95	-$62.24		$0.00
Transfer PMPM Difference			$8.83	$0.00	$0.00	$0.00	$0.00		TBD
HCRP assessment PMPM (amounts should be negative)		-$2.01	-$2.01	$0.00	-$2.01	-$2.01	-$2.01		$0.00
HCRP receipts PMPM (amounts should be positive)		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
RADV adjustment PMPM, if applicable		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
Final Risk Adjustment PMPM		$82.31	$82.31	$0.00	$648.78	$26.94	-$64.24		$0.00

PROJECTED (i.e., EXPECTED), 2026

Description	Statewide Metal Plans	Total for Metal + catastrophic.	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Cata-strophic
Billable Member Months (MM)		11,568	11,568	-	1,896	3,156	6,516		-
Actuarial Value (AV)	0.686		0.660	0.900	0.800	0.700	0.600	0.000	0.000
Plan Liability Risk Score (PLRS)	1.344		1.436	0.000	3.166	1.313	0.993	0.000	0.000
Allowable Rating Factor (ARF)	1.711		1.697	0.000	1.625	1.602	1.765	0.000	0.000
Induced Demand Factor (IDF)	1.030		1.021	0.000	1.080	1.030	1.000	0.000	0.000
Geographic Cost Factor (GCF)	1.000		0.949	0.000	0.946	0.941	0.954	0.000	0.000
Statewide Average Premium (SWAP) PMPM									
Starting SWAP PMPM	$590.07							$0.00	
Trend from 2024 to 2025	6.61%							0.00%	
Trend from 2025 to 2026	17.06%							0.00%	
Final SWAP PMPM (before 86% adjustment is applied)	$736.41							$0.00	
Plan Liability Component approximation = PLRS * IDF * GCF	1.384		1.393	0.000	3.236	1.272	0.948	0.000	0.000
Normalized PLRS * IDF * GCF (N1)			1.006	0.000	2.338	0.919	0.685		TBD
Allowable Rating Component approximation = AV * ARF * IDF * GCF	1.210		1.086	0.000	1.328	1.087	1.011	0.000	0.000
Normalized AV * PLRS * IDF * GCF (N2)			0.898	0.000	1.098	0.898	0.835		TBD
Approximate Transfer PMPM (P * [N1 - N2] * 0.86)			**$68.65**	$0.00	$785.21	$13.42	($95.36)		TBD
Approximate Aggregate Transfer (Transfer PMPM * MM)			**$794,199**	$0	$1,488,755	$42,359	($621,353)		TBD
Aggregate Projected (Rate Development) RA Transfer PMPM		78.64455086	$78.64	$0.00	$785.21	$13.42	-$95.36		$0.00
Transfer PMPM Difference			$9.99	$0.00	$0.00	$0.00	$0.00		TBD
HCRP assessment PMPM (amounts should be negative)		-$3.82	-$3.82	$0.00	-$3.82	-$3.82	-$3.82		$0.00
HCRP receipts PMPM (amounts should be positive)		$3.82	$3.82	$0.00	$3.82	$3.82	$3.82		$0.00
RADV adjustment PMPM, if applicable		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
Final Risk Adjustment PMPM		$78.64	$78.64	$0.00	$785.21	$13.42	-$95.36		$0.00

PROJECTED (i.e., EXPECTED), 2026 versus ACTUAL EXPERIENCE, 2024

Statewide Metal Plans	Total for Metal + catastrophi	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Cata-strophic
	0.991	0.991		0.948	1.011	0.995		
1.000		0.999	1.000	1.000	1.000	1.000	-	-
1.040		1.009		1.037	1.020	1.002		
1.000		1.012		1.037	1.020	1.002		
1.000		1.000		1.000	1.000	1.000		
1.000		1.001		1.003	0.996	1.003		
1.248								
1.040		1.009		1.040	1.016	1.004		
		0.971		1.000	0.977	0.966		
1.000		1.011		1.040	1.016	1.004		
		1.011		1.040	1.016	1.004		
		0.909		1.207	0.464	1.532		
		0.902		1.144	0.469	1.524		
	0.933	0.933		1.207	0.464	1.532		
		1.132		(0.167)	0.131	-		
	1.904	1.904		1.904	1.904	1.904		
	0.955	0.955		1.210	0.498	1.484		

PROJECTED (i.e., EXPECTED), 2024

Description	Statewide Metal Plans	Total for Metal + catastrophic.	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Cata-strophic
Billable Member Months (MM)		12,684	12,684	-	2,160	2,952	7,572		-
Actuarial Value (AV)	0.670		0.657	0.900	0.800	0.700	0.600	0.000	0.000
Plan Liability Risk Score (PLRS)	1.323		1.557	0.000	4.627	1.128	0.848	0.000	0.000
Allowable Rating Factor (ARF)	1.763		1.695	0.000	1.595	1.584	1.766	0.000	0.000
Induced Demand Factor (IDF)	1.024		1.021	0.000	1.080	1.030	1.000	0.000	0.000
Geographic Cost Factor (GCF)	1.000		1.005	0.000	1.005	0.996	1.009	0.000	0.000
Statewide Average Premium (SWAP) PMPM									
Starting SWAP PMPM	$537.44							$0.00	
Trend from 2022 to 2023	5.75%							0.00%	
Trend from 2023 to 2024	6.28%							0.00%	
Final SWAP PMPM (before 86% adjustment is applied)	$604.08							$0.00	
Plan Liability Component approximation = PLRS * IDF * GCF	1.355		1.597	0.000	5.020	1.157	0.856	0.000	0.000
Normalized PLRS * IDF * GCF (N1)			1.179	0.000	3.705	0.854	0.632		TBD
Allowable Rating Component approximation = AV * ARF * IDF * GCF	1.209		1.143	0.000	1.384	1.138	1.069	0.000	0.000
Normalized AV * PLRS * IDF * GCF (N2)			0.945	0.000	1.145	0.941	0.884		TBD
Approximate Transfer PMPM (P * [N1 - N2] * 0.86)			**$121.54**	$0.00	$1,330.15	($45.12)	($131.07)		TBD
Approximate Aggregate Transfer (Transfer PMPM * MM)			**$1,541,580**	$0	$2,873,129	($133,203)	($992,474)		TBD
Aggregate Projected (Rate Development) RA Transfer PMPM		TBD	TBD	$0.00	$1,289.76	-$53.26	-$133.06		$0.00
Transfer PMPM Difference			TBD	$0.00	-$40.39	-$8.14	-$1.99		TBD
HCRP assessment PMPM (amounts should be negative)		TBD	TBD	$0.00	-$3.16	-$3.16	-$3.16		$0.00
HCRP receipts PMPM (amounts should be positive)		TBD	TBD	$0.00	$3.16	$3.16	$3.16		$0.00
RADV adjustment PMPM, if applicable		TBD	TBD	$0.00	$0.00	$0.00	$0.00		$0.00
Final Risk Adjustment PMPM		TBD	TBD	$0.00	$1,289.76	-$53.26	-$133.06		$0.00

ACTUAL EXPERIENCE, 2024 versus PROJECTED (i.e., EXPECTED), 2024

Statewide Metal Plans	Total for Metal +	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Cata-strophic
	0.920	0.920		0.926	1.057	0.865		
1.025		1.006	1.000	1.000	1.000	1.000		
0.977		0.915		0.660	1.141	1.168		
0.971		0.990		0.983	0.991	0.998		
1.006		1.001		1.000	1.000	1.000		
1.000		0.943		0.939	0.948	0.943		
0.977								
0.982		0.864		0.620	1.082	1.102		
		0.879		0.631	1.102	1.122		
1.001		0.940		0.923	0.940	0.941		
		0.939		0.922	0.939	0.940		
		0.621		0.489	(0.642)	0.475		
		0.571		0.453	(0.678)	0.411		
				0.505	(0.544)	0.468		
				0.000	0.000	0.000		
				0.636	0.636	0.636		
				-	-	-		
				0.503	(0.506)	0.483		

Comments

WA Exhibit 11: Retention / Administrative Costs

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

	ACTUAL EXPERIENCE (A)						PROJECTED (i.e., EXPECTED; E)										YEAR-TO-YEAR SHIFTS in PROJECTED AMOUNTS								2024 EXPERIENCE to		A:E					
	2022		2023		2024		2022		2023		2024		2025		2026		2022 to 2023		2023 to 2024		2024 to 2025		2025 to 2026		2026 PROJECTED		2022		2023		2024	
Description	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM
Administrative Expenses																																
Commissions	2.76%	$15.15	2.42%	$14.80	2.56%	$14.71	2.85%	$15.67	2.52%	$15.42	2.59%	$14.88	2.30%	$15.16	1.87%	$14.27	-0.33%	-1.60%	0.07%	-3.50%	-0.29%	1.88%	-0.44%	-5.87%	-0.70%	-2.96%	0.09%	3.40%	0.10%	4.16%	0.03%	1.19%
Quality improvement	0.53%	$2.89	0.55%	$3.35	0.78%	$4.46	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	-0.78%	-100.00%	-0.53%	-100.00%	-0.55%	-100.00%	-0.78%	-100.00%
Investment income credit (enter as a negative number)	-0.01%	($0.03)	-0.12%	($0.75)	-0.16%	($0.92)	-0.01%	($0.03)	-0.12%	($0.75)	-0.16%	($0.92)	-0.23%	($1.50)	-0.22%	($1.70)	-0.12%	2400.00%	-0.04%	22.67%	-0.07%	63.04%	0.01%	13.33%	-0.06%	84.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Commercial reinsurance premium	0.37%	$2.04	0.37%	$2.23	0.36%	$2.06	0.31%	$1.70	0.41%	$2.51	0.55%	$3.16	0.41%	$2.70	0.50%	$3.82	0.10%	47.08%	0.14%	25.90%	-0.14%	-14.56%	0.09%	41.72%	0.14%	85.75%	-0.06%	-16.51%	0.04%	12.29%	0.19%	53.41%
Other administrative expenses	7.02%	$38.60	6.84%	$41.82	6.94%	$39.82	6.95%	$38.24	6.15%	$37.59	6.88%	$39.47	7.25%	$47.67	6.34%	$48.48	-0.81%	-1.70%	0.73%	5.00%	0.37%	20.78%	-0.90%	1.70%	-0.60%	21.74%	-0.06%	-0.93%	-0.69%	-10.10%	-0.06%	-0.88%
Total administrative expenses	**10.66%**	**$58.65**	**10.05%**	**$61.45**	**10.47%**	**$60.12**	**10.11%**	**$55.58**	**8.95%**	**$54.77**	**9.86%**	**$56.59**	**9.73%**	**$64.03**	**8.49%**	**$64.87**	**-1.15%**	**-1.47%**	**0.90%**	**3.32%**	**-0.13%**	**13.15%**	**-1.25%**	**1.32%**	**-1.99%**	**7.90%**	**-0.56%**	**-5.23%**	**-1.09%**	**-10.88%**	**-0.62%**	**-5.88%**
Taxes and Fees																																
Premium tax	2.00%	$11.00	2.00%	$12.23	2.00%	$11.48	2.00%	$11.00	2.00%	$12.23	2.00%	$11.48	2.00%	$13.16	2.00%	$15.29	0.00%	11.20%	0.00%	-6.15%	0.00%	14.61%	0.00%	16.21%	0.00%	33.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Federal income tax	3.20%	$17.58	3.16%	$19.31	-2.24%	($12.86)	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	2.24%	-100.00%	-3.20%	-100.00%	-3.16%	-100.00%	2.24%	-100.00%
WA OIC regulatory surcharge	0.0723%	$0.40	0.0784%	$0.48	0.0778%	$0.45	0.0815%	$0.45	0.0759%	$0.46	0.0712%	$0.41	0.0766%	$0.50	0.0763%	$0.58	-0.01%	3.56%	0.00%	-11.95%	0.01%	23.27%	0.00%	15.81%	0.00%	30.74%	0.01%	12.78%	0.00%	-3.24%	-0.01%	-8.42%
WA OIC fraud surcharge	0.0043%	$0.02	0.0047%	$0.03	0.0042%	$0.02	0.0052%	$0.03	0.0047%	$0.03	0.0042%	$0.02	0.0046%	$0.03	0.0041%	$0.03	0.00%	0.51%	0.00%	-15.92%	0.00%	24.77%	0.00%	4.54%	0.00%	30.74%	0.00%	21.70%	0.00%	0.12%	0.00%	0.23%
Risk adjustment user fee	0.05%	$0.25	0.04%	$0.22	0.04%	$0.21	0.05%	$0.25	0.04%	$0.22	0.04%	$0.21	0.03%	$0.18	0.03%	$0.20	-0.01%	-12.00%	0.00%	-4.55%	-0.01%	-14.29%	0.00%	11.11%	-0.01%	-5.35%	0.00%	-0.71%	0.00%	-0.77%	0.00%	-0.61%
PCORI fee	0.05%	$0.25	0.04%	$0.27	0.05%	$0.29	0.05%	$0.25	0.04%	$0.26	0.05%	$0.28	0.05%	$0.30	0.04%	$0.32	0.00%	4.00%	0.01%	7.69%	0.00%	7.14%	0.00%	6.67%	-0.01%	9.70%	0.00%	-0.32%	0.00%	-4.05%	0.00%	-4.01%
Mitigating inequity fee	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD
WSHIP assessment	0.11%	$0.62	0.10%	$0.61	0.07%	$0.39	0.12%	$0.64	0.07%	$0.40	0.06%	$0.36	0.03%	$0.17	0.04%	$0.32	-0.05%	-37.50%	0.00%	-10.00%	-0.04%	-52.78%	0.02%	88.24%	-0.03%	-18.66%	0.00%	3.97%	-0.03%	-34.18%	-0.01%	-8.49%
WAPAL assessment	0.06%	$0.32	0.05%	$0.33	0.05%	$0.31	0.01%	$0.04	0.01%	$0.07	0.01%	$0.06	0.01%	$0.07	0.01%	$0.07	0.00%	75.00%	0.00%	-14.29%	0.00%	16.67%	0.00%	0.00%	-0.05%	-77.70%	-0.05%	-87.35%	-0.04%	-79.04%	-0.04%	-80.88%
Total administrative expenses	**5.53%**	**$30.43**	**5.47%**	**$33.48**	**0.05%**	**$0.30**	**2.30%**	**$12.66**	**2.24%**	**$13.67**	**2.23%**	**$12.82**	**2.19%**	**$14.41**	**2.20%**	**$16.81**	**-0.07%**	**8.05%**	**0.00%**	**-6.23%**	**-0.04%**	**12.39%**	**0.01%**	**16.68%**	**2.15%**	**5494.10%**	**-3.23%**	**-58.41%**	**-3.24%**	**-59.16%**	**2.18%**	**4165.96%**
Profit & Risk Load	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	3.50%	$19.25	3.50%	$21.41	3.50%	$20.09	3.50%	$23.02	3.50%	$26.76	0.00%	11.20%	0.00%	-6.15%	0.00%	14.61%	0.00%	16.21%	3.50%	TBD	3.50%	TBD	3.50%	TBD	3.50%	TBD
Total Retention (excluding Exchange Fee)	**16.20%**	**$89.09**	**15.52%**	**$94.93**	**10.53%**	**$60.42**	**15.91%**	**$87.49**	**14.69%**	**$89.85**	**15.59%**	**$89.50**	**15.42%**	**$101.46**	**14.19%**	**$108.44**	**-1.22%**	**2.69%**	**0.90%**	**-0.39%**	**-0.17%**	**13.37%**	**-1.24%**	**6.88%**	**3.66%**	**79.48%**	**-0.29%**	**-1.79%**	**-0.83%**	**-5.36%**	**5.07%**	**48.13%**
Exchange User Fee *	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD
Total Retention (including Exchange Fee)	**16.20%**	**$89.09**	**15.52%**	**$94.93**	**10.53%**	**$60.42**	**15.91%**	**$87.49**	**14.69%**	**$89.85**	**15.59%**	**$89.50**	**15.42%**	**$101.46**	**14.19%**	**$108.44**	**-1.22%**	**2.69%**	**0.90%**	**-0.39%**	**-0.17%**	**13.37%**	**-1.24%**	**6.88%**	**3.66%**	**79.48%**	**-0.29%**	**-1.79%**	**-0.83%**	**-5.36%**	**5.07%**	**48.13%**
Projected Required Premium PMPM		$549.98		$611.60		$573.99		$549.98		$611.60		$573.99		$657.85		$764.49		11.20%		-6.15%		14.61%		16.21%		33.19%		0.00%		0.00%		0.00%

* Exchange User Fee on incurred claim basis (not on allowed claim basis like what is on URRT worksheet 1)

Comments

1. Actual investment income credit is assumed equal to projected investment income credit since actual investment income earned is not credited directly to a specific line of business.
2. Projected income tax is zero as this filing includes no explicit contribution to surplus, as indicated in Section 4.4.7(c) of the Actuarial Memorandum.
3. Quality Improvement expenses for the projected periods are embedded in Other Administrative Expenses

WA Exhibit 12: URRT Worksheet 2 (w2) Projections, Reconciliation

Carrier Name:	Asuris Northwest Health
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Description	PROJECTED (i.e., EXPECTED), 2026 % of Premium	PROJECTED (i.e., EXPECTED), 2026 PMPM
Aggregate Projected Administrative Costs		
3.6 Administrative Expense	8.49%	$64.87
3.7 Taxes and Fees	2.20%	$16.81
3.8 Profit & Risk Load	3.50%	$26.76
Total Retention (excluding Exchange Fee)	14.19%	$108.44
Aggregate Projected Amounts PMPM		
Exchange user fee		$0.00
4.15 Incurred Claims		$734.69
4.16 Risk Adjustment Transfer Amount		$78.64
4.17 Premium		$764.49
A. (Premium) + (Risk Adjustment Transfer Amount)		$843.13
B. (Incurred Claims) + (Admin, Taxes & Fees) + (Profit & Risk Load) + (Exchange User Fee)		$843.13
C. Difference = A - B (should be $0)		$0.00

Comments

Factor Summary

Age Factor Summary			
Age Band	Factor	Age Band	Factor
0-14	0.765	40	1.278
15	0.833	41	1.302
16	0.859	42	1.325
17	0.885	43	1.357
18	0.913	44	1.397
19	0.941	45	1.444
20	0.970	46	1.500
21	1.000	47	1.563
22	1.000	48	1.635
23	1.000	49	1.706
24	1.000	50	1.786
25	1.004	51	1.865
26	1.024	52	1.952
27	1.048	53	2.040
28	1.087	54	2.135
29	1.119	55	2.230
30	1.135	56	2.333
31	1.159	57	2.437
32	1.183	58	2.548
33	1.198	59	2.603
34	1.214	60	2.714
35	1.222	61	2.810
36	1.230	62	2.873
37	1.238	63	2.952
38	1.246	64 and older	3.000
39	1.262		

Area Factor Summary		
Rating Area	Service Area	Factor
1	N/A	N/A
2	N/A	N/A
3	N/A	N/A
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens	0.945
5	N/A	N/A
6	Benton, Franklin, Kittitas	1.000
7	Adams, Chelan, Douglas, Grant, Okanogan	1.082
8	N/A	N/A
9	Asotin, Columbia, Garfield, Walla Walla, Whitman	1.062
Only eligible portions of Rating Areas are listed under Service Area		

Tobacco Factor Summary		
Status	Description	Factor
Non-Tobacco	Does not use Tobacco	1.00
Tobacco	Uses Tobacco	1.00
Tobacco factors only apply to members aged 18 and over.		

Summary of Current and Prior Year Factors

Area Factor Changes

Rating Area	Service Area	2025 Factor	2026 Factor	% Change
1	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens	0.955	0.945	-1.0%
5	N/A	N/A	N/A	N/A
6	Benton, Franklin, Kittitas	1.000	1.000	0.0%
7	Adams, Chelan, Douglas, Grant, Okanogan	1.080	1.082	0.2%
8	N/A	N/A	N/A	N/A
9	Asotin, Columbia, Garfield, Walla Walla, Whitman	1.084	1.062	-2.0%

Tobacco Factor Changes

2025 Factor	2026 Factor	% Change
1.15	1.00	-13.0%

Plan Level Pricing AV and Base Rate Changes

HHS Plan ID	2025 Pricing AV	2026 Pricing AV	% Change	2025 Base Rate	2026 Base Rate	% Change
69364WA1220006	0.4890	0.6270	28.2%	$346.95	$403.21	16.2%
69364WA1220004	0.4740	0.6010	26.8%	$336.30	$386.49	14.9%
69364WA1220016	0.4920	0.6280	27.6%	$349.07	$403.85	15.7%
69364WA1220014	0.6940	0.8820	27.1%	$492.39	$567.20	15.2%
69364WA1220008	0.5580	0.7130	27.8%	$395.90	$458.52	15.8%

Plan Summary

2026 Pool Base Rate	$643.08

Network	Metal	Plan Name	HHS Plan ID	Benefits	Base Rates	Exchange Status	Available in Rating Areas
Individual Connect	Bronze	Bronze HSA 7750	69364WA1220006	BASE	$403.21	Outside the Exchange	4 6 7 9
Individual Connect	Bronze	Bronze Essential 9000	69364WA1220004	BASE	$386.49	Outside the Exchange	4 6 7 9
Individual Connect	Bronze	Bronze 8000	69364WA1220016	BASE	$403.85	Outside the Exchange	4 6 7 9
Individual Connect	Gold	Gold 2000	69364WA1220014	BASE	$567.20	Outside the Exchange	4 6 7 9
Individual Connect	Silver	Silver 5000	69364WA1220008	BASE	$458.52	Outside the Exchange	4 6 7 9

Asuris Northwest Health - Individual
ASURINH533OE
Supplementary Exhibits
Table of Contents

Asuris Northwest Health - Individual
ASURINH533OE
Rates Effective 1/1/2026
ANH Data Summary

	ANH Individual ACA		
Month	**Membership**	**Earned Premium**	**Incurred Claims**
12/2024	924	$516,411	$751,884
11/2024	957	$534,765	$1,249,928
10/2024	959	$535,412	$598,658
9/2024	962	$537,726	$533,549
8/2024	974	$547,585	$736,961
7/2024	981	$550,921	$846,434
6/2024	980	$551,557	$612,816
5/2024	994	$558,259	$554,328
4/2024	987	$556,463	$1,112,035
3/2024	994	$560,610	$449,875
2/2024	1,005	$568,892	$798,603
1/2024	999	$570,466	$433,265
Total	**11,716**	**$6,589,067**	**$8,678,338**

- Incurred Claims reflect March 2025 UCL and do not reflect pharmacy rebates

Asuris Northwest Health - Individual
ASURINH533OE
Rates Effective 1/1/2026
Medical and Rx Paid Claims Triangle

Medical

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	27,929	0	0	0	0	0	0	0	0	0	0	0
202402	127,061	36,292	0	0	0	0	0	0	0	0	0	0
202403	168,900	179,594	73,188	0	0	0	0	0	0	0	0	0
202404	774	8,261	149,877	94,480	0	0	0	0	0	0	0	0
202405	4,942	11,860	93,142	336,913	125,538	0	0	0	0	0	0	0
202406	210	307,415	11,591	107,627	225,111	106,960	0	0	0	0	0	0
202407	12,290	3,857	1,670	375,443	26,471	152,295	79,766	0	0	0	0	0
202408	2,107	7,679	2,382	8,262	14,510	181,819	235,422	107,533	0	0	0	0
202409	516	780	17,527	452	25,166	8,391	29,412	281,419	64,250	0	0	0
202410	457	140,159	39	18,053	4,357	16,091	47,156	155,731	185,418	54,211	0	0
202411	0	0	0	10	8,471	5,179	95,065	4,986	96,201	283,619	79,661	0
202412	0	26	-11,045	491	486	-3,913	3,469	8,981	12,616	87,866	219,801	92,952
202501	0	37,595	-12,258	0	112	460	1,221	180	0	360	171,843	297,520
202502	400	1,815	747	0	6,356	1,519	172,903	990	276	10,358	58,985	103,513
202503	0	2,562	4,411	91	336	290	803	1,476	142	732	502,335	6,721

Rx

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	90,219	0	0	0	0	0	0	0	0	0	0	0
202402	-11,008	61,013	0	0	0	0	0	0	0	0	0	0
202403	0	-380	140,691	0	0	0	0	0	0	0	0	0
202404	0	0	-21,987	156,215	0	0	0	0	0	0	0	0
202405	0	0	0	10,425	140,429	0	0	0	0	0	0	0
202406	0	0	0	0	-24,845	157,276	0	0	0	0	0	0
202407	0	0	0	0	0	-14,890	179,707	0	0	0	0	0
202408	0	0	0	0	0	0	-1,924	178,608	0	0	0	0
202409	0	0	0	0	0	0	0	-6,447	158,390	0	0	0
202410	0	0	0	0	0	0	0	0	13,617	171,898	0	0
202411	5,260	0	0	0	0	0	0	0	0	-17,744	205,270	0
202412	2,654	0	0	0	0	0	0	0	0	0	-11,194	226,233
202501	0	0	0	0	0	0	0	0	0	-255	12	-11,693
202502	0	0	0	0	0	0	0	0	0	0	0	0
202503	0	0	0	0	0	0	0	0	0	0	0	0

- Incurred Claims have not been adjusted for unpaid claims estimates or pharmacy rebates

Asuris Northwest Health - Individual
ASURINH533OE
Rates Effective 1/1/2026
Medical and Rx Allowed Claims Triangle

Medical

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	67,351	0	0	0	0	0	0	0	0	0	0	0
202402	255,420	77,158	0	0	0	0	0	0	0	0	0	0
202403	202,876	336,380	149,644	0	0	0	0	0	0	0	0	0
202404	2,440	17,772	240,369	139,434	0	0	0	0	0	0	0	0
202405	3,088	13,179	112,121	441,077	185,036	0	0	0	0	0	0	0
202406	1,880	313,966	15,947	121,495	314,887	157,171	0	0	0	0	0	0
202407	22,541	1,762	2,772	402,845	29,967	206,041	97,022	0	0	0	0	0
202408	2,574	7,698	2,535	10,564	16,086	187,577	288,400	146,905	0	0	0	0
202409	786	897	17,542	470	26,690	14,228	35,502	335,144	86,843	0	0	0
202410	448	140,853	192	20,562	4,663	12,231	70,885	158,070	233,931	87,885	0	0
202411	0	0	-66,355	-582	12,663	6,494	96,121	5,474	106,947	377,651	110,848	0
202412	0	119	52,484	1,150	875	2,033	3,460	10,881	10,793	90,696	288,853	111,904
202501	0	37,655	1,098	0	112	635	1,221	408	0	57,197	185,087	462,183
202502	475	1,875	845	0	6,832	1,529	172,618	990	504	19,835	70,220	24,537
202503	-468	2,796	4,471	216	-5,101	-36	804	1,616	60	-757	512,534	10,224

Rx

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	237,105	0	0	0	0	0	0	0	0	0	0	0
202402	-24,764	123,472	0	0	0	0	0	0	0	0	0	0
202403	0	-1,673	219,906	0	0	0	0	0	0	0	0	0
202404	0	0	-24,889	202,625	0	0	0	0	0	0	0	0
202405	0	0	-6,259	1,721	185,107	0	0	0	0	0	0	0
202406	0	0	0	-355	-26,551	209,961	0	0	0	0	0	0
202407	0	0	0	0	0	-18,828	228,434	0	0	0	0	0
202408	0	0	0	0	0	-18	-2,707	208,123	0	0	0	0
202409	0	0	0	0	0	0	0	-6,557	179,930	0	0	0
202410	0	0	0	0	0	0	0	-11	13,446	194,905	0	0
202411	0	0	0	0	0	0	0	0	0	-18,917	226,848	0
202412	0	0	-3	0	0	0	0	0	0	0	-12,235	248,040
202501	0	0	0	0	0	0	0	0	0	-1,844	18	-15,896
202502	0	0	0	0	0	0	0	0	0	0	0	0
202503	0	0	0	0	0	0	0	0	0	0	0	0

- Incurred Claims have not been adjusted for unpaid claims estimates or pharmacy rebates

Asuris Northwest Health - Individual
ASURINH533OE
Rates Effective 1/1/2026
Months of Surplus

Asuris Northwest Health	1/1/2026
Statutory Surplus*	$102,359,740
Statutory Claims Exp**	$143,047,548
Monthly Claims Exp	$11,920,629
Months of Surplus	8.59

Note: A contribution to surplus of 0.0% is proposed in this filing.
*Source: Annual Statement, Page 3, Column 3, Line 33
**Source: Annual Statement, Page 4, Column 2, Line 18

Checklist Item 25 b: Prescribed projection for 2026 Months of Surplus

Trend	10.40%
Risk and Contigency	3.50%
Loss Ratio	85.82%
Projected 2025 Claims	$157,924,493
Projected 2026 Claims	$174,348,640
Projected 2026 Monthly Claims	$14,529,053
Projected Change to Surplus	$13,551,896
Projected 2026 Surplus	$115,911,636
Projected 2026 Months of Surplus	7.98

- Projected Claims is the Statutory Claims Exp trended using the rate filing assumption of 10.4% annual trend.
- Projected Change to Surplus assumes 3.5% will be retained in 2024 and 2025 after applying the 85.8% loss ratio from the rate filing.

Asuris Northwest Health - Individual
ASURINH533OE
Rates Effective 1/1/2026
Financial Statements

This page left intentionally blank.
Balance Sheet from Annual Statement on next four pages.
Additional Data Statement Information on the following four pages.

ASSETS

		Current Year			Prior Year
		1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1.	Bonds (Schedule D)	112,038,727		112,038,727	111,652,532
2.	Stocks (Schedule D):				
	2.1 Preferred stocks			0	0
	2.2 Common stocks	357,103		357,103	348,592
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens			0	0
	3.2 Other than first liens			0	0
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
	4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
	4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5.	Cash ($ 3,749,606 , Schedule E - Part 1), cash equivalents ($ 1,044,622 , Schedule E - Part 2) and short-term investments ($ 0 , Schedule DA)	4,794,228		4,794,228	8,573,177
6.	Contract loans, (including $ ..... premium notes)			0	0
7.	Derivatives (Schedule DB)			0	0
8.	Other invested assets (Schedule BA)			0	0
9.	Receivables for securities			0	0
10.	Securities lending reinvested collateral assets (Schedule DL)			0	0
11.	Aggregate write-ins for invested assets	0	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	117,190,058	0	117,190,058	120,574,300
13.	Title plants less $ ..... charged off (for Title insurers only)			0	0
14.	Investment income due and accrued	618,418		618,418	593,130
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	710,286	143,572	566,714	564,286
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	0
	15.3 Accrued retrospective premiums ($ 712,544) and contracts subject to redetermination ($ 1,795,315)	2,507,859		2,507,859	4,619,318
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers	1,675		1,675	68,351
	16.2 Funds held by or deposited with reinsured companies			0	59,724
	16.3 Other amounts receivable under reinsurance contracts			0	0
17.	Amounts receivable relating to uninsured plans	6,338,626	241,981	6,096,645	10,655,049
18.1	Current federal and foreign income tax recoverable and interest thereon	102,150		102,150	476,805
18.2	Net deferred tax asset	559,181	4,567	554,614	855,024
19.	Guaranty funds receivable or on deposit			0	0
20.	Electronic data processing equipment and software			0	0
21.	Furniture and equipment, including health care delivery assets ($ .....)			0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23.	Receivables from parent, subsidiaries and affiliates	3,605,894		3,605,894	820,744
24.	Health care ($ 4,035,975) and other amounts receivable	5,330,118	1,294,143	4,035,975	3,606,655
25.	Aggregate write-ins for other-than-invested assets	137,704	77,461	60,243	129,765
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	137,101,969	1,761,724	135,340,245	143,023,151
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28.	Total (Lines 26 and 27)	137,101,969	1,761,724	135,340,245	143,023,151
	DETAILS OF WRITE-INS				
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199.	Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501.	Physician Deferred Compensation	42,998		42,998	45,260
2502.	Prepaid Assets	77,461	77,461	0	0
2503.	State Taxes Recoverable	17,245		17,245	84,505
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	137,704	77,461	60,243	129,765

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1	2	3	4
		Covered	Uncovered	Total	Total
1.	Claims unpaid (less $ 189,312 reinsurance ceded)	20,202,832	72,126	20,274,958	23,782,360
2.	Accrued medical incentive pool and bonus amounts	152,920		152,920	121,330
3.	Unpaid claims adjustment expenses	454,159		454,159	581,606
4.	Aggregate health policy reserves, including the liability of $ 2,300,000 for medical loss ratio rebate per the Public Health Service Act	4,029,958		4,029,958	5,783,203
5.	Aggregate life policy reserves			0	0
6.	Property/casualty unearned premium reserves			0	0
7.	Aggregate health claim reserves			0	0
8.	Premiums received in advance	3,027,459		3,027,459	3,251,853
9.	General expenses due or accrued	754,977		754,977	1,377,320
10.1	Current federal and foreign income tax payable and interest thereon (including $ on realized capital gains (losses))			0	0
10.2	Net deferred tax liability			0	0
11.	Ceded reinsurance premiums payable	167,590		167,590	129,493
12.	Amounts withheld or retained for the account of others	42,998		42,998	45,260
13.	Remittances and items not allocated	94,853		94,853	50,064
14.	Borrowed money (including $ current) and interest thereon $ (including $ current)			0	0
15.	Amounts due to parent, subsidiaries and affiliates	2,200,183		2,200,183	3,407,108
16.	Derivatives			0	0
17.	Payable for securities			0	0
18.	Payable for securities lending			0	0
19.	Funds held under reinsurance treaties (with $ authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)			0	0
20.	Reinsurance in unauthorized and certified ($) companies			0	0
21.	Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22.	Liability for amounts held under uninsured plans	1,621,458		1,621,458	2,146,431
23.	Aggregate write-ins for other liabilities (including $ 158,992 current)	158,992	0	158,992	161,073
24.	Total liabilities (Lines 1 to 23)	32,908,379	72,126	32,980,505	40,837,101
25.	Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26.	Common capital stock	XXX	XXX		
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	56,879,723	56,879,723
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other-than-special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	45,480,017	45,306,327
32.	Less treasury stock, at cost:				
	32.1 shares common (value included in Line 26 $)	XXX	XXX		
	32.2 shares preferred (value included in Line 27 $)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	102,359,740	102,186,050
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	135,340,245	143,023,151
	DETAILS OF WRITE-INS				
2301.	Unclaimed Property	158,992		158,992	161,073
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399.	Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	158,992	0	158,992	161,073
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	0	0
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year		Prior Year
		1 Uncovered	2 Total	3 Total
1.	Member Months	XXX	478,013	518,525
2.	Net premium income (including $ non-health premium income)	XXX	164,609,501	159,961,141
3.	Change in unearned premium reserves and reserve for rate credits	XXX	716,316	661,186
4.	Fee-for-service (net of $ medical expenses)	XXX	0	0
5.	Risk revenue	XXX	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	165,325,817	160,622,327
	Hospital and Medical:			
9.	Hospital/medical benefits	275,511	72,989,794	71,637,057
10.	Other professional services	31,914	8,454,792	8,765,400
11.	Outside referrals	2,604	689,756	1,128,847
12.	Emergency room and out-of-area	145,239	38,477,483	38,172,415
13.	Prescription drugs	95,768	25,371,384	21,753,412
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		324,069	175,311
16.	Subtotal (Lines 9 to 15)	551,036	146,307,278	141,632,442
	Less:			
17.	Net reinsurance recoveries		3,259,730	2,652,746
18.	Total hospital and medical (Lines 16 minus 17)	551,036	143,047,548	138,979,696
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $ 3,285,234 cost containment expenses		6,716,276	7,299,015
21.	General administrative expenses		18,767,647	19,805,050
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)		(700,000)	(700,000)
23.	Total underwriting deductions (Lines 18 through 22)	551,036	167,831,471	165,383,761
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(2,505,654)	(4,761,434)
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		4,308,129	3,567,217
26.	Net realized capital gains (losses) less capital gains tax of $ (324,405)		(1,220,381)	(677,725)
27.	Net investment gains (losses) (Lines 25 plus 26)	0	3,087,748	2,889,492
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $ 5,578)]		(5,578)	(14,141)
29.	Aggregate write-ins for other income or expenses	0	(9,887)	47,778
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	566,629	(1,838,305)
31.	Federal and foreign income taxes incurred	XXX	86,297	(353,443)
32.	Net income (loss) (Lines 30 minus 31)	XXX	480,332	(1,484,862)
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.		XXX		
0702.		XXX		
0703		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0
2901.	Other Expense		(10,100)	
2902.	Other Income		213	47,778
2903				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(9,887)	47,778

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	102,186,050	104,186,331
34.	Net income or (loss) from Line 32	480,332	(1,484,862)
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $	7,081	10,592
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	(300,981)	(16,377)
39.	Change in nonadmitted assets	(12,742)	(509,634)
40	Change in unauthorized and certified reinsurance	0	0
41.	Change in treasury stock	0	0
42.	Change in surplus notes	0	0
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in	0	0
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders		
47.	Aggregate write-ins for gains or (losses) in surplus	0	0
48.	Net change in capital and surplus (Lines 34 to 47)	173,690	(2,000,281)
49.	Capital and surplus end of reporting period (Line 33 plus 48)	102,359,740	102,186,050
	DETAILS OF WRITE-INS		
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0

Additional Data Statement Form for the Year Ending December 31, 2024

Company: Asuris Northwest Health NAIC Company Code: 47350

I. Analysis of Washington Operations by Lines of Business

See annual statement	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Total	Comprehensive (Medical & Hospital) Individual	Comprehensive (Medical & Hospital) Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVII Medicare	Title XIX Medicaid	Credit A&H	Disability Income	Long-term Care	Other Health	Other Non-Health
1. Net Premium Income	164,609,501	8,296,760	102,422,468	33,770,794	371,627	0		14,930,648					4,817,204	
7. Total Revenues (Lines 1 to 6)	165,325,817	8,296,760	103,138,784	33,770,794	371,627	0		14,930,648					4,817,204	
15. Subtotal (Lines 8 to 14)	143,899,938	8,183,794	86,138,936	28,414,025	253,605	391,453		16,593,547					3,924,578	XXX
16. Net Reinsurance Recoveries	852,389	37,760	129,961	0	0	391,453		293,215						XXX
17. Total hospital and medical (Lines 15 minus 16)	143,047,549	8,146,034	86,008,975	28,414,025	253,605	0	0	16,300,332	0	0	0	0	3,924,578	XXX
19. Claims adjustment expenses	6,716,272	233,728	3,236,356	1,357,691	11,907	15,963		1,131,962					728,665	
20. General administrative expenses	18,767,647	603,547	10,851,070	6,525,853	33,273	9,017		1,113,122					(368,235)	
21. Increase in reserves for accident and health contracts	(700,000)			0	0			(700,000)						XXX
23. Total underwriting deductions (Lines 17 to 22)	167,831,468	8,983,309	100,096,401	36,297,569	298,785	24,980	0	17,845,416	0	0	0	0	4,285,008	
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	(2,505,651)	(686,549)	3,042,383	(2,526,775)	72,842	(24,980)	0	(2,914,768)	0	0	0	0	532,196	0

Additional Data Statement Form for the Year Ending December 31, 2024

Company: Asuris Northwest Health NAIC Company Code: 47350

II. Analysis of the Washington Comprehensive Line

	1 Total Comprehensive (Hospital & Medical)	2a Individual Contracts	2b Children's Health Insurance Program	3 Small Group Contracts	Large Group Contracts 4a Public Employees Benefits Board	4b School Employees Benefits Board	4c Pathway 1 Association Health Plans	4d Large Group (what is not in columns 4a, 4b or 4c)	5 Other
1. Net Premium Income	110,719,228	8,296,760		39,118,105			16,687,205	46,617,158	
7. Total Revenues (Lines 1 to 6)	111,435,544	8,296,760		39,118,105			16,950,808	47,069,871	
15. Subtotal (Lines 8 to 14)	94,322,730	8,183,794		31,360,709			13,089,766	41,688,461	
16. Net Reinsurance Recoveries	167,721	37,760		129,961					
17. Total hospital and medical (Lines 15 minus 16)	94,155,009	8,146,034	0	31,230,748	0	0	13,089,766	41,688,461	0
19. Claims adjustment expenses	3,470,084	233,728		1,242,933			476,346	1,517,077	
20. General administrative expenses	11,454,617	603,547		4,025,160			1,631,115	5,194,795	
21. Increase in reserves for accident and health contracts	0	0		0			0	0	
23. Total underwriting deductions (Lines 17 to 22)	109,079,710	8,983,309	0	36,498,841	0	0	15,197,227	48,400,333	0
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	2,355,834	(686,549)	0	2,619,264	0	0	1,753,581	(1,330,462)	0

	6 List the full legal name of each Pathway 1 Association Health Plan included in column 4c
1	Building Industry Association of Washington
2	ALLTech Information Technology Group
3	Washington Commercial Construction Health Trust
4	Washington Manufacturing Health Trust
5	Washington Business Services Health Trust
6	Washington Retail Health Trust
7	Center for Advanced Manufacturing Puget Sound
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	

Additional Data Statement Form for the Year Ending December 31, 2024

Company: Asuris Northwest Health NAIC Company Code: 47350

III. Group Enrollment in Washington

Total Members at end of:	1 Total Comprehensive (Hospital & Medical)	2a Individual Contracts	2b Children's Health Insurance Program	3 Small Group Contracts	Large Group Contracts 4a Public Employees Benefits Board	4b School Employees Benefits Board	4c Pathway 1 Association Health Plans	4d Large Group (what is not in columns 4a, 4b or 4c)	5 Other
1. Prior Year	17,224	959		6,038			3,651	6,576	
2. First Quarter	17,147	1,002		5,675			3,384	7,086	
3. Second Quarter	17,373	988		5,636			3,530	7,219	
4. Third Quarter	17,418	976		5,738			3,538	7,166	
5. Current Year	17,597	941		5,876			3,718	7,062	

	6 List the full legal name of each Pathway 1 Association Health Plan included in column 4c (continued)
26	
27	
28	
29	
30	
31	
32	
33	
34	
35	
36	
37	
38	
39	
40	
41	
42	
43	
44	
45	
46	
47	
48	
49	
50	

Additional Data Statement Form for the Year Ending December 31, 2024

Company: Asuris Northwest Health NAIC Company Code: 47350

IV. Deposit or Funded Reserve or Underwriting of Indemnity Calculation

Mark the type of certificate the company holds and then fill in the data.

☐ Multiple Employer Welfare Organization (MEWA)

☐ Maintain a $200,000 restricted deposit held under a Depositary Agreement with the Commissioner.

☐ Health Maintenance Organization (HMO)

$150,000 Funded Reserve is maintained by:
☐ Cash or securities deposit
☐ Surety Bond
☐ Combination of the two

☑ Health Care Service Contractor (HCSC) **Complete both calculations**

Calculation of Deposit Requirements (WAC 284-44-320 and 284-44-330)

$165,436,410	A1. Premiums Collected
8.3%	A2. One-twelfth
$13,731,222	A3. Calculated Requirement (line A1 x line A2)
$150,000	A4. Minimum Indemnity
$13,731,222	A5. Indemnity Required (greater of line A3 or line A4)

Calculation of Indemnity Required (WAC 284-44-340)

	1 Incurred but Unpaid	2 Service Benefits	3 Non-Service (Indemnity)
B1. Line of Business Subtotal	$20,274,957	$20,202,831	$72,126
B2. Percentage of Claim Reserve and Claim Liability	100%	100%	0%
B3. Estimated Increase (Decrease) During Ensuing Year			($9,743)
B4. Adjusted Claim Reserve and Claim Liability (line B1 + line B3)			$62,383
B5. Policy Reserves	$4,029,958		$14,336
B6. Premiums Received in Advance	$3,027,696		$10,771
B7. Total Unearned Prepayments (line B5 + line B6)			$25,107
B8. Calculated Alternate Indemnity Requirement (line B4 + line B7)			$87,490
B9. Minimum Indemnity			$150,000
B10. Indemnity Required (greater of line B8 or line B9)			$150,000
B11. Total of Deposit Market Value, Surety Bond and Insurance Policy at December 31.			$177,484
B12. (Negative) means an Increase is Required; Positive means an Excess			$27,484

Indemnity is maintained by:
☑ Cash or securities deposit
☐ Surety Bond
☐ Insurance policy

☐ Limited Health Care Service Contractor (LHCSC)

☐ LHCSC certificate held three or MORE years

	C1. Uncovered Expenditures
	C2. Anticipated increase or (decrease) in the line above
$0	C3. Total (line C1 + line C2)
25%	C4. Twenty-five percent
$0	C5. Line C3 x line C4
	C6. Policy Reserves
	C7. Premiums Received in Advance
$0	C8. Indemnity Required (line C5 + line C6 + line C7)
	C9. Total of Deposit Market Value, Surety Bond and Insurance Policy at December 31
$0	C10. (Negative) means an Increase is Required; Positive means an Excess

Indemnity is maintained by:
☐ Cash or securities deposit
☐ Surety Bond
☐ Insurance policy

☐ LHCSC certificate held for LESS than three years

	D1. Projected net premiums earned for the next year
0.5%	D2. One-half of one percent
$0	D3. Indemnity Required (line D1 x D2)

D4. _____ insures or guarantees the LHCSC's Uncovered Expenditures and that insurer/guarantor's NAIC company code is _____

Question 1:

Part 1: Please provide issuer's name, market, and plan year information.
Part 2: Please provide a table with the following information:

1. In the first column, list all 2025 HIOS Plan IDs and all 2026 HIOS Plan IDs (one HIOS Plan ID per row; insert rows in the table as needed);
2. In the second column, state the 2025 plan name associated with the HIOS Plan ID (if the plan is new in 2026, state "N/A");
3. In the third column, state the 2026 plan name associated with the HIOS Plan ID (if the plan terminated in 2026, state "N/A");
4. In the fourth column, state if the plan is New (a new plan in 2026), Renewal (an existing plan from 2025), or Terminated (a 2025 plan that is not offered in 2026); and
5. In the fifth column provide the enrollment as of March 31, 2025.

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then complete the table as described above.

Response:

Part 1

Issuer Name:	Asuris Northwest Health
HIOS Issuer ID:	69364
Market:	Individual
Plan Year:	2026

Part 2

2025 HIOS Plan ID and 2026 HIOS Plan ID	2025 Plan Name	2026 Plan Name	New, Renewal, or Terminated in 2026?	Enrollment as of 3/31/2025
69364WA1220004	Bronze Essential 8700	Bronze Essential 9000	Renewal	235
69364WA1220006	Bronze HSA 7250	Bronze HSA 7750	Renewal	305
69364WA1220008	Silver 5000	Silver 5000	Renewal	263
69364WA1220014	Gold 2000	Gold 2000	Renewal	158
69364WA1220016	Bronze 8000	Bronze 8000	Renewal	3
Total				**964**

Question 2:

For each plan with a 2025 HIOS Plan ID that is included in the 2026 rate filing, justify and explain in detail that it is a renewal plan within a renewal product and meets all of the criteria listed in 45 CFR §147.106(e)(3).

Response:

All plans with a 2025 Plan ID included in the 2026 rate filing are considered renewal plans because:
i. They are offered by the same health insurance issuer.
ii. They are offered as the same product network type.
iii. Each product continues to cover at least a majority of the same service area.
iv. Each product has the same cost-sharing structure as before, except for changes related to cost and utilization of medical care or to maintain the same metal tier level. See Question 4a for detailed changes.
v. Each product covers essentially the same covered benefits, with cumulative benefit changes not exceeding +/- 2 percentage points.

2025 HIOS Plan ID	2026 Plan Name
69364WA1220004	Bronze Essential 9000
69364WA1220006	Bronze HSA 7750
69364WA1220008	Silver 5000
69364WA1220014	Gold 2000
69364WA1220016	Bronze 8000

Question 3:

For each 2026 plan with a new HIOS Plan ID (aka a new plan in 2026), explain in detail (in the table below) why the plan is not considered a renewal plan within a renewal product.

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then, complete the table as described above.

Response:

2025 HIOS Plan ID	Plan Name	Why is this a new plan?

Question 4a:

For each renewal plan (i.e., a plan offered in both 2025 and 2026), please provide the following:
1. State the HIOS Plan ID of the affected plan. State the applicable HIOS Plan ID on every row in the table as illustrated below.
2. State the 2025 Plan Name. State the plan name only once per plan as shown below.
3. State the 2026 Plan Name if the 2026 Plan Name is different than the 2025 Plan Name. Otherwise state "N/A-Same as 2025." State the plan name only once as shown below.
4. State the SERFF Tracking Number of the corresponding 2026 form filing (state only once per plan as illustrated below).
5. Provide a detailed description of each benefit change from 2025 to 2026, including changes required by Federal and State law (while the cursor is active in a cell in Excel, press [Alt+Enter] to start a new line of text). If no benefit changes, enter "None." State all the benefit changes in a single cell as shown below.

6. Cost-Share Changes: Provide a detailed description of each cost-share change from 2025 to 2026.
   - 6.1 For each cost-share change, enter one description of the change per row in the Cost-Share Description column as illustrated below. If no cost-share changes, enter "None" and go to your next plan.
   - 6.2 Enter the corresponding design for the 2025 plan year. Please include all applicable dollar signs ($), commas (,) and percent signs (%) for each value.
   - 6.3 Enter the corresponding design for the 2026 plan year. Please include all applicable dollar signs ($), commas (,) and percent signs (%) for each value.

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then, complete the table as described above.

Response:

					Cost-Share Changes		
HIOS Plan ID	**2025 Plan Name**	**2026 Plan Name (if different)**	**2026 Form Filing SERFF Tracking Number**	**Benefit Changes (2025 to 2026)**	**Cost-Share Description**	**From (2025)**	**To (2026)**
69364WA1220004	Bronze Essential 8700	Bronze Essential 9000	RGWA-134490715	None	In-Network Deductible	$8,700	$9,000
69364WA1220004					In-Network Out-of-Pocket Maximum	$9,200	$10,150
69364WA1220004					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
69364WA1220004					Artificial Insemination	Not Covered	Deductible and Coinsurance
69364WA1220004					Rx Tier 1 Retail	$20	$15
69364WA1220004					Rx Tier 1 Home Delivery	$60	$45
69364WA1220006	Bronze HSA 7250	Bronze HSA 7750	RGWA-134490715	None	In-Network Deductible	$7,250	$7,750
69364WA1220006					In-Network Out-of-Pocket Maximum	$8,050	$8,300
69364WA1220006					Hearing Instruments	Not Covered	Coinsurance Applies after the defined IRS Minimum Required Deductible amount is met
69364WA1220006					Artificial Insemination	Not Covered	Deductible and Coinsurance
69364WA1220008	Silver 5000	N/A - Same as 2025	RGWA-134490715	None	In-Network Out-of-Pocket Maximum	$9,200	$10,150
69364WA1220008					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
69364WA1220008					Artificial Insemination	Not Covered	Deductible and Coinsurance
69364WA1220008					Specialist Office Visit	$60	$70
69364WA1220008					Urgent Care Facility Office Visit	$60	$70
69364WA1220008					Rx Tier 1 Retail	$12	$15
69364WA1220008					Rx Tier 1 Home Delivery	$36	$45
69364WA1220014	Gold 2000	N/A - Same as 2025	RGWA-134490715	None	In-Network Out-of-Pocket Maximum	$9,200	$10,150
69364WA1220014					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
69364WA1220014					Artificial Insemination	Not Covered	Deductible and Coinsurance
69364WA1220016	Bronze 8000	N/A - Same as 2025	RGWA-134490715	None	In-Network Out-of-Pocket Maximum	$9,200	$10,150
69364WA1220016					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
69364WA1220016					Artificial Insemination	Not Covered	Deductible and Coinsurance
69364WA1220016					Specialist Office Visit	$100	$120
69364WA1220016					Urgent Care Facility Office Visit	$100	$120

Question 4b:

For each terminated plan (i.e., a plan offered in 2025 but not in 2026), please provide the following:

1. State the HIOS Plan ID of the terminated plan in 2025. State the applicable HIOS Plan ID on every row in the table as illustrated below.
2. State the 2025 Plan Name of the terminated plan. State the plan name only once per plan as shown below.
3. State the 2026 HIOS Plan ID of the plan that the terminated plan is mapped to in 2026. State the applicable HIOS Plan ID on every row in the table as illustrated below.
4. State the 2026 Plan Name of the plan that the terminated plan is mapped to in 2026. State the plan name only once per plan as shown below.
5. State the SERFF Tracking Number of the corresponding 2026 form filing (state only once per plan as illustrated below).
6. Provide a detailed description of each benefit change from the terminated plan to the mapped 2026 plan, including changes required by Federal and State law (while the cursor is active in a cell in Excel, press [Alt+Enter] to start a new line of text). If no benefit changes, enter "None."
7. Cost-Share Changes: Provide a detailed description of each cost-share change from terminated plan to the mapped 2026 plan.
   - 7.1 For each cost-share change, enter one description of the change per row in the Cost-Share Description column as illustrated below. If no cost-share changes, enter "None" and go to your next plan.
   - 7.2 Enter the corresponding design for the 2025 plan year. Please include all applicable dollar signs ($), commas (,) and percent signs (%) for each value.
   - 7.3 Enter the corresponding design for the 2026 plan year. Please include all applicable dollar signs ($), commas (,) and percent signs (%) for each value.

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then, complete the table as described above.

Response:

						Cost-Share Changes		
2025 Terminated HIOS Plan ID	**2025 Terminated Plan Plan Name**	**2026 Mapped Plan HIOS Plan ID**	**2026 Mapped Plan Plan Name**	**2026 Mapped Plan Form Filing SERFF Tracking Number**	**Benefit Changes (2025 Terminated to 2026 Mapped Plan)**	**Cost-Share Description**	**From (2025)**	**To (2026)**

Question 5:

Using the following table, provide the calculations of the proposed average rate change for this line of business and break out the average rate change by benefit, cost-share, and experience. For the 2025 plans that will discontinue in 2026, please apply appropriate mapping of membership for purposes of calculating the average rate increase.

1. In column 5(a), list all 2025 Plan IDs (one 2025 Plan ID per row; insert rows in the table as needed).
2. In column 5(b), list the corresponding 2025 Plan Names.
3. In column 5(c), state whether the 2025 plan is a "Renewal" plan (a plan offered in 2025 and 2026) or "Terminated" plan (a plan offered in 2025 but not 2026).
4. In column 5(d), provide the enrollment by plan as of March 31, 2025 in all renewing counties. Note: the total enrollment should match the enrollment provided in Question #1, unless the carrier is exiting counties in 2026 which are currently being covered.
5. In column 5(e), if the plan is a "Terminated" plan, provide the corresponding 2026 Plan ID that the 2025 Plan is mapped to. If the plan is a "Renewal" plan, state "N/A."
6. In column 5(f), if the plan is a "Terminated" plan, provide the corresponding 2026 Plan Name that the 2025 Plan is mapped to. If the plan is a "Renewal" plan, state "N/A."
7. In column 5(g), state the experience rate change for the plan. For "Terminated" plans, state the experience rate change by plan mapped from the 2025 Plan to the 2026 Plan.
8. In column 5(h), state the benefit rate change for the plan. For "Terminated" plans, base the rate change on mapping from the 2025 plan to the 2026 plan.
9. In column 5(i), state the cost-share rate change for the plan. For "Terminated" plans, base the rate change on mapping from the 2025 plan to the 2026 plan.
10. In column 5(j), the Overall Average Rate Change by plan is calculated automatically [calculated as (1+Experience Rate Change)*(1+Benefit Rate Change)*(1+Cost-Share Rate Change)-1]. Note that the percentage of overall average rate change by plan for renewal plans should be the same as the rate change indicated in the URRT.
11. In cell 5(k), the total enrollment as of March 31, 2025 is calculated automatically [calculated as the sum of column 5(d)].
12. In cell 5(l), the overall average rate change (weighted by March 2025 enrollment) for this line of business is calculated automatically [calculated as the sum-product of columns 5(d) and 5(j), divided by 5(k)].

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then, complete the table as described above.

Response:

Total Enrollment 5(k):	964
Overall Average Rate Change (weighted by 03/31/2025 enrollment) 5(l):	15.15%

COLUMN: 5(a)	5(b)	5(c)	5(d)	5(e)	5(f)	5(g)	5(h)	5(i)	5(j)
2025 HIOS Plan ID	2025 Plan Name	Renewal or Terminated in 2026?	Enrollment as of 03/31/2025	Terminated Plans: HIOS Plan ID of plan mapped to in 2026	Terminated Plans: Plan Name corresponding to HIOS Plan ID in column 5(e)	Experience Rate Change for Plan	Benefit Rate Change for Plan	Cost-Share Rate Change for Plan	Overall Average Rate Change for Plan
69364WA1220004	Bronze Essential 8700	Renewal	235	N/A	N/A	17.48%	0.00%	-2.55%	14.48%
69364WA1220006	Bronze HSA 7250	Renewal	305	N/A	N/A	17.86%	0.00%	-1.69%	15.87%
69364WA1220008	Silver 5000	Renewal	263	N/A	N/A	16.11%	0.00%	-0.83%	15.15%
69364WA1220014	Gold 2000	Renewal	158	N/A	N/A	15.29%	0.00%	-0.46%	14.76%
69364WA1220016	Bronze 8000	Renewal	3	N/A	N/A	17.16%	0.00%	-1.88%	14.96%

Benefit Components

Worksheet Controls

Company: Asuris Northwest Health | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	69364WA1220004	Line 1.3	**Metal Level**	Expanded Bronze	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Bronze Essential 9000	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	4
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	Yes
Line 2.13	**Includes Non-EHBs?**	Yes

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Connect
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Connect

	Medical	Drug	Combined	Errors/Warnings
Deductible			$9,000	
Default Coinsurance			10%	
MOOP			$10,150	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services	No	Yes				10%	After Deductible		Note 1	
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes				10%	After Deductible			
Primary Care Visit to Treat an Injury or Illness	Yes	Yes	$ 60	Before Deductible		10%	After Deductible		Note 2	
Specialist Visit	Yes	Yes	$ 60	Before Deductible		10%	After Deductible		Note 2	
Mental Health & Substance Use Disorder Office Visits	No	Yes				10%	After Deductible			
Mental Health & Substance Use Disorder All Other OP Services	No	Yes				10%	After Deductible			
Imaging (CT/PET Scans, MRIs)	No	Yes				10%	After Deductible			
Rehabilitative Speech Therapy	No	Yes				10%	After Deductible		Note 10	
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	Yes				10%	After Deductible		Note 10	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	Yes				10%	After Deductible			
X-rays and Diagnostic Imaging	No	Yes				10%	After Deductible			
Skilled Nursing Facility	No	Yes				10%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes				10%	After Deductible			
Outpatient Surgery Physician/Surgical Services	No	Yes				10%	After Deductible			
Urgent Care	Yes	Yes	$ 60	Before Deductible		10%	After Deductible		Note 3	
Emergency Transportation	No	Yes				10%	After Deductible		Note 1	
Other EHB Categories										
Infertility Treatment	No	Yes				10%	After Deductible			
Cosmetic Surgery	No	Yes				10%	After Deductible		Note 4	
Acupuncture	No	Yes				10%	After Deductible			
Chiropractic Care	No	Yes				10%	After Deductible			
Hearing Aids		No				10%	Before and After Deductible	No		
Routine Foot Care	No	Yes				10%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Dental Check-Up for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 5	
Basic Dental Care – Child	No	Yes				20%	Before and After Deductible			
Orthodontia – Child	No	Yes				50%	Before and After Deductible			
Major Dental Care – Child	No	Yes				50%	Before and After Deductible			
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No	$ -	Before and After Deductible						
Diabetes Care Management	No	Yes				10%	After Deductible			
Inherited Metabolic Disorder - PKU	No	Yes				10%	After Deductible			
Virtual Care - Store & Forward		No	$ -	Before and After Deductible					Note 6	
Virtural Care - Telehealth		No	$ -	Before and After Deductible						
Preventive Care for Specified Chronic Conditions		No	$ -	Before and After Deductible						
Reproductive Health Care		No	$ -	Before and After Deductible						
Non-EHB Benefits										
Gender Affirming Care	No	Yes				10%	After Deductible			
Embedded IAP		No	$ -	After Deductible					Note 7	
Travel Immunizations	No	Yes				10%	After Deductible			
Orthognathic Surgery	No	Yes				10%	After Deductible			
Palliative Care (Home Health Aide Care)	No	Yes				10%	After Deductible		Note 8	
Repair of Teeth Due to Injury	No	Yes				10%	After Deductible			
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1) (Retail)		No	$ 15	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 45	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		Yes				30%	After Deductible		Note 9	
Preferred Brand Drugs (Tier 2) (Mail Order)		Yes				30%	After Deductible		Note 9	
Non-Preferred Brand Drugs (Tier 3) (Retail)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3) (Mail Order)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				50%	After Deductible			
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				10%	After Deductible			

Notes

Note 1 Out of service area coverage is available

Note 2 The first 4 in-network Primary, in-network Specialist and Urgent Care office visits combined per calendar year are not subject to the deductible.

Note 3 Out of service area coverage is available. The first 4 in-network Primary, in-network Specialist and Urgent Care office visits combined per calendar year are not subject to the deductible

Note 4 Covers cosmetic surgery when medically necessary.

Note 5 Human donor milk must be covered as it is covered by the state base benchmark plan

Note 6 Only Member to Provider (not Provider to Provider)

Note 7 Individual Assistance Program - 4 mental health counseling visits per issue

Note 8 30 visits per year

Note 9 Deductible waived for medications on the Optimum Value Medication List only

Note 10 25 visits per year

Benefit Components

Worksheet Controls

Company: Asuris Northwest Health **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	69364WA1220006	Line 1.3	**Metal Level**	Expanded Bronze	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Bronze HSA 7750	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	Yes
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	Yes
Line 2.13	**Includes Non-EHBs?**	Yes

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Connect
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Connect

	Medical	Drug	Combined	Errors/Warnings
Deductible			$7,750	
Default Coinsurance			50%	
MOOP			$8,300	

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays: Amount	Copays: Applies	Copays: Accrues toward Deductible?	Coinsurance: Amount	Coinsurance: Applies	Coinsurance: Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services		Yes				50%	After Deductible		Note 1	
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				50%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		Yes				50%	After Deductible			
Specialist Visit		Yes				50%	After Deductible			
Mental Health & Substance Use Disorder Office Visits		Yes				50%	After Deductible			
Mental Health & Substance Use Disorder All Other OP Services		Yes				50%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				50%	After Deductible			
Rehabilitative Speech Therapy		Yes				50%	After Deductible		Note 8	
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				50%	After Deductible		Note 8	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		Yes				50%	After Deductible			
X-rays and Diagnostic Imaging		Yes				50%	After Deductible			
Skilled Nursing Facility		Yes				50%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				50%	After Deductible			
Outpatient Surgery Physician/Surgical Services		Yes				50%	After Deductible			
Urgent Care		Yes				50%	After Deductible		Note 1	
Emergency Transportation		Yes				50%	After Deductible		Note 1	
Other EHB Categories										
Infertility Treatment		Yes				50%	After Deductible			
Cosmetic Surgery		Yes				50%	After Deductible		Note 2	
Acupuncture		Yes				50%	After Deductible			
Chiropractic Care		Yes				50%	After Deductible			
Hearing Aids		Yes				50%	After Deductible		Note 9	
Routine Foot Care		Yes				50%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Dental Check-Up for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 3	
Basic Dental Care – Child		No				20%	Before and After Deductible	No		
Orthodontia – Child		No				50%	Before and After Deductible	No		
Major Dental Care – Child		No				50%	Before and After Deductible	No		
Abortion for Which Public Funding is Prohibited		Yes				0%	After Deductible			
Diabetes Education		Yes	$ -	Before and After Deductible						
Diabetes Care Management		Yes				0%	After Deductible			
Inherited Metabolic Disorder - PKU		Yes				50%	After Deductible			
Virtual Care - Store & Forward		Yes				0%	After Deductible		Note 4	
Virtural Care - Telehealth		Yes				50%	After Deductible			
Preventive Care for Specified Chronic Conditions		No				50%	Before and After Deductible	No		
Reproductive Health Care		Yes				0%	After Deductible			
Non-EHB Benefits										
Gender Affirming Care		Yes				50%	After Deductible			
Embedded IAP		No	$ -	Before and After Deductible					Note 5	
Travel Immunizations		Yes				50%	After Deductible			
Orthognathic Surgery		Yes				50%	After Deductible			
Palliative Care (Home Health Aide Care)		Yes				50%	After Deductible		Note 6	
Repair of Teeth Due to Injury		Yes				50%	After Deductible			

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		Yes				20%	After Deductible			
Generic Drugs (Tier 1) (Mail Order)		Yes				20%	After Deductible			
Preferred Brand Drugs (Tier 2) (Retail)		Yes				30%	After Deductible		Note 7	
Preferred Brand Drugs (Tier 2) (Mail Order)		Yes				30%	After Deductible		Note 7	
Non-Preferred Brand Drugs (Tier 3) (Retail)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3) (Mail Order)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				50%	After Deductible			
Opioid Rescure Medication Value List		Yes				0%	After Deductible			
Rx Chemo		Yes				50%	After Deductible			

Notes

Note 1 Out of service area coverage is available
Note 2 Covers cosmetic surgery when medically necessary.
Note 3 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 4 Only Member to Provider (not Provider to Provider)
Note 5 Individual Assistance Program - 4 mental health counseling visits per issue
Note 6 30 visits per year
Note 7 Deductible waived for medications on the Optimum Value Medication List only
Note 8 25 visits per year
Note 9 Coinsurance Applies after the defined IRS Minimum Required Deductible amount is met

Benefit Components

Worksheet Controls

Company: Asuris Northwest Health **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	69364WA1220008	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Silver 5000	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	No	Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	Yes
Line 2.13	**Includes Non-EHBs?**	Yes

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Connect
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Connect

	Medical	Drug	Combined	Errors/Warnings
Deductible			$5,000	
Default Coinsurance			10%	
MOOP			$10,150	

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays: Amount	Copays: Applies	Copays: Accrues toward Deductible?	Coinsurance: Amount	Coinsurance: Applies	Coinsurance: Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services		Yes				10%	After Deductible		Note 1	
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				10%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		No	$ 20	Before and After Deductible	No					
Specialist Visit		No	$ 70	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 20	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		Yes				10%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				10%	After Deductible			
Rehabilitative Speech Therapy		Yes				10%	After Deductible		Note 8	
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				10%	After Deductible		Note 8	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		Yes				10%	After Deductible			
X-rays and Diagnostic Imaging		Yes				10%	After Deductible			
Skilled Nursing Facility		Yes				10%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				10%	After Deductible			
Outpatient Surgery Physician/Surgical Services		Yes				10%	After Deductible			
Urgent Care		No	$ 70	Before and After Deductible	No				Note 1	
Emergency Transportation		Yes				10%	After Deductible		Note 1	
Other EHB Categories										
Infertility Treatment		Yes				10%	After Deductible			
Cosmetic Surgery		Yes				10%	After Deductible		Note 2	
Acupuncture		No	$ 20	Before and After Deductible	No					
Chiropractic Care		No	$ 20	Before and After Deductible	No					
Hearing Aids		No				10%	Before and After Deductible	No		
Routine Foot Care		Yes				10%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Dental Check-Up for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 3	
Basic Dental Care – Child		No				20%	Before and After Deductible	No		
Orthodontia – Child		No				50%	Before and After Deductible	No		
Major Dental Care – Child		No				50%	Before and After Deductible	No		
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No								
Diabetes Care Management		Yes				10%	After Deductible			
Inherited Metabolic Disorder - PKU		Yes				10%	After Deductible			
Virtual Care - Store & Forward		No	$ -	Before and After Deductible					Note 4	
Virtural Care - Telehealth		No	$ 10	Before and After Deductible	No					
Preventive Care for Specified Chronic Conditions		No				10%	Before and After Deductible	No		
Reproductive Health Care		No	$ -	Before and After Deductible						
Non-EHB Benefits										
Gender Affirming Care		Yes				10%	After Deductible			
Embedded IAP		No	$ -	Before and After Deductible					Note 5	
Travel Immunizations		Yes				10%	After Deductible			
Orthognathic Surgery		Yes				10%	After Deductible			
Palliative Care (Home Health Aide Care)		Yes				10%	After Deductible		Note 6	
Repair of Teeth Due to Injury		Yes				10%	After Deductible			

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 15	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 45	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		Yes				30%	After Deductible		Note 7	
Preferred Brand Drugs (Tier 2) (Mail Order)		Yes				30%	After Deductible		Note 7	
Non-Preferred Brand Drugs (Tier 3) (Retail)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3) (Mail Order)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				50%	After Deductible			
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				10%	After Deductible			

Notes

Note 1 Out of service area coverage is available
Note 2 Covers cosmetic surgery when medically necessary.
Note 3 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 4 Only Member to Provider (not Provider to Provider)
Note 5 Individual Assistance Program - 4 mental health counseling visits per issue
Note 6 30 visits per year
Note 7 Deductible waived for medications on the Optimum Value Medication List only
Note 8 25 visits per year

Benefit Components

Worksheet Controls

Company: Asuris Northwest Health **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	69364WA1220014	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Gold 2000	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	Yes
Line 2.13	**Includes Non-EHBs?**	Yes

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Connect
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Connect

	Medical	Drug	Combined	Errors/Warnings
Deductible			$2,000	
Default Coinsurance			10%	
MOOP			$10,150	

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays: Amount	Copays: Applies	Copays: Accrues toward Deductible?	Coinsurance: Amount	Coinsurance: Applies	Coinsurance: Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services		Yes				10%	After Deductible		Note 1	
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				10%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		No	$ 20	Before and After Deductible	No					
Specialist Visit		No	$ 50	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 20	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		Yes				10%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				10%	After Deductible			
Rehabilitative Speech Therapy		Yes				10%	After Deductible		Note 8	
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				10%	After Deductible		Note 8	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		Yes				10%	After Deductible			
X-rays and Diagnostic Imaging		Yes				10%	After Deductible			
Skilled Nursing Facility		Yes				10%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				10%	After Deductible			
Outpatient Surgery Physician/Surgical Services		Yes				10%	After Deductible			
Urgent Care		No	$ 50	Before and After Deductible	No				Note 1	
Emergency Transportation		Yes				10%	After Deductible		Note 1	
Other EHB Categories										
Infertility Treatment		Yes				10%	After Deductible			
Cosmetic Surgery		Yes				10%	After Deductible		Note 2	
Acupuncture		No	$ 20	Before and After Deductible	No					
Chiropractic Care		No	$ 20	Before and After Deductible	No					
Hearing Aids		No				10%	Before and After Deductible	No		
Routine Foot Care		Yes				10%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Dental Check-Up for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 3	
Basic Dental Care – Child		No				20%	Before and After Deductible	No		
Orthodontia – Child		No				50%	Before and After Deductible	No		
Major Dental Care – Child		No				50%	Before and After Deductible	No		
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No	$ -	Before and After Deductible						
Diabetes Care Management		Yes				10%	After Deductible			
Inherited Metabolic Disorder - PKU		Yes				10%	After Deductible			
Virtual Care - Store & Forward		No	$ -	Before and After Deductible					Note 4	
Virtural Care - Telehealth		No	$ 10	Before and After Deductible	No					
Preventive Care for Specified Chronic Conditions		No				10%	Before and After Deductible	No		
Reproductive Health Care		No	$ -	Before and After Deductible						
Non-EHB Benefits										
Gender Affirming Care		Yes				10%	After Deductible			
Embedded IAP		No	$ -	Before and After Deductible					Note 5	
Travel Immunizations		Yes				10%	After Deductible			
Orthognathic Surgery		Yes				10%	After Deductible			
Palliative Care (Home Health Aide Care)		Yes				10%	After Deductible		Note 6	
Repair of Teeth Due to Injury		Yes				10%	After Deductible			

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 10	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 30	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		Yes				20%	After Deductible		Note 7	
Preferred Brand Drugs (Tier 2) (Mail Order)		Yes				20%	After Deductible		Note 7	
Non-Preferred Brand Drugs (Tier 3) (Retail)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3) (Mail Order)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				50%	After Deductible			
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				10%	After Deductible			

Notes

Note 1 Out of service area coverage is available
Note 2 Covers cosmetic surgery when medically necessary.
Note 3 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 4 Only Member to Provider (not Provider to Provider)
Note 5 Individual Assistance Program - 4 mental health counseling visits per issue
Note 6 30 visits per year
Note 7 Deductible waived for medications on the Optimum Value Medication List only
Note 8 25 visits per year

Benefit Components

Worksheet Controls

Company: Asuris Northwest Health **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	69364WA1220016	Line 1.3	**Metal Level**	Expanded Bronze	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Bronze 8000	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes	
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes	
Line 2.3	**Apply Inpatient Copay per Day?**	No	
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No	
Line 2.5	**Separate MOOP for Medical & Drug Spending?**		
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A	
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A	
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A	
Line 2.9	**HSA Plan?**	No	
Line 2.10	**HSA Employer Contribution Amount**		
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes	*<- Provide Explanation in Note 1 (at the bottom of the page).*
Line 2.12	**Pediatric Dental Embedded?**	Yes	
Line 2.13	**Includes Non-EHBs?**	Yes	

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Connect
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Connect

	Medical	Drug	Combined	Errors/Warnings
Deductible			$8,000	
Default Coinsurance			50%	
MOOP			$10,150	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services		Yes				50%	After Deductible		Note 1	
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				50%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		No	$ 60	Before and After Deductible	No					
Specialist Visit		No	$ 120	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 60	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		Yes				50%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				50%	After Deductible			
Rehabilitative Speech Therapy		Yes				50%	After Deductible		Note 8	
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				50%	After Deductible		Note 8	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 60	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 60	Before and After Deductible	No					
Skilled Nursing Facility		Yes				50%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				50%	After Deductible			
Outpatient Surgery Physician/Surgical Services		Yes				50%	After Deductible			
Urgent Care		No	$ 120	Before and After Deductible	No				Note 1	
Emergency Transportation		Yes				50%	After Deductible		Note 1	
Other EHB Categories										
Infertility Treatment		Yes				50%	After Deductible			
Cosmetic Surgery		Yes				50%	After Deductible		Note 2	
Acupuncture		No	$ 60	Before and After Deductible	No					
Chiropractic Care		No	$ 60	Before and After Deductible	No					
Hearing Aids		No				50%	Before and After Deductible	No		
Routine Foot Care		Yes				50%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Dental Check-Up for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 3	
Basic Dental Care – Child		No				20%	Before and After Deductible	No		
Orthodontia – Child		No				50%	Before and After Deductible	No		
Major Dental Care – Child		No				50%	Before and After Deductible	No		
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No	$ -	Before and After Deductible						
Diabetes Care Management		Yes				50%	After Deductible			
Inherited Metabolic Disorder - PKU		Yes				50%	After Deductible			
Virtual Care - Store & Forward		No	$ -	Before and After Deductible					Note 4	
Virtural Care - Telehealth		No	$ 10	Before and After Deductible	No					
Preventive Care for Specified Chronic Conditions		No				50%	Before and After Deductible	No		
Reproductive Health Care		No	$ -	Before and After Deductible						
Non-EHB Benefits										
Gender Affirming Care		No				50%	After Deductible			
Embedded IAP		No	$ -	Before and After Deductible					Note 5	
Travel Immunizations		Yes				50%	After Deductible			
Orthognathic Surgery		Yes				50%	After Deductible			
Palliative Care (Home Health Aide Care)		Yes				50%	After Deductible		Note 6	
Repair of Teeth Due to Injury		Yes				50%	After Deductible			

Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1) (Retail)		No	$ 20	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 60	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		Yes				30%	After Deductible		Note 7	
Preferred Brand Drugs (Tier 2) (Mail Order)		Yes				30%	After Deductible		Note 7	
Non-Preferred Brand Drugs (Tier 3) (Retail)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3) (Mail Order)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				50%	After Deductible			
Opioid Rescure Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				50%	After Deductible			

Notes

Note 1 Out of service area coverage is available
Note 2 Covers cosmetic surgery when medically necessary.
Note 3 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 4 Only Member to Provider (not Provider to Provider)
Note 5 Individual Assistance Program - 4 mental health counseling visits per issue
Note 6 30 visits per year
Note 7 Deductible waived for medications on the Optimum Value Medication List only
Note 8 25 visits per year

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	Asuris Northwest Health
Address	1111 Lake Washington Blvd N
	Suite 900
	Renton, WA 98056
Carrier Identification Number	ASURINH533OE

Rate Renewal Period:	From	1/1/2026	To	12/31/2026
Date Submitted:		5/15/2025		

Proposed Rate Summary

Current community rate:	$663.94	per month
Proposed community rate:	$764.53	per month
Percentage change:	15.15%	%
Portion of carrier's total enrollment affected:	2.60	%
Portion of carrier's total premium revenue affected:	3.10	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims	$656.05	85.81%
b) Expenses	$83.42	10.91%
c) Contribution to surplus contingency charges, or risk charges	$26.76	3.50%
d) Investment earnings	$1.70	0.22%
e) Total (a + b + c - d)	$764.53	100.00%

Summary of Pooled Experience

	Experience Period	First Prior Period	Second Prior Period
	From 1/1/2024 To 12/31/2024	From 1/1/2023 To 12/31/2023	From 1/1/2022 To 12/31/2022
Member Months	11716	12208	13858
Earned Premium	$6,589,078.40	$7,472,394.72	$7,661,256.72
Paid Claims	$7,419,295.72	$8,732,849.66	$6,589,326.56
Beginning Claim Reserve	$892,738.93	$1,378,161.30	$1,141,847.41
Ending Claim Reserve	$1,404,275.78	$892,738.93	$1,378,161.30
Incurred Claims	$7,930,832.57	$8,247,427.29	$6,825,640.45
Expenses	$904,372.87	$969,827.76	$1,018,300.10
Gain/Loss	-$2,246,127.04	-$1,744,860.33	-$182,683.83
Loss Ratio Percentage	120.36%	110.37%	89.09%

General Information

1. Trend Factor Summary

Types of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	10.40%	55.21%
Professional	10.40%	19.50%
Prescription Drugs	10.40%	21.15%
Dental	N/A	N/A
Other	10.40%	4.14%

2. List the effective date and the rate increase for all rate changes in the past three periods.

1)	1/1/2025	15.49%	2)	1/1/2024	-7.03%	3)	1/1/2023	9.10%
	Date	%		Date	%		Date	%

3. Since the previous filing, have any changes been made to the factors or methodology for adjusting base rates?

Geographic Area		X	Yes		No
Family Size			Yes	X	No
Age			Yes	X	No
Wellness Activities			Yes	X	No
Other (specify)	Remove tobacco rating factor	X	Yes		No

4. Attach a table showing the base rate for each plan affected by this filing.

Please see Rate Factors exhibit for base rates by plan. Please see Rate Schedule exhibit for detailed rate information.

5. Attach comments or additional Information

6. Preparer's Information

Name:	Daniel Boeder
Title:	Manager, Actuarial Pricing
Telephone Number:	(206) 332-5619

Unified Rate Review v6.1

To add a pl
To add a pl
To validate
To finalize,

Company Legal Name:	**Asuris Northwest Health**		
HIOS Issuer ID:	**69364**	State:	**WA**
Effective Date of Rate Change(s):	**1/1/2026**	Market:	**Individual**

Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period: 1/1/2024 to 12/31/2024

	Total	PMPM
Allowed Claims	$10,309,180.57	$879.92
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$7,930,832.57	$676.92
Risk Adjustment	$960,505.10	$81.98
Experience Period Premium	$6,589,078.40	$562.40
Experience Period Member Months	11,716	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$228.72	1.050	1.025	1.050	1.025	$264.99
Outpatient Hospital	$256.11	1.050	1.025	1.050	1.025	$296.73
Professional	$171.22	1.050	1.025	1.050	1.025	$198.38
Other Medical	$36.40	1.050	1.025	1.050	1.025	$42.17
Capitation	$0.00	1.050	1.025	1.050	1.025	$0.00
Prescription Drug	$185.72	1.055	1.044	1.055	1.044	$225.19
Total	$878.17					**$1,027.46**

Morbidity Adjustment	0.999
Demographic Shift	1.007
Plan Design Changes	0.998
Other	0.900
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$928.20**

Manual EHB Allowed Claims PMPM	$922.48
Applied Credibility %	31.02%

			Projected Period Totals
Projected Index Rate for	**1/1/2026**	**$924.25**	$10,691,724.00
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		$122.91	$1,421,777.86
Exchange User Fees		0.00%	$0.00
Market Adjusted Index Rate		**$801.34**	**$9,269,946.14**

Projected Member Months	**11,568**

Product-Plan Data Collection

Company Legal Name: **Asuris Northwest Health**
HIOS Issuer ID: **69364** State: **WA**
Effective Date of Rate Change(s): **1/1/2026** Market: **Individual**

Product/Plan Level Calculations

Field #	Section I: General Product and Plan Information						
1.1	Product Name		Asuris Direct EPO				
1.2	Product ID		69364WA122				
1.3	Plan Name		Bronze Essential	Bronze HSA 7750	Silver 5000	Gold 2000	Bronze 8000
1.4	Plan ID (Standard Component ID)		69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
1.5	Metal		Bronze	Bronze	Silver	Gold	Bronze
1.6	AV Metal Value		0.626	0.626	0.700	0.786	0.644
1.7	Plan Category		Renewing	Renewing	Renewing	Renewing	Renewing
1.8	Plan Type		EPO	EPO	EPO	EPO	EPO
1.9	Exchange Plan?		No	No	No	No	No
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		10.89%	12.23%	11.54%	11.16%	11.35%
1.12	Product Rate Increase %		11.54%				
1.13	Submission Level Rate Increase %		11.54%				

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information						
	2.1	Plan ID (Standard Component ID)	Total	69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
$10,309,181	2.2	Allowed Claims	$10,309,181	$1,216,039	$3,201,172	$2,583,087	$3,308,882	$0
$0	2.3	Reinsurance	$0	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$2,378,348	$420,230	$753,523	$547,914	$656,681	$0
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$7,930,833	2.6	Incurred Claims	$7,930,833	$795,809	$2,447,649	$2,035,173	$2,652,201	$0
$960,505	2.7	Risk Adjustment Transfer Amount	$960,505	-$191,277	-$229,468	$84,088	$1,297,162	$0
$6,589,078	2.8	Premium	$6,589,078	$1,544,620	$2,007,325	$1,710,110	$1,327,023	$0
11,716	2.9	Experience Period Member Months	11,716	2,970	3,563	3,206	1,977	0
	2.10	Current Enrollment	964	235	305	263	158	3
	2.11	Current Premium PMPM	$667.65	$598.06	$658.55	$650.09	$823.41	$379.58
	2.12	Loss Ratio	105.05%	58.80%	137.67%	113.43%	101.07%	#DIV/0!
		Per Member Per Month						
	2.13	Allowed Claims	$879.92	$409.44	$898.45	$805.70	$1,673.69	#DIV/0!
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
	2.15	Member Cost Sharing	$203.00	$141.49	$211.49	$170.90	$332.16	#DIV/0!
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
	2.17	Incurred Claims	$676.92	$267.95	$686.96	$634.80	$1,341.53	#DIV/0!
	2.18	Risk Adjustment Transfer Amount	$81.98	-$64.40	-$64.40	$26.23	$656.13	#DIV/0!
	2.19	Premium	$562.40	$520.07	$563.38	$533.41	$671.23	#DIV/0!

	Section III: Plan Adjustment Factors						
3.1	Plan ID (Standard Component ID)		69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
3.2	Market Adjusted Index Rate		$801.34				
3.3	AV and Cost Sharing Design of Plan		0.6953	0.7261	0.8257	1.0215	0.7273
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB		1.0020	1.0010	1.0010	1.0010	1.0010
	Administrative Costs						
3.6	Administrative Expense		8.25%	8.25%	8.25%	8.25%	8.25%
3.7	Taxes and Fees		2.20%	2.20%	2.20%	2.20%	2.20%
3.8	Profit & Risk Load		3.50%	3.50%	3.50%	3.50%	3.50%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**		$648.86	$676.92	$769.77	$952.24	$678.01
3.11	Age Calibration Factor	0.5944	0.5944				
3.12	Geographic Calibration Factor	0.9707	0.9707				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$374.38	$390.57	$444.14	$549.43	$391.20

	Section IV: Projected Plan Level Information						
4.1	Plan ID (Standard Component ID)	Total	69364WA1220004	69364WA1220006	69364WA1220008	69364WA1220014	69364WA1220016
4.2	Allowed Claims	$10,705,004	$2,557,148	$3,315,539	$2,944,742	$1,854,963	$32,612
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$2,204,461	$593,732	$725,993	$586,787	$290,824	$7,124
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$8,500,544	$1,963,416	$2,589,546	$2,357,955	$1,564,139	$25,488
4.7	Risk Adjustment Transfer Amount	$1,128,918	-$223,741	-$290,387	$100,634	$1,545,268	-$2,856
4.8	Premium	$8,566,528	$1,829,778	$2,477,517	$2,429,385	$1,805,440	$24,408
4.9	Projected Member Months	11,568	2,820	3,660	3,156	1,896	36
4.10	Loss Ratio	87.68%	122.25%	118.40%	93.20%	46.68%	118.26%
	Per Member Per Month						
4.11	Allowed Claims	$925.40	$906.79	$905.89	$933.06	$978.36	$905.89
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$190.57	$210.54	$198.36	$185.93	$153.39	$197.90
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$734.83	$696.25	$707.53	$747.13	$824.97	$707.99
4.16	Risk Adjustment Transfer Amount	$97.59	-$79.34	-$79.34	$31.89	$815.01	-$79.34
4.17	Premium	$740.54	$648.86	$676.92	$769.77	$952.24	$678.01

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 4	0.9450
Rating Area 6	1.0000
Rating Area 7	1.0820
Rating Area 9	1.0620

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Bronze HSA 7750
HIOS Plan ID: 69364WA1220006
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				282.35		298.78	323.28		317.30				282.35		298.78	323.28		317.30
15				307.45		325.34	352.02		345.51				307.45		325.34	352.02		345.51
16				317.04		335.49	363.00		356.29				317.04		335.49	363.00		356.29
17				326.64		345.65	373.99		367.08				326.64		345.65	373.99		367.08
18				336.97		356.58	385.82		378.69				336.97		356.58	385.82		378.69
19				347.31		367.52	397.66		390.31				347.31		367.52	397.66		390.31
20				358.00		378.84	409.90		402.33				358.00		378.84	409.90		402.33
21				369.08		390.56	422.59		414.77				369.08		390.56	422.59		414.77
22				369.08		390.56	422.59		414.77				369.08		390.56	422.59		414.77
23				369.08		390.56	422.59		414.77				369.08		390.56	422.59		414.77
24				369.08		390.56	422.59		414.77				369.08		390.56	422.59		414.77
25				370.55		392.12	424.27		416.43				370.55		392.12	424.27		416.43
26				377.93		399.93	432.72		424.73				377.93		399.93	432.72		424.73
27				386.80		409.31	442.87		434.69				386.80		409.31	442.87		434.69
28				401.19		424.54	459.35		450.86				401.19		424.54	459.35		450.86
29				413.00		437.04	472.88		464.14				413.00		437.04	472.88		464.14
30				418.91		443.29	479.64		470.77				418.91		443.29	479.64		470.77
31				427.76		452.66	489.78		480.72				427.76		452.66	489.78		480.72
32				436.62		462.03	499.92		490.68				436.62		462.03	499.92		490.68
33				442.16		467.89	506.26		496.90				442.16		467.89	506.26		496.90
34				448.06		474.14	513.02		503.54				448.06		474.14	513.02		503.54
35				451.01		477.26	516.40		506.85				451.01		477.26	516.40		506.85
36				453.97		480.39	519.78		510.17				453.97		480.39	519.78		510.17
37				456.92		483.51	523.16		513.49				456.92		483.51	523.16		513.49
38				459.87		486.64	526.54		516.81				459.87		486.64	526.54		516.81
39				465.78		492.89	533.31		523.45				465.78		492.89	533.31		523.45
40				471.69		499.14	540.07		530.09				471.69		499.14	540.07		530.09
41				480.54		508.51	550.21		540.04				480.54		508.51	550.21		540.04
42				489.03		517.49	559.92		549.57				489.03		517.49	559.92		549.57
43				500.84		529.99	573.45		562.85				500.84		529.99	573.45		562.85
44				515.60		545.61	590.35		579.44				515.60		545.61	590.35		579.44
45				532.95		563.97	610.22		598.94				532.95		563.97	610.22		598.94
46				553.62		585.84	633.88		622.16				553.62		585.84	633.88		622.16
47				576.88		610.45	660.51		648.30				576.88		610.45	660.51		648.30
48				603.45		638.57	690.93		678.16				603.45		638.57	690.93		678.16
49				629.65		666.30	720.94		707.61				629.65		666.30	720.94		707.61
50				659.18		697.54	754.74		740.79				659.18		697.54	754.74		740.79
51				688.33		728.39	788.12		773.55				688.33		728.39	788.12		773.55
52				720.44		762.37	824.88		809.64				720.44		762.37	824.88		809.64
53				752.92		796.74	862.07		846.14				752.92		796.74	862.07		846.14
54				787.99		833.85	902.23		885.55				787.99		833.85	902.23		885.55
55				823.05		870.95	942.37		924.95				823.05		870.95	942.37		924.95
56				861.07		911.18	985.90		967.67				861.07		911.18	985.90		967.67
57				899.44		951.79	1029.84		1010.80				899.44		951.79	1029.84		1010.80
58				940.42		995.15	1076.75		1056.85				940.42		995.15	1076.75		1056.85
59				960.72		1016.63	1099.99		1079.66				960.72		1016.63	1099.99		1079.66
60				1001.68		1059.98	1146.90		1125.70				1001.68		1059.98	1146.90		1125.70
61				1037.11		1097.47	1187.46		1165.51				1037.11		1097.47	1187.46		1165.51
62				1060.37		1122.08	1214.09		1191.65				1060.37		1122.08	1214.09		1191.65
63				1089.52		1152.93	1247.47		1224.41				1089.52		1152.93	1247.47		1224.41
64 and over				1107.24		1171.68	1267.76		1244.31				1107.24		1171.68	1267.76		1244.31

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Bronze Essential 9000
HIOS Plan ID: 69364WA1220004
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				270.64		286.39	309.87		304.15				270.64		286.39	309.87		304.15
15				294.70		311.85	337.42		331.18				294.70		311.85	337.42		331.18
16				303.89		321.58	347.95		341.52				303.89		321.58	347.95		341.52
17				313.10		331.32	358.49		351.86				313.10		331.32	358.49		351.86
18				323.00		341.80	369.83		362.99				323.00		341.80	369.83		362.99
19				332.90		352.28	381.17		374.12				332.90		352.28	381.17		374.12
20				343.17		363.14	392.92		385.65				343.17		363.14	392.92		385.65
21				353.78		374.37	405.07		397.58				353.78		374.37	405.07		397.58
22				353.78		374.37	405.07		397.58				353.78		374.37	405.07		397.58
23				353.78		374.37	405.07		397.58				353.78		374.37	405.07		397.58
24				353.78		374.37	405.07		397.58				353.78		374.37	405.07		397.58
25				355.20		375.87	406.69		399.17				355.20		375.87	406.69		399.17
26				362.27		383.35	414.78		407.12				362.27		383.35	414.78		407.12
27				370.76		392.34	424.51		416.67				370.76		392.34	424.51		416.67
28				384.56		406.94	440.31		432.17				384.56		406.94	440.31		432.17
29				395.88		418.92	453.27		444.89				395.88		418.92	453.27		444.89
30				401.54		424.91	459.75		451.25				401.54		424.91	459.75		451.25
31				410.03		433.89	469.47		460.79				410.03		433.89	469.47		460.79
32				418.52		442.88	479.20		470.34				418.52		442.88	479.20		470.34
33				423.83		448.50	485.28		476.31				423.83		448.50	485.28		476.31
34				429.49		454.49	491.76		482.67				429.49		454.49	491.76		482.67
35				432.32		457.48	494.99		485.84				432.32		457.48	494.99		485.84
36				435.15		460.48	498.24		489.03				435.15		460.48	498.24		489.03
37				437.98		463.47	501.47		492.21				437.98		463.47	501.47		492.21
38				440.81		466.47	504.72		495.39				440.81		466.47	504.72		495.39
39				446.47		472.45	511.19		501.74				446.47		472.45	511.19		501.74
40				452.13		478.44	517.67		508.10				452.13		478.44	517.67		508.10
41				460.62		487.43	527.40		517.65				460.62		487.43	527.40		517.65
42				468.76		496.04	536.72		526.79				468.76		496.04	536.72		526.79
43				480.08		508.02	549.68		539.52				480.08		508.02	549.68		539.52
44				494.23		522.99	565.88		555.42				494.23		522.99	565.88		555.42
45				510.86		540.59	584.92		574.11				510.86		540.59	584.92		574.11
46				530.67		561.56	607.61		596.38				530.67		561.56	607.61		596.38
47				552.96		585.14	633.12		621.42				552.96		585.14	633.12		621.42
48				578.43		612.09	662.28		650.04				578.43		612.09	662.28		650.04
49				603.55		638.68	691.05		678.28				603.55		638.68	691.05		678.28
50				631.85		668.62	723.45		710.07				631.85		668.62	723.45		710.07
51				659.80		698.20	755.45		741.49				659.80		698.20	755.45		741.49
52				690.58		730.77	790.69		776.08				690.58		730.77	790.69		776.08
53				721.71		763.71	826.33		811.06				721.71		763.71	826.33		811.06
54				755.32		799.28	864.82		848.84				755.32		799.28	864.82		848.84
55				788.93		834.85	903.31		886.61				788.93		834.85	903.31		886.61
56				825.37		873.41	945.03		927.56				825.37		873.41	945.03		927.56
57				862.16		912.34	987.15		968.91				862.16		912.34	987.15		968.91
58				901.43		953.89	1032.11		1013.03				901.43		953.89	1032.11		1013.03
59				920.89		974.49	1054.40		1034.91				920.89		974.49	1054.40		1034.91
60				960.16		1016.04	1099.36		1079.03				960.16		1016.04	1099.36		1079.03
61				994.12		1051.98	1138.24		1117.20				994.12		1051.98	1138.24		1117.20
62				1016.41		1075.57	1163.77		1142.26				1016.41		1075.57	1163.77		1142.26
63				1044.36		1105.14	1195.76		1173.66				1044.36		1105.14	1195.76		1173.66
64 and over				1061.34		1123.11	1215.21		1192.74				1061.34		1123.11	1215.21		1192.74

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Bronze 8000
HIOS Plan ID: 69364WA1220016
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				282.80		299.26	323.80		317.81				282.80		299.26	323.80		317.81
15				307.94		325.86	352.58		346.06				307.94		325.86	352.58		346.06
16				317.55		336.03	363.58		356.86				317.55		336.03	363.58		356.86
17				327.16		346.20	374.59		367.66				327.16		346.20	374.59		367.66
18				337.52		357.16	386.45		379.30				337.52		357.16	386.45		379.30
19				347.86		368.11	398.30		390.93				347.86		368.11	398.30		390.93
20				358.58		379.45	410.56		402.98				358.58		379.45	410.56		402.98
21				369.67		391.19	423.27		415.44				369.67		391.19	423.27		415.44
22				369.67		391.19	423.27		415.44				369.67		391.19	423.27		415.44
23				369.67		391.19	423.27		415.44				369.67		391.19	423.27		415.44
24				369.67		391.19	423.27		415.44				369.67		391.19	423.27		415.44
25				371.15		392.75	424.96		417.10				371.15		392.75	424.96		417.10
26				378.55		400.58	433.43		425.42				378.55		400.58	433.43		425.42
27				387.42		409.97	443.59		435.39				387.42		409.97	443.59		435.39
28				401.83		425.22	460.09		451.58				401.83		425.22	460.09		451.58
29				413.66		437.74	473.63		464.88				413.66		437.74	473.63		464.88
30				419.58		444.00	480.41		471.53				419.58		444.00	480.41		471.53
31				428.45		453.39	490.57		481.50				428.45		453.39	490.57		481.50
32				437.33		462.78	500.73		491.47				437.33		462.78	500.73		491.47
33				442.87		468.65	507.08		497.71				442.87		468.65	507.08		497.71
34				448.78		474.90	513.84		504.34				448.78		474.90	513.84		504.34
35				451.74		478.03	517.23		507.67				451.74		478.03	517.23		507.67
36				454.70		481.16	520.62		510.99				454.70		481.16	520.62		510.99
37				457.65		484.29	524.00		514.32				457.65		484.29	524.00		514.32
38				460.61		487.42	527.39		517.64				460.61		487.42	527.39		517.64
39				466.53		493.68	534.16		524.29				466.53		493.68	534.16		524.29
40				472.44		499.94	540.94		530.94				472.44		499.94	540.94		530.94
41				481.32		509.33	551.10		540.91				481.32		509.33	551.10		540.91
42				489.82		518.33	560.83		550.47				489.82		518.33	560.83		550.47
43				501.64		530.84	574.37		563.75				501.64		530.84	574.37		563.75
44				516.43		546.49	591.30		580.37				516.43		546.49	591.30		580.37
45				533.81		564.88	611.20		599.90				533.81		564.88	611.20		599.90
46				554.52		586.79	634.91		623.17				554.52		586.79	634.91		623.17
47				577.80		611.43	661.57		649.34				577.80		611.43	661.57		649.34
48				604.42		639.60	692.05		679.26				604.42		639.60	692.05		679.26
49				630.66		667.37	722.09		708.75				630.66		667.37	722.09		708.75
50				660.24		698.67	755.96		741.99				660.24		698.67	755.96		741.99
51				689.44		729.57	789.39		774.80				689.44		729.57	789.39		774.80
52				721.60		763.60	826.22		810.94				721.60		763.60	826.22		810.94
53				754.14		798.03	863.47		847.51				754.14		798.03	863.47		847.51
54				789.25		835.19	903.68		886.97				789.25		835.19	903.68		886.97
55				824.37		872.35	943.88		926.44				824.37		872.35	943.88		926.44
56				862.45		912.65	987.49		969.23				862.45		912.65	987.49		969.23
57				900.90		953.33	1031.50		1012.44				900.90		953.33	1031.50		1012.44
58				941.93		996.75	1078.48		1058.55				941.93		996.75	1078.48		1058.55
59				962.27		1018.27	1101.77		1081.40				962.27		1018.27	1101.77		1081.40
60				1003.30		1061.69	1148.75		1127.51				1003.30		1061.69	1148.75		1127.51
61				1038.78		1099.24	1189.38		1167.39				1038.78		1099.24	1189.38		1167.39
62				1062.08		1123.89	1216.05		1193.57				1062.08		1123.89	1216.05		1193.57
63				1091.28		1154.79	1249.48		1226.39				1091.28		1154.79	1249.48		1226.39
64 and over				1109.01		1173.57	1269.80		1246.32				1109.01		1173.57	1269.80		1246.32

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Gold 2000
HIOS Plan ID: 69364WA1220014
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Gold
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				397.18		420.30	454.76		446.36				397.18		420.30	454.76		446.36
15				432.49		457.66	495.19		486.03				432.49		457.66	495.19		486.03
16				445.98		471.94	510.64		501.20				445.98		471.94	510.64		501.20
17				459.49		486.23	526.10		516.38				459.49		486.23	526.10		516.38
18				474.02		501.61	542.74		532.71				474.02		501.61	542.74		532.71
19				488.56		516.99	559.38		549.04				488.56		516.99	559.38		549.04
20				503.62		532.93	576.63		565.97				503.62		532.93	576.63		565.97
21				519.19		549.41	594.46		583.47				519.19		549.41	594.46		583.47
22				519.19		549.41	594.46		583.47				519.19		549.41	594.46		583.47
23				519.19		549.41	594.46		583.47				519.19		549.41	594.46		583.47
24				519.19		549.41	594.46		583.47				519.19		549.41	594.46		583.47
25				521.27		551.61	596.84		585.81				521.27		551.61	596.84		585.81
26				531.66		562.60	608.73		597.48				531.66		562.60	608.73		597.48
27				544.11		575.78	622.99		611.48				544.11		575.78	622.99		611.48
28				564.36		597.21	646.18		634.24				564.36		597.21	646.18		634.24
29				580.98		614.79	665.20		652.91				580.98		614.79	665.20		652.91
30				589.28		623.58	674.71		662.24				589.28		623.58	674.71		662.24
31				601.75		636.77	688.99		676.25				601.75		636.77	688.99		676.25
32				614.20		649.95	703.25		690.25				614.20		649.95	703.25		690.25
33				621.99		658.19	712.16		699.00				621.99		658.19	712.16		699.00
34				630.30		666.98	721.67		708.33				630.30		666.98	721.67		708.33
35				634.45		671.38	726.43		713.01				634.45		671.38	726.43		713.01
36				638.60		675.77	731.18		717.67				638.60		675.77	731.18		717.67
37				642.76		680.17	735.94		722.34				642.76		680.17	735.94		722.34
38				646.91		684.56	740.69		727.00				646.91		684.56	740.69		727.00
39				655.23		693.36	750.22		736.35				655.23		693.36	750.22		736.35
40				663.53		702.15	759.73		745.68				663.53		702.15	759.73		745.68
41				675.99		715.33	773.99		759.68				675.99		715.33	773.99		759.68
42				687.93		727.97	787.66		773.10				687.93		727.97	787.66		773.10
43				704.54		745.55	806.69		791.77				704.54		745.55	806.69		791.77
44				725.32		767.53	830.47		815.12				725.32		767.53	830.47		815.12
45				749.72		793.35	858.40		842.54				749.72		793.35	858.40		842.54
46				778.79		824.12	891.70		875.22				778.79		824.12	891.70		875.22
47				811.50		858.73	929.15		911.97				811.50		858.73	929.15		911.97
48				848.88		898.29	971.95		953.98				848.88		898.29	971.95		953.98
49				885.74		937.29	1014.15		995.40				885.74		937.29	1014.15		995.40
50				927.28		981.25	1061.71		1042.09				927.28		981.25	1061.71		1042.09
51				968.29		1024.65	1108.67		1088.18				968.29		1024.65	1108.67		1088.18
52				1013.47		1072.45	1160.39		1138.94				1013.47		1072.45	1160.39		1138.94
53				1059.16		1120.80	1212.71		1190.29				1059.16		1120.80	1212.71		1190.29
54				1108.48		1172.99	1269.18		1245.72				1108.48		1172.99	1269.18		1245.72
55				1157.80		1225.18	1325.64		1301.14				1157.80		1225.18	1325.64		1301.14
56				1211.27		1281.77	1386.88		1361.24				1211.27		1281.77	1386.88		1361.24
57				1265.27		1338.91	1448.70		1421.92				1265.27		1338.91	1448.70		1421.92
58				1322.91		1399.90	1514.69		1486.69				1322.91		1399.90	1514.69		1486.69
59				1351.45		1430.11	1547.38		1518.78				1351.45		1430.11	1547.38		1518.78
60				1409.09		1491.10	1613.37		1583.55				1409.09		1491.10	1613.37		1583.55
61				1458.93		1543.84	1670.43		1639.56				1458.93		1543.84	1670.43		1639.56
62				1491.64		1578.45	1707.88		1676.31				1491.64		1578.45	1707.88		1676.31
63				1532.66		1621.86	1754.85		1722.42				1532.66		1621.86	1754.85		1722.42
64 and over				1557.57		1648.23	1783.38		1750.41				1557.57		1648.23	1783.38		1750.41

Asuris Northwest Health
RATE SCHEDULE

Plan Information

Plan Name: Silver 5000
HIOS Plan ID: 69364WA1220008
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the Exchange
Metal Level: Silver
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	N/A	
2	N/A	
3	N/A	
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	N/A	
6	Yes	Benton, Franklin, Kittitas
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	N/A	
9	Yes	Asotin, Garfield, Whitman, Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14				321.07		339.76	367.62		360.83				321.07		339.76	367.62		360.83
15				349.61		369.96	400.30		392.90				349.61		369.96	400.30		392.90
16				360.53		381.51	412.79		405.16				360.53		381.51	412.79		405.16
17				371.44		393.06	425.29		417.43				371.44		393.06	425.29		417.43
18				383.19		405.49	438.74		430.63				383.19		405.49	438.74		430.63
19				394.94		417.93	452.20		443.84				394.94		417.93	452.20		443.84
20				407.12		430.81	466.14		457.52				407.12		430.81	466.14		457.52
21				419.70		444.13	480.55		471.67				419.70		444.13	480.55		471.67
22				419.70		444.13	480.55		471.67				419.70		444.13	480.55		471.67
23				419.70		444.13	480.55		471.67				419.70		444.13	480.55		471.67
24				419.70		444.13	480.55		471.67				419.70		444.13	480.55		471.67
25				421.38		445.91	482.47		473.56				421.38		445.91	482.47		473.56
26				429.78		454.79	492.08		482.99				429.78		454.79	492.08		482.99
27				439.85		465.45	503.62		494.31				439.85		465.45	503.62		494.31
28				456.22		482.77	522.36		512.70				456.22		482.77	522.36		512.70
29				469.65		496.98	537.73		527.79				469.65		496.98	537.73		527.79
30				476.37		504.09	545.43		535.34				476.37		504.09	545.43		535.34
31				486.44		514.75	556.96		546.66				486.44		514.75	556.96		546.66
32				496.51		525.41	568.49		557.99				496.51		525.41	568.49		557.99
33				502.81		532.07	575.70		565.06				502.81		532.07	575.70		565.06
34				509.52		539.17	583.38		572.60				509.52		539.17	583.38		572.60
35				512.88		542.73	587.23		576.38				512.88		542.73	587.23		576.38
36				516.23		546.28	591.07		580.15				516.23		546.28	591.07		580.15
37				519.59		549.83	594.92		583.92				519.59		549.83	594.92		583.92
38				522.95		553.39	598.77		587.70				522.95		553.39	598.77		587.70
39				529.66		560.49	606.45		595.24				529.66		560.49	606.45		595.24
40				536.38		567.60	614.14		602.79				536.38		567.60	614.14		602.79
41				546.46		578.26	625.68		614.11				546.46		578.26	625.68		614.11
42				556.10		588.47	636.72		624.96				556.10		588.47	636.72		624.96
43				569.53		602.68	652.10		640.05				569.53		602.68	652.10		640.05
44				586.33		620.45	671.33		658.92				586.33		620.45	671.33		658.92
45				606.05		641.32	693.91		681.08				606.05		641.32	693.91		681.08
46				629.56		666.20	720.83		707.50				629.56		666.20	720.83		707.50
47				656.00		694.18	751.10		737.22				656.00		694.18	751.10		737.22
48				686.21		726.15	785.69		771.17				686.21		726.15	785.69		771.17
49				716.02		757.69	819.82		804.67				716.02		757.69	819.82		804.67
50				749.59		793.22	858.26		842.40				749.59		793.22	858.26		842.40
51				782.74		828.30	896.22		879.65				782.74		828.30	896.22		879.65
52				819.26		866.94	938.03		920.69				819.26		866.94	938.03		920.69
53				856.20		906.03	980.32		962.20				856.20		906.03	980.32		962.20
54				896.07		948.22	1025.97		1007.01				896.07		948.22	1025.97		1007.01
55				935.94		990.41	1071.62		1051.82				935.94		990.41	1071.62		1051.82
56				979.17		1036.16	1121.13		1100.40				979.17		1036.16	1121.13		1100.40
57				1022.81		1082.34	1171.09		1149.45				1022.81		1082.34	1171.09		1149.45
58				1069.40		1131.64	1224.43		1201.80				1069.40		1131.64	1224.43		1201.80
59				1092.49		1156.07	1250.87		1227.75				1092.49		1156.07	1250.87		1227.75
60				1139.07		1205.37	1304.21		1280.10				1139.07		1205.37	1304.21		1280.10
61				1179.37		1248.01	1350.35		1325.39				1179.37		1248.01	1350.35		1325.39
62				1205.81		1275.99	1380.62		1355.10				1205.81		1275.99	1380.62		1355.10
63				1238.96		1311.07	1418.58		1392.36				1238.96		1311.07	1418.58		1392.36
64 and over				1259.10		1332.39	1441.65		1415.00				1259.10		1332.39	1441.65		1415.00

Asuris Norwest Health – Individual
Actuarial Memorandum and Certification
ARPA Extended

The purpose of this memorandum is to identify the key assumptions and material factors that differ from the default set of rates should Congress extend the Expanded Premium Tax Credits guaranteed under the American Rescue Plan Act (ARPA) and the Inflation Reduction Act (IRA).

If Congress extends the EPTC as currently constituted through 2026, Asuris Northwest Health (ANH) expects the following interrelated assumptions to be impacted:

- Increase to market and carrier projected enrollment
- Decrease to market and carrier projected morbidity
- Decrease to the statewide average premium
- Smaller absolute value of transfer payment (reflecting the reduction to statewide average premium)

ANH's default rates assume that individuals no longer eligible for PTC, or who will receive less PTC, will drop out of Washington's individual market more readily than individuals with current or long-term health issues. The default rates assume a 4% increase to market morbidity. This increases the statewide average premium by a similar amount, which magnifies the anticipated transfer payment/receivable.

ANH's morbidity model is not sensitive to the total projected market membership, nor to the mix of EPTC membership among metal levels. While these underlying assumptions may change as a result of EPTC extension, their impact is muted by offsetting effects.

If EPTC as currently constituted is extended through 2026, ANH's 2026 rates would decrease by 3.7%.

The following table compares the key assumption changes under the default rates and ARPA extension:

Assumption	**Default Rates**	**ARPA Extension Rates**
Market morbidity change	4.0%	0.0%
Asuris morbidity change	0.0%	0.0%
Projected statewide average premium	$736.41	$713.98
Transfer payment	$78.64	$101.29
Base rate	$643.08	$622.91
Consumer rate change	15.2%	11.5%

Please see the document, "Part III Rate Filing Documentation and Actuarial Memorandum" for all other actuarial assumptions related to the rates with ARPA extension.

Asuris Norwest Health – Individual
Actuarial Memorandum and Certification
ARPA Extended

Please see the following files for the resulting full rate schedule and Unified Rate Review Template:

- *Rate Schedule with ARPA extension duplicate.xlsx*
- *Rate Schedule with ARPA extension.pdf*
- *Part I Unified Rate Review Template with ARPA extension duplicate.xlsx*
- *Part I Unified Rate Review Template with ARPA extension.pdf*

The rates and assumptions above assume a specific scenario in which EPTCs are extended into 2026 with their current structure and subsidy levels remaining unchanged. It should be emphasized that this represents only one possible legislative outcome. The more probable scenario is that Congress will implement modifications to both the amounts and structure of future PTCs rather than a simple extension of the current framework. Should Congress enact any alterations to the PTC structure— including eligibility thresholds, subsidy amounts, or calculation methodologies— ANH would need to comprehensively reevaluate our pricing assumptions and potentially recalculate rates to reflect the new market dynamics and consumer behavior patterns that would emerge under the revised subsidy environment. This current analysis should therefore be understood as conditional upon the specific extension scenario requested, rather than a prediction of the most likely outcome.

Actuarial Certification

I, Daniel Boeder, am an actuary employed by Cambia Health Solutions, the parent company of ANH. I am a member of the American Academy of Actuaries (AAA), in good standing, and meet the education and experience standards necessary to complete this actuarial certification.

On behalf of ANH, I have reviewed this rate filing for a January 1, 2026 effective date for the Individual block of business. I hereby certify that, in my opinion:

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations
    - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
    - Reasonable in relation to the benefits provided and the population anticipated to be covered
    - Neither excessive nor deficient
- 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 factor representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, was calculated in accordance with actuarial standards of practice
- 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
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2. Unique plan designs were fit appropriately in accordance with generally accepted actuarial principles and methodologies, as detailed in a separate certification.

- This rate filing is consistent with internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- 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. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*
- Professional Code of Conduct

Daniel Boeder

Digitally signed by Daniel Boeder
Date: 2025.05.15 09:41:35 -07'00'

Daniel Boeder, FSA, MAAA
Manager, Actuarial Pricing
Cambia Health Solutions, on behalf of Asuris Northwest Health