Filing at a Glance

Company:	Molina Healthcare of Washington, Inc.
Product Name:	2026 Non-grandfathered Individual Rate Filing MHW01012026
State:	Washington
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005C Individual - Other
Filing Type:	Rate
Date Submitted:	05/14/2025
SERFF Tr Num:	MLWA-134518839
SERFF Status:	Assigned
State Tr Num:	484742
State Status:	Review Pending
Co Tr Num:	
Effective Date Requested:	01/01/2026
Author(s):	Melissa Saiz, Barbara Tait, Genesis Bravo
Reviewer(s):	Ben Driver (primary), Amy Peach
Disposition Date:	
Disposition Status:	
Effective Date:	
Destruction Date:	

State Filing Description:

State: *Washington* ***Filing Company:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
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:

Deemer Date:
Submitted By: Melissa Saiz

Status of Filing in Domicile: Authorized
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: Melissa Saiz
Corresponding Filing Tracking Number: MLWA-WA26-125120380, MLWA-134518816

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions:

Exchange Only

Filing Description:
This is the rate submission for Molina's On and Off Exchange 2026 Individual (HMO) Marketplace Product, please review the rates checklists and summary of changes in the supporting documentation tab for further details.

Affiliated Binder Filing SERFF Tracking #: MLWA-WA26-125120380
Affiliated Form Filing SERFF Tracking #: MLWA-134518816

Company and Contact

Filing Contact Information

Melissa Saiz, Director
200 Oceangate
Ste 100
Long Beach, CA 90802

Melissa.Saiz2@molinahealthcare.com
425-697-9402 [Phone]

Filing Company Information

Molina Healthcare of Washington, Inc.
21540 30th Dr SE
Suite 400
Bothell, WA 98021
(425) 286-8356 ext. [Phone]

CoCode: 96270
Group Code: 96270
Group Name:
FEIN Number: 91-1284790

State of Domicile: Washington
Company Type: HMO
State ID Number: 136

State: *Washington* ***Filing Company:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
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): No

SERFF Tracking #:	*MLWA-134518839*	***State Tracking #:***	*484742*	***Company Tracking #:***	

State:	*Washington*	***Filing Company:***	*Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*2026 Non-grandfathered Individual Rate Filing MHW01012026*		
Project Name/Number:	*/*		

Correspondence Summary

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
URRT	Other Supporting Documents	Melissa Saiz	05/15/2025	05/15/2025

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Notice for Second Set of Rates Review Process	Note To Filer	Ben Driver	05/19/2025	05/19/2025
Additional correction needed	Note To Filer	Alyson Bragg	05/15/2025	05/15/2025
Opportunity for corrections	Note To Filer	Alyson Bragg	05/15/2025	05/15/2025
Rate Request Summary	Reviewer Note	Kelli Armfield	05/27/2025	

SERFF Tracking #:	*MLWA-134518839*	***State Tracking #:***	*484742*	***Company Tracking #:***	

State:	*Washington*	***Filing Company:***	*Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*2026 Non-grandfathered Individual Rate Filing MHW01012026*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 05/15/2025

Comments:

Hello Alyson, I've added the Part 1 unified rate review to the URRT Supporting Documents section. I also submitted a post submission update adding the corresponding filing tracker numbers to the appropriate section and selected "Yes" for the Exchange Intentions and entered Exchange only.
Please let me know if you have any other corrections. -Melissa

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

URRT Schedule Item Changes	
Item Name	**Attachment(s)**
Other Supporting Documents	PartIUnifiedRateReviewTemplate.pdf
Previous Version	
Other Supporting Documents	

No Supporting Documents Changed.

State: *Washington* ***Filing Company:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
Project Name/Number: */*

Note To Filer

Created By:

Ben Driver on 05/19/2025 06:32 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 10:43 AM

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:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
Project Name/Number: */*

Note To Filer

Created By:

Alyson Bragg on 05/15/2025 03:49 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 10:43 AM

Subject:

Additional correction needed

Comments:

You have not followed our requirements for the "Exchange Intentions" field.

Please refer to the Submission Requirements under the appropriate Sub-TOI. You must choose either (a) Exchange only, (b) Outside Market only, or (c) Exchange and Outside Market. You should only use the language in the examples given.

Please submit a Post-Submission Update to correct this field. If you have any questions contact the Rates & Forms Helpdesk at (360) 725-7111.

State: *Washington* ***Filing Company:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
Project Name/Number: */*

Note To Filer

Created By:

Alyson Bragg on 05/15/2025 03:44 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 10:43 AM

Subject:

Opportunity for corrections

Comments:

Our initial review of your submission has revealed errors.

On the General Information tab the Corresponding Filing Tracking Number field should list the SERFF tracking number of the corresponding rate filing. You have it listed in the filing description field.

Also, on the URRT tab you must attach the Part I unified rate review template pdf document under the Other Supporting Documentation area. You have it attached to the Supporting Documentation tab.

Please make a post submission update to complete the Corresponding Filing Tracking number field and make an amendment to attach the Part I unified rate review template pdf document to the URRT tab.

If there are questions, please contact the RFPN help desk at (360) 725 - 7111.

State: *Washington* ***Filing Company:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
Project Name/Number: */*

Reviewer Note

Created By:

Kelli Armfield on 05/27/2025 10:08 AM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 10:43 AM

Subject:

Rate Request Summary

Comments:

See attached

Molina Healthcare of Washington, Inc. – 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:	24.59% *average**
Requested effective date:	Jan. 1, 2026
Plans impacted:	Molina Healthcare of Washington, Inc.'s Individual plans
People impacted:	43,346
Counties:	Benton, Clark, Cowlitz, Ferry, Franklin, King, Kitsap, Klickitat, Lewis, Lincoln, Mason, Pend Oreille, Pierce, Skamania, Snohomish, Spokane, Stevens and Thurston

Key information used to develop the rate request

(Jan. 2024 - Dec. 2024)

Premiums	$293,930,108
Claims	$289,111,115
Administrative expenses	$38,388,624
Risk adjustment	$40,175,841
Company made	**$6,606,210**

The company expects its annual medical costs to increase 9.1%.

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:

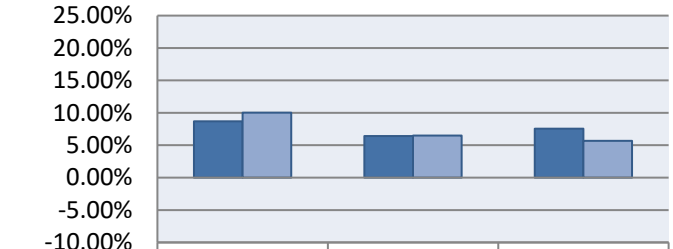
Claims:	83.10**%**
Administration:	13.90**%**
Profit:	3.00**%**

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	8.69%	6.41%	7.55%
Accepted	10.02%	6.50%	5.68%

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.

State: *Washington* ***Filing Company:*** *Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *2026 Non-grandfathered Individual Rate Filing MHW01012026*
Project Name/Number: */*

Post Submission Update Request Processed On 05/15/2025

Status:	Allowed
Created By:	Melissa Saiz
Processed By:	Alyson Bragg
Comments:	

General Information:

Field Name	Requested Change	Prior Value
Include Exchange Intentions	Yes	No
Exchange Intentions	Exchange Only	
Corresponding Filing Tracking Number	MLWA-WA26-125120380, MLWA-134518816	

Company Rate Information:

Company Name:Molina Healthcare of Washington, Inc.

Field Name	Requested Change	Prior Value
Product:	NEW	
Product Name	2026 Non-Grandfathered Individual Form Filing	
HIOS Product ID	84481WA006	
Number of Covered Lives	43346	

State: Washington **Filing Company:** Molina Healthcare of Washington, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: 2026 Non-grandfathered Individual Rate Filing MHW01012026
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 5.700%
Effective Date of Last Rate Revision: 01/01/2025
Filing Method of Last Filing: SERFF
SERFF Tracking Number of Last Filing: MLWA-134066835, MLWA-WA25-125118608

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):
Molina Healthcare of Washington, Inc.	Increase	24.590%	24.590%	$82,123,804	29,226	$334,023,819	36.980%	9.300%

Rate Review Detail

COMPANY:

Company Name: Molina Healthcare of Washington, Inc.
HHS Issuer Id: 84481

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
2026 Non-Grandfathered Individual Form Filing	84481WA006		43346

Trend Factors: Molina trended the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026 at a 9.1% annualized trend rate.

FORMS:

New Policy Forms: MHW01012026
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 489,287
Benefit Change: Increase
Percent Change Requested: Min: 9.3 Max: 37.0 Avg: 24.6

PRIOR RATE:

Total Earned Premium: 311,763,504.00
Total Incurred Claims: 288,770,194.00
Annual $: Min: 223.56 Max: 1,385.16 Avg: 599.37

REQUESTED RATE:

Projected Earned Premium: 216,375,285.00
Projected Incurred Claims: 203,779,242.00
Annual $: Min: 261.69 Max: 1,817.70 Avg: 746.73

State: Washington **Filing Company:** Molina Healthcare of Washington, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: 2026 Non-grandfathered Individual Rate Filing MHW01012026
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		Rate Schedule		Revised	Previous State Filing Number: MLWA-134066835 Percent Rate Change Request: 24.59	Rate Schedule DUPLICATE.xlsm, Rate Schedule.pdf, 84481WAMolinaFamilyRatingExDuplicate20250512.xlsx, 84481WAMolinaFamilyRatingExample20250512.pdf,

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Complete Gold
HIOS Plan ID: 84481WA0060005
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	341.74	348.19	392.92	341.86	341.85	353.35		346.47		341.74	348.19	392.92	341.86	341.85	353.35		346.47	
15	372.12	379.15	427.84	372.24	372.23	384.76		377.27		372.12	379.15	427.84	372.24	372.23	384.76		377.27	
16	383.73	390.98	441.20	383.86	383.85	396.77		389.04		383.73	390.98	441.20	383.86	383.85	396.77		389.04	
17	395.35	402.81	454.55	395.48	395.47	408.77		400.82		395.35	402.81	454.55	395.48	395.47	408.77		400.82	
18	407.86	415.56	468.93	407.99	407.98	421.71		413.50		407.86	415.56	468.93	407.99	407.98	421.71		413.50	
19	420.36	428.30	483.31	420.50	420.49	434.64		426.18		420.36	428.30	483.31	420.50	420.49	434.64		426.18	
20	433.32	441.50	498.21	433.46	433.45	448.04		439.31		433.32	441.50	498.21	433.46	433.45	448.04		439.31	
21	446.72	455.16	513.62	446.87	446.86	461.89		452.90		446.72	455.16	513.62	446.87	446.86	461.89		452.90	
22	446.72	455.16	513.62	446.87	446.86	461.89		452.90		446.72	455.16	513.62	446.87	446.86	461.89		452.90	
23	446.72	455.16	513.62	446.87	446.86	461.89		452.90		446.72	455.16	513.62	446.87	446.86	461.89		452.90	
24	446.72	455.16	513.62	446.87	446.86	461.89		452.90		446.72	455.16	513.62	446.87	446.86	461.89		452.90	
25	448.51	456.98	515.67	448.66	448.64	463.74		454.71		448.51	456.98	515.67	448.66	448.64	463.74		454.71	
26	457.44	466.08	525.94	457.59	457.58	472.98		463.77		457.44	466.08	525.94	457.59	457.58	472.98		463.77	
27	468.16	477.00	538.27	468.32	468.31	484.06		474.64		468.16	477.00	538.27	468.32	468.31	484.06		474.64	
28	485.59	494.76	558.30	485.75	485.73	502.08		492.30		485.59	494.76	558.30	485.75	485.73	502.08		492.30	
29	499.88	509.32	574.74	500.05	500.03	516.86		506.80		499.88	509.32	574.74	500.05	500.03	516.86		506.80	
30	507.03	516.60	582.96	507.20	507.18	524.25		514.04		507.03	516.60	582.96	507.20	507.18	524.25		514.04	
31	517.75	527.53	595.28	517.92	517.91	535.33		524.91		517.75	527.53	595.28	517.92	517.91	535.33		524.91	
32	528.47	538.45	607.61	528.65	528.63	546.42		535.78		528.47	538.45	607.61	528.65	528.63	546.42		535.78	
33	535.17	545.28	615.31	535.35	535.33	553.35		542.57		535.17	545.28	615.31	535.35	535.33	553.35		542.57	
34	542.32	552.56	623.53	542.50	542.48	560.74		549.82		542.32	552.56	623.53	542.50	542.48	560.74		549.82	
35	545.89	556.20	627.64	546.07	546.06	564.43		553.44		545.89	556.20	627.64	546.07	546.06	564.43		553.44	
36	549.47	559.84	631.75	549.65	549.63	568.13		557.07		549.47	559.84	631.75	549.65	549.63	568.13		557.07	
37	553.04	563.48	635.86	553.22	553.21	571.82		560.69		553.04	563.48	635.86	553.22	553.21	571.82		560.69	
38	556.61	567.13	639.97	556.80	556.78	575.52		564.31		556.61	567.13	639.97	556.80	556.78	575.52		564.31	
39	563.76	574.41	648.18	563.95	563.93	582.91		571.56		563.76	574.41	648.18	563.95	563.93	582.91		571.56	
40	570.91	581.69	656.40	571.10	571.08	590.30		578.81		570.91	581.69	656.40	571.10	571.08	590.30		578.81	
41	581.63	592.61	668.73	581.82	581.81	601.38		589.68		581.63	592.61	668.73	581.82	581.81	601.38		589.68	
42	591.90	603.08	680.54	592.10	592.08	612.01		600.09		591.90	603.08	680.54	592.10	592.08	612.01		600.09	
43	606.20	617.65	696.98	606.40	606.38	626.79		614.59		606.20	617.65	696.98	606.40	606.38	626.79		614.59	
44	624.07	635.85	717.52	624.28	624.26	645.26		632.70		624.07	635.85	717.52	624.28	624.26	645.26		632.70	
45	645.06	657.25	741.66	645.28	645.26	666.97		653.99		645.06	657.25	741.66	645.28	645.26	666.97		653.99	
46	670.08	682.74	770.43	670.30	670.28	692.84		679.35		670.08	682.74	770.43	670.30	670.28	692.84		679.35	
47	698.22	711.41	802.78	698.46	698.44	721.94		707.88		698.22	711.41	802.78	698.46	698.44	721.94		707.88	
48	730.39	744.18	839.76	730.63	730.61	755.19		740.49		730.39	744.18	839.76	730.63	730.61	755.19		740.49	
49	762.11	776.50	876.23	762.36	762.34	787.99		772.65		762.11	776.50	876.23	762.36	762.34	787.99		772.65	
50	797.84	812.91	917.32	798.11	798.09	824.94		808.88		797.84	812.91	917.32	798.11	798.09	824.94		808.88	
51	833.13	848.87	957.90	833.41	833.39	861.43		844.66		833.13	848.87	957.90	833.41	833.39	861.43		844.66	
52	872.00	888.47	1002.58	872.29	872.26	901.61		884.06		872.00	888.47	1002.58	872.29	872.26	901.61		884.06	
53	911.31	928.52	1047.78	911.61	911.59	942.26		923.92		911.31	928.52	1047.78	911.61	911.59	942.26		923.92	
54	953.75	971.76	1096.57	954.07	954.04	986.14		966.94		953.75	971.76	1096.57	954.07	954.04	986.14		966.94	
55	996.19	1015.00	1145.37	996.52	996.49	1030.02		1009.97		996.19	1015.00	1145.37	996.52	996.49	1030.02		1009.97	
56	1042.20	1061.88	1198.27	1042.55	1042.52	1077.59		1056.62		1042.20	1061.88	1198.27	1042.55	1042.52	1077.59		1056.62	
57	1088.66	1109.22	1251.69	1089.02	1088.99	1125.63		1103.72		1088.66	1109.22	1251.69	1089.02	1088.99	1125.63		1103.72	
58	1138.24	1159.74	1308.70	1138.62	1138.59	1176.90		1153.99		1138.24	1159.74	1308.70	1138.62	1138.59	1176.90		1153.99	
59	1162.81	1184.77	1336.95	1163.20	1163.17	1202.31		1178.90		1162.81	1184.77	1336.95	1163.20	1163.17	1202.31		1178.90	
60	1212.40	1235.30	1393.96	1212.80	1212.77	1253.58		1229.17		1212.40	1235.30	1393.96	1212.80	1212.77	1253.58		1229.17	
61	1255.28	1278.99	1443.26	1255.70	1255.67	1297.92		1272.65		1255.28	1278.99	1443.26	1255.70	1255.67	1297.92		1272.65	
62	1283.43	1307.67	1475.62	1283.86	1283.82	1327.02		1301.18		1283.43	1307.67	1475.62	1283.86	1283.82	1327.02		1301.18	
63	1318.72	1343.62	1516.20	1319.16	1319.12	1363.51		1336.96		1318.72	1343.62	1516.20	1319.16	1319.12	1363.51		1336.96	
64 and over	1340.16	1365.47	1540.85	1340.61	1340.57	1385.67		1358.70		1340.16	1365.47	1540.85	1340.61	1340.57	1385.67		1358.70	

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Silver
HIOS Plan ID: 84481WA0060006
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Silver
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	403.14	410.76	463.51	403.28	403.26	416.83		408.72		403.14	410.76	463.51	403.28	403.26	416.83		408.72	
15	438.98	447.27	504.71	439.12	439.11	453.89		445.05		438.98	447.27	504.71	439.12	439.11	453.89		445.05	
16	452.68	461.23	520.47	452.83	452.82	468.05		458.94		452.68	461.23	520.47	452.83	452.82	468.05		458.94	
17	466.38	475.19	536.22	466.54	466.52	482.22		472.83		466.38	475.19	536.22	466.54	466.52	482.22		472.83	
18	481.14	490.22	553.19	481.30	481.28	497.48		487.79		481.14	490.22	553.19	481.30	481.28	497.48		487.79	
19	495.89	505.26	570.15	496.06	496.04	512.73		502.75		495.89	505.26	570.15	496.06	496.04	512.73		502.75	
20	511.17	520.83	587.72	511.34	511.33	528.53		518.25		511.17	520.83	587.72	511.34	511.33	528.53		518.25	
21	526.98	536.94	605.90	527.16	527.14	544.88		534.27		526.98	536.94	605.90	527.16	527.14	544.88		534.27	
22	526.98	536.94	605.90	527.16	527.14	544.88		534.27		526.98	536.94	605.90	527.16	527.14	544.88		534.27	
23	526.98	536.94	605.90	527.16	527.14	544.88		534.27		526.98	536.94	605.90	527.16	527.14	544.88		534.27	
24	526.98	536.94	605.90	527.16	527.14	544.88		534.27		526.98	536.94	605.90	527.16	527.14	544.88		534.27	
25	529.09	539.08	608.32	529.27	529.25	547.06		536.41		529.09	539.08	608.32	529.27	529.25	547.06		536.41	
26	539.63	549.82	620.44	539.81	539.79	557.96		547.10		539.63	549.82	620.44	539.81	539.79	557.96		547.10	
27	552.28	562.71	634.98	552.46	552.45	571.03		559.92		552.28	562.71	634.98	552.46	552.45	571.03		559.92	
28	572.83	583.65	658.61	573.02	573.01	592.29		580.76		572.83	583.65	658.61	573.02	573.01	592.29		580.76	
29	589.69	600.83	678.00	589.89	589.87	609.72		597.85		589.69	600.83	678.00	589.89	589.87	609.72		597.85	
30	598.13	609.42	687.70	598.33	598.31	618.44		606.40		598.13	609.42	687.70	598.33	598.31	618.44		606.40	
31	610.77	622.31	702.24	610.98	610.96	631.52		619.22		610.77	622.31	702.24	610.98	610.96	631.52		619.22	
32	623.42	635.19	716.78	623.63	623.61	644.59		632.05		623.42	635.19	716.78	623.63	623.61	644.59		632.05	
33	631.33	643.25	725.87	631.54	631.52	652.77		640.06		631.33	643.25	725.87	631.54	631.52	652.77		640.06	
34	639.76	651.84	735.56	639.97	639.95	661.49		648.61		639.76	651.84	735.56	639.97	639.95	661.49		648.61	
35	643.97	656.13	740.41	644.19	644.17	665.84		652.88		643.97	656.13	740.41	644.19	644.17	665.84		652.88	
36	648.19	660.43	745.26	648.41	648.39	670.20		657.16		648.19	660.43	745.26	648.41	648.39	670.20		657.16	
37	652.40	664.73	750.10	652.62	652.60	674.56		661.43		652.40	664.73	750.10	652.62	652.60	674.56		661.43	
38	656.62	669.02	754.95	656.84	656.82	678.92		665.70		656.62	669.02	754.95	656.84	656.82	678.92		665.70	
39	665.05	677.61	764.64	665.27	665.26	687.64		674.25		665.05	677.61	764.64	665.27	665.26	687.64		674.25	
40	673.48	686.20	774.34	673.71	673.69	696.36		682.80		673.48	686.20	774.34	673.71	673.69	696.36		682.80	
41	686.13	699.09	788.88	686.36	686.34	709.43		695.62		686.13	699.09	788.88	686.36	686.34	709.43		695.62	
42	698.25	711.44	802.82	698.49	698.47	721.97		707.91		698.25	711.44	802.82	698.49	698.47	721.97		707.91	
43	715.12	728.62	822.21	715.35	715.33	739.40		725.01		715.12	728.62	822.21	715.35	715.33	739.40		725.01	
44	736.20	750.10	846.44	736.44	736.42	761.20		746.38		736.20	750.10	846.44	736.44	736.42	761.20		746.38	
45	760.96	775.33	874.92	761.22	761.20	786.81		771.49		760.96	775.33	874.92	761.22	761.20	786.81		771.49	
46	790.47	805.40	908.85	790.74	790.72	817.32		801.41		790.47	805.40	908.85	790.74	790.72	817.32		801.41	
47	823.67	839.23	947.02	823.95	823.93	851.65		835.07		823.67	839.23	947.02	823.95	823.93	851.65		835.07	
48	861.62	877.89	990.64	861.90	861.88	890.88		873.54		861.62	877.89	990.64	861.90	861.88	890.88		873.54	
49	899.03	916.01	1033.66	899.33	899.31	929.57		911.47		899.03	916.01	1033.66	899.33	899.31	929.57		911.47	
50	941.19	958.97	1082.14	941.51	941.48	973.16		954.21		941.19	958.97	1082.14	941.51	941.48	973.16		954.21	
51	982.82	1001.38	1130.00	983.15	983.12	1016.20		996.42		982.82	1001.38	1130.00	983.15	983.12	1016.20		996.42	
52	1028.67	1048.10	1182.71	1029.01	1028.98	1063.61		1042.90		1028.67	1048.10	1182.71	1029.01	1028.98	1063.61		1042.90	
53	1075.05	1095.35	1236.03	1075.40	1075.37	1111.56		1089.92		1075.05	1095.35	1236.03	1075.40	1075.37	1111.56		1089.92	
54	1125.11	1146.36	1293.59	1125.48	1125.45	1163.32		1140.67		1125.11	1146.36	1293.59	1125.48	1125.45	1163.32		1140.67	
55	1175.17	1197.37	1351.15	1175.56	1175.53	1215.08		1191.43		1175.17	1197.37	1351.15	1175.56	1175.53	1215.08		1191.43	
56	1229.45	1252.67	1413.56	1229.86	1229.83	1271.21		1246.46		1229.45	1252.67	1413.56	1229.86	1229.83	1271.21		1246.46	
57	1284.26	1308.51	1476.58	1284.69	1284.65	1327.87		1302.02		1284.26	1308.51	1476.58	1284.69	1284.65	1327.87		1302.02	
58	1342.75	1368.11	1543.83	1343.20	1343.16	1388.36		1361.33		1342.75	1368.11	1543.83	1343.20	1343.16	1388.36		1361.33	
59	1371.74	1397.64	1577.16	1372.19	1372.15	1418.32		1390.71		1371.74	1397.64	1577.16	1372.19	1372.15	1418.32		1390.71	
60	1430.23	1457.24	1644.41	1430.71	1430.67	1478.81		1450.02		1430.23	1457.24	1644.41	1430.71	1430.67	1478.81		1450.02	
61	1480.82	1508.79	1702.58	1481.32	1481.27	1531.11		1501.31		1480.82	1508.79	1702.58	1481.32	1481.27	1531.11		1501.31	
62	1514.02	1542.61	1740.75	1514.53	1514.48	1565.44		1534.97		1514.02	1542.61	1740.75	1514.53	1514.48	1565.44		1534.97	
63	1555.65	1585.03	1788.61	1556.17	1556.13	1608.49		1577.17		1555.65	1585.03	1788.61	1556.17	1556.13	1608.49		1577.17	
64 and over	1580.94	1610.81	1817.70	1581.48	1581.42	1634.64		1602.81		1580.94	1610.81	1817.70	1581.48	1581.42	1634.64		1602.81	

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Bronze
HIOS Plan ID: 84481WA0060007
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Bronze
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	261.69	266.63	300.88	261.78	261.77	270.58		265.31		261.69	266.63	300.88	261.78	261.77	270.58		265.31	
15	284.95	290.33	327.62	285.05	285.04	294.63		288.89		284.95	290.33	327.62	285.05	285.04	294.63		288.89	
16	293.85	299.40	337.85	293.94	293.94	303.83		297.91		293.85	299.40	337.85	293.94	293.94	303.83		297.91	
17	302.74	308.46	348.08	302.84	302.83	313.02		306.93		302.74	308.46	348.08	302.84	302.83	313.02		306.93	
18	312.32	318.22	359.09	312.42	312.41	322.93		316.64		312.32	318.22	359.09	312.42	312.41	322.93		316.64	
19	321.90	327.98	370.10	322.00	321.99	332.83		326.35		321.90	327.98	370.10	322.00	321.99	332.83		326.35	
20	331.82	338.08	381.51	331.93	331.92	343.09		336.41		331.82	338.08	381.51	331.93	331.92	343.09		336.41	
21	342.08	348.54	393.31	342.19	342.18	353.70		346.81		342.08	348.54	393.31	342.19	342.18	353.70		346.81	
22	342.08	348.54	393.31	342.19	342.18	353.70		346.81		342.08	348.54	393.31	342.19	342.18	353.70		346.81	
23	342.08	348.54	393.31	342.19	342.18	353.70		346.81		342.08	348.54	393.31	342.19	342.18	353.70		346.81	
24	342.08	348.54	393.31	342.19	342.18	353.70		346.81		342.08	348.54	393.31	342.19	342.18	353.70		346.81	
25	343.45	349.93	394.88	343.56	343.55	355.11		348.20		343.45	349.93	394.88	343.56	343.55	355.11		348.20	
26	350.29	356.90	402.74	350.41	350.40	362.19		355.13		350.29	356.90	402.74	350.41	350.40	362.19		355.13	
27	358.50	365.27	412.18	358.62	358.61	370.67		363.46		358.50	365.27	412.18	358.62	358.61	370.67		363.46	
28	371.84	378.86	427.52	371.96	371.95	384.47		376.98		371.84	378.86	427.52	371.96	371.95	384.47		376.98	
29	382.79	390.02	440.11	382.91	382.90	395.79		388.08		382.79	390.02	440.11	382.91	382.90	395.79		388.08	
30	388.26	395.59	446.40	388.39	388.38	401.45		393.63		388.26	395.59	446.40	388.39	388.38	401.45		393.63	
31	396.47	403.96	455.84	396.60	396.59	409.93		401.95		396.47	403.96	455.84	396.60	396.59	409.93		401.95	
32	404.68	412.32	465.28	404.81	404.80	418.42		410.28		404.68	412.32	465.28	404.81	404.80	418.42		410.28	
33	409.81	417.55	471.18	409.95	409.94	423.73		415.48		409.81	417.55	471.18	409.95	409.94	423.73		415.48	
34	415.28	423.13	477.47	415.42	415.41	429.39		421.03		415.28	423.13	477.47	415.42	415.41	429.39		421.03	
35	418.02	425.91	480.62	418.16	418.15	432.22		423.80		418.02	425.91	480.62	418.16	418.15	432.22		423.80	
36	420.76	428.70	483.77	420.90	420.89	435.05		426.58		420.76	428.70	483.77	420.90	420.89	435.05		426.58	
37	423.49	431.49	486.91	423.64	423.62	437.88		429.35		423.49	431.49	486.91	423.64	423.62	437.88		429.35	
38	426.23	434.28	490.06	426.37	426.36	440.71		432.13		426.23	434.28	490.06	426.37	426.36	440.71		432.13	
39	431.70	439.86	496.35	431.85	431.84	446.37		437.68		431.70	439.86	496.35	431.85	431.84	446.37		437.68	
40	437.18	445.43	502.64	437.32	437.31	452.02		443.22		437.18	445.43	502.64	437.32	437.31	452.02		443.22	
41	445.39	453.80	512.08	445.54	445.52	460.51		451.55		445.39	453.80	512.08	445.54	445.52	460.51		451.55	
42	453.25	461.81	521.13	453.41	453.39	468.65		459.53		453.25	461.81	521.13	453.41	453.39	468.65		459.53	
43	464.20	472.97	533.72	464.36	464.34	479.97		470.62		464.20	472.97	533.72	464.36	464.34	479.97		470.62	
44	477.88	486.91	549.45	478.04	478.03	494.11		484.50		477.88	486.91	549.45	478.04	478.03	494.11		484.50	
45	493.96	503.29	567.93	494.13	494.11	510.74		500.80		493.96	503.29	567.93	494.13	494.11	510.74		500.80	
46	513.12	522.81	589.96	513.29	513.27	530.55		520.22		513.12	522.81	589.96	513.29	513.27	530.55		520.22	
47	534.67	544.77	614.74	534.85	534.83	552.83		542.07		534.67	544.77	614.74	534.85	534.83	552.83		542.07	
48	559.30	569.86	643.05	559.49	559.47	578.29		567.04		559.30	569.86	643.05	559.49	559.47	578.29		567.04	
49	583.59	594.61	670.98	583.78	583.76	603.41		591.66		583.59	594.61	670.98	583.78	583.76	603.41		591.66	
50	610.95	622.49	702.44	611.16	611.14	631.70		619.41		610.95	622.49	702.44	611.16	611.14	631.70		619.41	
51	637.98	650.03	733.51	638.19	638.17	659.64		646.80		637.98	650.03	733.51	638.19	638.17	659.64		646.80	
52	667.74	680.35	767.73	667.96	667.94	690.42		676.98		667.74	680.35	767.73	667.96	667.94	690.42		676.98	
53	697.84	711.02	802.34	698.07	698.05	721.54		707.50		697.84	711.02	802.34	698.07	698.05	721.54		707.50	
54	730.34	744.13	839.71	730.58	730.56	755.14		740.44		730.34	744.13	839.71	730.58	730.56	755.14		740.44	
55	762.84	777.24	877.07	763.09	763.07	788.74		773.39		762.84	777.24	877.07	763.09	763.07	788.74		773.39	
56	798.07	813.14	917.58	798.34	798.31	825.17		809.11		798.07	813.14	917.58	798.34	798.31	825.17		809.11	
57	833.65	849.39	958.49	833.92	833.90	861.96		845.18		833.65	849.39	958.49	833.92	833.90	861.96		845.18	
58	871.62	888.08	1002.14	871.91	871.88	901.22		883.68		871.62	888.08	1002.14	871.91	871.88	901.22		883.68	
59	890.43	907.25	1023.77	890.73	890.70	920.67		902.75		890.43	907.25	1023.77	890.73	890.70	920.67		902.75	
60	928.40	945.94	1067.43	928.71	928.69	959.93		941.25		928.40	945.94	1067.43	928.71	928.69	959.93		941.25	
61	961.24	979.40	1105.19	961.56	961.53	993.89		974.54		961.24	979.40	1105.19	961.56	961.53	993.89		974.54	
62	982.79	1001.35	1129.97	983.12	983.09	1016.17		996.39		982.79	1001.35	1129.97	983.12	983.09	1016.17		996.39	
63	1009.82	1028.89	1161.04	1010.15	1010.12	1044.11		1023.79		1009.82	1028.89	1161.04	1010.15	1010.12	1044.11		1023.79	
64 and over	1026.24	1045.62	1179.92	1026.57	1026.54	1061.09		1040.43		1026.24	1045.62	1179.92	1026.57	1026.54	1061.09		1040.43	

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Vital Gold
HIOS Plan ID: 84481WA0060008
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	321.95	328.03	370.16	322.06	322.05	332.88		326.40		321.95	328.03	370.16	322.06	322.05	332.88		326.40	
15	350.57	357.19	403.06	350.68	350.67	362.47		355.42		350.57	357.19	403.06	350.68	350.67	362.47		355.42	
16	361.51	368.33	415.64	361.63	361.62	373.79		366.51		361.51	368.33	415.64	361.63	361.62	373.79		366.51	
17	372.45	379.48	428.22	372.57	372.56	385.10		377.60		372.45	379.48	428.22	372.57	372.56	385.10		377.60	
18	384.23	391.49	441.77	384.36	384.35	397.28		389.55		384.23	391.49	441.77	384.36	384.35	397.28		389.55	
19	396.02	403.50	455.32	396.15	396.14	409.47		401.50		396.02	403.50	455.32	396.15	396.14	409.47		401.50	
20	408.22	415.93	469.35	408.36	408.35	422.09		413.87		408.22	415.93	469.35	408.36	408.35	422.09		413.87	
21	420.85	428.79	483.87	420.99	420.98	435.14		426.67		420.85	428.79	483.87	420.99	420.98	435.14		426.67	
22	420.85	428.79	483.87	420.99	420.98	435.14		426.67		420.85	428.79	483.87	420.99	420.98	435.14		426.67	
23	420.85	428.79	483.87	420.99	420.98	435.14		426.67		420.85	428.79	483.87	420.99	420.98	435.14		426.67	
24	420.85	428.79	483.87	420.99	420.98	435.14		426.67		420.85	428.79	483.87	420.99	420.98	435.14		426.67	
25	422.53	430.51	485.80	422.67	422.66	436.88		428.38		422.53	430.51	485.80	422.67	422.66	436.88		428.38	
26	430.95	439.09	495.48	431.09	431.08	445.58		436.91		430.95	439.09	495.48	431.09	431.08	445.58		436.91	
27	441.05	449.38	507.09	441.20	441.18	456.03		447.15		441.05	449.38	507.09	441.20	441.18	456.03		447.15	
28	457.46	466.10	525.97	457.61	457.60	473.00		463.79		457.46	466.10	525.97	457.61	457.60	473.00		463.79	
29	470.93	479.82	541.45	471.09	471.07	486.92		477.44		470.93	479.82	541.45	471.09	471.07	486.92		477.44	
30	477.66	486.68	549.19	477.82	477.81	493.88		484.27		477.66	486.68	549.19	477.82	477.81	493.88		484.27	
31	487.76	496.97	560.80	487.92	487.91	504.33		494.51		487.76	496.97	560.80	487.92	487.91	504.33		494.51	
32	497.86	507.26	572.42	498.03	498.01	514.77		504.75		497.86	507.26	572.42	498.03	498.01	514.77		504.75	
33	504.17	513.70	579.68	504.34	504.33	521.30		511.15		504.17	513.70	579.68	504.34	504.33	521.30		511.15	
34	510.91	520.56	587.42	511.08	511.06	528.26		517.98		510.91	520.56	587.42	511.08	511.06	528.26		517.98	
35	514.28	523.99	591.29	514.45	514.43	531.74		521.39		514.28	523.99	591.29	514.45	514.43	531.74		521.39	
36	517.64	527.42	595.16	517.81	517.80	535.22		524.80		517.64	527.42	595.16	517.81	517.80	535.22		524.80	
37	521.01	530.85	599.03	521.18	521.17	538.70		528.22		521.01	530.85	599.03	521.18	521.17	538.70		528.22	
38	524.38	534.28	602.90	524.55	524.54	542.18		531.63		524.38	534.28	602.90	524.55	524.54	542.18		531.63	
39	531.11	541.14	610.64	531.29	531.27	549.15		538.46		531.11	541.14	610.64	531.29	531.27	549.15		538.46	
40	537.84	548.00	618.38	538.02	538.01	556.11		545.28		537.84	548.00	618.38	538.02	538.01	556.11		545.28	
41	547.94	558.29	630.00	548.13	548.11	566.55		555.52		547.94	558.29	630.00	548.13	548.11	566.55		555.52	
42	557.62	568.15	641.13	557.81	557.79	576.56		565.34		557.62	568.15	641.13	557.81	557.79	576.56		565.34	
43	571.09	581.87	656.61	571.28	571.26	590.49		578.99		571.09	581.87	656.61	571.28	571.26	590.49		578.99	
44	587.92	599.03	675.97	588.12	588.10	607.89		596.06		587.92	599.03	675.97	588.12	588.10	607.89		596.06	
45	607.70	619.18	698.71	607.91	607.89	628.34		616.11		607.70	619.18	698.71	607.91	607.89	628.34		616.11	
46	631.27	643.19	725.80	631.48	631.46	652.71		640.00		631.27	643.19	725.80	631.48	631.46	652.71		640.00	
47	657.78	670.21	756.29	658.00	657.98	680.12		666.88		657.78	670.21	756.29	658.00	657.98	680.12		666.88	
48	688.09	701.08	791.13	688.31	688.29	711.45		697.60		688.09	701.08	791.13	688.31	688.29	711.45		697.60	
49	717.97	731.52	825.48	718.20	718.18	742.35		727.90		717.97	731.52	825.48	718.20	718.18	742.35		727.90	
50	751.63	765.83	864.19	751.88	751.86	777.16		762.03		751.63	765.83	864.19	751.88	751.86	777.16		762.03	
51	784.88	799.70	902.42	785.14	785.12	811.54		795.74		784.88	799.70	902.42	785.14	785.12	811.54		795.74	
52	821.49	837.01	944.51	821.77	821.74	849.39		832.86		821.49	837.01	944.51	821.77	821.74	849.39		832.86	
53	858.53	874.74	987.09	858.81	858.79	887.69		870.40		858.53	874.74	987.09	858.81	858.79	887.69		870.40	
54	898.51	915.48	1033.06	898.81	898.78	929.02		910.94		898.51	915.48	1033.06	898.81	898.78	929.02		910.94	
55	938.49	956.21	1079.03	938.80	938.77	970.36		951.47		938.49	956.21	1079.03	938.80	938.77	970.36		951.47	
56	981.84	1000.38	1128.87	982.16	982.14	1015.18		995.42		981.84	1000.38	1128.87	982.16	982.14	1015.18		995.42	
57	1025.60	1044.97	1179.19	1025.95	1025.92	1060.44		1039.79		1025.60	1044.97	1179.19	1025.95	1025.92	1060.44		1039.79	
58	1072.32	1092.57	1232.90	1072.68	1072.64	1108.74		1087.15		1072.32	1092.57	1232.90	1072.68	1072.64	1108.74		1087.15	
59	1095.47	1116.15	1259.51	1095.83	1095.80	1132.67		1110.62		1095.47	1116.15	1259.51	1095.83	1095.80	1132.67		1110.62	
60	1142.18	1163.75	1313.22	1142.56	1142.53	1180.97		1157.98		1142.18	1163.75	1313.22	1142.56	1142.53	1180.97		1157.98	
61	1182.58	1204.91	1359.67	1182.98	1182.94	1222.74		1198.94		1182.58	1204.91	1359.67	1182.98	1182.94	1222.74		1198.94	
62	1209.09	1231.93	1390.16	1209.50	1209.46	1250.16		1225.82		1209.09	1231.93	1390.16	1209.50	1209.46	1250.16		1225.82	
63	1242.34	1265.80	1428.38	1242.76	1242.72	1284.53		1259.53		1242.34	1265.80	1428.38	1242.76	1242.72	1284.53		1259.53	
64 and over	1262.54	1286.37	1451.61	1262.96	1262.93	1305.42		1280.01		1262.54	1286.37	1451.61	1262.96	1262.93	1305.42		1280.01	

Molina Healthcare of Washington, Inc.
Rating Example
1/1/2026-12/31/2026

Family Rating Example

Plan Design: Molina Cascade Silver
Product: 84481WA006
HIOS: 84481WA0060006

				(a)	(b)	(c)	(d)	
				Base Premium				
Member	**Age**	**Smoking Status**	**Rating Area**	**Rate[1]**	**Age Factor[2]**	**Tobacco**	**Area**	**Final Premium[2]**
Subscriber	40	Smoker	Rating Area 2	$526.98	1.2780	1.0000	1.0189	$686.20
Spouse	38	Non-Smoker	Rating Area 2	$526.98	1.2460	1.0000	1.0189	$669.02
Child 1	18	Non-Smoker	Rating Area 2	$526.98	0.9130	1.0000	1.0189	$490.22
Child 2	16	Non-Smoker	Rating Area 2	$526.98	0.8590	1.0000	1.0189	$461.23
Child 3	14	Non-Smoker	Rating Area 2	$526.98	0.7650	1.0000	1.0189	$410.76
Child 4	11	Non-Smoker	Rating Area 2	$526.98	0.0000	1.0000	1.0189	$0.00
Total								**$2,717.43**

The rate schedule includes a table outlining premiums by age, smoking status and rating area by each plan. 'Final Premium' is taken directly from the rate schedule for the appropriate plan, age, smoking status and rating area combination
(1) Corresponds to Calibrated Plan Adjusted Index Rate in URRT
(2) Rates are charged to no more than three oldest covered children under 21 for family coverage

SERFF Tracking #:	*MLWA-134518839*	***State Tracking #:***	*484742*	***Company Tracking #:***	

State:	*Washington*	***Filing Company:***	*Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*2026 Non-grandfathered Individual Rate Filing MHW01012026*		
Project Name/Number:	*/*		

URRT

State Determination

Review Status:	Incomplete

SERFF Tracking #:	*MLWA-134518839*	***State Tracking #:***	*484742*	***Company Tracking #:***	

State:	*Washington*	***Filing Company:***	*Molina Healthcare of Washington, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*2026 Non-grandfathered Individual Rate Filing MHW01012026*		
Project Name/Number:	*/*		

URRT Items

Item Name	Attachment(s)
Unified Rate Review Template	*UnifiedRateReviewSubmission_20250511175956.xml*
Actuarial Memorandum	*PartIIIRateFilingDocumentatonandActuarialMemorandum.pdf*
Actuarial Memorandum - Redacted	*PartIIIRateFilingDocumentationandMemorandum_Redacted.pdf*
Consumer Justification Narrative	*PartIIWrittenDescriptionJustifyingtheRateIncrease.pdf*
Other Supporting Documents	*PartIUnifiedRateReviewTemplate.pdf*

Actuarial Memorandum and Certification

Effective January 1, 2026

The purpose of this actuarial memorandum and certification is to provide information related to Molina Healthcare of Washington, Inc.'s (Molina) Part I Unified Rate Review Template submission to the Washington Individual Marketplace (Washington Marketplace).

The actuarial memorandum and certification describe Molina's rating methodology used to develop rates for Individual products offered on the Washington Marketplace effective January 1, 2026. Molina will not market Individual products outside of the Washington Marketplace.

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services individuals eligible for Medicaid, Medicare, and Marketplace throughout the State of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 20 states across the nation, Molina serves more than 5 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern Washington. Today, we continue his mission of providing high quality and cost-effective health care to those who need it most.

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MolinaHealthcare.com

Contents

GENERAL INFORMATION

The information below documents the company identifying and contact information entered into the general information section of Worksheet 1 of the Unified Rate Review Template (URRT).

The rate methodology and resulting premiums outlined in this Actuarial Memorandum assume current law, which includes the following:

- The expiration of the American Rescue Plan (ARP) enhanced premium tax credit subsidies at the end of 2025.
- Cost-Sharing Reduction (CSR) subsidies remain unfunded.
- The parameters of the HHS Notice of Benefit and Payment Parameters for 2026 (Final 2026 Payment Notice), which became effective on January 15th, 2025.

Notably, the Marketplace Integrity and Affordability Proposed Rule (Program Integrity Rule) was published by CMS in the Federal Register on March 19th, 2025, followed by a comment period that could substantially alter the proposed rule. The rate methodology and resulting premiums outlined in this Actuarial Memorandum were prepared prior to the finalization of the Program Integrity Rule and therefore do not reflect the changes proposed in the Program Integrity Rule.

Molina will seek regulatory approval to file revised rates if material changes to the regulatory environment occur, including, but not limited to, changes to the above mentioned items.

Company Identifying Information

Company Identifying Information	
Legal Name:	Molina Healthcare of Washington, Inc.
State:	Washington
HIOS Issuer ID:	84481
Market:	Washington Individual Marketplace
Effective Date:	January 1, 2026

Company Contact Information

Company Contact Information	
Contact Name	Kathryn Hall
E-mail	Kathryn.Hall@molinahealthcare.com

PROPOSED RATE INCREASE(S)

Molina's rate filing reflects a rate change of 24.59% as calculated by section Q5 of the Uniform Product Modification Justification (UPMJ) template for Molina's 43,346 members enrolled effective March 2025, reported as of April 2025. The UPMJ Q5 rate change is calculated using the average rate change of each plan weighted by membership in each plan.

Molina's rate filing reflects the following rate changes as calculated by Part I of the Unified Rate Review Template in Section 1 of Worksheet 2 for Molina's 36,212 members enrolled in plans that are renewing for 2026. Enrollment data is as of March 2025, reported as of April 2025. The URRT rate change is calculated using the rate change of each renewing plan weighted by the membership and premium in each renewing plan.

The rate changes vary by plan due to changes in the Actuarial Value (AV) Pricing Values assigned to each metal plan that are applied to the Plan Adjusted Index Rate.

14-Digit Plan ID	Plan Name	Metal	202503 Mbrs	2025 PMPM	2026 PMPM	Avg	Min	Max
84481WA0060005	Molina Cascade Complete Gold	Gold	10,687	$685	$748	9.3%	8.6%	11.4%
84481WA0060006	Molina Cascade Silver	Silver	13,965	$662	$907	37.0%	36.0%	39.4%
84481WA0060007	Molina Cascade Bronze	Bronze	11,560	$547	$635	16.1%	15.4%	18.3%
84481WA0060008	Molina Cascade Vital Gold	Gold	0	$0	$0	-	-	-
Total			**36,212**	**$632**	**$773**	**22.4%**	**8.6%**	**39.4%**

Reason for Rate Change(s): The following factors contribute toward the overall change in the proposed rates.

- **Claims:** Projected claims for 2026 are expected to contribute toward a 17.3% increase in rates due to updated base period experience claims, trend, changes in product, acuity, and demographic mix.
- **Taxes and Fees:** Taxes, fees, and retention are expected to contribute toward a 0.5% increase in rates.
- **Margin:** Margins are expected to contribute toward a 0.5% increase in rates at our company standard 3.0% after-tax profit margin.
- **Risk Transfer:** Risk transfer is expected to contribute toward a 1.9% decrease in rates.
- **Administrative Expenses:** Administrative expenses are expected to contribute toward a 0.3% increase in rates.
- **Membership Mix:** The membership mix from the base period to the projection period compared to the membership mix for comparable time periods from the prior year rate filing is expected to contribute toward a 5.7% increase in rates.

Rate changes vary by plan due to changes in Actuarial Value, Cost Share Design (CSD), and Geographic factors.

MARKET EXPERIENCE

The single risk pool was established according to the requirements in 45 CFR 156.80. No transitional products/plans or grandfathered products are included in the development of the single risk pool.

Molina's 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months or 40,774 average members in the period of January 1, 2024 to December 31, 2024.

Experience Period Premium and Claims

Paid Through Date: The market experience reported in Worksheet 1, Section I of the URRT represents 2024 incurred claims paid through March 2025. The completion factors applied to the 2024 claims experience were updated with data through March 2025.

Current Date: The current enrollment and premium are reported as of April 2025.

Premiums (Net of MLR Rebate) in Experience Period: The premiums reported in Worksheet 1, Section I of the URRT represent the earned premium from 2024, excluding risk adjustment transfer payments for the 2024 benefit year. Earned premium does not reflect any MLR rebates. No amounts were subtracted from the earned premium for any reductions prescribed by the federal MLR formula, such as taxes and assessments.

Allowed and Incurred Claims in Experience Period: The following table reports the allowed and incurred claims during the experience period of January 1, 2024 to December 31, 2024.

Description	Medical	Pharmacy	Capitation	Total
Allowed	$237,949,720	$80,067,777	$13,196,321	$331,213,818
IBNR Factor	1.014	1.000	1.000	1.010
Allowed w/ IBNR	**$241,277,636**	**$80,067,777**	**$13,196,321**	**$334,541,734**
Paid	$204,905,854	$71,110,323	$10,164,514	$286,180,691
IBNR Factor	1.014	1.000	1.000	1.010
Paid w/ IBNR	**$207,836,278**	**$71,110,323**	**$10,164,514**	**$289,111,115**

The experience is for all 2024 individual non-grandfathered plans including subsidized populations defined under the Cost Sharing Reduction (CSR) programs. The experience does include data for the American Indian/Alaska Native (AIAN) population which is funded by the federal government and is not tied to any metal level in the Marketplace.

Allowed claims for the experience period were obtained from the claims records by adding the plan incurred paid claims and the member cost-sharing for medical and pharmacy claims net of rebates received from drug manufacturers. The allowed claims calculation applies to both fee-for-service claims and capitation costs.

Completion factors were applied to both the allowed and incurred medical claim amounts. The completion factors were developed separately for inpatient and non-inpatient medical claims based on Molina's Washington Marketplace data. The IBNR factor for medical allowed claims is 1.014. The IBNR factor for medical incurred and paid claims is 1.014. IBNR factors were not applied to capitation and pharmacy claims.

The IBNR reserves were determined based on best estimates. Explicit margin for loss adjustment expenses and provision for adverse deviation are accounted for in the financial system in separate accounts that do not impact the completion factors used for IBNR reserves.

All medical claims are paid through Molina's claims system. Pharmacy claims are processed through Molina's pharmacy benefit manager.

In the experience period 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 not counted toward the annual limitation on cost sharing.

There were no federal or state reinsurance amounts to report in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Experience Period Premium and Experience Period Member Months in 2024 were reported in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Inclusion of Capitation Payments: All capitated payments are included in the experience data and rate development. For pediatric vision coverage Molina has a vision care agreement with Vision Service Plan (VSP), a California not-for-profit corporation, with its principal place of business located in Rancho Cordova, CA and Molina Healthcare of Washington, Inc. which is in Bothell, WA. No changes have occurred to the 2026 agreement terms compared with 2024 and 2025.

Actual to Projected Analysis: Molina tracks Marketplace experience on an ongoing monthly basis through IBNR reserving, claims forecasting based on current and prior year results, and Risk Adjustment estimation. The experience is tracked at the single risk pool level. 2024 experience was used as the baseline experience period for the 2026 rate filing, so the extent that 2024 experience deviated from projected 2024 results is captured in 2026 rates. No extra adjustments were made in 2026 pricing to account for 2024 deviations in claims.

Benefit Categories

Molina assigned all experience claims to benefit categories utilizing Milliman's MedInsight Health Cost Guidelines (HCG) grouper. The following table displays the measurement units related to each benefit category.

Benefit Category	Util Type
Inpatient Hospital	Days
Outpatient Hospital	Visits
Professional	Services
Other Medical	Services
Capitation	Benefit Period
Prescription Drug	Prescriptions

Projection Factors

Trend Factors

Trend Factors: Trend factors were applied separately for unit cost and utilization and by each major benefit category shown in Worksheet 1, Section II of the URRT. The Year 1 and Year 2 trend factors represent the annual trend numbers that were used to trend the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026.

Unit cost trends were measured by calculating average reimbursement rates in the base period and projection period, which consider reimbursement changes and provider mix changes. The unit cost trends include the expected impact of Medicare reimbursement changes from 2024 to 2026 for provider reimbursement contracts that are based on a percentage of the Medicare fee schedule. Pharmacy unit cost trends are based on an analysis of AWP changes over time for a fixed basket of drugs.

The unit cost projections reflect input on likely network and provider contract term changes for the projection year. Provider contracting is already complete for plan year 2026 for counties within Molina's existing footprint. The status of projected reimbursement trend is mostly locked in for plan year 2026.

Utilization trends were developed through a review of trends from the 2025 URRT public use files in Worksheet 1, Section II, with a focus on Individual Market plans with non-zero credibility and nonzero trend factors in states where Molina offers coverage. Year 1 utilization trends include the impact of emerging experience in 2025. Changes in average health status and mix of services are considered in the Acuity and Plan Mix adjustments included in the rate filing and are not considered in utilization trends.

Cost-sharing benefit features such as deductible, copay, out-of-pocket maximum would impact utilization leveraging of trend. However, for pricing purposes allowed trends (utilization before leveraging) were used according to the URR instructions for developing the single risk pool.

Trends were selected based on expectations for a more stable On-Exchange population and were compared to historical and prospective trends for our On-Exchange experience in other states. In general, prospective utilization trends were selected in a way that does not expect abnormally high and abnormally low historical experience to continue.

Please see WA Exhibit 3 for support of the selected trends applied in pricing and WA Exhibits 4 and 5 as support for the historical and adjusted trends described above.

Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment: The morbidity adjustment is comprised of an acuity factor that represents anticipated changes in Molina's single risk pool.

Changes in acuity: The morbidity of Molina's covered population is expected to decrease between the experience period and the projection period.

An acuity adjustment of 1.039 was made to the 2024 experience period data to reflect changes in the population acuity from the experience period to the 2025 current period. The acuity changes from the 2024 experience period to the 2025 current period are measured by calculating the difference in the 2024 risk scores and 2025 risk scores, both weighted by 2026 projected metal mix to avoid double counting with the plan mix adjustment.

The acuity change from the 2025 current period to the 2026 projection period is calculated in the same way, weighting 2025 and 2026 risk scores with 2026 projected metal mix. With the implementation of uniform silver-loading, the majority of Molina's Silver members are expected to move to Gold plans decreasing the projected average risk score for Gold members.

Under current law, Enhanced Premium Tax Credits (ePTCs) are scheduled to expire at the end of 2025. Molina retained Milliman to analyze the impact of expiring premium subsidies on statewide morbidity. We reviewed the study and determined that the best estimate for an acuity adjustment is 1.023. The total acuity adjustment factor for the 2025 current period to the 2026 projection period is 0.930.

The final acuity adjustment factor is 0.967. Please refer to Appendix Exhibit 4.1.

Demographic Shift: A demographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the demographic mix from the 2024 experience data to the 2026 projection period.

The anticipated demographic mix is based on a review of enrollment through March 2025 and projected 2026 enrollment compared to the experience period. Molina anticipates that its 2026 demographics will be consistent with its 2025 demographics for existing membership. The demographic adjustments were developed using allowed claims by age cohort normalized for differences in metal and acuity. The total demographic adjustment made to the 2024 experience period data is 1.007. Please refer to Appendix Exhibit 4.2a.

Geographic Adjustment: A geographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the area membership mix from the 2024 experience data to the 2026 projection period. A geographic adjustment of 1.002 was made to the 2024 experience period data. Please refer to Appendix Exhibit 4.2c.

Plan Mix Adjustment: The plan mix adjustment reflects anticipated changes in the average utilization of services due to differences in average cost-sharing requirements during the experience period and

average cost-sharing requirements in the projection period. This includes changes in induced demand and the effects of selection for the single risk pool.

The 2024 claims experience by Metal and CSR variant was used to weight the 2024 membership mix against the projected membership mix expected in the 2026 projection period to develop a plan mix adjustment factor between the 2024 experience period and 2026 projection period. The Gold allowed claims amount was adjusted to reflect the membership migration to Gold as a result of uniform silver-loading. The adjusted allowed claims are a weighted average calculated using the membership moving from Silver and Bronze to Gold.

The plan mix adjustment made to the 2024 experience period data is 1.121. Please refer to Appendix Exhibit 4.3.

Manual Rate Adjustments

Not Applicable.

Credibility of Experience

A Monte Carlo simulation was used to determine the credibility level to assign to the base period experience. The simulation used a claims probability distribution (CPD) from the Final 2026 Actuarial Value calculator to generate random samples of members and calculated the average annual cost for each sample.

The results showed that 60,000 member months are needed so that the average annual cost is within 10% of the mean (expected claims amount) 95% of the time.

The credibility percentage to apply to the experience data is based on experience period member months and the credibility formula below:

- 0 - 59,999 member months: 100% manual
- 60,000+ member months: 100% experience

The 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months resulting in a credibility percentage that is 100% experience rated. This method is consistent with the applicable American Academy of Actuaries' Actuarial Standards of Practice (ASOP) No. 25 Credibility Procedures.

Establishing the Index Rate

Index Rate: The index rate is developed following the specifications of 45 CFR part 156.80(d)(1). The index rate for the projection period is estimated to be $892.52. The index rate represents the estimated total allowed claims experience for the essential health benefits within the Washington Marketplace. The index rate does not include adjustments for the risk adjustment and reinsurance programs or an adjustment for the Washington Marketplace user fee. Please refer to Appendix Exhibit 5.1a.

Development of the Market-wide Adjusted Index Rate

Reinsurance

Not Applicable.

Risk Adjustment and Payment Change

Experience Period Risk Adjustment PMPM:
Molina used results from the Wakely National Risk Adjustment Reporting (WNRAR) Project to supplement internal estimates of risk scores, statewide premiums, and related risk adjustment transfer amounts. For the 2024 experience period, the risk transfer receivable is $80.25 per member per month (PMPM) or $39,265,304.

Projected Risk Adjustments PMPM: Molina estimated the risk transfer amount for 2026 using the 2024 experience period risk transfer amounts. The 2026 risk transfer estimates were developed by projecting 2025 relative risk scores and transfer payments, then projecting 2026 relative risk scores and transfer payments. The risk transfer payment amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium. The projection is based on the 2026 calibrated model. The population was grouped into the following cohorts:

- *2025 Renewal Members* – Some of Molina's current members previously had coverage in 2024 and renewed in 2025 with Molina. Molina relied on the renewal member's 2024 experience and risk scores to project their 2025 relative risk scores, taking into consideration any applicable changes in enrollment across metal tiers.
- *2025 New Members* – To estimate the relative risk of the 2025 new members, Molina referred to the estimated risk scores and transfer amounts from the 2024 experience period. Estimated risk scores were adjusted in consideration of the metal tier mix between the 2024 members and the 2025 new members.

- *2026 Members* – Molina assumed the 2026 members would have the higher relative risk scores as the 2025 members, with consideration for the metal tier mix between the two years.

The impact of the national high-risk pool fund was incorporated using 2024 claims experience and a white paper report from Wakely on the estimated high-cost risk pooling charges based on information voluntarily provided by issuers. The net impact of estimated charges and recoveries was calculated as $1.45 PMPM payable.

The impact of the risk adjustment data validation program was incorporated using historical error rates from the final CMS RADV results and the RADV error rate report from Wakely based on information voluntarily provided by issuers. The net impact of estimated payment was calculated as $1.97 PMPM receivable.

The resulting 2026 risk transfer receivable estimate is $82.23 PMPM. Molina included $1.45 PMPM payable for projected national high-risk pooling funding and $1.97 PMPM receivable for projected risk adjustment data validation to get a net risk transfer receivable estimate of $82.75 PMPM. This amount was converted from a paid to allowed basis and entered in the URRT Worksheet I, Section II.

The risk transfer receivable amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium.

The 2026 statewide average premium was projected using historical experience and information from Wakely, including the estimated 2025 statewide average premium. An adjustment of was made to the statewide average premium to account for changes due to uniform silver-loading. Using historical experience and the adjustment for silver-loading, the 2026 statewide average premium increase is estimated to be 8.2%.

Please refer to WA Exhibit 10 for further information on projected risk adjustment.

Washington Marketplace Exchange Fee:
Washington Marketplace will charge a fee of $5.11 PMPM which was divided by the total paid to allowed factor of 0.787 to convert to an allowed basis of $6.49 PMPM for the Market Adjusted Index Rate. Please refer to Appendix Exhibit 5.1a to locate the same percentage for the Exchange User Fee entered in Worksheet 1, Section II.

Market Adjusted Index Rate: The market adjusted index rate is developed following the specifications of 45 CFR part 156.80(d)(1). Molina modified the index rate provided in URRT Worksheet I to a market adjusted index rate. Please refer to Appendix Exhibit 5.1a

Plan Adjusted Index Rates

The plan adjusted index rates are developed following the specifications of 45 CFR part 156.80(d)(2). The plan adjusted index rates are entered in Worksheet 2, Section IV, of the URRT. Molina calculated the plan adjusted index rates by applying plan specific level adjustments for actuarial value, cost

sharing utilization, additional benefits, and administrative costs, excluding exchange user fees, to the market adjusted index rate. Please refer to Appendix Exhibit 10.2.

Paid to Allowed Ratio: The Paid to Allowed ratio reflects the estimated cost-sharing in the projected period. The Final 2026 AV Calculator was used to determine metal AVs, but for pricing a different calculator was used. This is detailed in the Pricing AVs section. The Paid to Allowed ratio is the member-weighted average of the Actuarial Values. Please refer to Appendix Exhibit 5.1b.

Benefits in Addition to EHBs:
There are no benefits in addition to EHBs. However, Molina covers the elective termination of pregnancy benefit. Per Checklist Item #10d, abortion services must be treated as non-EHBs in the URRT. Therefore, elective termination of pregnancy costs are included in the Index Rate and field 3.5 in the URRT has been adjusted to account for these costs. An estimated $1.00 PMPM is used to account for abortion services. The percentage of premium by plan is used to calculate the Benefits in Addition to EHB, field 3.5 of Worksheet 2. Please refer to Appendix Exhibit 5.1b.

Retention Loads, excluding Exchange User Fees: All costs related to admin, profit & risk and taxes & fees, excluding the Washington Marketplace Fee, are calculated for each expected plan offering. Please refer to WA Exhibit 11.

Provider Network, Delivery System Characteristics, and Utilization Management Practices: Plan rates do not vary for variation in provider network, delivery system characteristics, or utilization management.

Provider Compensation Statement: Provider compensation does not include bonuses in addition to other payments.

Catastrophic plans: Not applicable.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Administrative expenses for the Marketplace product from 2024 and 2025 were reviewed and projected forward to 2026 to develop the administrative costs required to manage the Washington Marketplace population. An internal administrative cost budget was developed on a PMPM basis and applied to the Washington Marketplace rates. Part of the total administrative expense load is a subcomponent for Quality Expenses which are administrative costs dedicated to improving health care quality for Molina Marketplace members. The Quality Expense load is $10.48 PMPM. Amounts for broker commissions were added to the administrative costs. The expected administrative expense load is 10.3%. Please refer to WA Exhibit 11.

Broker Commissions: Broker commissions of $11.83 PMPM are expected based on historical broker-sold business and a projection of new and renewing members sold through the broker channel.

Profit Margin: The target after-tax margin is 3.0%, which aligns with Molina's company standard target. Molina's current capital and surplus did not impact the filing. The profit and risk load of 3.0% of premium is consistent with the target margin filed and approved for each rating period from 2015 through 2026.

Taxes and Fees: Molina's estimated taxes and fees (excluding Exchange Fee) are 3.0%. The taxes and fees estimates are comprised of the following:

- **Income Tax:** An estimated 0.8% of premiums will be paid in Federal income taxes.
- **WSHIP:** The WSHIP assessment is projected at $0.13 PMPM. Per the most recent information available in the 2023 Annual Report, WSHIP assessments were $12 million in 2023 (an estimated $0.25 PMPM). WSHIP assessments for 2024 were projected to be $6 million. Therefore, Molina has estimated the WSHIP assessment to be $0.13 PMPM for 2026.
- **Regulatory Surcharge:** The regulatory surcharge is an annual cost of operating the Office of the Insurance Commissioner which is charged to insurers like Molina. The 0.08% of premium is based on internal budgetary forecasts. The 2026 regulatory surcharge was assumed to be 0.08% of premium.
- **Risk Adjustment User Fee:** $0.20 PMPM will be paid toward the risk adjustment user fee.
- **Insurance Fraud Surcharge:** The 2026 insurance fraud surcharge is estimated to be .004% of premium.
- **Premium Tax:** Molina has assumed 2.0% for the state premium tax.
- **PCORI:** An estimated $0.33 PMPM ($4.01 PMPY) will be paid toward the PCORI fee. This was estimated by projecting forward the $3.47 PMPY value for members whose plan year ends September 2024 through October 2025 forward two years at a rate of 7.5% per year, the 3-year average annual increase.
- **WAPAL:** An estimated $0.06 PMPM will be paid toward the WAPAL fund. The 2026 estimate is based on the most recent information available from the FY2025 Assessment Rate Notification to Payers.

Calibration

Age Curve Calibration: Molina calibrated the Plan Adjusted Index Rates to an age 21 rate. The average composite age factor was estimated by multiplying the population distribution by the age factors. The calibration factor is 0.580.

Molina estimated the average age of the single risk pool to be 43 years of age by multiplying the expected age distribution percentages by the age. Molina assumed an average age of 7 for the Age 0-14 cohort in the average age estimate and an average age of 71 for the Age 65+ cohort. Premium rates are based on the attained age as of the coverage effective date and will not be re-rated/adjusted when a birthdate occurs during the year after the coverage starts.

Please refer to Appendix Exhibit 4.2b.

Geographic Factor Calibration: Molina applied geographic factors to the index rate in the calculation of region-specific rates. The geographic factors are based on the provider reimbursement expectations in each region.

None of the following items were used in establishing the geographic rating area factors:

(i) Health status of enrollees or the population in an area;
(ii) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health 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.

Adjustments were made to the geographic factors to ensure that the minimum geographic factor and the maximum geographic factor did not deviate by more than 15% per Washington regulations. The calibration factor of 0.975 equals the inverse of the weighted average geographic factor.

Please refer to Appendix Exhibit 7.1.

Tobacco Factor Calibration: Molina does not price in a tobacco surcharge. The calibration factor is set to 1.000. The tobacco calibration factor has been set to 1.000 in 2023, 2024, and 2025 as well.

Base Premium Rate Development

The Base Premium Rates are calibrated to an age 21 premium with an area factor of 1.0. Only the allowable rating factors will be applied to the Base Premium Rates. Please see Appendix Exhibit 6.1.

PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) using the federally prescribed MLR methodology is for calendar year 2026 based on the ratio of projected incurred claims divided by projected revenue. The MLR result was calculated to be 87.1%. Please refer to Appendix Exhibit 11.1 for a full demonstration of the projected loss ratio. In the Part I Unified Rate Review Template, Worksheet 2, item 4.10 Loss Ratio displays a loss ratio in total and by plan adjusted index rates. The loss ratio calculated here follows a different formula than the federally prescribed MLR methodology and will not match that figure. The URRT loss ratio is incurred claims divided the sum of the risk adjustment transfer amount and the plan adjusted index rate premium. The federal MLR considers quality in the numerator and taxes and fees in the denominator.

PLAN PRODUCT INFORMATION

AV Metal Values

All plan offerings have cost-sharing levels that are different for Preferred Generic Drugs and Non-Preferred Generic Drugs. These plans are considered unique benefit design according to the logic used in the Final 2026 Actuarial Value Calculator (AVC). The AV metal values were determined by using a permissible alternative method that complies with 45 CFR 156.135(b)(3).

The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

The Bronze and Silver Standard plans were adjusted according to the same generic drug methodology. An adjustment factor was calculated for the standard plans using the original AV compared with the blended AV and applied to the Adjusted AV prepared by Wakely. Please refer to Appendix Exhibit 11.4.

Please refer to the supporting document "Unique Plan Design Documentation" unique plan design certification for documentation on the generic drug cost-sharing component of the plans.

For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature. The unique plan design certification for the Bronze and Silver plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Silver CSR Loading: In accordance with WAC 284-43-6820, a uniform CSR silver load adjustment factor of 1.435 has been applied to Silver plans for plan year 2026. Please refer to WA Exhibit 8.

AV Pricing Values

AV pricing value of each plan only includes the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). Cost-sharing adjustments ensure that differences due to health status were not included in the adjustment. The modifiers are applied to the index rate. Molina relied on the Final 2026 AV Calculator to evaluate the Actuarial Value of the plan designs.

Plan ID	Plan Name	AV Metal Value	AV Pricing Value
84481WA0060005	Molina Cascade Complete Gold	0.8171	0.8171
84481WA0060006	Molina Cascade Silver	0.7184	0.7184
84481WA0060007	Molina Cascade Bronze	0.6499	0.6499
84481WA0060008	Molina Cascade Vital Gold	0.7801	0.7801

Essential Health Benefits

All benefit plans offered meet essential health benefit (EHB) requirements. Molina plan designs in 2026 are all standard plan designs. The State of Washington has added new EHBs for plan years beginning on or after January 1, 2026. The EHB additions are as follows:

- Hearing Exams shall be categorized as Primary Care Visits.
- Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
- Artificial Insemination shall be categorized as All Other Benefits.
- Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).

Membership Projections

Molina is filing Washington Marketplace rates in 18 counties representing 7 rating regions. The membership projection is based on anticipated renewals of existing members and new members. New membership is based on an estimate of the total number of members enrolled in Washington Marketplace by county. The source of new members is mostly from other carriers.

The enrollment projections by plan, including cost-sharing reduction eligible plans, were based on a projection of 2025 membership calculated early in 2025. The baseline membership projections reflected a decline in membership across all plans as a result of the 2026 rate change. Members are also anticipated to migrate away from Silver plans due to uniform silver-loading. Some of these members are expected to migrate toward Molina Gold plans.

We are anticipating that Molina will not offer one of the lowest cost Silver plans in 2026, and as a result, will continue to decline in Silver membership. This is partially because new members tend to select one of the lowest cost offerings in the market, including Cascade Select plan offerings from other carriers. As a result, Molina modeled a reduction in the proportion of available Silver members in the market compared to current membership. With the anticipated expiration of ePTCs, Molina modeled a reduction in membership. These members may move to other carriers or leave the market.

Molina plans to offer its products in the counties listed by region below.

Region	County List
1	King
2	Cowlitz, Kitsap, Lewis
3	Clark, Klickitat, Skamania
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Mason, Pierce, Thurston
6	Benton, Franklin
8	Snohomish

Terminated Products

Molina is terminating the Constant Care Silver 1 plan design for 2026. Members currently enrolled in this plan will be mapped to the Molina Cascade Silver plan.

A summary of Molina's terminated, renewing, and new products is provided in the following table:

Plan ID	Plan Name	Metal	2026 Status
84481WA0060005	Molina Cascade Complete Gold	Gold	Renewing
84481WA0060006	Molina Cascade Silver	Silver	Renewing
84481WA0060007	Molina Cascade Bronze	Bronze	Renewing
84481WA0060008	Molina Cascade Vital Gold	Gold	New
84481WA0060004	Constant Care Silver 1	Silver	Terminated

PLAN TYPE

All benefit plans are comprehensive HMO individual products.

MISCELLANEOUS INSTRUCTIONS

Effective Rate Review Information

URRT Comparison: Tables comparing the 2026 values with the 2025 values entered in the URRT (Worksheet I, Sections II) are provided in Appendix Exhibit 2.1.

Mental Health / Substance Use Disorder Financial Requirement Checklist: In Molina's mental health parity calculation template, the underlying claim data source is Molina's WA marketplace 2024

experience data projected forward to 2026 as described in the Actuarial Memorandum. No adjustment has been made to the data. The projections reflect the plan level assumptions and are based on the amounts that the Plan allows before reductions for enrollee cost sharing. A reasonable actuarial method was used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Reliance

The unique plan design certification for the Standard plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Milliman's MedInsight Health Cost Guidelines (HCG) grouper was relied upon for categorizing claims data for the experience period.

Wakely's white paper report on the estimated high-cost risk pooling charges (2023, 2024, and 2025 High-Cost Risk Pooling Program – National Estimate) was relied upon for our estimate of High Cost Risk Pool (HCRP) amounts.

Actuarial Certification

I, Kathryn Hall, am an employee of Molina Healthcare and I am a member in good standing with the American Academy of Actuaries meeting its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries. I have the education and experience necessary to the perform the work and hereby certify, to the best of my knowledge and judgment, that this filing complies with applicable State and Federal Statues for individual rate filings. I certify the following:

The projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
b. Developed in compliance with the applicable Actuarial Standards of Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Termination of pregnancy is a WA EHB under the “maternity and newborn services” category [WAC 284-43-5642]. The “Benefits in Addition to EHB” field is the multiplicative inverse of the value entered into the “EHB Percent of Total Premium” field on the Plans & Benefits Template (PBT). For the purposes of filling out the URRT Worksheets, abortion services for which public funding is prohibited was entered as Benefits in Addition to EHB, even though the benefits are considered EHBs in Washington.

The Final 2026 AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. Adjustments were made for unique benefit designs as described in the Reliance and in the Plan Product Information / AV Metal Values sections of this memorandum.

Please refer to the supporting document “Unique Plan Design Documentation” unique plan design certification.

I certify that the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct, including:

- ASOP 5: Incurred Health and Disability Claims
- ASOP 8: Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP 12: Risk Classification
- ASOP 23: Data Quality
- ASOP 25: Credibility Procedures
- ASOP 41: Actuarial Communications
- ASOP 45: The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act
- ASOP 56: Modeling

05/13/2025

Kathryn Hall, ASA, MAAA
Actuarial Manager
Molina Healthcare

Date

Actuarial Memorandum and Certification

Effective January 1, 2026

The purpose of this actuarial memorandum and certification is to provide information related to Molina Healthcare of Washington, Inc.'s (Molina) Part I Unified Rate Review Template submission to the Washington Individual Marketplace (Washington Marketplace).

The actuarial memorandum and certification describe Molina's rating methodology used to develop rates for Individual products offered on the Washington Marketplace effective January 1, 2026. Molina will not market Individual products outside of the Washington Marketplace.

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services individuals eligible for Medicaid, Medicare, and Marketplace throughout the State of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 20 states across the nation, Molina serves more than 5 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern Washington. Today, we continue his mission of providing high quality and cost-effective health care to those who need it most.

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MolinaHealthcare.com

Contents

GENERAL INFORMATION

The information below documents the company identifying and contact information entered into the general information section of Worksheet 1 of the Unified Rate Review Template (URRT).

The rate methodology and resulting premiums outlined in this Actuarial Memorandum assume current law, which includes the following:

- The expiration of the American Rescue Plan (ARP) enhanced premium tax credit subsidies at the end of 2025.
- Cost-Sharing Reduction (CSR) subsidies remain unfunded.
- The parameters of the HHS Notice of Benefit and Payment Parameters for 2026 (Final 2026 Payment Notice), which became effective on January 15th, 2025.

Notably, the Marketplace Integrity and Affordability Proposed Rule (Program Integrity Rule) was published by CMS in the Federal Register on March 19th, 2025, followed by a comment period that could substantially alter the proposed rule. The rate methodology and resulting premiums outlined in this Actuarial Memorandum were prepared prior to the finalization of the Program Integrity Rule and therefore do not reflect the changes proposed in the Program Integrity Rule.

Molina will seek regulatory approval to file revised rates if material changes to the regulatory environment occur, including, but not limited to, changes to the above mentioned items.

Company Identifying Information

Company Identifying Information	
Legal Name:	Molina Healthcare of Washington, Inc.
State:	Washington
HIOS Issuer ID:	84481
Market:	Washington Individual Marketplace
Effective Date:	January 1, 2026

Company Contact Information

Company Contact Information	
Contact Name	Kathryn Hall
E-mail	Kathryn.Hall@molinahealthcare.com

PROPOSED RATE INCREASE(S)

Molina's rate filing reflects a rate change of 24.59% as calculated by section Q5 of the Uniform Product Modification Justification (UPMJ) template for Molina's 43,346 members enrolled effective March 2025, reported as of April 2025. The UPMJ Q5 rate change is calculated using the average rate change of each plan weighted by membership in each plan.

Molina's rate filing reflects the following rate changes as calculated by Part I of the Unified Rate Review Template in Section 1 of Worksheet 2 for Molina's 36,212 members enrolled in plans that are renewing for 2026. Enrollment data is as of March 2025, reported as of April 2025. The URRT rate change is calculated using the rate change of each renewing plan weighted by the membership and premium in each renewing plan.

The rate changes vary by plan due to changes in the Actuarial Value (AV) Pricing Values assigned to each metal plan that are applied to the Plan Adjusted Index Rate.

14-Digit Plan ID	Plan Name	Metal	202503 Mbrs	2025 PMPM	2026 PMPM	Avg	Min	Max
84481WA0060005	Molina Cascade Complete Gold	Gold	10,687	$685	$748	9.3%	8.6%	11.4%
84481WA0060006	Molina Cascade Silver	Silver	13,965	$662	$907	37.0%	36.0%	39.4%
84481WA0060007	Molina Cascade Bronze	Bronze	11,560	$547	$635	16.1%	15.4%	18.3%
84481WA0060008	Molina Cascade Vital Gold	Gold	0	$0	$0	-	-	-
Total			**36,212**	**$632**	**$773**	**22.4%**	**8.6%**	**39.4%**

Reason for Rate Change(s): The following factors contribute toward the overall change in the proposed rates.

- **Claims:** Projected claims for 2026 are expected to contribute toward a 17.3% increase in rates due to updated base period experience claims, trend, changes in product, acuity, and demographic mix.
- **Taxes and Fees:** Taxes, fees, and retention are expected to contribute toward a 0.5% increase in rates.
- **Margin:** Margins are expected to contribute toward a 0.5% increase in rates at our company standard 3.0% after-tax profit margin.
- **Risk Transfer:** Risk transfer is expected to contribute toward a 1.9% decrease in rates.
- **Administrative Expenses:** Administrative expenses are expected to contribute toward a 0.3% increase in rates.
- **Membership Mix:** The membership mix from the base period to the projection period compared to the membership mix for comparable time periods from the prior year rate filing is expected to contribute toward a 5.7% increase in rates.

Rate changes vary by plan due to changes in Actuarial Value, Cost Share Design (CSD), and Geographic factors.

MARKET EXPERIENCE

The single risk pool was established according to the requirements in 45 CFR 156.80. No transitional products/plans or grandfathered products are included in the development of the single risk pool.

Molina's 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months or 40,774 average members in the period of January 1, 2024 to December 31, 2024.

Experience Period Premium and Claims

Paid Through Date: The market experience reported in Worksheet 1, Section I of the URRT represents 2024 incurred claims paid through March 2025. The completion factors applied to the 2024 claims experience were updated with data through March 2025.

Current Date: The current enrollment and premium are reported as of April 2025.

Premiums (Net of MLR Rebate) in Experience Period: The premiums reported in Worksheet 1, Section I of the URRT represent the earned premium from 2024, excluding risk adjustment transfer payments for the 2024 benefit year. Earned premium does not reflect any MLR rebates. No amounts were subtracted from the earned premium for any reductions prescribed by the federal MLR formula, such as taxes and assessments.

Allowed and Incurred Claims in Experience Period: The following table reports the allowed and incurred claims during the experience period of January 1, 2024 to December 31, 2024.

Description	Medical	Pharmacy	Capitation	Total
Allowed	$237,949,720	$80,067,777	$13,196,321	$331,213,818
IBNR Factor	1.014	1.000	1.000	1.010
Allowed w/ IBNR	**$241,277,636**	**$80,067,777**	**$13,196,321**	**$334,541,734**
Paid	$204,905,854	$71,110,323	$10,164,514	$286,180,691
IBNR Factor	1.014	1.000	1.000	1.010
Paid w/ IBNR	**$207,836,278**	**$71,110,323**	**$10,164,514**	**$289,111,115**

The experience is for all 2024 individual non-grandfathered plans including subsidized populations defined under the Cost Sharing Reduction (CSR) programs. The experience does include data for the American Indian/Alaska Native (AIAN) population which is funded by the federal government and is not tied to any metal level in the Marketplace.

Allowed claims for the experience period were obtained from the claims records by adding the plan incurred paid claims and the member cost-sharing for medical and pharmacy claims net of rebates received from drug manufacturers. The allowed claims calculation applies to both fee-for-service claims and capitation costs.

Completion factors were applied to both the allowed and incurred medical claim amounts. The completion factors were developed separately for inpatient and non-inpatient medical claims based on Molina's Washington Marketplace data. The IBNR factor for medical allowed claims is 1.014. The IBNR factor for medical incurred and paid claims is 1.014. IBNR factors were not applied to capitation and pharmacy claims.

The IBNR reserves were determined based on best estimates. Explicit margin for loss adjustment expenses and provision for adverse deviation are accounted for in the financial system in separate accounts that do not impact the completion factors used for IBNR reserves.

All medical claims are paid through Molina's claims system. Pharmacy claims are processed through Molina's pharmacy benefit manager.

In the experience period 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 not counted toward the annual limitation on cost sharing.

There were no federal or state reinsurance amounts to report in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Experience Period Premium and Experience Period Member Months in 2024 were reported in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Inclusion of Capitation Payments: All capitated payments are included in the experience data and rate development. For pediatric vision coverage Molina has a vision care agreement with Vision Service Plan (VSP), a California not-for-profit corporation, with its principal place of business located in Rancho Cordova, CA and Molina Healthcare of Washington, Inc. which is in Bothell, WA. No changes have occurred to the 2026 agreement terms compared with 2024 and 2025.

Actual to Projected Analysis: Molina tracks Marketplace experience on an ongoing monthly basis through IBNR reserving, claims forecasting based on current and prior year results, and Risk Adjustment estimation. The experience is tracked at the single risk pool level. 2024 experience was used as the baseline experience period for the 2026 rate filing, so the extent that 2024 experience deviated from projected 2024 results is captured in 2026 rates. No extra adjustments were made in 2026 pricing to account for 2024 deviations in claims.

Benefit Categories

Molina assigned all experience claims to benefit categories utilizing Milliman's MedInsight Health Cost Guidelines (HCG) grouper. The following table displays the measurement units related to each benefit category.

Benefit Category	Util Type
Inpatient Hospital	Days
Outpatient Hospital	Visits
Professional	Services
Other Medical	Services
Capitation	Benefit Period
Prescription Drug	Prescriptions

Projection Factors

Trend Factors

Trend Factors: Trend factors were applied separately for unit cost and utilization and by each major benefit category shown in Worksheet 1, Section II of the URRT. The Year 1 and Year 2 trend factors represent the annual trend numbers that were used to trend the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026.

Unit cost trends were measured by calculating average reimbursement rates in the base period and projection period, which consider reimbursement changes and provider mix changes. The unit cost trends include the expected impact of Medicare reimbursement changes from 2024 to 2026 for provider reimbursement contracts that are based on a percentage of the Medicare fee schedule. Pharmacy unit cost trends are based on an analysis of AWP changes over time for a fixed basket of drugs.

The unit cost projections reflect input on likely network and provider contract term changes for the projection year. Provider contracting is already complete for plan year 2026 for counties within Molina's existing footprint. The status of projected reimbursement trend is mostly locked in for plan year 2026.

Utilization trends were developed through a review of trends from the 2025 URRT public use files in Worksheet 1, Section II, with a focus on Individual Market plans with non-zero credibility and nonzero trend factors in states where Molina offers coverage. Year 1 utilization trends include the impact of emerging experience in 2025. Changes in average health status and mix of services are considered in the Acuity and Plan Mix adjustments included in the rate filing and are not considered in utilization trends.

Cost-sharing benefit features such as deductible, copay, out-of-pocket maximum would impact utilization leveraging of trend. However, for pricing purposes allowed trends (utilization before leveraging) were used according to the URR instructions for developing the single risk pool.

Trends were selected based on expectations for a more stable On-Exchange population and were compared to historical and prospective trends for our On-Exchange experience in other states. In general, prospective utilization trends were selected in a way that does not expect abnormally high and abnormally low historical experience to continue.

Please see WA Exhibit 3 for support of the selected trends applied in pricing and WA Exhibits 4 and 5 as support for the historical and adjusted trends described above.

Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment: The morbidity adjustment is comprised of an acuity factor that represents anticipated changes in Molina's single risk pool.

Changes in acuity: The morbidity of Molina's covered population is expected to decrease between the experience period and the projection period.

An acuity adjustment of 1.039 was made to the 2024 experience period data to reflect changes in the population acuity from the experience period to the 2025 current period. The acuity changes from the 2024 experience period to the 2025 current period are measured by calculating the difference in the 2024 risk scores and 2025 risk scores, both weighted by 2026 projected metal mix to avoid double counting with the plan mix adjustment.

The acuity change from the 2025 current period to the 2026 projection period is calculated in the same way, weighting 2025 and 2026 risk scores with 2026 projected metal mix. With the implementation of uniform silver-loading, the majority of Molina's Silver members are expected to move to Gold plans decreasing the projected average risk score for Gold members.

Under current law, Enhanced Premium Tax Credits (ePTCs) are scheduled to expire at the end of 2025. Molina retained Milliman to analyze the impact of expiring premium subsidies on statewide morbidity. We reviewed the study and determined that the best estimate for an acuity adjustment is 1.023. The total acuity adjustment factor for the 2025 current period to the 2026 projection period is 0.930.

The final acuity adjustment factor is 0.967. Please refer to Appendix Exhibit 4.1.

Demographic Shift: A demographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the demographic mix from the 2024 experience data to the 2026 projection period.

The anticipated demographic mix is based on a review of enrollment through March 2025 and projected 2026 enrollment compared to the experience period. Molina anticipates that its 2026 demographics will be consistent with its 2025 demographics for existing membership. The demographic adjustments were developed using allowed claims by age cohort normalized for differences in metal and acuity. The total demographic adjustment made to the 2024 experience period data is 1.007. Please refer to Appendix Exhibit 4.2a.

Geographic Adjustment: A geographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the area membership mix from the 2024 experience data to the 2026 projection period. A geographic adjustment of 1.002 was made to the 2024 experience period data. Please refer to Appendix Exhibit 4.2c.

Plan Mix Adjustment: The plan mix adjustment reflects anticipated changes in the average utilization of services due to differences in average cost-sharing requirements during the experience period and

average cost-sharing requirements in the projection period. This includes changes in induced demand and the effects of selection for the single risk pool.

The 2024 claims experience by Metal and CSR variant was used to weight the 2024 membership mix against the projected membership mix expected in the 2026 projection period to develop a plan mix adjustment factor between the 2024 experience period and 2026 projection period. The Gold allowed claims amount was adjusted to reflect the membership migration to Gold as a result of uniform silver-loading. The adjusted allowed claims are a weighted average calculated using the membership moving from Silver and Bronze to Gold.

The plan mix adjustment made to the 2024 experience period data is 1.121. Please refer to Appendix Exhibit 4.3.

Manual Rate Adjustments

Not Applicable.

Credibility of Experience

A Monte Carlo simulation was used to determine the credibility level to assign to the base period experience. The simulation used a claims probability distribution (CPD) from the Final 2026 Actuarial Value calculator to generate random samples of members and calculated the average annual cost for each sample.

The results showed that 60,000 member months are needed so that the average annual cost is within 10% of the mean (expected claims amount) 95% of the time.

The credibility percentage to apply to the experience data is based on experience period member months and the credibility formula below:

- 0 - 59,999 member months: 100% manual
- 60,000+ member months: 100% experience

The 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months resulting in a credibility percentage that is 100% experience rated. This method is consistent with the applicable American Academy of Actuaries' Actuarial Standards of Practice (ASOP) No. 25 Credibility Procedures.

Establishing the Index Rate

Index Rate: The index rate is developed following the specifications of 45 CFR part 156.80(d)(1). The index rate for the projection period is estimated to be $892.52. The index rate represents the estimated total allowed claims experience for the essential health benefits within the Washington Marketplace. The index rate does not include adjustments for the risk adjustment and reinsurance programs or an adjustment for the Washington Marketplace user fee. Please refer to Appendix Exhibit 5.1a.

Development of the Market-wide Adjusted Index Rate

Reinsurance

Not Applicable.

Risk Adjustment and Payment Change

Experience Period Risk Adjustment PMPM:
Molina used results from the Wakely National Risk Adjustment Reporting (WNRAR) Project to supplement internal estimates of risk scores, statewide premiums, and related risk adjustment transfer amounts. For the 2024 experience period, the risk transfer receivable is $80.25 per member per month (PMPM) or $39,265,304.

Projected Risk Adjustments PMPM: Molina estimated the risk transfer amount for 2026 using the 2024 experience period risk transfer amounts. The 2026 risk transfer estimates were developed by projecting 2025 relative risk scores and transfer payments, then projecting 2026 relative risk scores and transfer payments. The risk transfer payment amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium. The projection is based on the 2026 calibrated model. The population was grouped into the following cohorts:

- *2025 Renewal Members* – Some of Molina's current members previously had coverage in 2024 and renewed in 2025 with Molina. Molina relied on the renewal member's 2024 experience and risk scores to project their 2025 relative risk scores, taking into consideration any applicable changes in enrollment across metal tiers.
- *2025 New Members* – To estimate the relative risk of the 2025 new members, Molina referred to the estimated risk scores and transfer amounts from the 2024 experience period. Estimated risk scores were adjusted in consideration of the metal tier mix between the 2024 members and the 2025 new members.

- *2026 Members* – Molina assumed the 2026 members would have the higher relative risk scores as the 2025 members, with consideration for the metal tier mix between the two years.

The impact of the national high-risk pool fund was incorporated using 2024 claims experience and a white paper report from Wakely on the estimated high-cost risk pooling charges based on information voluntarily provided by issuers. The net impact of estimated charges and recoveries was calculated as $1.45 PMPM payable.

The impact of the risk adjustment data validation program was incorporated using historical error rates from the final CMS RADV results and the RADV error rate report from Wakely based on information voluntarily provided by issuers. The net impact of estimated payment was calculated as $1.97 PMPM receivable.

The resulting 2026 risk transfer receivable estimate is $82.23 PMPM. Molina included $1.45 PMPM payable for projected national high-risk pooling funding and $1.97 PMPM receivable for projected risk adjustment data validation to get a net risk transfer receivable estimate of $82.75 PMPM. This amount was converted from a paid to allowed basis and entered in the URRT Worksheet I, Section II.

The risk transfer receivable amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium.

The 2026 statewide average premium was projected using historical experience and information from Wakely, including the estimated 2025 statewide average premium. An adjustment of was made to the statewide average premium to account for changes due to uniform silver-loading. Using historical experience and the adjustment for silver-loading, the 2026 statewide average premium increase is estimated to be 8.2%.

Please refer to WA Exhibit 10 for further information on projected risk adjustment.

Washington Marketplace Exchange Fee:
Washington Marketplace will charge a fee of $5.11 PMPM which was divided by the total paid to allowed factor of 0.787 to convert to an allowed basis of $6.49 PMPM for the Market Adjusted Index Rate. Please refer to Appendix Exhibit 5.1a to locate the same percentage for the Exchange User Fee entered in Worksheet 1, Section II.

Market Adjusted Index Rate: The market adjusted index rate is developed following the specifications of 45 CFR part 156.80(d)(1). Molina modified the index rate provided in URRT Worksheet I to a market adjusted index rate. Please refer to Appendix Exhibit 5.1a

Plan Adjusted Index Rates

The plan adjusted index rates are developed following the specifications of 45 CFR part 156.80(d)(2). The plan adjusted index rates are entered in Worksheet 2, Section IV, of the URRT. Molina calculated the plan adjusted index rates by applying plan specific level adjustments for actuarial value, cost

sharing utilization, additional benefits, and administrative costs, excluding exchange user fees, to the market adjusted index rate. Please refer to Appendix Exhibit 10.2.

Paid to Allowed Ratio: The Paid to Allowed ratio reflects the estimated cost-sharing in the projected period. The Final 2026 AV Calculator was used to determine metal AVs, but for pricing a different calculator was used. This is detailed in the Pricing AVs section. The Paid to Allowed ratio is the member-weighted average of the Actuarial Values. Please refer to Appendix Exhibit 5.1b.

Benefits in Addition to EHBs:
There are no benefits in addition to EHBs. However, Molina covers the elective termination of pregnancy benefit. Per Checklist Item #10d, abortion services must be treated as non-EHBs in the URRT. Therefore, elective termination of pregnancy costs are included in the Index Rate and field 3.5 in the URRT has been adjusted to account for these costs. An estimated $1.00 PMPM is used to account for abortion services. The percentage of premium by plan is used to calculate the Benefits in Addition to EHB, field 3.5 of Worksheet 2. Please refer to Appendix Exhibit 5.1b.

Retention Loads, excluding Exchange User Fees: All costs related to admin, profit & risk and taxes & fees, excluding the Washington Marketplace Fee, are calculated for each expected plan offering. Please refer to WA Exhibit 11.

Provider Network, Delivery System Characteristics, and Utilization Management Practices: Plan rates do not vary for variation in provider network, delivery system characteristics, or utilization management.

Provider Compensation Statement: Provider compensation does not include bonuses in addition to other payments.

Catastrophic plans: Not applicable.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Administrative expenses for the Marketplace product from 2024 and 2025 were reviewed and projected forward to 2026 to develop the administrative costs required to manage the Washington Marketplace population. An internal administrative cost budget was developed on a PMPM basis and applied to the Washington Marketplace rates. Part of the total administrative expense load is a subcomponent for Quality Expenses which are administrative costs dedicated to improving health care quality for Molina Marketplace members. The Quality Expense load is $10.48 PMPM. Amounts for broker commissions were added to the administrative costs. The expected administrative expense load is 10.3%. Please refer to WA Exhibit 11.

Broker Commissions: Broker commissions of $11.83 PMPM are expected based on historical broker-sold business and a projection of new and renewing members sold through the broker channel.

Profit Margin: The target after-tax margin is 3.0%, which aligns with Molina's company standard target. Molina's current capital and surplus did not impact the filing. The profit and risk load of 3.0% of premium is consistent with the target margin filed and approved for each rating period from 2015 through 2026.

Taxes and Fees: Molina's estimated taxes and fees (excluding Exchange Fee) are 3.0%. The taxes and fees estimates are comprised of the following:

- **Income Tax:** An estimated 0.8% of premiums will be paid in Federal income taxes.
- **WSHIP:** The WSHIP assessment is projected at $0.13 PMPM. Per the most recent information available in the 2023 Annual Report, WSHIP assessments were $12 million in 2023 (an estimated $0.25 PMPM). WSHIP assessments for 2024 were projected to be $6 million. Therefore, Molina has estimated the WSHIP assessment to be $0.13 PMPM for 2026.
- **Regulatory Surcharge:** The regulatory surcharge is an annual cost of operating the Office of the Insurance Commissioner which is charged to insurers like Molina. The 0.08% of premium is based on internal budgetary forecasts. The 2026 regulatory surcharge was assumed to be 0.08% of premium.
- **Risk Adjustment User Fee:** $0.20 PMPM will be paid toward the risk adjustment user fee.
- **Insurance Fraud Surcharge:** The 2026 insurance fraud surcharge is estimated to be .004% of premium.
- **Premium Tax:** Molina has assumed 2.0% for the state premium tax.
- **PCORI:** An estimated $0.33 PMPM ($4.01 PMPY) will be paid toward the PCORI fee. This was estimated by projecting forward the $3.47 PMPY value for members whose plan year ends September 2024 through October 2025 forward two years at a rate of 7.5% per year, the 3-year average annual increase.
- **WAPAL:** An estimated $0.06 PMPM will be paid toward the WAPAL fund. The 2026 estimate is based on the most recent information available from the FY2025 Assessment Rate Notification to Payers.

Calibration

Age Curve Calibration: Molina calibrated the Plan Adjusted Index Rates to an age 21 rate. The average composite age factor was estimated by multiplying the population distribution by the age factors. The calibration factor is 0.580.

Molina estimated the average age of the single risk pool to be 43 years of age by multiplying the expected age distribution percentages by the age. Molina assumed an average age of 7 for the Age 0-14 cohort in the average age estimate and an average age of 71 for the Age 65+ cohort. Premium rates are based on the attained age as of the coverage effective date and will not be re-rated/adjusted when a birthdate occurs during the year after the coverage starts.

Please refer to Appendix Exhibit 4.2b.

Geographic Factor Calibration: Molina applied geographic factors to the index rate in the calculation of region-specific rates. The geographic factors are based on the provider reimbursement expectations in each region.

None of the following items were used in establishing the geographic rating area factors:

(i) Health status of enrollees or the population in an area;
(ii) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health 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.

Adjustments were made to the geographic factors to ensure that the minimum geographic factor and the maximum geographic factor did not deviate by more than 15% per Washington regulations. The calibration factor of 0.975 equals the inverse of the weighted average geographic factor.

Please refer to Appendix Exhibit 7.1.

Tobacco Factor Calibration: Molina does not price in a tobacco surcharge. The calibration factor is set to 1.000. The tobacco calibration factor has been set to 1.000 in 2023, 2024, and 2025 as well.

Base Premium Rate Development

The Base Premium Rates are calibrated to an age 21 premium with an area factor of 1.0. Only the allowable rating factors will be applied to the Base Premium Rates. Please see Appendix Exhibit 6.1.

PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) using the federally prescribed MLR methodology is for calendar year 2026 based on the ratio of projected incurred claims divided by projected revenue. The MLR result was calculated to be 87.1%. Please refer to Appendix Exhibit 11.1 for a full demonstration of the projected loss ratio. In the Part I Unified Rate Review Template, Worksheet 2, item 4.10 Loss Ratio displays a loss ratio in total and by plan adjusted index rates. The loss ratio calculated here follows a different formula than the federally prescribed MLR methodology and will not match that figure. The URRT loss ratio is incurred claims divided the sum of the risk adjustment transfer amount and the plan adjusted index rate premium. The federal MLR considers quality in the numerator and taxes and fees in the denominator.

PLAN PRODUCT INFORMATION

AV Metal Values

All plan offerings have cost-sharing levels that are different for Preferred Generic Drugs and Non-Preferred Generic Drugs. These plans are considered unique benefit design according to the logic used in the Final 2026 Actuarial Value Calculator (AVC). The AV metal values were determined by using a permissible alternative method that complies with 45 CFR 156.135(b)(3).

The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

The Bronze and Silver Standard plans were adjusted according to the same generic drug methodology. An adjustment factor was calculated for the standard plans using the original AV compared with the blended AV and applied to the Adjusted AV prepared by Wakely. Please refer to Appendix Exhibit 11.4.

Please refer to the supporting document "Unique Plan Design Documentation" unique plan design certification for documentation on the generic drug cost-sharing component of the plans.

For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature. The unique plan design certification for the Bronze and Silver plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Silver CSR Loading: In accordance with WAC 284-43-6820, a uniform CSR silver load adjustment factor of 1.435 has been applied to Silver plans for plan year 2026. Please refer to WA Exhibit 8.

AV Pricing Values

AV pricing value of each plan only includes the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). Cost-sharing adjustments ensure that differences due to health status were not included in the adjustment. The modifiers are applied to the index rate. Molina relied on the Final 2026 AV Calculator to evaluate the Actuarial Value of the plan designs.

Plan ID	Plan Name	AV Metal Value	AV Pricing Value
84481WA0060005	Molina Cascade Complete Gold	0.8171	0.8171
84481WA0060006	Molina Cascade Silver	0.7184	0.7184
84481WA0060007	Molina Cascade Bronze	0.6499	0.6499
84481WA0060008	Molina Cascade Vital Gold	0.7801	0.7801

Essential Health Benefits

All benefit plans offered meet essential health benefit (EHB) requirements. Molina plan designs in 2026 are all standard plan designs. The State of Washington has added new EHBs for plan years beginning on or after January 1, 2026. The EHB additions are as follows:

- Hearing Exams shall be categorized as Primary Care Visits.
- Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
- Artificial Insemination shall be categorized as All Other Benefits.
- Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).

Membership Projections

Molina is filing Washington Marketplace rates in 18 counties representing 7 rating regions. The membership projection is based on anticipated renewals of existing members and new members. New membership is based on an estimate of the total number of members enrolled in Washington Marketplace by county. The source of new members is mostly from other carriers.

The enrollment projections by plan, including cost-sharing reduction eligible plans, were based on a projection of 2025 membership calculated early in 2025. The baseline membership projections reflected a decline in membership across all plans as a result of the 2026 rate change. Members are also anticipated to migrate away from Silver plans due to uniform silver-loading. Some of these members are expected to migrate toward Molina Gold plans.

We are anticipating that Molina will not offer one of the lowest cost Silver plans in 2026, and as a result, will continue to decline in Silver membership. This is partially because new members tend to select one of the lowest cost offerings in the market, including Cascade Select plan offerings from other carriers. As a result, Molina modeled a reduction in the proportion of available Silver members in the market compared to current membership. With the anticipated expiration of ePTCs, Molina modeled a reduction in membership. These members may move to other carriers or leave the market.

Molina plans to offer its products in the counties listed by region below.

Region	County List
1	King
2	Cowlitz, Kitsap, Lewis
3	Clark, Klickitat, Skamania
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Mason, Pierce, Thurston
6	Benton, Franklin
8	Snohomish

Terminated Products

Molina is terminating the Constant Care Silver 1 plan design for 2026. Members currently enrolled in this plan will be mapped to the Molina Cascade Silver plan.

A summary of Molina's terminated, renewing, and new products is provided in the following table:

Plan ID	Plan Name	Metal	2026 Status
84481WA0060005	Molina Cascade Complete Gold	Gold	Renewing
84481WA0060006	Molina Cascade Silver	Silver	Renewing
84481WA0060007	Molina Cascade Bronze	Bronze	Renewing
84481WA0060008	Molina Cascade Vital Gold	Gold	New
84481WA0060004	Constant Care Silver 1	Silver	Terminated

PLAN TYPE

All benefit plans are comprehensive HMO individual products.

MISCELLANEOUS INSTRUCTIONS

Effective Rate Review Information

URRT Comparison: Tables comparing the 2026 values with the 2025 values entered in the URRT (Worksheet I, Sections II) are provided in Appendix Exhibit 2.1.

Mental Health / Substance Use Disorder Financial Requirement Checklist: In Molina's mental health parity calculation template, the underlying claim data source is Molina's WA marketplace 2024

experience data projected forward to 2026 as described in the Actuarial Memorandum. No adjustment has been made to the data. The projections reflect the plan level assumptions and are based on the amounts that the Plan allows before reductions for enrollee cost sharing. A reasonable actuarial method was used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Reliance

The unique plan design certification for the Standard plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Milliman's MedInsight Health Cost Guidelines (HCG) grouper was relied upon for categorizing claims data for the experience period.

Wakely's white paper report on the estimated high-cost risk pooling charges (2023, 2024, and 2025 High-Cost Risk Pooling Program – National Estimate) was relied upon for our estimate of High Cost Risk Pool (HCRP) amounts.

Actuarial Certification

I, Kathryn Hall, am an employee of Molina Healthcare and I am a member in good standing with the American Academy of Actuaries meeting its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries. I have the education and experience necessary to the perform the work and hereby certify, to the best of my knowledge and judgment, that this filing complies with applicable State and Federal Statues for individual rate filings. I certify the following:

The projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
b. Developed in compliance with the applicable Actuarial Standards of Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Termination of pregnancy is a WA EHB under the “maternity and newborn services” category [WAC 284-43-5642]. The “Benefits in Addition to EHB” field is the multiplicative inverse of the value entered into the “EHB Percent of Total Premium” field on the Plans & Benefits Template (PBT). For the purposes of filling out the URRT Worksheets, abortion services for which public funding is prohibited was entered as Benefits in Addition to EHB, even though the benefits are considered EHBs in Washington.

The Final 2026 AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. Adjustments were made for unique benefit designs as described in the Reliance and in the Plan Product Information / AV Metal Values sections of this memorandum.

Please refer to the supporting document “Unique Plan Design Documentation” unique plan design certification.

I certify that the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct, including:

- ASOP 5: Incurred Health and Disability Claims
- ASOP 8: Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP 12: Risk Classification
- ASOP 23: Data Quality
- ASOP 25: Credibility Procedures
- ASOP 41: Actuarial Communications
- ASOP 45: The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act
- ASOP 56: Modeling

05/13/2025

Kathryn Hall, ASA, MAAA
Actuarial Manager
Molina Healthcare

Date

Molina Healthcare of Washington, Inc.

Part II: Explanation of the Rate Increase
Effective January 1, 2026

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services for over 1 million individuals eligible for Medicaid, Medicare, and Marketplace throughout the state of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

1. Scope and range of the rate increase: Molina is requesting on average a 24.6% premium increase for its individual policies sold in the Washington Marketplace effective January 1, 2026. 43,346 Molina Marketplace members would receive changes to their premiums ranging from an 8.6 percent increase to a 39.4 percent increase depending on their geographic location and metal tier. Molina will renew the Molina Cascade Complete Gold, Molina Cascade Silver, and Molina Cascade Bronze plans, terminate the Constant Care Silver 1 plan, and add Molina Cascade Vital Gold as a new plan for 2026. Finally, please note these are averages, by plan and due to members aging, premium changes could be larger or smaller than anticipated.

The key drivers of the rate change are an increase in projected claims costs mentioned in "Section 3. Changes in Medical Service Costs" and a decrease as a result of projected Risk Adjustment contributing toward a 1.9% decrease in rates.

2. Financial experience of the product: Premium of $293,930,108 was received for 2024 compared to incurred claims of $289,111,115, risk transfer receivable of $41,355,022 and federal reimbursement recoveries from the High-Risk Enrollee Reimbursement Pool of $0. The High-Risk Enrollee Reimbursement Pool Charge was -$1,179,182. The HHS-RADV Adjustment was -$910,537. Taxes and fees were $7,579,925. Admin expenses were $30,808,699. Molina's financial experience in 2024 resulted in a gain of 2.2 percent or pretax net income of $6,606,210.

The proposed premium rates yield a medical loss ratio of 87.1 percent. The medical loss ratio represents the percentage of every premium dollar that Molina expects to spend on medical expenses and improving health care quality for our members. The projected medical loss ratio exceeds the Affordable Care Act minimum required loss ratio of 80 percent.

3. Changes in Medical Service Costs: Medical and pharmacy combined trend of 9.2 percent was applied in the development of the rates for expected increases in the utilization and cost of covered services. 5.1 percent of the total trend is due to utilization, driven by a 6.8 percent trend in pharmacy drug utilization and a 5.9% trend in outpatient utilization. 3.9 percent of the total trend is due to unit cost.

4. Changes in benefits:

The Molina Cascade Gold plan is being renewed with changes such as deductible from $600 to $1,000.

The Molina Cascade Silver plan is being renewed with changes to the out-of-pocket maximum on Silver 100, from $1,900 to $2,400, Silver 150, from $2,500 to $2,850, Silver 200, from $7,250 to $7,950, Silver 250 from $9,200 to $9,750.

The Molina Cascade Bronze plan is being renewed with changes to the out-of-pocket maximum from $9,200 to $10,150

The Constant Care Silver 1 plan is terminating in 2026 and the Molina Cascade Vital Gold plan is new in 2026.

The collective plan design changes result in a small decrease to the aggregate rate change.

Additional changes beyond what has been described have also occurred. Please consult our public rate filing for further detail.

5. Administrative costs and anticipated profits: Administrative expenses are expected to contribute toward a 0.3% increase in rates. Taxes and fees are expected to contribute toward a 0.5% increase in rates. The Exchange Fee did not change from prior year. The targeted profit margin is 3.0% after tax and remains unchanged and does not contribute toward a change in rates.

Summary of Pooled Experience with Adjustments:

Summary of Pooled Experience with Adjustments			
	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	489,287	486,415	646581
Earned Premium	$293,930,108	$276,235,335	$329,468,565
Paid Claims	$286,180,691	$249,889,529	$268,337,168
Beginning Claim Reserve	$23,001,474	$19,041,149	$19,955,631
Ending Claim Reserve	$25,931,898	$23,001,474	$19,041,149
Incurred Claims	$289,111,115	$253,849,854	$267,422,686
Expenses	$38,388,624	$42,156,119	$52,071,396
Gain/Loss	-$33,569,630	-$19,770,639	$9,974,482
Loss Ratio Percentage	98.36%	91.90%	81.17%
Risk Adjustment	$41,355,022	$39,648,209	$1,693,969
High Risk Enrollee Reimbursement Pool Recoveries	$0	$1,249,071	$956,859
High Risk Enrollee Reimbursement Pool Charge	-$1,179,182	-$990,369	-$1,193,688
HHS-RADV adjustments	-$910,537	$0	$0
Total Commercial Reimbursements	$0	$0	$1,000
Adjusted Gain Loss with Adjustments	$6,606,210	$20,136,272	$11,432,622
MLR Rebates	$0	$0	$0

Unified Rate Review v6.1

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Company Legal Name:	Molina Healthcare of Washington, Inc.		
HIOS Issuer ID:	84481	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	$334,541,734.48	$683.73
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$289,111,115.00	$590.88
Risk Adjustment	$39,265,304.12	$80.25
Experience Period Premium	$293,930,108.29	$600.73
Experience Period Member Months	489,287	

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	$96.49	1.088	1.055	1.066	1.025	$121.11
Outpatient Hospital	$204.16	1.023	1.095	1.059	1.025	$248.17
Professional	$178.55	1.016	1.055	1.044	1.025	$204.77
Other Medical	$13.92	1.016	1.055	1.044	1.025	$15.96
Capitation	$26.97	1.025	1.000	1.025	1.000	$28.34
Prescription Drug	$163.64	1.025	1.108	1.031	1.029	$197.39
Total	$683.73					**$815.75**

Morbidity Adjustment	0.967
Demographic Shift	1.009
Plan Design Changes	1.121
Other	1.000
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$892.52**

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.00%

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$892.52**	$258,620,165.28
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	$105.13	$30,461,851.98
Exchange User Fees	0.82%	$1,881,076.49
Market Adjusted Index Rate	**$793.89**	**$230,039,389.79**

Projected Member Months	**289,764**

Product-Plan Data Collection

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.
To remove a product, navigate to the corresponding Product Name/Product ID field and select the Remove Product button or Ctrl + Shift + Q.
To remove a plan, navigate to the corresponding Plan Name/Plan ID field and select the Remove Plan button or Ctrl + Shift + A.

Company Legal Name: **Molina Healthcare of Washington, Inc.**
HIOS Issuer ID: **84481** 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		Molina Healthcare				
1.2	Product ID		84481WA006				
1.3	Plan Name		Complete Gold	Silver	Bronze	Vital Gold	Silver 1
1.4	Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
1.5	Metal		Gold	Silver	Bronze	Gold	Silver
1.6	AV Metal Value		0.817	0.718	0.650	0.780	0.718
1.7	Plan Category		Renewing	Renewing	Renewing	New	Terminated
1.8	Plan Type		HMO	HMO	HMO	HMO	HMO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes	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)		9.30%	36.98%	16.10%	0.00%	0.00%
1.12	Product Rate Increase %		22.36%				
1.13	Submission Level Rate Increase %		22.36%				

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information						
	2.1	Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
$334,541,734	2.2	Allowed Claims	$334,541,734	$124,966,258	$93,809,113	$48,346,479	$0	$67,419,884
$0	2.3	Reinsurance	$0	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$45,430,619	$12,367,072	$10,653,230	$14,646,891	$0	$7,763,426
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$289,111,115	2.6	Incurred Claims	$289,111,115	$112,599,186	$83,155,883	$33,699,588	$0	$59,656,459
$39,265,304	2.7	Risk Adjustment Transfer Amount	$39,265,304	$34,124,368	$15,564,739	-$13,851,047	$0	$3,427,244
$293,930,108	2.8	Premium	$293,930,108	$80,139,504	$84,613,801	$63,913,855	$0	$65,262,949
489,287	2.9	Experience Period Member Months	489,287	125,397	137,373	124,626	0	101,891
	2.10	Current Enrollment	43,346	10,687	13,965	11,560	0	7,134
	2.11	Current Premium PMPM	$640.20	$684.82	$662.33	$547.01	$0.00	$681.02
	2.12	Loss Ratio	86.77%	98.54%	83.01%	67.31%	#DIV/0!	86.85%
		Per Member Per Month						
	2.13	Allowed Claims	$683.73	$996.56	$682.88	$387.93	#DIV/0!	$661.69
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
	2.15	Member Cost Sharing	$92.85	$98.62	$77.55	$117.53	#DIV/0!	$76.19
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
	2.17	Incurred Claims	$590.88	$897.94	$605.33	$270.41	#DIV/0!	$585.49
	2.18	Risk Adjustment Transfer Amount	$80.25	$272.13	$113.30	-$111.14	#DIV/0!	$33.64
	2.19	Premium	$600.73	$639.09	$615.94	$512.85	#DIV/0!	$640.52

	Section III: Plan Adjustment Factors						
3.1	Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
3.2	Market Adjusted Index Rate		$793.89				
3.3	AV and Cost Sharing Design of Plan		0.8377	1.0059	0.6184	0.7835	0.0000
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.5	Benefits in Addition to EHB		1.0013	1.0011	1.0017	1.0013	0.0000
	Administrative Costs						
3.6	Administrative Expense		9.68%	8.21%	12.65%	10.28%	0.00%
3.7	Taxes and Fees		2.98%	2.96%	3.02%	2.99%	0.00%
3.8	Profit & Risk Load		3.00%	3.00%	3.00%	3.00%	0.00%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.10	**Plan Adjusted Index Rate**		$789.59	$931.46	$604.64	$743.86	$0.00
3.11	Age Calibration Factor	0.580082251	0.5801				
3.12	Geographic Calibration Factor	0.975310488	0.9753				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$446.72	$526.98	$342.08	$420.85	$0.00

	Section IV: Projected Plan Level Information						
4.1	Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
4.2	Allowed Claims	$258,620,163	$65,342,439	$19,473,252	$40,450,770	$133,353,702	$0
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$54,840,920	$11,952,655	-$601,840	$14,160,216	$29,329,889	$0
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$203,779,242	$53,389,784	$20,075,092	$26,290,554	$104,023,813	$0
4.7	Risk Adjustment Transfer Amount	$23,978,123	$5,901,519	$1,848,316	$3,935,036	$12,293,252	$0
4.8	Premium	$216,375,294	$56,311,427	$20,805,088	$28,752,256	$110,506,523	$0
4.9	Projected Member Months	289,764	71,317	22,336	47,553	148,558	0
4.10	Loss Ratio	84.78%	85.82%	88.62%	80.43%	84.71%	#DIV/0!
	Per Member Per Month						
4.11	Allowed Claims	$892.52	$916.23	$871.83	$850.65	$897.65	#DIV/0!
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.13	Member Cost Sharing	$189.26	$167.60	-$26.94	$297.78	$197.43	#DIV/0!
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.15	Incurred Claims	$703.26	$748.63	$898.78	$552.87	$700.22	#DIV/0!
4.16	Risk Adjustment Transfer Amount	$82.75	$82.75	$82.75	$82.75	$82.75	#DIV/0!
4.17	Premium	$746.73	$789.59	$931.46	$604.64	$743.86	#DIV/0!

Rating Area Data Collection

Specify the total number of Rating Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.
Select only the Rating Areas you are offering plans within and add a factor for each area.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.0189
Rating Area 3	1.1498
Rating Area 4	1.0003
Rating Area 5	1.0003
Rating Area 6	1.0340
Rating Area 8	1.0138

SERFF Tracking #:	MLWA-134518839	**State Tracking #:**	484742	**Company Tracking #:**	

State:	Washington	**Filing Company:**	Molina Healthcare of Washington, Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other		
Product Name:	2026 Non-grandfathered Individual Rate Filing MHW01012026		
Project Name/Number:	/		

Supporting Document Schedules

Bypassed - Item:	Written Description Justifying the Rate Increase
Bypass Reason:	Molina has satisfied this requirement in the section titled URRT below. Thank you
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	2026 Individual Supplemental Checklist 1332 Waiver
Comments:	
Attachment(s):	84481_WA_1332WaiverChecklist_20250512.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum Exhibits and Supporting Documents
Comments:	
Attachment(s):	Actuarial Memorandum Exhibits DUPLICATE.xlsx Actuarial Memorandum Exhibits.pdf 2024 MWA Form IC-13A-HC_Form IC-14-HMO.pdf
Item Status:	
Status Date:	

Satisfied - Item:	2026 AV Screenshot
Comments:	
Attachment(s):	84481_WA_AVScreenshots_20250512.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Certification-Rates-2026 Ind Mental Health and Substance Use Disorder Financial Reqs
Comments:	
Attachment(s):	Certification-Rates-2026 Ind Mental Health and Substance Use Disorder Financial Reqs.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Certification-Rates 2026 MSHUD Parity Calculations
Comments:	
Attachment(s):	Certification - Rates - 2026 MHSUD Parity Calculations.pdf Certification - Rates - 2026 MHSUD Parity Calculations Duplicate.xlsm

State: Washington **Filing Company:** Molina Healthcare of Washington, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: 2026 Non-grandfathered Individual Rate Filing MHW01012026
Project Name/Number: /

Item Status:	
Status Date:	

Satisfied - Item:	PY 2026 Individual Non-grandfathered Health Plan Rate Filing Checklist
Comments:	
Attachment(s):	Checklist-Rates-2026 Individual Nongrandfathered Health Plans.pdf
Item Status:	
Status Date:	

Satisfied - Item:	SERFF Rate Review Detail
Comments:	
Attachment(s):	84481_SERFFRateReviewDetail.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unique Plan Design Documentation and Crosswalk
Comments:	
Attachment(s):	84481WAUniquePlanDesignBenefitCrosswalk.pdf 84481WAUniquePlanDesignSuppDocAndJust.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Wakely 2026 Standard Plan AV Certification
Comments:	
Attachment(s):	WakelyAVCertificationforWAHBE2026StandardPlanDesign.pdf
Item Status:	
Status Date:	

Satisfied - Item:	WAC 284-43-6660
Comments:	
Attachment(s):	WAC 284-43-6660 Duplicate.xlsx WAC 284-43-6660.pdf 84481WAMolinaFamilyRatingExample20250512.pdf 84481WAMolinaFamilyRatingExDuplicate20250512.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	2026 Individual Medical Uniform Product Modification Justification
Comments:	

State: Washington **Filing Company:** Molina Healthcare of Washington, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: 2026 Non-grandfathered Individual Rate Filing MHW01012026
Project Name/Number: /

Attachment(s):	84481_WA_Uniform Product Modification Justification_05.12.2025.pdf 84481_WA_Uniform Product Modification Justification Duplicate_05.12.2025.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	WA Broker Commission Rates 2026
Comments:	
Attachment(s):	2026 Commission Information and Officer Certification FINAL.docx.pdf
Item Status:	
Status Date:	

Satisfied - Item:	URRT
Comments:	
Attachment(s):	Part I Unified Rate Review Template Duplicate.xlsm Part I Unified Rate Review Template.pdf PartIIWrittenDescriptionJustifyingtheRateIncrease.pdf PartIIIRateFilingDocumentationandMemorandum_Redacted.pdf PartIIIRateFilingDocumentatonandActuarialMemorandum.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Benefit Components
Comments:	
Attachment(s):	84481_WA_Benefit Components_05.09.2025.pdf 84481_WA_Benefit Components Duplicate_05.09.2025.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Rating Documents for Extended ARPA Subsidies
Comments:	
Attachment(s):	Rate Schedule DUPLICATE with ARPA extension.xlsm Rate Schedule with ARPA extension.pdf Part I Unified Rate Review Template Duplicate with ARPA extension.xlsm Part I Unified Rate Review Template with ARPA extension.pdf PartIIIRateFilingDocumentationandActuarialMemorandumwithARPAextension.pdf
Item Status:	
Status Date:	

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:	Molina Healthcare of Washington, Inc.
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.

    Not applicable

    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.

Total premiums will decrease due to lower enrollment.

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**.

Geographic Region	Projected Members
Region 1	8,834
Region 2	2,127
Region 3	3,408
Region 4	2,162
Region 5	4,092
Region 6	499
Region 8	3,025
Total	**24,147**

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.

Geographic Region	Projected Members
Region 1	8,767
Region 2	2,117
Region 3	3,398
Region 4	2,156
Region 5	4,048
Region 6	492
Region 8	2,986
Total	**23,964**

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.

Projected enrollment is lower in the without-waiver scenario. No plan mix differences are expected as all plan offerings are standard plans.

Projected Enrollment by Plan - with waiver

Plan ID	Projected Members
84481WA0060005	5,943
84481WA0060006	1,861
84481WA0060007	3,963
84481WA0060008	12,380
Total	**24,147**

Projected Enrollment by Plan - without waiver

Plan ID	Projected Members
84481WA0060005	5,898
84481WA0060006	1,847
84481WA0060007	3,933
84481WA0060008	12,286
Total	**23,964**

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.

Geographic Region	Premium
Region 1	79,027,576.11
Region 2	19,145,265.43
Region 3	30,866,682.52
Region 4	19,350,285.60
Region 5	36,634,515.22
Region 6	4,471,091.40
Region 8	26,879,877.51
Total	**216,375,293.78**

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.

Geographic Region	Premium
Region 1	78,426,982.49
Region 2	19,055,603.83
Region 3	30,776,987.82
Region 4	19,296,466.43
Region 5	36,240,138.64
Region 6	4,408,353.50
Region 8	26,530,332.24
Total	**214,734,864.95**

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.

There are no impacts to individual rating cell premium rates or premium PMPMs. However, total premium amount will be higher with the waiver in effect due to enrollment differences with and without waiver. The morbidity of the population is not assumed to shift significantly due to the waiver being in effect.

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.

Not applicable

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.

Geographic Region	Claims
Region 1	94,571,356.19
Region 2	22,810,034.69
Region 3	36,566,023.38
Region 4	23,152,270.94
Region 5	43,817,896.90
Region 6	5,351,226.98
Region 8	32,351,353.70
Total	**258,620,162.78**

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.

Geographic Region	Claims
Region 1	93,853,489.87
Region 2	22,702,864.70
Region 3	36,458,812.62
Region 4	23,087,940.89
Region 5	43,346,516.49
Region 6	5,276,239.44
Region 8	31,933,558.47
Total	**256,659,422.49**

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.

The spending of 1332 waiver enrollees is assumed to be similar to the current population of enrollees due to lower utilization offset by higher severity claims as a result of pent up demand after being uninsured. The projected PMPM allowed claims are not anticipated to differ. However, due to the decrease in enrollment, the total projected allowed claims spending would be expected to decrease slightly without waiver.

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.
    The morbidity of the population of 1332 waiver enrollees is assumed to be similar to the morbidity of the without waiver population. The projected PMPM risk adjustment amounts are not anticipated to differ.

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.
    There is assumed to be no material impact to Administrative Expense projections with the 1332 waiver. Molina does not expect to incur additional significant expenses as a result of 1332 waiver enrollees. Membership projections are not expected to materially change.

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.

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Appendix Exhibit 1.1

Financial Data Consistency

Checklist Item 1a

	URRT Wksh 1, Section I	URRT Wksh 2, Section II	WAC 284-43-6660	Appendix Exhibits	*Variance*
Allowed Claims	$334,541,734	$334,541,734	N/A	$334,541,734	*$0.00*
Reinsurance	$0	$0	N/A	N/A	*N/A*
Incurred Claims	$289,111,115	$289,111,115	$289,111,115	$289,111,115	*$0.00*
Risk Adjustment Transfer Amount	$39,265,304	$39,265,304	N/A	$39,265,304	*$0.00*
Premium	$293,930,108	$293,930,108	$293,930,108	$293,930,108	*$0.00*
Experience Period Member Months	489,287	489,287	489,287	489,287	*$0.00*

Notes:

URRT Wksh 2, Section II amounts by plan are based on each plan's experience

Appendix Exhibit 1.2
Support for URRT Experience Period
Checklist Item 1b, 3a

	Medical Allowed Claims by Paid Month																				
Incurred Month	**202401**	**202402**	**202403**	**202404**	**202405**	**202406**	**202407**	**202408**	**202409**	**202410**	**202411**	**202412**	**202501**	**202502**	**202503**	**Total Medical Allowed**	**Membership**	**Premium**	*RA Transfer*	*HCRP Net Charge*	*RADV Adjustment*	**Risk Adjustment**
202401	$5,219,627	$8,839,255	$1,679,754	$1,251,457	$1,096,078	$399,991	$300,268	$191,648	$120,277	$203,219	$275,471	$770,635	$189,285	$183,018	$31,538	**$20,751,522**	39,695	$24,251,051				
202402	$0	$5,162,202	$8,566,121	$2,789,323	$1,249,667	$556,249	$369,247	$261,340	$132,385	$296,898	$587,748	$512,368	$353,440	$327,568	$178,218	**$21,342,775**	41,022	$24,850,254				
202403	$0	$0	$9,544,343	$6,044,494	$1,782,827	$954,811	$400,777	$385,389	$156,933	$302,860	$454,646	$397,077	$259,637	$126,098	$131,548	**$20,941,442**	41,117	$24,860,388				
202404	$0	$0	$0	$8,224,800	$7,313,977	$2,470,354	$1,273,908	$444,080	$207,699	$447,672	$379,919	$576,127	$738,191	$203,727	$475,120	**$22,755,573**	41,304	$24,904,683				
202405	$0	$0	$0	$0	$8,207,749	$8,157,811	$2,326,333	$877,634	$398,286	$404,131	$524,077	$660,003	$147,766	$228,744	$228,626	**$22,161,161**	41,278	$24,852,005				
202406	$0	$0	$0	$0	$0	$6,844,902	$8,758,097	$1,252,135	$637,822	$610,901	$460,416	$459,299	$235,396	$496,105	$180,268	**$19,935,341**	41,252	$24,761,230				
202407	$0	$0	$0	$0	$0	$0	$8,973,092	$7,677,000	$1,476,669	$974,097	$722,428	$516,391	$398,453	$359,364	$308,077	**$21,405,571**	41,041	$24,620,682				
202408	$0	$0	$0	$0	$0	$0	$0	$9,850,891	$7,024,001	$2,025,905	$618,556	$736,003	$793,008	$486,071	$391,864	**$21,926,301**	40,959	$24,524,619				
202409	$0	$0	$0	$0	$0	$0	$0	$0	$6,461,702	$9,633,102	$1,303,021	$730,560	$758,317	$472,255	$372,419	**$19,731,376**	40,983	$24,460,938				
202410	$0	$0	$0	$0	$0	$0	$0	$0	$0	$9,101,132	$8,038,597	$3,187,649	$1,249,507	$623,991	$457,484	**$22,658,360**	40,830	$24,314,889				
202411	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,595,558	$9,878,601	$2,409,345	$626,064	$694,584	**$20,204,153**	40,340	$24,016,584				
202412	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,600,589	$10,288,837	$2,048,053	$722,904	**$20,660,384**	39,466	$23,512,784				
Total	**$5,219,627**	**$14,001,457**	**$19,790,218**	**$18,310,074**	**$19,650,298**	**$19,384,118**	**$22,401,724**	**$20,940,116**	**$16,615,775**	**$23,999,918**	**$19,960,438**	**$26,025,303**	**$17,821,182**	**$6,181,059**	**$4,172,651**	**$254,473,957**	**489,287**	**$293,930,108**	*$41,355,022*	*-$1,179,182*	*-$910,537*	**$39,265,304**

	Medical Incurred Claims by Paid Month															
Incurred Month	**202401**	**202402**	**202403**	**202404**	**202405**	**202406**	**202407**	**202408**	**202409**	**202410**	**202411**	**202412**	**202501**	**202502**	**202503**	**Total Medical Incurred**
202401	$3,947,396	$7,275,984	$1,433,322	$1,060,693	$949,410	$360,209	$249,706	$177,876	$95,333	$182,679	$248,007	$750,624	$175,728	$174,434	$27,275	**$17,108,675**
202402	$0	$4,051,463	$7,053,970	$2,470,503	$1,114,072	$492,348	$322,075	$230,254	$95,306	$249,400	$561,920	$470,189	$328,019	$313,314	$165,513	**$17,918,345**
202403	$0	$0	$7,651,855	$5,125,904	$1,617,840	$857,110	$336,493	$346,347	$128,773	$267,558	$424,669	$367,964	$226,213	$104,919	$110,805	**$17,566,449**
202404	$0	$0	$0	$6,607,637	$6,261,830	$2,211,973	$1,203,108	$399,106	$186,282	$391,736	$349,898	$538,437	$697,059	$190,839	$449,466	**$19,487,369**
202405	$0	$0	$0	$0	$6,647,512	$7,042,956	$2,105,667	$794,135	$366,264	$341,089	$486,096	$619,620	$128,088	$208,240	$208,044	**$18,947,709**
202406	$0	$0	$0	$0	$0	$5,463,979	$7,583,397	$1,142,224	$596,622	$541,984	$436,864	$401,173	$208,799	$477,121	$154,144	**$17,006,308**
202407	$0	$0	$0	$0	$0	$0	$7,291,501	$6,796,512	$1,379,497	$886,442	$680,725	$453,542	$366,406	$332,558	$276,645	**$18,463,829**
202408	$0	$0	$0	$0	$0	$0	$0	$8,130,845	$6,278,013	$1,854,654	$580,130	$679,890	$717,387	$458,289	$360,959	**$19,060,167**
202409	$0	$0	$0	$0	$0	$0	$0	$0	$5,214,654	$8,404,120	$1,211,534	$670,112	$697,184	$423,527	$340,399	**$16,961,530**
202410	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,529,642	$7,029,460	$3,014,520	$1,169,928	$584,143	$416,531	**$19,744,224**
202411	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,417,908	$8,745,269	$2,269,102	$568,052	$638,034	**$17,638,366**
202412	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,287,424	$9,208,891	$1,941,540	$659,965	**$18,097,820**
Total	**$3,947,396**	**$11,327,447**	**$16,139,147**	**$15,264,737**	**$16,590,664**	**$16,428,575**	**$19,091,946**	**$18,017,299**	**$14,340,744**	**$20,649,304**	**$17,427,210**	**$22,998,763**	**$16,192,805**	**$5,776,975**	**$3,807,781**	**$218,000,792**

	Rx Allowed Claims by Paid Month																
Incurred Month	**202401**	**202402**	**202403**	**202404**	**202405**	**202406**	**202407**	**202408**	**202409**	**202410**	**202411**	**202412**	**202501**	**202502**	**202503**	**Total Rx Allowed**	**Rx Rebates**
202401	$5,499,077	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$5,499,077**	
202402	$0	$5,895,521	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$5,895,521**	
202403	$0	$0	$6,129,067	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$6,129,067**	
202404	$0	$0	$0	$6,661,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$6,661,445**	
202405	$0	$0	$0	$0	$6,808,656	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$6,808,656**	
202406	$0	$0	$0	$0	$0	$6,446,054	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$6,446,054**	
202407	$0	$0	$0	$0	$0	$0	$6,982,223	$0	$0	$0	$0	$0	$0	$0	$0	**$6,982,223**	
202408	$0	$0	$0	$0	$0	$0	$0	$6,716,762	$0	$0	$0	$0	$0	$0	$0	**$6,716,762**	
202409	$0	$0	$0	$0	$0	$0	$0	$0	$7,037,216	$0	$0	$0	$0	$0	$0	**$7,037,216**	
202410	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,577,175	$0	$0	$0	$0	$0	**$7,577,175**	
202411	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,056,949	$0	$0	$0	$0	**$7,056,949**	
202412	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,257,630	$0	$0	$0	**$7,257,630**	
Total	**$5,499,077**	**$5,895,521**	**$6,129,067**	**$6,661,445**	**$6,808,656**	**$6,446,054**	**$6,982,223**	**$6,716,762**	**$7,037,216**	**$7,577,175**	**$7,056,949**	**$7,257,630**	**$0**	**$0**	**$0**	**$80,067,777**	**-$23,496,212**

	Rx Incurred Claims by Paid Month															
Incurred Month	**202401**	**202402**	**202403**	**202404**	**202405**	**202406**	**202407**	**202408**	**202409**	**202410**	**202411**	**202412**	**202501**	**202502**	**202503**	**Total Rx Incurred**
202401	$4,452,408	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$4,452,408**
202402	$0	$5,047,636	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$5,047,636**
202403	$0	$0	$5,303,499	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$5,303,499**
202404	$0	$0	$0	$5,916,599	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$5,916,599**
202405	$0	$0	$0	$0	$6,015,649	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$6,015,649**
202406	$0	$0	$0	$0	$0	$5,782,158	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$5,782,158**
202407	$0	$0	$0	$0	$0	$0	$6,245,151	$0	$0	$0	$0	$0	$0	$0	$0	**$6,245,151**
202408	$0	$0	$0	$0	$0	$0	$0	$6,009,480	$0	$0	$0	$0	$0	$0	$0	**$6,009,480**
202409	$0	$0	$0	$0	$0	$0	$0	$0	$6,363,041	$0	$0	$0	$0	$0	$0	**$6,363,041**
202410	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,907,919	$0	$0	$0	$0	$0	**$6,907,919**
202411	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,442,212	$0	$0	$0	$0	**$6,442,212**
202412	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,624,573	$0	$0	$0	**$6,624,573**
Total	**$4,452,408**	**$5,047,636**	**$5,303,499**	**$5,916,599**	**$6,015,649**	**$5,782,158**	**$6,245,151**	**$6,009,480**	**$6,363,041**	**$6,907,919**	**$6,442,212**	**$6,624,573**	**$0**	**$0**	**$0**	**$71,110,323**

Appendix Exhibit 1.3

Experience Period Claims by Metal Level

Checklist Item 11h

	2024 Incurred Claims	2024 Allowed Claims	2024 Paid-to-Allowed Ratios
Gold	$112,599,186	$124,966,258	90.10%
Silver	$142,812,342	$161,228,997	88.58%
Bronze	$33,699,588	$48,346,479	69.70%
Total	**$289,111,115**	**$334,541,734**	**86.42%**

Appendix Exhibit 2.1
URRT Worksheet 1, Section II
Checklist Item 5c, 28c

2026 Filing		Year 1 Trend		Year 2 Trend	
Benefit Category	WAC Category	Cost	Utilization	Cost	Utilization
Inpatient Hospital	Hospital	1.088	1.055	1.066	1.025
Outpatient Hospital	Hospital	1.023	1.095	1.059	1.025
Professional	Professional	1.016	1.055	1.044	1.025
Other Medical	Other	1.016	1.055	1.044	1.025
Capitation	Other	1.025	1.000	1.025	1.000
Prescription Drug	Prescription Drugs	1.025	1.108	1.031	1.029

2025 Filing		Year 1 Trend		Year 2 Trend	
Benefit Category	WAC Category	Cost	Utilization	Cost	Utilization
Inpatient Hospital	Hospital	1.035	1.068	1.045	1.026
Outpatient Hospital	Hospital	1.035	1.068	1.040	1.032
Professional	Professional	1.025	1.068	1.051	1.026
Other Medical	Other	1.025	1.028	1.051	1.026
Capitation	Other	1.025	1.000	1.025	1.000
Prescription Drug	Prescription Drugs	1.040	1.184	1.038	1.045

Change		Year 1 Trend		Year 2 Trend	
Benefit Category	WAC Category	Cost	Utilization	Cost	Utilization
Inpatient Hospital	Hospital	0.053	-0.013	0.021	-0.001
Outpatient Hospital	Hospital	-0.013	0.028	0.019	-0.007
Professional	Professional	-0.009	-0.013	-0.007	-0.001
Other Medical	Other	-0.009	0.027	-0.007	-0.001
Capitation	Other	0.000	0.000	0.000	0.000
Prescription Drug	Prescription Drugs	-0.015	-0.076	-0.007	-0.016

	2026	*2025*	*Change*
Morbidity Adjustment	0.967	1.017	-0.050
Demographic Shift	1.009	1.002	0.007
Plan Design Changes	1.121	0.999	0.123
Other	1.000	1.000	0.000

Appendix Exhibit 3.1

WAC 284-43-6660 Incurred Claims Trend

Checklist Item 6b

WAC Category	2024 Incurred Claims PMPM	Incurred Unit Cost Trend	Incurred Utilization Trend	Total	Portion of Claim Dollars
Hospital	$259.66	1.050	1.053	10.54%	43.94%
Professional	$154.11	1.028	1.040	6.87%	26.08%
Prescription Drugs	$145.33	1.029	1.068	9.94%	24.60%
Dental	$0.00	-	-	0.00%	0.00%
Other[(1)]	$31.78	1.025	1.014	3.91%	5.38%
Total	**$590.88**			**9.10%**	**100.00%**

URRT Wksh 2 Field 2.17:	$590.88
URRT Wksh 2 Field 4.15:	$703.26
Annualized Trend:	**9.10%**
Rate Review Detail Trend:	9.10%

Notes:

(1) Cap is included in 'Other'

(2) The Annual Incurred Claims Projected Trend includes the impact of morbidity, demographic shift, plan design, and other changes.

Appendix Exhibit 4.1

Non-Trend EHB Factors: Morbidity Adjustment

Checklist Item 7

							Pricing Year				
	Base Year Risk Scores			*Intermediate Year Risk Scores*			Renewing Members		New Members		Total
Metal Tier	**Renew**	**New**	**Total**	**Renew**	**New**	**Total**	**Mbr Mix**	**Risk score**	**Mbr Mix**	**Risk score**	**Total**
Gold	2.189	2.286		2.409	2.352		68%	1.891	8%	1.903	
Silver 100	1.856	1.612		2.009	1.694		2%	2.065	0%	1.777	
Silver 150	1.762	1.470		1.633	1.546		4%	1.644	0%	1.624	
Silver 200	1.396	1.221		1.206	1.284		0%	1.276	0%	0.000	
Silver 250	1.370	1.210		1.435	1.270		0%	1.436	0%	0.000	
Bronze	0.838	0.798		0.834	0.840		15%	0.870	1%	0.881	
Total (Pricing Yr Weight)			**1.939**			**2.091**					**1.713**

% Risk Score change due to Morbidity:	50%
Acuity Adjustment (Base to Int Yr):	**1.039**
Acuity Adjustment (Int to Pricing Yr):	**0.930**
eAPTC Expiration Adjustment:	1.023
Final Acuity Adjustment:	**0.967**

Appendix Exhibit 4.2a
Non-Trend EHB Factors: Demographic Shift
Checklist Item 7

Age Band	Assumed Avg Age	Base Yr Member Mix %	Pricing Yr Member Mix %	Age Factor	Age Band	Assumed Avg Age	Base Yr Member Mix %	Pricing Yr Member Mix %	Age Factor	Age Band	Assumed Avg Age	Base Yr Member Mix %	Pricing Yr Member Mix %	Age Factor
0 - 14*	7	0.2%	0.2%	0.765	31	31	1.8%	1.7%	1.159	49	49	1.8%	1.8%	1.706
0-14	7	5.4%	5.4%	0.765	32	32	1.9%	1.8%	1.183	50	50	1.7%	1.8%	1.786
15	15	0.5%	0.5%	0.833	33	33	1.9%	1.8%	1.198	51	51	1.8%	1.8%	1.865
16	16	0.5%	0.5%	0.859	34	34	1.9%	1.8%	1.214	52	52	2.0%	1.8%	1.952
17	17	0.5%	0.5%	0.885	35	35	1.8%	1.9%	1.222	53	53	2.2%	2.1%	2.040
18	18	0.4%	0.4%	0.913	36	36	1.9%	1.9%	1.230	54	54	2.1%	2.3%	2.135
19	19	1.6%	1.3%	0.941	37	37	1.8%	1.9%	1.238	55	55	2.1%	2.2%	2.230
20	20	1.3%	1.3%	0.970	38	38	1.8%	1.8%	1.246	56	56	2.2%	2.2%	2.333
21	21	1.3%	1.3%	1.000	39	39	1.9%	1.8%	1.262	57	57	2.2%	2.2%	2.437
22	22	1.3%	1.3%	1.000	40	40	1.8%	1.9%	1.278	58	58	2.4%	2.2%	2.548
23	23	1.2%	1.3%	1.000	41	41	1.7%	1.8%	1.302	59	59	2.7%	2.4%	2.603
24	24	1.2%	1.2%	1.000	42	42	1.8%	1.8%	1.325	60	60	3.0%	2.8%	2.714
25	25	1.3%	1.2%	1.004	43	43	1.9%	1.9%	1.357	61	61	3.2%	3.2%	2.810
26	26	1.8%	1.6%	1.024	44	44	1.9%	1.9%	1.397	62	62	3.7%	3.5%	2.873
27	27	1.8%	1.7%	1.048	45	45	1.9%	2.0%	1.444	63	63	4.1%	3.9%	2.952
28	28	1.8%	1.8%	1.087	46	46	1.8%	1.9%	1.500	64	64	2.5%	3.7%	3.000
29	29	1.9%	1.8%	1.119	47	47	1.7%	1.8%	1.563	65+	71	1.7%	1.8%	3.000
30	30	1.8%	1.9%	1.135	48	48	1.8%	1.7%	1.635					

**% of membership impacted by the 3 children under age 21 dependent cap.*

Average Age Factor (Base Yr Weight): 1.711
Average Age Factor (Pricing Yr Weight): 1.724

Deomgraphic Adjustment: **1.007**

Appendix Exhibit 4.2b
Age Factors and Age Calibration Factors
Checklist Item 15

Calibration Factors, Projected vs Prior

2026	2025	2024	2023
0.580	0.578	0.571	0.571

Average Age (Pricing Year): **42.5**

Appendix Exhibit 4.2c

Non-Trend EHB Factors: Demographic Shift

Checklist Item 7

Region	Base Yr Member Mix %	Pricing Yr Member Mix %	Pricing Yr Area Factor
1	39.4%	36.6%	1.000
2	4.9%	8.8%	1.019
3	13.6%	14.1%	1.150
4	9.8%	9.0%	1.000
5	18.3%	16.9%	1.000
6	1.2%	2.1%	1.034
8	12.8%	12.5%	1.014

Area Factor (Base Yr Mix):	1.024
Area Factor (Pricing Yr Mix):	1.025
Geographic Adjustment:	**1.002**

Appendix Exhibit 4.3

Non-Trend EHB Factors: Plan Design Changes

Checklist Item 7

CSR Tier	Base Yr Member Mix %	Pricing Yr Member Mix %	Adj Base Yr Allowed
Gold	26%	76%	$767.74
Silver 100	10%	2%	$764.56
Silver 150	19%	5%	$700.54
Silver 200	8%	0%	$613.19
Silver 250	12%	0%	$592.80
Bronze	25%	16%	$387.93

Plan Mix Adjustment:	**1.121**

Notes:

Adj Base Yr Allowed claims have been adjusted from the 2024 experience period to reflect the impact of uniform silver-loading

Appendix Exhibit 5.1a
Market Adjusted Index Rate
Checklist Item 19c, 28a

Description	Paid Basis	Paid to Allowed	Allowed Basis	% of MAIR
Projected Index Rate			$892.52	
Risk Adjustment	$82.75	0.787	$105.13	
Exchange Fee	$5.11	0.787	$6.49	0.82%
Market Adjusted Index Rate			**$793.89**	

Appendix Exhibit 5.1b
AV and Cost-Sharing Design of Plan
Checklist Item 11d, 11e, 13, 27

	3.1 Plan ID (Standard Component ID)	**Total**	**84481WA0060005**	**84481WA0060006**	**84481WA0060007**	**84481WA0060008**
3.2	Market Adjusted Index Rate		$793.89	$793.89	$793.89	$793.89
	Pricing AV	*0.7631*	*0.8171*	*0.7184*	*0.6499*	*0.7801*
	Uniform Silver-Load Adjustment	*1.0335*	*1.0000*	*1.4350*	*1.0000*	*1.0000*
	Induced Demand Factor	*1.0623*	*1.0905*	*1.0377*	*1.0125*	*1.0684*
	Normalized IDF	*1.0000*	*1.0266*	*0.9768*	*0.9531*	*1.0058*
3.3	AV and Cost Sharing Design of Plan	0.7869	0.8377	1.0059	0.6184	0.7835
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000
	Benefits in Addition to EHB		*$1.00*	*$1.00*	*$1.00*	*$1.00*
	EHB % of Total Premium	*99.86%*	*99.87%*	*99.89%*	*99.83%*	*99.87%*
3.5	Benefits in Addition to EHB	1.0014	1.0013	1.0011	1.0017	1.0013
	Plan Adjusted Index Rate		*$789.59*	*$931.46*	*$604.64*	*$743.86*
	Projected Membership	*289,764*	*71,317*	*22,336*	*47,553*	*148,558*

Appendix Exhibit 6.1

Base Premium Rates vs CPAIR

Checklist Item 11g

	Molina Cascade Complete Gold 84481WA0060005	Molina Cascade Silver 84481WA0060006	Molina Cascade Bronze 84481WA0060007	Molina Cascade Vital Gold 84481WA0060008
Base Premium Rates [1]	$446.72	$526.98	$342.08	$420.85
URRT Worksheet 3 Field 3.14 (CPAIR)	$446.72	$526.98	$342.08	$420.85
Difference	*$0.00*	*$0.00*	*$0.00*	*$0.00*

Notes:

1) Base Premium Rates are sourced from the Rate Schedule; King county, Age 21 Rates

Appendix Exhibit 7.1

Area Factors and Geographic Calibration Factors

Checklist Item 16

2026 Area Factor Development

Region	Projected Members	Trended EHB Allowed Claims	Calculated Area Factors	Final Area Factors
1	8,834	$795.60	0.9753	1.0000
2	2,127	$810.63	0.9937	1.0189
3	3,408	$914.75	1.1214	1.1498
4	2,162	$795.87	0.9756	1.0003
5	4,092	$795.85	0.9756	1.0003
6	499	$822.63	1.0084	1.0340
8	3,025	$806.61	0.9888	1.0138
Total	**24,147**	**$815.75**	**1.0000**	**1.0253**
			Calibration Factors:	**0.975**
			Highest vs Lowest:	*1.1498*

Projected vs Prior

2025 Area Factors	2024 Area Factors	2023 Area Factors
1.0000	1.0000	1.0000
1.0104	1.0120	1.0423
1.1227	1.1148	1.0729
0.9858	0.9871	1.0236
0.9985	0.9993	1.0327
1.0082	0.9861	0.9814
1.0045	0.9875	0.9857
0.983	**0.974**	**0.975**

Appendix Exhibit 8.1

HCRP: Projected vs Prior

Checklist Item 19e

	Actual HCRP Receipts	Actual HCRP Assessments	Projected HCRP Receipts	Projected HCRP Assessments
2022	$1.47	-$1.82	$0.33	-$1.98
2023	$2.57	-$2.03	$0.36	-$2.56
2024	$0.00	-$2.41	$1.07	-$3.51
2025			$1.53	-$2.72
2026			$1.85	-$3.30

Notes:

2024 Actual HCRP amounts are based on best estimates

Appendix Exhibit 9.1

Section IV: Projected Plan Level Information Development

Checklist Item 28f, 28h

		Molina Cascade Complete Gold	Molina Cascade Silver	Molina Cascade Bronze	Molina Cascade Vital Gold
4.1 Plan ID (Standard Component ID)	**Total**	**84481WA0060005**	**84481WA0060006**	**84481WA0060007**	**84481WA0060008**
4.2 Allowed Claims	**$258,620,163**	$65,342,439	$19,473,252	$40,450,770	$133,353,702
4.3 Reinsurance	**$0**	$0	$0	$0	$0
4.4 Member Cost Sharing	**$54,840,920**	$11,952,655	-$601,840	$14,160,216	$29,329,889
4.5 Cost Sharing Reduction	**$0**	$0	$0	$0	$0
4.6 Incurred Claims	**$203,779,242**	**$53,389,784**	**$20,075,092**	**$26,290,554**	**$104,023,813**
4.7 Risk Adjustment Transfer Amount	**$23,978,123**	$5,901,519	$1,848,316	$3,935,036	$12,293,252
4.8 Premium	**$216,375,294**	$56,311,427	$20,805,088	$28,752,256	$110,506,523
4.9 Projected Member Months	**289,764**	71,317	22,336	47,553	148,558

Per Member Per Month

4.1 Allowed Claims	**$892.52**	$916.23	$871.83	$850.65	$897.65
4.1 Reinsurance	**$0.00**	$0.00	$0.00	$0.00	$0.00
4.1 Member Cost Sharing	**$189.26**	$167.60	-$26.94	$297.78	$197.43
4.1 Cost Sharing Reduction	**$0.00**	$0.00	$0.00	$0.00	$0.00
4.2 Incurred Claims	**$703.26**	**$748.63**	**$898.78**	**$552.87**	**$700.22**
4.2 Risk Adjustment Transfer Amount	**$82.75**	$82.75	$82.75	$82.75	$82.75
4.2 Premium	**$746.73**	$789.59	$931.46	$604.64	$743.86

Plan Adjusted Index Rate	*$746.73*	*$789.59*	*$931.46*	*$604.64*	*$743.86*
PAIR vs Premium	*$0.00*				

Appendix Exhibit 10.1
Unified Rate Review Template - Worksheet 1

Section 1: Experience Period Data

Experience Period:	1/1/2024	to	12/31/2024
		Total	PMPM
Allowed Claims		$334,541,734.48	$683.73
Reinsurance		$0.00	$0.00
Incurred Claims in Experience Period		$289,111,115.00	$590.88
Risk Adjustment		$39,265,304.12	$80.25
Experience Period Premium		$293,930,108.29	$600.73
Experience Period Member Months		489,287	

Section II: Projections

		Year 1 Trend		Year 2 Trend		
Benefit Category	**Exp Period Index Rate PMPM**	**Cost**	**Utilization**	**Cost**	**Utilization**	**Trended EHB Allowed Claims PMPM**
Inpatient Hospital	$96.49	1.088	1.055	1.066	1.025	$121.11
Outpatient Hospital	$204.16	1.023	1.095	1.059	1.025	$248.17
Professional	$178.55	1.016	1.055	1.044	1.025	$204.77
Other Medical	$13.92	1.016	1.055	1.044	1.025	$15.96
Capitation	$26.97	1.025	1.000	1.025	1.000	$28.34
Prescription Drug	$163.64	1.025	1.108	1.031	1.029	$197.39
Total	**$683.73**					**$815.75**

Morbidity Adjustment		0.967
Demographic Shift		1.009
Plan Design Changes		1.121
Other		1.000
Adjusted Trended EHB Allowed Claims PMPM for	**1/1/2026**	**$892.52**

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.0%

			Projected Period Totals
Projected Index Rate for	**1/1/2026**	**$892.52**	$258,620,165.28
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		$105.13	$30,461,851.98
Exchange User Fees		0.82%	$1,881,076.49
Market Adjusted Index Rate		**$793.89**	**$230,039,389.79**

Projected Member Months	**289,764**

Appendix Exhibit 10.2
Unified Rate Review Template - Worksheet 2

Section I: General Product and Plan Information

1.1 Product Name		Molina Healthcare	Molina Healthcare	Molina Healthcare	Molina Healthcare	Molina Healthcare
1.2 Product ID		84481WA006	84481WA006	84481WA006	84481WA006	84481WA006
1.3 Plan Name		Molina Cascade Complete Gold	Molina Cascade Silver	Molina Cascade Bronze	Molina Cascade Vital Gold	Constant Care Silver 1
1.4 Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
1.5 Metal		Gold	Silver	Bronze	Gold	Silver
1.6 AV Metal Value		0.8171	0.7184	0.6499	0.7801	0.7184
1.7 Plan Category		Renewing	Renewing	Renewing	New	Terminated
1.8 Plan Type		HMO	HMO	HMO	HMO	HMO
1.9 Exchange Plan?		Yes	Yes	Yes	Yes	No
1.1 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)		9.30%	36.98%	16.10%	0.00%	0.00%
1.12 Product Rate Increase %		22.36%				
1.13 Submission Level Rate Increase %		22.36%				

Section II: Experience Period and Current Plan Level Information

2.1 Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
2.2 Allowed Claims	$334,541,734	$124,966,258	$93,809,113	$48,346,479	$0	$67,419,884
2.3 Reinsurance	$0	$0	$0	$0	$0	$0
2.4 Member Cost Sharing	$45,430,619	$12,367,072	$10,653,230	$14,646,891	$0	$7,763,426
2.5 Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
2.6 Incurred Claims	$289,111,115	$112,599,186	$83,155,883	$33,699,588	$0	$59,656,459
2.7 Risk Adjustment Transfer Amount	$39,265,304	$34,124,368	$15,564,739	-$13,851,047	$0	$3,427,244
2.8 Premium	$293,930,108	$80,139,504	$84,613,801	$63,913,855	$0	$65,262,949
2.9 Experience Period Member Months	489,287	125,397	137,373	124,626	0	101,891
2.1 Current Enrollment	43,346	10,687	13,965	11,560	0	7,134
2.11 Current Premium PMPM	$640.20	$684.82	$662.33	$547.01	$0.00	$681.02
2.12 Loss Ratio	86.8%	98.5%	83.0%	67.3%	#DIV/0!	86.8%
Per Member Per Month						
2.13 Allowed Claims	$683.73	$996.56	$682.88	$387.93	#DIV/0!	$661.69
2.14 Reinsurance	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
2.15 Member Cost Sharing	$92.85	$98.62	$77.55	$117.53	#DIV/0!	$76.19
2.16 Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
2.17 Incurred Claims	$590.88	$897.94	$605.33	$270.41	#DIV/0!	$585.49
2.18 Risk Adjustment Transfer Amount	$80.25	$272.13	$113.30	-$111.14	#DIV/0!	$33.64
2.19 Premium	$600.73	$639.09	$615.94	$512.85	#DIV/0!	$640.52

Section III: Plan Adjustment Factors

3.1 Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
3.2 Market Adjusted Index Rate		$793.89	$793.89	$793.89	$793.89	$793.89
3.3 AV and Cost Sharing Design of Plan		0.838	1.006	0.618	0.783	0.000
3.4 Provider Network Adjustment		1.000	1.000	1.000	1.000	0.000
3.5 Benefits in Addition to EHB		1.001	1.001	1.002	1.001	0.000
Administrative Costs						
3.6 Administrative Expense		9.68%	8.21%	12.65%	10.28%	0.00%
3.7 Taxes and Fees		2.98%	2.96%	3.02%	2.99%	0.00%
3.8 Profit & Risk Load		3.00%	3.00%	3.00%	3.00%	0.00%
3.9 Catastrophic Adjustment		1.000	1.000	1.000	1.000	0.000
3.1 **Plan Adjusted Index Rate**		$789.59	$931.46	$604.64	$743.86	$0.00
3.11 Age Calibration Factor	0.580					
3.12 Geographic Calibration Factor	0.975					
3.13 Tobacco Calibration Factor	1.000					
3.14 **Calibrated Plan Adjusted Index Rate**		$446.72	$526.98	$342.08	$420.85	$0.00

Section IV: Projected Plan Level Information

4.1 Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
4.2 Allowed Claims	$258,620,163	$65,342,439	$19,473,252	$40,450,770	$133,353,702	$0
4.3 Reinsurance	$0	$0	$0	$0	$0	$0
4.4 Member Cost Sharing	$54,840,920	$11,952,655	-$601,840	$14,160,216	$29,329,889	$0
4.5 Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6 Incurred Claims	$203,779,242	$53,389,784	$20,075,092	$26,290,554	$104,023,813	$0
4.7 Risk Adjustment Transfer Amount	$23,978,123	$5,901,519	$1,848,316	$3,935,036	$12,293,252	$0
4.8 Premium	$216,375,294	$56,311,427	$20,805,088	$28,752,256	$110,506,523	$0
4.9 Projected Member Months	289,764	71,317	22,336	47,553	148,558	0
4.1 Loss Ratio	84.8%	85.8%	88.6%	80.4%	84.7%	#DIV/0!
Per Member Per Month						
4.11 Allowed Claims	$892.52	$916.23	$871.83	$850.65	$897.65	#DIV/0!
4.12 Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.13 Member Cost Sharing	$189.26	$167.60	-$26.94	$297.78	$197.43	#DIV/0!
4.14 Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.15 Incurred Claims	$703.26	$748.63	$898.78	$552.87	$700.22	#DIV/0!
4.16 Risk Adjustment Transfer Amount	$82.75	$82.75	$82.75	$82.75	$82.75	#DIV/0!
4.17 Premium	$746.73	$789.59	$931.46	$604.64	$743.86	#DIV/0!

Appendix Exhibit 11.1

MLR Calculation

Checklist Item 24(xi)

Item	MLR Item	Formula	PMPM
a	Trended Adjusted Paid Cost		$703.26
b	Total Risk Adjustment		-$82.75
c	ACA/State Reinsurance		$0.00
d	QI Expense Estimate		$6.42
e	**MLR Numerator**	**e = sum(a:d)**	**$626.93**
f	Total Premium		$746.73
g	Exchange User Fee		$5.11
h	PCORI		$0.33
i	Risk Adjustment User Fee		$0.20
j	State Fee		$0.00
k	Federal Income Tax		$5.95
l	Health Insurer Fee		$0.61
m	Premium Tax		$14.93
n	Other Tax/Fee		$0.19
o	**MLR Denominator**	**o = f - sum(g:n)**	**$719.40**
p	Estimated 3-Year Total Average Membership		102,980
q	Estimated Credibility Adjustment		0.0%
r	**Estimated Single-Year Federal MLR**	**r = e / o + q**	**87.1%**

Appendix Exhibit 11.2a

Reconcile to ADS

Checklist Item 26a

Revenue Reconciliation

ADS Total Revenues (line 7)	**$346,097,567**
URRT Premium	$293,930,108
RA	$39,265,304
URRT Revenue	**$333,195,412**
Variance	**-3.73%**

Claims Reconciliation

ADS Total Hospital and Medical Claims (line 17)	**$280,248,257**
URRT Incurred Claims	**$289,111,115**
Variance	**3.2%**

Expenses Reconciliation

ADS Administrative Expenses (lines 19+20)	**$43,497,675**
WAC 284-43-6660 Expenses	**$38,388,624**
Variance	**-11.7%**

Appendix Exhibit 11.2b

Months of Surplus

Checklist Item 26b

Health Statement

Description	**Amount**
Total Capital and Surplus (Page 3 Line 33)	$508,549,225
Total Hospital and Medical Claims (Page 4 Line 18)	$4,164,557,877
Months of Surplus	**1.5**

Appendix Exhibit 11.3
UPMJ - Q5
Checklist Item 31b

Total Enrollment **5(k)**:	43,346
Overall Average Rate Change (weighted by 03/31/2025 enrollment) **5(l)**:	24.59%

COLUMN: 5(a)	**5(b)**	**5(c)**	**5(d)**	**5(e)**	**5(f)**	**5(g)**	**5(h)**	**5(i)**	**5(j)**	**Cost-Share Rate Change**			**Overall Rate Change**		
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	2025 Paid to Allowed Ratios	2026 Paid to Allowed Ratios	Change	2025 PMPM	2026 PMPM	Avg Rate Change
84481WA0060004	Constant Care Silver 1	Terminated	7,134	84481WA0060006	Molina Cascade Silver	36.93%	0.00%	0.04%	36.98%	N/A	N/A	0.04%	N/A	N/A	36.98%
84481WA0060005	Molina Cascade Gold	Renewal	10,687	N/A	N/A	10.25%	0.00%	-0.87%	9.30%	82.42%	81.71%	-0.87%	$685	$748	9.30%
84481WA0060006	Molina Cascade Silver	Renewal	13,965	N/A	N/A	36.93%	0.00%	0.04%	36.98%	71.81%	71.84%	0.04%	$662	$907	36.98%
84481WA0060007	Molina Cascade Bronze	Renewal	11,560	N/A	N/A	13.52%	0.00%	2.28%	16.10%	63.55%	64.99%	2.28%	$547	$635	16.10%

Notes:
2025 Paid to Allowed Ratios are the filed 2025 benefit designs passed through the 2026 AV Calculator
2026 Paid to Allowed Ratios are the 2026 Pricing AVs
The 2025 PMPM's are the weighted average results of weighting 2025 final approved rates with Molina's March 2025 snapshot of enrollment
The 2026 PMPM's are the weighted average results of weighting 2026 final approved rates with Molina's March 2025 snapshot of enrollment

Appendix Exhibit 11.4
Unique Benefit Design Support
Checklist Item 9

Impact of Rx Generic varying cost-sharing levels on Actuarial Value

			Utilization of Generics		AV Calculated with...					
Plan ID	Plan Name	CSR Variant	% Preferred Generic Drug	% Non-Preferred Generic Drug	Preferred Generic Cost-Share	Non-Preferred Generic Cost-Share	Weighted Average AV	Wakely Adj AV	Generic Rx Adj Factor	Final AV
84481WA0060005	Molina Cascade Complete Gold	Standard	95%	5%	81.81%	79.69%	81.71%			**81.71%**
84481WA0060006	Molina Cascade Silver 250	Base	96%	4%	71.33%	71.33%	71.33%	71.84%	1.0000	**71.84%**
84481WA0060006	Molina Cascade Silver 200	73%	97%	3%	73.49%	73.39%	73.49%	73.95%	1.0000	**73.95%**
84481WA0060006	Molina Cascade Silver 150	87%	96%	4%	87.78%	86.70%	87.74%	87.87%	0.9995	**87.83%**
84481WA0060006	Molina Cascade Silver 100	94%	95%	5%	94.76%	92.24%	94.64%	94.86%	0.9987	**94.74%**
84481WA0060007	Molina Cascade Bronze	Standard	95%	5%	63.64%	64.13%	63.66%	64.97%	1.0004	**64.99%**
84481WA0060008	Molina Cascade Vital Gold	Standard	96%	4%	78.06%	76.57%	78.01%			**78.01%**

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 ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$7,000.00			
MOOP if Separate ($)						

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	☑	☐		$450.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$525.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$25.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$25.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$100.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$100.00	☑	☑			☐	☐

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):	5
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: 2026 Molina Cascade Complete Gold - Preferred Generic Cost Share
Name: Cascade Complete Gold
Plan HIOS ID: 84481WA0060005
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 81.71%

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.81%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1172 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	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$7,000.00			
MOOP if Separate ($)						

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	☑	☐		$450.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$525.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$25.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$25.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$100.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$100.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$100.00	☑	☑			☐	☐

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):	5
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: 2026 Molina Cascade Complete Gold - Non-Preferred Generic Cost Share
Name: Cascade Complete Gold
Plan HIOS ID: 84481WA0060005
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 81.71%

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.69%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.0781 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	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 ($)			$1,900.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$8,800.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$650.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$30.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$200.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$200.00	☑	☑			☑	☐

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):	5
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: 2026 Molina Cascade Vital Gold - Preferred Generic Cost Share
Name: Cascade Vital Gold
Plan HIOS ID: 84481WA0060008
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 78.01%

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.06%
Metal Tier: Gold
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0742 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	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,900.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$8,800.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$650.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$30.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$200.00	☑	☑			☑	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$200.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$200.00	☑	☑			☑	☐

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):	5
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: 2026 Molina Cascade Vital Gold - Non-Preferred Generic Cost Share
Name: Cascade Vital Gold
Plan HIOS ID: 84481WA0060008
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 78.01%

Output

Calculate

Status/Error Messages:	Error: Result is outside of [-2, +2] percent de minimis variation.
Actuarial Value:	76.57%
Metal Tier:	
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.0781 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 ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,750.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

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):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description: 2026 Molina Cascade Silver 250 - Preferred Generic Cost Share
Name: Cascade Silver
Plan HIOS ID: 84481WA0060006
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 71.84%

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.33%
Metal Tier: Silver
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0625 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 ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,750.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$250.00	☑	☑			☑	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

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):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description: 2026 Molina Cascade Silver 250 - Non-Preferred Generic Cost Share
Name: Cascade Silver
Plan HIOS ID: 84481WA0060006
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 71.84%

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.33%
Metal Tier: Silver
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.082 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 ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

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)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
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	☐	☐		$32.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

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):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description: 2026 Molina Cascade Bronze - Preferred Generic Cost Share
Name: Cascade Bronze
Plan HIOS ID: 84481WA0060007
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 64.99%

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	63.64%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.082 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 ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

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)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
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	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

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):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description: 2026 Molina Cascade Bronze - Non-Preferred Generic Cost Share
Name: Cascade Bronze
Plan HIOS ID: 84481WA0060007
Issuer HIOS ID: 84481
AVC Version: 2026_1b

Note: Issuer AV is 64.99%

Output

Calculate

Status/Error Messages: Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value: 64.13%
Metal Tier: Bronze
NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0664 seconds

Final 2026 AV Calculator

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:	Molina Healthcare of Washington, Inc.
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:

   5. Certification - Rates - 2026 MHSUD Parity Calculations Duplicate
   6. Certification - Rates - 2026 MHSUD Parity Calculations

Actuarial Certification
of MHSUD Financial Requirement Parity
for the PY2026 ACA Rate Filing:

I, Kathryn Hall, ASA, MAAA, certify the following:
☒ I am an employee of Molina Healthcare, Inc. or
☐ I am a consultant associated with the firm of <<insert name of consulting firm>>;

☒ 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 (*Certification - Rates - 2026 MHSUD Parity Calculations Duplicate*) 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:	Kathryn Hall, ASA, MAAA
Signature:	
Title:	Manager, Actuarial Services
Contact Information:	Kathryn.Hall@molinahealthcare.com
Date of Attestation:	May 13, 2025

Mental Health/Substance Use Disorder (MHSUD)
Financial Requirement Parity Workbook for Plan Year (PY) 2026
Individual or Small Group Market Rate Filing

Last Updated: 4/7/2025

Purpose

● Issuers and plans must comply with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations and guidance such as Chapter 284-43 WAC Subchapter K, Mental Health and Substance Use Disorder. For ease of reference highlighted excerpts of relevant citations are included at the bottom of this page.

● 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 workbook provides a framework to demonstrate compliance with these financial requirements.

● Populate this workbook in addition to the Word document that further certifies parity of Mental Health and Substance Use Disorder Financial Requirements.

'Summary' Worksheet

- Populate only one 'Summary' worksheet for each Excel file.
  Unless file size limitations dictate otherwise, only create one Excel file per filing.
  See specific instructions on the 'Summary' worksheet.

- Note that the **[GENERATE TESTING TEMPLATES]** macro button on the Summary worksheet creates one testing worksheet per plan, using the HIOS Plan ID field for the tab names.

'Data Information' Worksheet

- Populate only one 'Data Information' worksheet for each Excel file.
  See specific instructions on the 'Data Information' worksheet.

'Mapping Information' Worksheet

- Populate only one 'Mapping Information' worksheet for each Excel file.
  See specific instructions on the 'Mapping Information' worksheet.

'Template' Worksheet - One worksheet for each plan

● PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

- **Results By Benefit Classification:**
  For each benefit classification, make a selection in the second column (labeled column "B"). Select "Yes" if all cost shares for medical/surgical services in the benefit classification are the same as those for MH/SUD services in the benefit classification; consider cost shares in terms of deductible, copay, coinsurance, and out-of-pocket maximum.
  Note: The remaining columns will auto-update based on entries here and elsewhere in the file.

---- IMPORTANT ----
Test results will appear in this table after all PART 1 and PART 2 entries are made in the worksheet.
No Benefit Classification results should reflect "Fail" after all PART 1 and 2 entries have been made.
If any result still reflects "Fail" after all entries have been made, please revisit PART 1 and 2 entries. Check that information was entered accurately and flows through as expected. If needed, edit the plan's medical/surgical and/or MHSUD service financial requirements to bring the results into compliance.

- **Testing Options** (located to the right of Results by Benefit Classification):
  - Out-of-network Tier?
    If out-of-network benefits apply, select "Yes;" if not, select "No."
    When "No," you can leave blank the corresponding out-of-network section(s) in the upcoming PARTS 1 and 2.

  - Outpatient Benefit Testing:
    Indicate whether outpatient parity will be demonstrated "All Combined" or with "Office Visits Separate."
    Select "All Combined" to use the single outpatient classification.
    Select "Office Visits Separate" to use the subclassifications described in WAC 284-43-7020(6),
    namely (i) Office visits (a.k.a. Outpatient - Office visits) and
    (ii) All other outpatient items and services (a.k.a. Outpatient - all other).
    Note: If "Office Visits Separate" is selected, testing must be performed for both subclassifiations.

● PART 1 -- COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

For each benefit classification/subclassification that requires testing (see table Results by Benefit Classification):
List services and cost shares for covered medical/surgical benefits + other embedded non-MHSUD benefits like pediatric dental.
Include every possible financial requirement type and level for each benefit classification/subclassification.
Include preventive services and other services with no cost shares.

- ***Service Description:***
  Briefly describe the service.
  Be consistent with what is in the 'Mapping Information' worksheet in this file, the Form filing,
  the Plans and Benefits Template (PBT) in the Binder filing, the Benefit Components file,
  and other information in this rate filing.

● ***Cost-Share Description:***
Describe the member's cost-shares.
Be consistent with what is in the Form filing, the Plans and Benefits Template (PBT) in the Binder filing, the Benefit Components file, and other information in this rate filing.
This entry should contain the wording "Before Deductible", "After Deductible", or "Before and After Deductible" to describe when the cost shares apply, similarly to the Benefit Components file.
This entry should contain the wording "Accrues towards deductible" if the cost share accrues towards the deductible. If the cost share does not accrue towards the deductible, the entry should not contain the word "Accrues" at all.

● ***Plan Projected Allowed Amount:***
Enter a projected "allowed" dollar amount for each plan and listed service.
Reminder: Dollar amounts should reflect what the plan "allows," before accounting for enrollee cost sharing and should be consistent with projections for the rate filing. The amounts should generally be specific to each plan. [WAC 284-43-7040(1)(c)]

● ***Deductible:***
Enter the deductible level that applies to each service. If not subject to deductible, enter "N/A".
Every row in PART 1 should have a deductible value entered of "N/A" or greater than $0.
In other words: The deductible should only be blank in extra data rows or if an entire benefit classification section is not used (e.g., when there are no out-of-network benefits).

● ***Copayment:***
Enter the copayment level that applies to each service. If not applicable, enter "N/A".

● ***Coinsurance:***
Enter the coinsurance level that applies to each service. If not applicable, enter "N/A".

● ***Out-of-Pocket Maximum (OOPM):***
Enter the OOPM level that applies to each service. If not applicable, enter "N/A".

● ***No Cost Share:***
Leave this column blank unless the member has no cost share for the service.
If no cost share applies, enter "x" in this column and enter "N/A" for Deductible, Copayment, Coinsurance, and OOPM.

● PART 2 -- ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Note: the remaining columns of the top table will auto-populate after entries are made throughout PARTS 1 and 2.
For each benefit classification/subclassification that requires testing (see table Results by Benefit Classification):

● ***MHSUD Cost Shares in Plan Design:***
Indicate the plan design's MHSUD benefit financial requirements for each benefit classification/subclassification.
If a particular type of financial requirement does not apply, enter "N/A".

● ***Step 1 Substantially All:***
This table will auto-populate from PARTS 1 and 2.
Confirm details appear as expected. If not, revisit information entered elsewhere in PARTS 1 and 2.

● ***Step 2 Predominant Level:***
For each financial type that passed the Step 1 Substantially All test:
Inputs are required in each section.
Enter every unique amount (a.k.a. level), from smallest to largest, separately by financial requirement type (i.e., deductible, copayment, coinsurance, and OOPM).
If a particular type of financial requirement does not apply, simply leave blank those value fields.

If you need room to enter additional unique amounts for a particular type of financial requirement, you can insert rows. For example, to enter an additional deductible amount, insert a row above the "Total" row in the deductible table; to do so, click in the bottom-right white cell of the deductible section and click [Tab].

The remaining fields will auto-populate using other information from PARTS 1 and 2.
Confirm details flow through as expected. If not, revisit information entered elsewhere in PARTS 1 and 2.

Sample of Relevant Requirements, Citations, and Definitions

1. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
and Chapter 284-43 WAC Subchapter K, Mental Health and Substance Use Disorder:
Financial requirements applicable to mental health/substance use disorder (MHSUD) benefits cannot be more restrictive than those applicable to medical/surgical benefits.

2. Financial requirements:
[WAC 284-43-7010] Financial requirements are cost sharing measures such as deductibles, copayments, coinsurance, and out-of-pocket maximums but do not include aggregate lifetime or annual dollar limits.

3. See WAC 284-43-7010 for descriptions of "Medical/surgical benefits," "Mental health benefits," and "Substance use disorder benefits."

4. Substantially all:
[WAC 284-43-7010] A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits 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).

5. Predominant level:
[WAC 284-43-7010] If a type of financial requirement or quantitative treatment limitation 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 or quantitative treatment limitation.

6. Data used in the calculations:
[WAC 284-43-7040(1)(c)] The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification *expected to be paid under the plan for the plan year* .
See WAC 284-43-7040(1)(c) (i) and (ii) for additional details.

7. Classification of Benefits [WAC 284-43-7020]:

a) Inpatient, in-network:

Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.

b) Inpatient, out-of-network:

Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage; also includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers.

c) Outpatient, in-network:

Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.

Note: outpatient can optionally be subclassified into "Office Visits" and "All Other Outpatient Items and Services."

d) Outpatient, out-of-network:

Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage; also includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers.

Note: outpatient can optionally be subclassified into "Office Visits" and "All Other Outpatient Items and Services."

e) Emergency care:

Benefits for treatment of an emergency condition related to a mental health or substance use disorder.

Such benefits must comply with the requirements for emergency medical services in RCW 48.43.093.

Medically necessary detoxification must be covered as an emergency medical condition according to RCW 48.43.093, and may be provided in hospitals licensed under chapter 70.41 RCW. Medically necessary detoxification services must not require prenotification.

f) Prescription drugs:

Benefits for prescription drugs.

MHSUD Financial Requirement Parity Testing -- Summary

Issuer and Filing Information

Issuer Name:	Molina Healthcare of Washington, Inc.
HIOS Issuer ID:	84481
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
84481WA0060005	Molina Cascade Complete Gold	Pass	
84481WA0060006-06	Molina Cascade Silver 94	Pass	
84481WA0060006-05	Molina Cascade Silver 87	Pass	
84481WA0060006-04	Molina Cascade Silver 73	Pass	
84481WA0060006-01	Molina Cascade Silver	Pass	
84481WA0060007	Molina Cascade Bronze	Pass	
84481WA0060008	Molina Cascade Vital Gold	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.
	WA marketplace 2026 Projected Allowed Amount
2	Identify the period (i.e., date range) represented in the data.
	The period is 1/1/2026-12/31/2026
3	Address the credibility of the data used in your MHSUD financial requirement parity testing.
	WA marketplace projected 2026 data are considered 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.
	Yes, it's consistent with 2026 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?
	N/A

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
Inpatient Hospital Services (e.g., Hospital Stay)	Inpatient	<<select mapped Ben. Comp. category>>	
Skilled Nursing Facility	Inpatient	<<select mapped Ben. Comp. category>>	
Primary Care Visit to Treat an Injury or Illness	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Specialist Visit	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Urgent Care Centers or Facilities	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Nutritional Counseling	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Inherited Metabolic Disorder - PKU	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Diabetes Care Management	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Preventive Care/Screening/Immunization	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
virtual / telehealth visits	Outpatient - Office Visits	<<select mapped Ben. Comp. category>>	
Routine Foot Care	Outpatient - Office Visits		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient - All Other		
Laboratory Outpatient and Professional Services	Outpatient - All Other		
Imaging (CT/PET Scans, MRIs)	Outpatient - All Other		
Outpatient Surgery Physician/Surgical Services	Outpatient - All Other		
Chemotherapy	Outpatient - All Other		
Dialysis	Outpatient - All Other		
Home Health Care Services	Outpatient - All Other		
Durable Medical Equipment	Outpatient - All Other		
Prosthetic Devices	Outpatient - All Other		
Dental Anesthesia	Outpatient - All Other		
Hearing Aids	Outpatient - All Other		
X-rays and Diagnostic Imaging	Outpatient - All Other		
Treatment for Temporomandibular Joint Disorders	Outpatient - All Other		
Rehabilitative Occupational and Rehabilitative Physical Therapy	Outpatient - All Other		
Outpatient Rehabilitation Services	Outpatient - All Other		
Rehabilitative Speech therapy	Outpatient - All Other		
Habilitation Services	Outpatient - All Other		
Acupuncture	Outpatient - All Other		
Chiropractic Care	Outpatient - All Other		
Radiation	Outpatient - All Other		
Infusion Therapy	Outpatient - All Other		
Eye Glasses for Children	Outpatient - All Other		
Hospice Services	Outpatient - All Other		
Abortion for Which Public Funding is Prohibited	Outpatient - All Other		
Infertility Treatment	Outpatient - All Other		
Cosmetic Surgery	Outpatient - All Other		
Emergency Room Services	Emergency Care		
Emergency Transportation/Ambulance	Emergency Care		
Generic Drugs	Prescription Drugs		
Preferred Brand Drugs	Prescription Drugs		
Non-Preferred Brand Drugs	Prescription Drugs		
Specialty Drugs	Prescription Drugs		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Complete Gold *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060005 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	No	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combined							
Outpatient - Office Visits Separate							
Outpatient - Office Visits	No	Yes			Pass		Pass
Outpatient - All Other	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 **(1) Inpatient, In-Network (IP 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 **(1) Inpatient, In-Network (IP INN)**

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_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")*
Inpatient Hospital Services (e.g., Hospital Stay)	Copayment per day, maximum of five copays per stay; not subject to deductible; covers the facility fee (Inpatient Hospital Services) and professional services (Inpatient Physician and Surgical Services)	$9,288,555.05	$0.00	$525.00	N/A	$7,000.00	
Skilled Nursing Facility	Copayment per day after deductible	$93,048.36	$1,000.00	$350.00	N/A	$7,000.00	
Total Row		$9,381,603.42					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (1) Inpatient, In-Network (IP 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	$525.00	$525.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,000.00	$7,000.00	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	$93,048.36	0.99%	Fail
Copayment	$9,381,603.42	100.00%	IP INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$9,381,603.42	100.00%	IP INN OOPM
Total Projected	$9,381,603.42		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP 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 & Smaller	Error Checking
	$9,288,555.05	100.00%		
Total	$9,288,555.05	100.00%		

Copayment ---- (1) Inpatient, In-Network (IP 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
$350.00	$93,048.36	0.99%	$350.00	
$525.00	$9,288,555.05	99.01%	$525.00	
	$0.00			
	$0.00			
Total	$9,381,603.42	100.00%		

Coinsurance ---- (1) Inpatient, In-Network (IP 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 ---- (1) Inpatient, In-Network (IP 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
$7,000.00	$9,381,603.42	100.00%	$7,000.00	
	$0.00			
	$0.00			
	$0.00			
Total	$9,381,603.42	100.00%		

Benefit Classification	(2) Inpatient, Out-of-Network (IP OON)	Ber

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 **(2) Inpatient, Out-of-Network (IP OON)** **Ber**

Classification	Inpatient	IP
Network (In/Out)	Out-of-Network	OON
Classification Code	2	IP OON
Table Name		tbl_IPOON_P1

Number of Rows 6 **C**

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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (2) Inpatient, Out-of-Network (IP OON)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

ıefit 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

ıefit 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
:lassification Code	3	OP INN
Table Name		tbl_OPINN_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

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 in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

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

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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 OOI	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 Visit	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; not subject to deductible	$4,693,784.33	$0.00	$15.00	N/A	$7,000.00	
Specialist Visit	Copayment; not subject to deductible	$3,488,672.43	$0.00	$40.00	N/A	$7,000.00	
Urgent Care Centers or Facilities	Copayment; not subject to deductible	$270,394.81	$0.00	$35.00	N/A	$7,000.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$378,048.38	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment; not subject to deductible	$0.00	$0.00	$15.00	N/A	$7,000.00	
Inherited Metabolic Disorder - PKU	Copayment; not subject to deductible	$132,012.36	$0.00	$15.00	N/A	$7,000.00	
Diabetes Care Management	Copayment; not subject to deductible	$0.00	$0.00	$15.00	N/A	$7,000.00	
Diabetes Education	Preventive services -	$2,589.09	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$2,254,381.90	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$37,943.02	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$43,378.98	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$17,116.00	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment; not subject to deductible	$3,278.68	$0.00	$15.00	N/A	$7,000.00	
Total Row		$11,321,599.97					

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	$15.00	$15.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,000.00	$7,000.00	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	$8,588,142.61	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$8,588,142.61	75.86%	OP-OV INN OOPM
Total Projected	$11,321,599.97		

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 & Smaller	Error Checking
	$11,321,599.97	100.00%		
Total	$11,321,599.97	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
$15.00	$4,829,075.37	56.23%	$15.00	
$35.00	$270,394.81	3.15%		
$40.00	$3,488,672.43	40.62%		
	$0.00			
Total	$8,588,142.61	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 &	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
$7,000.00	$8,588,142.61	100.00%	$7,000.00	
	$0.00			
	$0.00			
	$0.00			
Total	$8,588,142.61	100.00%		

Benefit Classification **(3b) Outpatient - All Other, In-Network (OP-AO INN)** **Be**

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)** **Be**

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: 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copayment after deductible	$7,552,652.80	$1,000.00	$350.00	N/A	$7,000.00	
Laboratory Outpatient and Professional Services	Copayment; not subject to deductible	$1,313,794.58	$0.00	$20.00	N/A	$7,000.00	
Imaging (CT/PET Scans, MRIs)	Copayment after deductible	$1,113,662.93	$1,000.00	$300.00	N/A	$7,000.00	
Outpatient Surgery Physician/Surgical Services	Copayment after deductible	$2,314,297.81	$1,000.00	$75.00	N/A	$7,000.00	
Chemotherapy	Copayment; not subject to deductible	$2,458,464.55	$0.00	$100.00	N/A	$7,000.00	
Dialysis	Coinsurance after deductible	$229,673.54	$1,000.00	N/A	20%	$7,000.00	
Home Health Care Services	Copayment; not subject to deductible	$183,294.64	$0.00	$15.00	N/A	$7,000.00	
Durable Medical	Coinsurance after	$215,477.21	$1,000.00	N/A	20%	$7,000.00	
Prosthetic Devices	Coinsurance after deductible	$18,123.70	$1,000.00	N/A	20%	$7,000.00	
Dental Anesthesia	Copayment after deductible	$18.97	$1,000.00	$350.00	N/A	$7,000.00	
Hearing Aids	Coinsurance after deductible	$0.00	$1,000.00	N/A	20%	$7,000.00	
X-rays and Diagnostic Imaging	Copayment; not subject to deductible	$558,013.28	$0.00	$30.00	N/A	$7,000.00	
Treatment for Temporomandibular Joint Disorders	Copayment after deductible	$0.00	$1,000.00	$75.00	N/A	$7,000.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copayment; not subject to deductible	$569,905.43	$0.00	$25.00	N/A	$7,000.00	
Outpatient Rehabilitation Services	Copayment; not subject to deductible	$73,912.20	$0.00	$25.00	N/A	$7,000.00	
Rehabilitative Speech therapy	Copayment; not subject to deductible	$117,758.00	$0.00	$25.00	N/A	$7,000.00	
Habilitation Services	Copayment; not subject	$73,912.20	$0.00	$25.00	N/A	$7,000.00	
Acupuncture	Copayment; not subject to deductible	$15,810.44	$0.00	$15.00	N/A	$7,000.00	
Chiropractic Care	Copayment; not subject to deductible	$13,018.07	$0.00	$15.00	N/A	$7,000.00	
Radiation	Copayment after deductible	$560,632.98	$1,000.00	$350.00	N/A	$7,000.00	
Infusion Therapy	Coinsurance after deductible	$71,316.69	$1,000.00	N/A	20%	$7,000.00	
Eye Glasses for Children	No cost-sharing	$1,362.23	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day; not subject to deductible	$61,098.21	$0.00	$15.00	N/A	$7,000.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$3,565.83	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Copayment after deductible	$1,257.66	$1,000.00	$350.00	N/A	$7,000.00	
Cosmetic Surgery	Copayment; not subject to deductible	$41,858.13	$0.00	$525.00	N/A	$7,000.00	
Total Row		$17,562,882.08					

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	N/A	$1,000.00	Pass
Copayment	$15.00	$300.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,000.00	$7,000.00	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	$12,077,114.29	68.76%	OP-AO INN Deductible
Copayment	$17,023,362.89	96.93%	OP-AO INN Copayment
Coinsurance	$534,591.13	3.04%	Fail
OOPM	$17,557,954.02	99.97%	OP-AO INN OOPM
Total Projected	$17,562,882.08		

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
$1,000.00	$12,077,114.29	100.00%	$1,000.00	
Total	$12,077,114.29	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO 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
$15.00	$273,221.36	1.60%	$15.00	
$20.00	$1,313,794.58	7.72%	$20.00	
$25.00	$835,487.83	4.91%	$25.00	
$30.00	$558,013.28	3.28%	$30.00	
$75.00	$2,314,297.81	13.59%	$75.00	
$100.00	$2,458,464.55	14.44%	$100.00	
$300.00	$1,113,662.93	6.54%	$300.00	
$350.00	$8,114,562.42	47.67%		
$525.00	$41,858.13	0.25%		
Total	$17,023,362.89	100.00%		

Coinsurance ---- (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.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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
$7,000.00	$17,557,954.02	100.00%	$7,000.00	
	$0.00			
	$0.00			
	$0.00			
Total	$17,557,954.02	100.00%		

ɜnefit Classification **(4) Outpatient, Out-of-Network (OP OON)**

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

enefit Classification **(4) Outpatient, Out-of-Network (OP OON)**

Notes: *Use this table if you are testing all outpatient services combined.*

Classification	Outpatient	OP
Network (In/Out)	Out-of-Network	OON
Classification Code	4	OP OON
Table Name		tbl_OPOON_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (4) Outpatient, Out-of-Network (OP OON)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (4) Outpatient, Out-of-Network (OP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (4) Outpatient, Out-of-Network (OP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (4) Outpatient, Out-of-Network (OP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (4) Outpatient, Out-of-Network (OP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Benefit Classification **(4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON)**

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 **(4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON)**

Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - Office Visits	OP-OV
Network (In/Out)	Out-of-Network	OON
Classification Code	4a	OP-OV OON
Table Name		tbl_OPOVOON_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (4a) Outpatient - Office Visits, Out-of-Network (OP-OV OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Benefit Classification **(4b) Outpatient - All Other, Out-of-Network (OP-AO OON)**

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 **(4b) Outpatient - All Other, Out-of-Network (OP-AO OON)**

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)	Out-of-Network	OON
Classification Code	4b	OP-AO OON
Table Name		tbl_OPAOOON_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (4b) Outpatient - All Other, Out-of-Network (OP-AO OON)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (4b) Outpatient - All Other, Out-of-Network (OP-AO OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (4b) Outpatient - All Other, Out-of-Network (OP-AO OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (4b) Outpatient - All Other, Out-of-Network (OP-AO OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (4b) Outpatient - All Other, Out-of-Network (OP-AO OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Benefit Classification **(5) Emergency Care, (ER)**

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 **(5) Emergency Care, (ER)**

Classification	Emergency Care	ER
Network (In/Out)	N/A	
Classification Code	5	ER
Table Name		tbl_ER_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (5) Emergency Care, (ER)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (5) Emergency Care, (ER) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (5) Emergency Care, (ER) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (5) Emergency Care, (ER) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (5) Emergency Care, (ER) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Benefit Classification **(6) Prescription Drugs, (RX)**

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 **(6) Prescription Drugs, (RX)**

Classification	Prescription Drugs	RX
Network (In/Out)	N/A	
Classification Code	6	RX
Table Name		tbl_RX_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (6) Prescription Drugs, (RX)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (6) Prescription Drugs, (RX) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (6) Prescription Drugs, (RX) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (6) Prescription Drugs, (RX) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (6) Prescription Drugs, (RX) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Silver 94 *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060006-06 *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: Silver 100 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services Combi							
Outpatient - Office Visits Separate							
Outpatient - Office	No	Yes			Pass		Pass
Outpatient - All Oth	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 **(1) Inpatient, In-Network (IP 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 **(1) Inpatient, In-Network (IP INN)**

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_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")*
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (1) Inpatient, In-Network (IP INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (1) Inpatient, In-Network (IP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (1) Inpatient, In-Network (IP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (1) Inpatient, In-Network (IP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Benefit Classification **(2) Inpatient, Out-of-Network (IP OON)**

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 **(2) Inpatient, Out-of-Network (IP OON)**

Classification	Inpatient	IP
Network (In/Out)	Out-of-Network	OON
Classification Code	2	IP OON
Table Name		tbl_IPOON_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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (2) Inpatient, Out-of-Network (IP OON)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Coinsurance ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (2) Inpatient, Out-of-Network (IP OON) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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: 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")*
<<Enter description>>	<<Enter description>>						
Total Row		$0.00					

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 in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible		N/A	N/A
Copayment		N/A	N/A
Coinsurance		N/A	N/A
OOPM		N/A	N/A
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		N/A
Copayment	$0.00		N/A
Coinsurance	$0.00		N/A
OOPM	$0.00		N/A
Total Projected	$0.00		

Step 2 Predominant Level

Deductible ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Copayment ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

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

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

OOPM ---- (3) Outpatient, In-Network (OP INN) — **Errors found:** 0

If testing is required for this benefit classification:
Please ensure each different cost-share combination is entered above in PART 1.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

Benefit Classification	(3a) Outpatient - Office Visits, In-Network (OP-OV INN)	Ben

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 (3a) Outpatient - Office Visits, In-Network (OP-OV INN) **Ben**

Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - Office Visi	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; Primary Care Visits and MHSUD office visits each eligible for two visits at $1 copay, after which stated cost-sharing applies.	$447,267.21	$0.00	$1.00	N/A	$2,400.00	
Specialist Visit	Copayment	$332,433.00	$0.00	$15.00	N/A	$2,400.00	
Urgent Care Centers or Facilities	Copayment	$25,765.72	$0.00	$15.00	N/A	$2,400.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$36,023.95	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment	$0.00	$0.00	$1.00	N/A	$2,400.00	
Inherited Metabolic Disorder - PKU	Copayment	$12,579.36	$0.00	$1.00	N/A	$2,400.00	
Diabetes Care Management	Copayment	$0.00	$0.00	$1.00	N/A	$2,400.00	
Diabetes Education	Preventive services -	$246.71	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$214,818.37	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$3,615.56	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$4,133.55	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$1,630.97	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment	$312.42	$0.00	$1.00	N/A	$2,400.00	
Total Row		$1,078,826.83					

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	$1.00	$1.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,400.00	$2,400.00	Pass
Overall			**Pass**

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
$1 copay allowances are separate for two primary care office visits and two MHSUD office visits.

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$818,357.71	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$818,357.71	75.86%	OP-OV INN OOPM
Total Projected	$1,078,826.83		

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 & Smaller	Error Checking
	$1,078,826.83	100.00%		
Total	$1,078,826.83	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
$1.00	$460,159.00	56.23%	$1.00	
$15.00	$358,198.72	43.77%		
	$0.00			
	$0.00			
Total	$818,357.71	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 &	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
$2,400.00	$818,357.71	100.00%	$2,400.00	
	$0.00			
	$0.00			
	$0.00			
Total	$818,357.71	100.00%		

efit 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 EB	Move to RX

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

efit 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
lassification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copayment	$719,686.66	$0.00	$100.00	N/A	$2,400.00	
Laboratory Outpatient and Professional Services	Copayment	$125,190.51	$0.00	$5.00	N/A	$2,400.00	
Imaging (CT/PET Scans, MRIs)	Coinsurance	$106,120.11	$0.00	N/A	15%	$2,400.00	
Outpatient Surgery Physician/Surgical Services	Copayment	$220,527.72	$0.00	$25.00	N/A	$2,400.00	
Chemotherapy	Copayment	$234,265.26	$0.00	$35.00	N/A	$2,400.00	
Dialysis	Coinsurance	$21,885.42	$0.00	N/A	15%	$2,400.00	
Home Health Care Services	Copayment	$17,466.01	$0.00	$5.00	N/A	$2,400.00	
Durable Medical	Coinsurance	$20,532.66	$0.00	N/A	15%	$2,400.00	
Prosthetic Devices	Coinsurance	$1,726.99	$0.00	N/A	15%	$2,400.00	
Dental Anesthesia	Copayment	$1.81	$0.00	$100.00	N/A	$2,400.00	
Hearing Aids	Coinsurance	$0.00	$0.00	N/A	15%	$2,400.00	
X-rays and Diagnostic Imaging	Copayment	$53,172.67	$0.00	$15.00	N/A	$2,400.00	
Treatment for Temporomandibular Joint Disorders	Copayment	$0.00	$0.00	$25.00	N/A	$2,400.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copayment	$54,305.86	$0.00	$5.00	N/A	$2,400.00	
Outpatient Rehabilitation Services	Copayment	$7,043.04	$0.00	$5.00	N/A	$2,400.00	
Rehabilitative Speech therapy	Copayment	$11,221.07	$0.00	$5.00	N/A	$2,400.00	
Habilitation Services	Copayment	$7,043.04	$0.00	$5.00	N/A	$2,400.00	
Acupuncture	Copayment	$1,506.56	$0.00	$1.00	N/A	$2,400.00	
Chiropractic Care	Copayment	$1,240.48	$0.00	$1.00	N/A	$2,400.00	
Radiation	Copayment	$53,422.30	$0.00	$100.00	N/A	$2,400.00	
Infusion Therapy	Coinsurance	$6,795.71	$0.00	N/A	15%	$2,400.00	
Eye Glasses for Children	No cost-sharing	$129.81	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day	$5,822.00	$0.00	$5.00	N/A	$2,400.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$339.79	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Copayment	$119.84	$0.00	$100.00	N/A	$2,400.00	
Cosmetic Surgery	Copayment	$3,988.63	$0.00	$100.00	N/A	$2,400.00	
Total Row		$1,673,553.95					

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	N/A	Fail	Pass
Copayment	$5.00	$100.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,400.00	$2,400.00	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	$1,516,023.46	90.59%	OP-AO INN Copayment
Coinsurance	$157,060.90	9.38%	Fail
OOPM	$1,673,084.36	99.97%	OP-AO INN OOPM
Total Projected	$1,673,553.95		

Step 2 Predominant Level

Deductible ---- (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.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$1,673,553.95	100.00%		
Total	$1,673,553.95	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO 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
$1.00	$2,747.05	0.18%	$1.00	
$5.00	$228,091.53	15.05%	$5.00	
$15.00	$53,172.67	3.51%	$15.00	
$25.00	$220,527.72	14.55%	$25.00	
$35.00	$234,265.26	15.45%	$35.00	
$100.00	$777,219.24	51.27%	$100.00	
Total	$1,516,023.46	100.00%		

Coinsurance ---- (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.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$157,060.90	100.00%	15%	
	$0.00			
	$0.00			
	$0.00			
Total	$157,060.90	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
$2,400.00	$1,673,084.36	100.00%	$2,400.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,673,084.36	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Silver 87 *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060006-05 *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: Silver 150 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services Combi							
Outpatient - Office Visits Separate							
Outpatient - Office	No	Yes			Pass		Pass
Outpatient - All Oth	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 Visi	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; not subject to deductible; Primary Care Visits and MHSUD office visits each eligible for two visits at $1 copay, after which stated cost-sharing applies.	$878,238.94	$0.00	$5.00	N/A	$2,850.00	
Specialist Visit	Copayment; not subject to deductible	$652,754.32	$0.00	$30.00	N/A	$2,850.00	
Urgent Care Centers or Facilities	Copayment; not subject to deductible	$50,592.71	$0.00	$30.00	N/A	$2,850.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$70,735.42	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment; not subject to deductible	$0.00	$0.00	$5.00	N/A	$2,850.00	
Inherited Metabolic Disorder - PKU	Copayment; not subject to deductible	$24,700.41	$0.00	$5.00	N/A	$2,850.00	
Diabetes Care Management	Copayment; not subject to deductible	$0.00	$0.00	$5.00	N/A	$2,850.00	
Diabetes Education	Preventive services -	$484.44	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$421,810.17	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$7,099.40	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$8,116.50	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$3,202.52	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment; not subject to deductible	**$613.46**	$0.00	$5.00	N/A	$2,850.00	
Total Row		$2,118,348.29					

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	$5.00	$5.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,850.00	$2,850.00	Pass
Overall			**Pass**

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
$1 copay allowances are separate for two primary care office visits and two MHSUD office visits.

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$1,606,899.84	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$1,606,899.84	75.86%	OP-OV INN OOPM
Total Projected	$2,118,348.29		

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 & Smaller	Error Checking
	$2,118,348.29	100.00%		
Total	$2,118,348.29	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
$5.00	$903,552.82	56.23%	$5.00	
$30.00	$703,347.02	43.77%		
	$0.00			
	$0.00			
Total	$1,606,899.84	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 &	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
$2,850.00	$1,606,899.84	100.00%	$2,850.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,606,899.84	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 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copayment after deductible	$1,413,152.66	$750.00	$325.00	N/A	$2,850.00	
Laboratory Outpatient and Professional Services	Copayment; not subject to deductible	$245,819.89	$0.00	$20.00	N/A	$2,850.00	
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$208,373.90	$750.00	N/A	20%	$2,850.00	
Outpatient Surgery Physician/Surgical Services	Copayment after deductible	$433,020.85	$750.00	$120.00	N/A	$2,850.00	
Chemotherapy	Copayment; not subject to deductible	$459,995.42	$0.00	$160.00	N/A	$2,850.00	
Dialysis	Coinsurance after deductible	$42,973.48	$750.00	N/A	20%	$2,850.00	
Home Health Care Services	Copayment; not subject to deductible	$34,295.67	$0.00	$10.00	N/A	$2,850.00	
Durable Medical	Coinsurance after	$40,317.25	$750.00	N/A	20%	$2,850.00	
Prosthetic Devices	Coinsurance after deductible	$3,391.07	$750.00	N/A	20%	$2,850.00	
Dental Anesthesia	Copayment after deductible	$3.55	$750.00	$325.00	N/A	$2,850.00	
Hearing Aids	Coinsurance after deductible	$0.00	$750.00	N/A	20%	$2,850.00	
X-rays and Diagnostic Imaging	Copayment; not subject to deductible	$104,408.08	$0.00	$40.00	N/A	$2,850.00	
Treatment for Temporomandibular Joint Disorders	Copayment after deductible	$0.00	$750.00	$120.00	N/A	$2,850.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copayment; not subject to deductible	$106,633.18	$0.00	$20.00	N/A	$2,850.00	
Outpatient Rehabilitation Services	Copayment; not subject to deductible	$13,829.47	$0.00	$20.00	N/A	$2,850.00	
Rehabilitative Speech therapy	Copayment; not subject to deductible	$22,033.32	$0.00	$20.00	N/A	$2,850.00	
Habilitation Services	Copayment; not subject	$13,829.47	$0.00	$20.00	N/A	$2,850.00	
Acupuncture	Copayment; not subject to deductible	$2,958.24	$0.00	$5.00	N/A	$2,850.00	
Chiropractic Care	Copayment; not subject to deductible	$2,435.77	$0.00	$5.00	N/A	$2,850.00	
Radiation	Copayment after deductible	$104,898.24	$750.00	$325.00	N/A	$2,850.00	
Infusion Therapy	Coinsurance after deductible	$13,343.84	$750.00	N/A	20%	$2,850.00	
Eye Glasses for Children	No cost-sharing	$254.88	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day; not subject to deductible	$11,431.89	$0.00	$10.00	N/A	$2,850.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$667.19	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Copayment after deductible	$235.32	$750.00	$325.00	N/A	$2,850.00	
Cosmetic Surgery	Copayment after deductible	$7,831.94	$750.00	$425.00	N/A	$2,850.00	
Total Row		$3,286,134.58					

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	N/A	$750.00	Pass
Copayment	$10.00	$325.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,850.00	$2,850.00	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	$2,267,542.09	69.00%	OP-AO INN Deductible
Copayment	$2,976,812.97	90.59%	OP-AO INN Copayment
Coinsurance	$308,399.53	9.38%	Fail
OOPM	$3,285,212.51	99.97%	OP-AO INN OOPM
Total Projected	$3,286,134.58		

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
$750.00	$2,267,542.09	100.00%	$750.00	
Total	$2,267,542.09	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO 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
$5.00	$5,394.01	0.18%	$5.00	
$10.00	$45,727.56	1.54%	$10.00	
$20.00	$402,145.34	13.51%	$20.00	
$40.00	$104,408.08	3.51%	$40.00	
$120.00	$433,020.85	14.55%	$120.00	
$160.00	$459,995.42	15.45%	$160.00	
$325.00	$1,518,289.77	51.00%	$325.00	
$425.00	$7,831.94	0.26%		
Total	$2,976,812.97	100.00%		

Coinsurance ---- (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.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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
$2,850.00	$3,285,212.51	100.00%	$2,850.00	
	$0.00			
	$0.00			
	$0.00			
Total	$3,285,212.51	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Silver 73 *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060006-04 *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: Silver 200 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services Combi							
Outpatient - Office Visits Separate							
Outpatient - Office	No	Yes			Pass		Pass
Outpatient - All Oth	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 OON	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 Visi	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; not subject to deductible; Primary Care Visits and MHSUD office visits each eligible for two visits at $1 copay, after which stated cost-sharing applies.	$53,776.41	$0.00	$20.00	N/A	$7,950.00	
Specialist Visit	Copayment; not subject to deductible	$39,969.51	$0.00	$65.00	N/A	$7,950.00	
Urgent Care Centers or Facilities	Copayment; not subject to deductible	$3,097.90	$0.00	$65.00	N/A	$7,950.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$4,331.28	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment; not subject to deductible	$0.00	$0.00	$20.00	N/A	$7,950.00	
Inherited Metabolic Disorder - PKU	Copayment; not subject to deductible	$1,512.46	$0.00	$20.00	N/A	$7,950.00	
Diabetes Care Management	Copayment; not subject to deductible	$0.00	$0.00	$20.00	N/A	$7,950.00	
Diabetes Education	Preventive services -	$29.66	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$25,828.32	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$434.71	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$496.99	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$196.10	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment; not subject to deductible	$37.56	$0.00	$20.00	N/A	$7,950.00	
Total Row		$129,710.89					

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	$7,950.00	$7,950.00	Pass
Overall			**Pass**

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
$1 copay allowances are separate for two primary care office visits and two MHSUD office visits.

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$98,393.83	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$98,393.83	75.86%	OP-OV INN OOPM
Total Projected	$129,710.89		

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 & Smaller	Error Checking
	$129,710.89	100.00%		
Total	$129,710.89	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
$20.00	$55,326.43	56.23%	$20.00	
$65.00	$43,067.41	43.77%		
	$0.00			
	$0.00			
Total	$98,393.83	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 &	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
$7,950.00	$98,393.83	100.00%	$7,950.00	
	$0.00			
	$0.00			
	$0.00			
Total	$98,393.83	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 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copayment after deductible	$86,530.29	$2,500.00	$600.00	N/A	$7,950.00	
Laboratory Outpatient and Professional Services	Copayment; not subject to deductible	$15,052.07	$0.00	$40.00	N/A	$7,950.00	
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$12,759.17	$2,500.00	N/A	30%	$7,950.00	
Outpatient Surgery Physician/Surgical Services	Copayment after deductible	$26,514.77	$2,500.00	$200.00	N/A	$7,950.00	
Chemotherapy	Copayment after deductible	$28,166.48	$2,500.00	$250.00	N/A	$7,950.00	
Dialysis	Coinsurance after deductible	$2,631.36	$2,500.00	N/A	30%	$7,950.00	
Home Health Care Services	Copayment; not subject to deductible	$2,100.00	$0.00	$30.00	N/A	$7,950.00	
Durable Medical	Coinsurance after	$2,468.71	$2,500.00	N/A	30%	$7,950.00	
Prosthetic Devices	Coinsurance after deductible	$207.64	$2,500.00	N/A	30%	$7,950.00	
Dental Anesthesia	Copayment after deductible	$0.22	$2,500.00	$600.00	N/A	$7,950.00	
Hearing Aids	Coinsurance after deductible	$0.00	$2,500.00	N/A	30%	$7,950.00	
X-rays and Diagnostic Imaging	Copayment; not subject to deductible	$6,393.12	$0.00	$65.00	N/A	$7,950.00	
Treatment for Temporomandibular Joint Disorders	Copayment after deductible	$0.00	$2,500.00	$200.00	N/A	$7,950.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copayment; not subject to deductible	$6,529.37	$0.00	$40.00	N/A	$7,950.00	
Outpatient Rehabilitation Services	Copayment; not subject to deductible	$846.81	$0.00	$40.00	N/A	$7,950.00	
Rehabilitative Speech therapy	Copayment; not subject to deductible	$1,349.15	$0.00	$40.00	N/A	$7,950.00	
Habilitation Services	Copayment; not subject	$846.81	$0.00	$40.00	N/A	$7,950.00	
Acupuncture	Copayment; not subject to deductible	$181.14	$0.00	$20.00	N/A	$7,950.00	
Chiropractic Care	Copayment; not subject to deductible	$149.15	$0.00	$20.00	N/A	$7,950.00	
Radiation	Copayment after deductible	$6,423.14	$2,500.00	$600.00	N/A	$7,950.00	
Infusion Therapy	Coinsurance after deductible	$817.07	$2,500.00	N/A	30%	$7,950.00	
Eye Glasses for Children	No cost-sharing	$15.61	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day; not subject to deductible	$700.00	$0.00	$30.00	N/A	$7,950.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$40.85	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Copayment after deductible	$14.41	$2,500.00	$600.00	N/A	$7,950.00	
Cosmetic Surgery	Copayment after deductible	$479.57	$2,500.00	$800.00	N/A	$7,950.00	
Total Row		$201,216.89					

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	N/A	$2,500.00	Pass
Copayment	$30.00	$600.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,950.00	$7,950.00	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	$167,012.82	83.00%	OP-AO INN Deductible
Copayment	$182,276.48	90.59%	OP-AO INN Copayment
Coinsurance	$18,883.95	9.38%	Fail
OOPM	$201,160.42	99.97%	OP-AO INN OOPM
Total Projected	$201,216.89		

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
$2,500.00	$167,012.82	83.00%	$2,500.00	
	$34,204.07	17.00%		
Total	$201,216.89	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO 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
$20.00	$330.29	0.18%	$20.00	
$30.00	$2,799.99	1.54%	$30.00	
$40.00	$24,624.20	13.51%	$40.00	
$65.00	$6,393.12	3.51%	$65.00	
$200.00	$26,514.77	14.55%	$200.00	
$250.00	$28,166.48	15.45%	$250.00	
$600.00	$92,968.05	51.00%	$600.00	
$800.00	$479.57	0.26%		
Total	$182,276.48	100.00%		

Coinsurance ---- (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.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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
$7,950.00	$201,160.42	100.00%	$7,950.00	
	$0.00			
	$0.00			
	$0.00			
Total	$201,160.42	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Silver *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060006-01 *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: Silver 250 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services Combi							
Outpatient - Office Visits Separate							
Outpatient - Office	No	Yes			Pass		Pass
Outpatient - All Oth	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 OON	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 Visi	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; not subject to deductible; Primary Care Visits and MHSUD office visits each eligible for two visits at $1 copay, after which stated cost-sharing applies.	$90,782.68	$0.00	$20.00	N/A	$9,750.00	
Specialist Visit	Copayment; not subject to deductible	$67,474.56	$0.00	$65.00	N/A	$9,750.00	
Urgent Care Centers or Facilities	Copayment; not subject to deductible	$5,229.72	$0.00	$65.00	N/A	$9,750.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$7,311.85	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment; not subject to deductible	$0.00	$0.00	$20.00	N/A	$9,750.00	
Inherited Metabolic Disorder - PKU	Copayment; not subject to deductible	$2,553.26	$0.00	$20.00	N/A	$9,750.00	
Diabetes Care Management	Copayment; not subject to deductible	$0.00	$0.00	$20.00	N/A	$9,750.00	
Diabetes Education	Preventive services -	$50.08	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$43,602.10	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$733.86	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$838.99	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$331.04	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment; not subject to deductible	$63.41	$0.00	$20.00	N/A	$9,750.00	
Total Row		$218,971.55					

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	$9,750.00	$9,750.00	Pass
Overall			**Pass**

**If not applicable, enter "N/A"*

Enter Footnotes (as needed) about
$1 copay allowances are separate for two primary care office visits and two MHSUD office visits.

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$166,103.63	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$166,103.63	75.86%	OP-OV INN OOPM
Total Projected	$218,971.55		

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 & Smaller	Error Checking
	$218,971.55	100.00%		
Total	$218,971.55	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
$20.00	$93,399.35	56.23%	$20.00	
$65.00	$72,704.28	43.77%		
	$0.00			
	$0.00			
Total	$166,103.63	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 &	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
$9,750.00	$166,103.63	100.00%	$9,750.00	
	$0.00			
	$0.00			
	$0.00			
Total	$166,103.63	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: 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copayment after deductible	$146,076.18	$2,500.00	$600.00	N/A	$9,750.00	
Laboratory Outpatient and Professional Services	Copayment; not subject to deductible	$25,410.16	$0.00	$40.00	N/A	$9,750.00	
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$21,539.40	$2,500.00	N/A	30%	$9,750.00	
Outpatient Surgery Physician/Surgical Services	Copayment after deductible	$44,760.93	$2,500.00	$200.00	N/A	$9,750.00	
Chemotherapy	Copayment after deductible	$47,549.27	$2,500.00	$250.00	N/A	$9,750.00	
Dialysis	Coinsurance after deductible	$4,442.13	$2,500.00	N/A	30%	$9,750.00	
Home Health Care Services	Copayment; not subject to deductible	$3,545.11	$0.00	$30.00	N/A	$9,750.00	
Durable Medical	Coinsurance after	$4,167.55	$2,500.00	N/A	30%	$9,750.00	
Prosthetic Devices	Coinsurance after deductible	$350.53	$2,500.00	N/A	30%	$9,750.00	
Dental Anesthesia	Copayment after deductible	$0.37	$2,500.00	$600.00	N/A	$9,750.00	
Hearing Aids	Coinsurance after deductible	$0.00	$2,500.00	N/A	30%	$9,750.00	
X-rays and Diagnostic Imaging	Copayment; not subject to deductible	$10,792.56	$0.00	$65.00	N/A	$9,750.00	
Treatment for Temporomandibular Joint Disorders	Copayment after deductible	$0.00	$2,500.00	$200.00	N/A	$9,750.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copayment; not subject to deductible	$11,022.57	$0.00	$40.00	N/A	$9,750.00	
Outpatient Rehabilitation Services	Copayment; not subject to deductible	$1,429.54	$0.00	$40.00	N/A	$9,750.00	
Rehabilitative Speech therapy	Copayment; not subject to deductible	$2,277.56	$0.00	$40.00	N/A	$9,750.00	
Habilitation Services	Copayment; not subject	$1,429.54	$0.00	$40.00	N/A	$9,750.00	
Acupuncture	Copayment; not subject to deductible	$305.79	$0.00	$20.00	N/A	$9,750.00	
Chiropractic Care	Copayment; not subject to deductible	$251.78	$0.00	$20.00	N/A	$9,750.00	
Radiation	Copayment after deductible	$10,843.23	$2,500.00	$600.00	N/A	$9,750.00	
Infusion Therapy	Coinsurance after deductible	$1,379.34	$2,500.00	N/A	30%	$9,750.00	
Eye Glasses for Children	No cost-sharing	$26.35	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day; not subject to deductible	$1,181.70	$0.00	$30.00	N/A	$9,750.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$68.97	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Copayment after deductible	$24.32	$2,500.00	$600.00	N/A	$9,750.00	
Cosmetic Surgery	Copayment after deductible	$809.58	$2,500.00	$800.00	N/A	$9,750.00	
Total Row		$339,684.45					

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	N/A	$2,500.00	Pass
Copayment	$30.00	$600.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$9,750.00	$9,750.00	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	$281,942.83	83.00%	OP-AO INN Deductible
Copayment	$307,710.19	90.59%	OP-AO INN Copayment
Coinsurance	$31,878.95	9.38%	Fail
OOPM	$339,589.14	99.97%	OP-AO INN OOPM
Total Projected	$339,684.45		

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
$2,500.00	$281,942.83	83.00%	$2,500.00	
	$57,741.62	17.00%		
Total	$339,684.45	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO 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
$20.00	$557.57	0.18%	$20.00	
$30.00	$4,726.81	1.54%	$30.00	
$40.00	$41,569.36	13.51%	$40.00	
$65.00	$10,792.56	3.51%	$65.00	
$200.00	$44,760.93	14.55%	$200.00	
$250.00	$47,549.27	15.45%	$250.00	
$600.00	$156,944.10	51.00%	$600.00	
$800.00	$809.58	0.26%		
Total	$307,710.19	100.00%		

Coinsurance ---- (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.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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
$9,750.00	$339,589.14	100.00%	$9,750.00	
	$0.00			
	$0.00			
	$0.00			
Total	$339,589.14	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Bronze *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060007 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services Combi							
Outpatient - Office Visits Separate							
Outpatient - Office	No	Yes			Pass		Pass
Outpatient - All Oth	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 OON	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 Visi	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; not subject to deductible; Primary Care Visits and MHSUD office visits each eligible for two visits at $1 copay, after which stated cost-sharing applies.	$3,129,724.37	$0.00	$40.00	N/A	$10,150.00	
Specialist Visit	Copayment; not subject to deductible	$2,326,179.12	$0.00	$100.00	N/A	$10,150.00	
Urgent Care Centers or Facilities	Copayment; not subject to deductible	$180,294.01	$0.00	$100.00	N/A	$10,150.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$252,075.33	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment; not subject to deductible	$0.00	$0.00	$50.00	N/A	$10,150.00	
Inherited Metabolic Disorder - PKU	Copayment; not subject to deductible	$88,023.28	$0.00	$40.00	N/A	$10,150.00	
Diabetes Care Management	Copayment; not subject to deductible	$0.00	$0.00	$40.00	N/A	$10,150.00	
Diabetes Education	Preventive services -	$1,726.35	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$1,503,178.14	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$25,299.67	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$28,924.26	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$11,412.62	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment; not subject to deductible	$2,186.16	$0.00	$40.00	N/A	$10,150.00	
Total Row		$7,549,023.32					

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	$40.00	$40.00	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
$1 copay allowances are separate for two primary care office visits and two MHSUD office visits.

Step 1 Substantially All (i.e., ≥ ⅔ of medical/surgical benefits)

Deductible	$0.00	0.00%	Fail
Copayment	$5,726,406.95	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$5,726,406.95	75.86%	OP-OV INN OOPM
Total Projected	$7,549,023.32		

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 & Smaller	Error Checking
	$7,549,023.32	100.00%		
Total	$7,549,023.32	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
$40.00	$3,219,933.81	56.23%	$40.00	
$100.00	$2,506,473.14	43.77%		
	$0.00			
	$0.00			
Total	$5,726,406.95	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 &	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	$5,726,406.95	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$5,726,406.95	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 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Coinsurance after deductible	$5,035,962.43	$6,000.00	N/A	40%	$10,150.00	
Laboratory Outpatient and Professional Services	Coinsurance after deductible	$876,012.75	$6,000.00	N/A	40%	$10,150.00	
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$742,568.85	$6,000.00	N/A	40%	$10,150.00	
Outpatient Surgery Physician/Surgical Services	Coinsurance after deductible	$1,543,128.91	$6,000.00	N/A	40%	$10,150.00	
Chemotherapy	Coinsurance after deductible	$1,639,256.49	$6,000.00	N/A	40%	$10,150.00	
Dialysis	Coinsurance after deductible	$153,141.86	$6,000.00	N/A	40%	$10,150.00	
Home Health Care Services	Copayment; not subject to deductible	$122,217.31	$0.00	$50.00	N/A	$10,150.00	
Durable Medical	Coinsurance after	$143,676.02	$6,000.00	N/A	40%	$10,150.00	
Prosthetic Devices	Coinsurance after deductible	$12,084.53	$6,000.00	N/A	40%	$10,150.00	
Dental Anesthesia	Coinsurance after deductible	$12.65	$6,000.00	N/A	40%	$10,150.00	
Hearing Aids	Coinsurance after deductible	$0.00	$6,000.00	N/A	40%	$10,150.00	
X-rays and Diagnostic Imaging	Coinsurance after deductible	$372,072.44	$6,000.00	N/A	40%	$10,150.00	
Treatment for Temporomandibular Joint Disorders	Coinsurance after deductible	$0.00	$6,000.00	N/A	40%	$10,150.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Coinsurance after deductible	$380,001.89	$6,000.00	N/A	40%	$10,150.00	
Outpatient Rehabilitation Services	Coinsurance after deductible	$49,283.22	$6,000.00	N/A	40%	$10,150.00	
Rehabilitative Speech therapy	Coinsurance after deductible	$78,518.75	$6,000.00	N/A	40%	$10,150.00	
Habilitation Services	Coinsurance after	$49,283.22	$6,000.00	N/A	40%	$10,150.00	
Acupuncture	Copayment not subject to deductible	$10,542.09	$0.00	$40.00	N/A	$10,150.00	
Chiropractic Care	Copayment not subject to deductible	$8,680.20	$0.00	$40.00	N/A	$10,150.00	
Radiation	Coinsurance after deductible	$373,819.20	$6,000.00	N/A	40%	$10,150.00	
Infusion Therapy	Coinsurance after deductible	$47,552.58	$6,000.00	N/A	40%	$10,150.00	
Eye Glasses for Children	No cost-sharing	$908.31	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day; not subject to deductible	$40,739.10	$0.00	$50.00	N/A	$10,150.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$2,377.63	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Coinsurance after deductible	$838.58	$6,000.00	N/A	40%	$10,150.00	
Cosmetic Surgery	Coinsurance after deductible	$27,910.19	$6,000.00	N/A	40%	$10,150.00	
Total Row		$11,710,589.20					

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	$6,000.00	$6,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	40%	40%	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	$11,525,124.56	98.42%	OP-AO INN Deductible
Copayment	$182,178.70	1.56%	Fail
Coinsurance	$11,525,124.56	98.42%	OP-AO INN Coinsurance
OOPM	$11,707,303.27	99.97%	OP-AO INN OOPM
Total Projected	$11,710,589.20		

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
$6,000.00	$11,525,124.56	98.42%	$6,000.00	
	$185,464.64	1.58%		
Total	$11,710,589.20	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
40%	$11,525,124.56	100.00%	40%	
	$0.00			
	$0.00			
	$0.00			
Total	$11,525,124.56	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	$11,707,303.27	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$11,707,303.27	100.00%		

MHSUD Financial Requirement (a.k.a. Cost Share) Parity Testing

Issuer / Market: Molina Healthcare of Washington, Inc.
Market: Individual

Workbook Info
Link back to Summary Sheet
User Inputs Cell Format
See the Example worksheet for additional details.

PLAN INFORMATION

Plan Name: Molina Cascade Vital Gold *<<<<This will auto populate from summary sheet macro*
Plan ID: 84481WA0060008 *<<<<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		E. Test Results
					D1. In-Network	D2. Out-of-Network	
Inpatient	No	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combi							
Outpatient - Office Visits Separate							
Outpatient - Office	No	Yes			Pass		Pass
Outpatient - All Oth	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 **(1) Inpatient, In-Network (IP 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 **(1) Inpatient, In-Network (IP INN)**

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_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")*
Inpatient Hospital Services (e.g., Hospital Stay)	Copayment per day, maximum of five copays per stay; not subject to deductible; covers the facility fee (Inpatient Hospital Services) and professional services (Inpatient Physician and Surgical Services)	$19,348,743.28	$0.00	$650.00	N/A	$8,800.00	
Skilled Nursing Facility	Copayment per day after deductible	$193,826.58	$1,900.00	$350.00	N/A	$8,800.00	
Total Row		$19,542,569.86					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (1) Inpatient, In-Network (IP 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	$650.00	$650.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,800.00	$8,800.00	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	$193,826.58	0.99%	Fail
Copayment	$19,542,569.86	100.00%	IP INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$19,542,569.86	100.00%	IP INN OOPM
Total Projected	$19,542,569.86		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP 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 & Smaller	Error Checking
	$19,348,743.28	100.00%		
Total	$19,348,743.28	100.00%		

Copayment ---- (1) Inpatient, In-Network (IP 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
$350.00	$193,826.58	0.99%	$350.00	
$650.00	$19,348,743.28	99.01%	$650.00	
	$0.00			
	$0.00			
Total	$19,542,569.86	100.00%		

Coinsurance ---- (1) Inpatient, In-Network (IP 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 ---- (1) Inpatient, In-Network (IP 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
$8,800.00	$19,542,569.86	100.00%	$8,800.00	
	$0.00			
	$0.00			
	$0.00			
Total	$19,542,569.86	100.00%		

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 OON	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 Visi	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_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")*
Primary Care Visit to Treat an Injury or Illness	Copayment; not subject to deductible	$9,777,497.95	$0.00	$15.00	N/A	$8,800.00	
Specialist Visit	Copayment; not subject to deductible	$7,267,161.23	$0.00	$40.00	N/A	$8,800.00	
Urgent Care Centers or Facilities	Copayment; not subject to deductible	$563,252.27	$0.00	$35.00	N/A	$8,800.00	
Prenatal and Postnatal Care	Preventive services - no cost-sharing	$787,502.58	$0.00	N/A	N/A	N/A	x
Nutritional Counseling	Copayment; not subject to deductible	$0.00	$0.00	$15.00	N/A	$8,800.00	
Inherited Metabolic Disorder - PKU	Copayment; not subject to deductible	$274,991.46	$0.00	$15.00	N/A	$8,800.00	
Diabetes Care Management	Copayment; not subject to deductible	$0.00	$0.00	$15.00	N/A	$8,800.00	
Diabetes Education	Preventive services -	$5,393.26	$0.00	N/A	N/A	N/A	x
Preventive Care/Screening/Immunization	Preventive services - no cost-sharing	$4,696,043.29	$0.00	N/A	N/A	N/A	x
Well Baby Visits and Care	Preventive services - no cost-sharing	$79,038.09	$0.00	N/A	N/A	N/A	x
Routine Eye Exam for Children	Preventive services - no cost-sharing	$90,361.60	$0.00	N/A	N/A	N/A	x
virtual / telehealth visits	No cost sharing	$35,653.90	$0.00	N/A	N/A	N/A	x
Routine Foot Care	Copayment; not subject to deductible	$6,829.74	$0.00	$15.00	N/A	$8,800.00	
Total Row		$23,583,725.36					

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	$15.00	$15.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,800.00	$8,800.00	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	$17,889,732.64	75.86%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$17,889,732.64	75.86%	OP-OV INN OOPM
Total Projected	$23,583,725.36		

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 & Smaller	Error Checking
	$23,583,725.36	100.00%		
Total	$23,583,725.36	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
$15.00	$10,059,319.14	56.23%	$15.00	
$35.00	$563,252.27	3.15%		
$40.00	$7,267,161.23	40.62%		
	$0.00			
Total	$17,889,732.64	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 &	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
$8,800.00	$17,889,732.64	100.00%	$8,800.00	
	$0.00			
	$0.00			
	$0.00			
Total	$17,889,732.64	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: 26

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")*
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copayment after deductible	$15,732,731.23	$1,900.00	$350.00	N/A	$8,800.00	
Laboratory Outpatient and Professional Services	Copayment; not subject to deductible	$2,736,730.73	$0.00	$30.00	N/A	$8,800.00	
Imaging (CT/PET Scans, MRIs)	Copayment after deductible	$2,319,841.79	$1,900.00	$300.00	N/A	$8,800.00	
Outpatient Surgery Physician/Surgical Services	Copayment after deductible	$4,820,852.55	$1,900.00	$75.00	N/A	$8,800.00	
Chemotherapy	Copayment after deductible	$5,121,162.46	$1,900.00	$200.00	N/A	$8,800.00	
Dialysis	Coinsurance after deductible	$478,426.87	$1,900.00	N/A	20%	$8,800.00	
Home Health Care Services	Copayment; not subject to deductible	$381,816.21	$0.00	$15.00	N/A	$8,800.00	
Durable Medical	Coinsurance after	$448,854.87	$1,900.00	N/A	20%	$8,800.00	
Prosthetic Devices	Coinsurance after deductible	$37,753.00	$1,900.00	N/A	20%	$8,800.00	
Dental Anesthesia	Copayment after deductible	$39.52	$1,900.00	$350.00	N/A	$8,800.00	
Hearing Aids	Coinsurance after deductible	$0.00	$1,900.00	N/A	20%	$8,800.00	
X-rays and Diagnostic Imaging	Copayment; not subject to deductible	$1,162,382.71	$0.00	$30.00	N/A	$8,800.00	
Treatment for Temporomandibular Joint Disorders	Copayment after deductible	$0.00	$1,900.00	$75.00	N/A	$8,800.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copayment; not subject to deductible	$1,187,154.92	$0.00	$30.00	N/A	$8,800.00	
Outpatient Rehabilitation Services	Copayment; not subject to deductible	$153,964.55	$0.00	$30.00	N/A	$8,800.00	
Rehabilitative Speech therapy	Copayment; not subject to deductible	$245,298.58	$0.00	$30.00	N/A	$8,800.00	
Habilitation Services	Copayment; not subject	$153,964.55	$0.00	$30.00	N/A	$8,800.00	
Acupuncture	Copayment; not subject to deductible	$32,934.31	$0.00	$15.00	N/A	$8,800.00	
Chiropractic Care	Copayment; not subject to deductible	$27,117.60	$0.00	$15.00	N/A	$8,800.00	
Radiation	Copayment after deductible	$1,167,839.74	$1,900.00	$350.00	N/A	$8,800.00	
Infusion Therapy	Coinsurance after deductible	$148,557.90	$1,900.00	N/A	20%	$8,800.00	
Eye Glasses for Children	No cost-sharing	$2,837.62	$0.00	N/A	N/A	N/A	x
Hospice Services	Copayment per day; not subject to deductible	$127,272.07	$0.00	$15.00	N/A	$8,800.00	
Abortion for Which Public Funding is Prohibited	No cost-sharing	$7,427.90	$0.00	N/A	N/A	N/A	x
Infertility Treatment	Copayment after deductible	$2,619.79	$1,900.00	$350.00	N/A	$8,800.00	
Cosmetic Surgery	Copayment; not subject to deductible	$87,193.55	$0.00	$650.00	N/A	$8,800.00	
Total Row		$36,584,774.98					

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	N/A	$1,900.00	Pass
Copayment	$15.00	$300.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,800.00	$8,800.00	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	$30,278,679.71	82.76%	OP-AO INN Deductible
Copayment	$35,460,916.83	96.93%	OP-AO INN Copayment
Coinsurance	$1,113,592.64	3.04%	Fail
OOPM	$36,574,509.47	99.97%	OP-AO INN OOPM
Total Projected	$36,584,774.98		

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
$1,900.00	$30,278,679.71	82.76%	$1,900.00	
	$6,306,095.27	17.24%		
Total	$36,584,774.98	100.00%		

Copayment ---- (3b) Outpatient - All Other, In-Network (OP-AO 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
$15.00	$569,140.18	1.60%	$15.00	
$30.00	$5,639,496.03	15.90%	$30.00	
$75.00	$4,820,852.55	13.59%	$75.00	
$200.00	$5,121,162.46	14.44%	$200.00	
$300.00	$2,319,841.79	6.54%	$300.00	
$350.00	$16,903,230.28	47.67%		
$650.00	$87,193.55	0.25%		
Total	$35,460,916.83	100.00%		

Coinsurance ---- (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.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
	$0.00			
	$0.00			
	$0.00			
Total	$0.00	0.00%		

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
$8,800.00	$36,574,509.47	100.00%	$8,800.00	
	$0.00			
	$0.00			
	$0.00			
Total	$36,574,509.47	100.00%		

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: **Molina Healthcare of Washington, Inc.**

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
84481WA0060005	Molina Cascade Complete Gold	No, Cascade	Gold	0.8171
84481WA0060006	Molina Cascade Silver	No, Cascade	Silver	0.7184
84481WA0060007	Molina Cascade Bronze	No, Cascade	Bronze	0.6499
84481WA0060008	Molina Cascade Vital Gold	No, Cascade	Gold	0.7801

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."		
84481WA0060005	Molina Cascade Complete Gold	Yes	Varying levels of cost-sharing for generic drug categories.	No	N/A
84481WA0060006	Molina Cascade Silver	Yes	Copays applied for services that are not subject to deductible, and copay does not accrue toward deductible; There is a $1 copay for the first two primary care and MHSUD outpatient office visits – the AVC does not accommodate this; Varying levels of cost-sharing for generic drug categories.	No	N/A
84481WA0060007	Molina Cascade Bronze	Yes	Copays applied for services that are not subject to deductible, and copay does not accrue toward deductible; There is a $1 copay for the first two primary care and MHSUD outpatient office visits – the AVC does not	No	N/A

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."		
			accommodate this; Varying levels of cost-sharing for generic drug categories.		
84481WA0060008	Molina Cascade Vital Gold	Yes	Varying levels of cost-sharing for generic drug categories.	No	N/A

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
84481WA0060007	Molina Cascade Bronze	No	Yes	Primary Office Visits

[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
Molina Marketplace	HMO	Single	05/15/2025

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	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 1.1

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		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.		
	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	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 1.2
	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. (iii) Demonstrate how URRT Worksheet 1, Section II, categories map to WAC 284-43-6660 summary categories. Reconcile data between the two summaries.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 1

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		(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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 2
	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	
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.		
	a	Manual data relevance: Explain the relevance of the data used to determine the Manual EHB Allowed Claims PMPM.	N/A	
	b	Manual EHB allowed claims PMPM: • Show the detailed calculation of the Manual EHB Allowed Claims PMPM entered in URRT Worksheet 1, Section II.	N/A	

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		• 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.		
	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?	N/A	
	d	Show how you estimated credibility of the 2024 allowed claims and member months used in rate development. Use your credibility procedure.	N/A	
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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 1.2

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	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 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.	"Summary of Pooled Experience with Adjustments Duplicate.xlsx" and "Summary of Pooled Experience with Adjustments.pdf"	Entire Document

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		• 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.	"WAC 284-43-6660 Duplicate.xlsx" and "WAC 284-43-6660.pdf"	General information #5
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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 1.1, Appendix Exhibit 10.2
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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 3, WA Exhibit 4, WA Exhibit 5

Line		Task	Issuer Response:	
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		• 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.		
	b	Allowed claims non-EHB trend analysis: If applicable, include an exhibit that develops the non-EHB allowed claims trend.	N/A	

	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).
		  ○ 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
			"Part III Rate Filing Documentation and Actuarial Memorandum.pdf"
			
			"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"
			
			"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"
				Section: Trend Factors
				
				WA Exhibit 3
				
				Appendix Exhibit 2.1

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		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.pdf"	Section: Trend Factors
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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 3.1

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	• 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).		
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 • 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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf" "WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	Appendix Exhibits 4.1, 4.2a, 4.2b, 4.2c, 4.3 WA Exhibit 5
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	"84481_WA_AVScreenshots.pdf"	Entire Document

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	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. • 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. • <u>Metal Levels</u> 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:		

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	○ 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. ○ 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. ○ Include enough detail for the reviewer to determine whether the methods, assumptions, and results are appropriate and reasonable. ○ 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		

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		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. o *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. o *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 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.	N/A	

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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.	"84481_WA_UniquePlanDesignSuppDocAndJust.pdf" "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs.pdf"	Entire Document 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.	"84481_WA_UniquePlanDesignSuppDocAndJust.pdf"	Entire document
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.	"84481_WA_UniquePlanDesignSuppDocAndJust.pdf"	Entire document
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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 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.	

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		• 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.
			"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 6

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		▪ 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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 8

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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 8
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf" "Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Appendix Exhibit 5.1b Section: Plan Adjusted Index Rates

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).	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 5.1b
	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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 6, WA Exhibit 9
	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)	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 6.1
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 1.3
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:	N/A	

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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 5.1b
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	

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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 4.2b
	b	Age calibration factors, projected versus prior: Compare the 2026 age calibration factor to the 2023, 2024, and 2025 factors.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 4.2b
	c	Average age: Show the average age and provide actuarial justification for the methodology employed to calculate the average age.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 4.2b
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:	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 7.1

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		○ Health status of enrollees or the population in an area. ○ 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.	"Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Calibration
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 7.1
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 7.1
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 7.1

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.	"Part I Unified Rate Review Template Duplicate.xlsm" and "Part I Unified Rate Review Template.pdf"	Worksheet 3
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.pdf"	Section: Calibration
	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.	"Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Calibration
	c	Tobacco factors, projected versus prior: Compare the 2026 tobacco use factor and calibration factor to amounts for 2023, 2024, and 2025.	"Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Calibration
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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 10

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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf" "Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	WA Exhibit 10 Appendix Exhibit 10.2
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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 10
	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.pdf"	Section: Risk Adjustment and Payment Change

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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 5.1a
	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.pdf"	Section: Risk Adjustment and Payment Change
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 8.1
	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.	"WA Exhibits Duplicate.xlsx" and "WA Exhibits.pdf"	WA Exhibit 10

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.	"84481_WA_SERFFRateReviewDetail.pdf"	Entire Document
	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)	"84481_WA_SERFFRateReviewDetail.pdf"	Entire Document

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.		

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.		
	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.		
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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 2.1
	(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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 2.1
	(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.pdf"	Section: Projection Factors
	(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.pdf"	Section: Essential Health Benefits
	(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.pdf"	Section: Projection Factors
	(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.pdf"	Section: Projection Factors
	(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.pdf"	Section: Projection Factors

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(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.pdf"	Section: Non-Benefit Expenses and Profit & Risk
	(ix) The impact of ***changes in*** other administrative costs. Include a discussion of any such changes.	**"**Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Non-Benefit Expenses and Profit & Risk
	(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.pdf"	Section: Non-Benefit Expenses and Profit & Risk
	(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)]	**"**Part III Rate Filing Documentation and Actuarial Memorandum.pdf" "Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Section: Projected Loss Ratio Appendix Exhibit 11.1

Line	Task	Issuer Response:	
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	– 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)] + 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: ○ How total CBE are allocated to lines of business (e.g., individual, small group, and large group) ○ 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		

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	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] o 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)] o 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]		

Line	Task	Issuer Response:	
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	○ 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)]: 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)		

Line	Task	Issuer Response:	
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	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.	"Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Non-Benefit Expenses and Profit & Risk
	(xiii) The impacts of geographic factors and variations.	"Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Calibration
	(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.pdf"	
	(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.pdf"	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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.pdf"	Section: Projection Factors / Trend Factors / Pharmacy Unit Cost Trends
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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 11.2a

Line	Task	Issuer Response:	
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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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 11.2b
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 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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 5.1b
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		

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		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. • 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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 5.1a
	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	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 5.1a

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		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.		
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 2.1
	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). 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.	**"**Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Terminated Products
	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."	N/A	

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 9.1
	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.pdf"	Section: Membership Projections

Line		Task	Issuer Response:	
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	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.	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 9.1
	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	
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,	"Part II Written Description Justifying the Rate Increase.pdf"	

Line		Task	Issuer Response:	
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		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.		
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 certification and update the date throughout the filing review season, as needed, if assumptions or rates change.	**"**Part III Rate Filing Documentation and Actuarial Memorandum.pdf"	Section: Actuarial Certification
	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."	N/A	

Line		Task	Issuer Response:	
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		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.		
	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.pdf"	Section: Proposed Rate Increases
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.		
	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)."	"84481_WA_Uniform Product Modification Justification Duplicate.xlsx" and "84481_WA_Uniform Product Modification Justification.pdf"	Entire Document

Line		Task	Issuer Response:	
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		• 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.		
	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. • 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	"Actuarial Memorandum Exhibits DUPLICATE.xlsx" and "Actuarial Memorandum Exhibits.pdf"	Appendix Exhibit 11.3

Line		Task	Issuer Response:	
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		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 Duplicate.xlsx" and "WAC 284-43-6660.pdf"	Entire Document
	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	"WAC 284-43-6660 Duplicate.xlsx" and "WAC 284-43-6660.pdf"	Entire Document

Line		Task	Issuer Response:	
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		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.		
	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 Duplicate.xlsx" and "WAC 284-43-6660.pdf"	Entire Document
	d	General Information section #4: Respond with "See Rate Schedule."	"WAC 284-43-6660 Duplicate.xlsx" and "WAC 284-43-6660.pdf"	Entire Document

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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).	"84481_WA_Benefit Components Duplicate.xlsx" and "84481_WA_Benefit Components.pdf"	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.	"Certification-Rates-2026 Ind Mental Health and Substance Use Disorder Financial Reqs.pdf"	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.	"Certification - Rates - 2026 MHSUD Parity Calculations Duplicate.xlsx" and "Certification - Rates - 2026 MHSUD Parity Calculations.pdf"	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	"84481_WA_CommissionSchedule.pdf"	Entire Document

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	manager of your company who oversees commission schedule implementation. The officer or senior 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 Duplicate.xlsx" and "Rate Schedule.pdf"	Entire Document

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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.	"Molina Family Rating Example Duplicate.xlsx" and "Molina Family Rating Example.pdf	Entire Document
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	
40	**1332 waiver checklist:** Complete and submit the file "Checklist – Rates – 2026 Individual Supplemental Checklist for 1332 Waiver Reporting."	"84481_WA_1332WaiverChecklist.pdf"	Entire Document

HIOS Product ID(s): 84481WA006
Product(s): 2026 non-grandfathered individual form filing MHW01012026

Rate Information
Rate data applies to filing in SERFF.

Filing Method:	SERFF
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	5.7%
Effective Date of Last Rate Revision:	1/1/2025
Filling Method of Last Filing:	SERFF

2026 Marketplace
Company Rate Information

Company Name	Company Rate Change? (Increase/Decrease)	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program[1]:	Written Premium for this Program[2]:	Maximum % Change (where required):	Minimum % Change (where required):
Molina Healthcare of Washington, Inc.	Increase	24.59%	24.59%	$82,123,804	29,226	$334,023,819	36.98%	9.30%

Notes:
(1): The Number of Policyholders is the number of policyholders effective Mar 31, 2025 (subscribers, not members)
(2): This is calculated based on membership effective Mar 31, 2025 annualized and multiplied by the corresponding 2025 rate (by region, metal, and age). Terminated plan membership is mapped to a renewing plan.

Rate Review Detail Documentation

The purpose of this document is to explain the assumptions used when calculating fields for the rate review detail window in SERFF.

HHS Issuer ID:	84481
Product Name:	2026 non-grandfathered individual form filing MHW01012026
HIOS Product ID:	84481WA006
HIOS Submission ID:	

Number of Covered Lives:	43,346
Trend Factor:	Molina trended the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026 at a 9.1% annualized trend rate.

Requested Rate Change Information

Change Period:	Annually		
Member Months[(1)]:	489,287		
Benefit Change:	Increase		
	Min[(2)]	**Max[(2)]**	**Weighted Avg[(2)]**
Annualized Percent Rate Change Requested:	9.3%	37.0%	24.6%

Prior Rate

Projected Earned Premium[(3)]:	$311,763,504		
Total Incurred Claims[(3)]:	$288,770,194		
	Min[(4)]	**Max[(4)]**	**Weighted Avg[(4)]**
PMPM $:	$223.56	$1,385.16	$599.37

Requested Rate

Projected Earned Premium[(5)]:	$216,375,285		
Projected Incurred Claims[(5)]:	$203,779,242		
	Min[(6)]	**Max[(7)]**	**Weighted Avg[(8)]**
PMPM $:	$261.69	$1,817.70	$746.73

Notes:

(1) Molina member months for 2024

(2) The % of rate changes are calculated based on the filed rates

(3) Membership effective Apr 1, 2025 annualized and multiplied by the approved Weighted Avg PMPM in prior rate filing

(4) Approved rates in Molina's prior rate filing

(5) Projected for 2026. Claims exclude risk adjustment.

(6) The Minimum PMPM $ is the lowest possible monthly rate per member for lowest metal tier plan in 2026. The rates only vary by benefit plan design, age and geographic region.

(7) The Maximum PMPM $ is the highest possible monthly rate per member for highest metal tier plan in 2026. The rates only vary by benefit plan design, age and geographic region.

(8) The Weighted Average PMPM $ is the projected product premium PMPM for 2026.

UNIQUE PLAN DESIGN BENEFIT CROSSWALK

Issuer Name: Molina Healthcare of Washington, Inc.
Market Type: Individual
Coverage Type: **Medical Health Plans**
Exchange Marketing Intentions: Inside Only

Benefit Translation Crosswalk

HIOS Plan ID (Re-Enter for Each Unique Benefit)	Plans and Benefits Template - Benefit Name with Unique Plan Design Provision	Form Filing SERFF Tracking Number (Example: ABCD-123456789)	Form Filing - Document Name, and Section or Page Number	Form Filing - Benefit (Copay and/or Coinsurance) Amount and Explanation	Plans and Benefits Template - Benefit (Copay and/or Coinsurance) Amount and Explanation	Why This Benefit Is Unique	Translation of Benefits - Explain How You Translated the Benefit Cost Sharing Information from the Form into the PBT	Justify That the Translation Is Appropriate and Reasonable
84481WA0060006	Primary Care Visit to Treat an Injury or Illness		Plan Schedule of Benefits - Page 2	$20.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$20.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2065 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"
84481WA0060006	Other Practicioner Office Visit (Nurse, Physician Assistant)		Plan Schedule of Benefits - Page 2	$20.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$20.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"
84481WA0060006	Mental/Behavioral Health Outpatient Services		Plan Schedule of Benefits - Page 2	$20.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$20.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"
84481WA0060006	Substance Abuse Disorder Outpatient Services		Plan Schedule of Benefits - Page 2	$20.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$20.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"

84481WA0060006	Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$25.00 Copay	$25.00 Copay	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.
84481WA0060006	Non-Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$250.00 Copay after Deductible	N/A	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.
84481WA0060007	Primary Care Visit to Treat an Injury or Illness		Plan Schedule of Benefits - Page 2	$40.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$40.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"
84481WA0060007	Other Practicioner Office Visit (Nurse, Physician Assistant)		Plan Schedule of Benefits - Page 2	$40.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$40.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"
84481WA0060007	Mental/Behavioral Health Outpatient Services		Plan Schedule of Benefits - Page 2	$40.00 Copayment per visit First two visits covered at $1 copay, then regular copay amounts apply.)	$40.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"

84481WA0060007	Substance Abuse Disorder Outpatient Services		Plan Schedule of Benefits - Page 2	$40.00 Copayment per visit (First two visits covered at $1 copay, then regular copay amounts apply.)	$40.00 Copay	First two visits covered at $1 copay, then regular copay amounts apply.	The first two PCP and MH/SUD office visits have a $1 copay. Bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.	To modify the CMS AV Calculator to account for the $1 copay for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables as described in the Wakely "2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification"
84481WA0060007	Mental/Behavioral Health Outpatient Services		Plan Schedule of Benefits - Page 2	40% Coinsurance after Deductible	N/A	The PBT no longer accommodates addition of a separate "Mental/Behavioral Health Outpatient Services - Other" benefit as it did in past years. Thus, the only benefit available for MHSUD outpatient cost-sharing is the "Mental/Behavioral Health Outpatient Services" benefit which lists MHSUD Office Visit cost-sharing.	Cost-sharing for Mental Health and Substance Use Disorder (MHSUD) outpatient services is different for MSHUD office visits, MHSUD facility fees, and MHSUD professional services. Plan & Benefits Template and AVC do not include a benefit to cover this category.	The AVC only accepts one MHSUD (mental health/substance use disorder) outpatient cost-share structure. Plan design includes different cost-sharing for MHSUD outpatient professional (Office Visits) versus MHSUD outpatient Other . Mental Health Services - Non-Office Visits. This Includes outpatient mental health and behavioral health medically necessary treatments and eating disorder treatments for DSM classified disorders.
84481WA0060007	Substance Abuse Disorder Outpatient Services		Plan Schedule of Benefits - Page 2	40% Coinsurance after Deductible	N/A	The PBT no longer accommodates addition of a separate "Mental/Behavioral Health Outpatient Services - Other" benefit as it did in past years. Thus, the only benefit available for MHSUD outpatient cost-sharing is the "Mental/Behavioral Health Outpatient Services" benefit which lists MHSUD Office Visit cost-sharing.	Cost-sharing for Mental Health and Substance Use Disorder (MHSUD) outpatient services is different for MSHUD office visits, MHSUD facility fees, and MHSUD professional services. Plan & Benefits Template and AVC do not include a benefit to cover this category.	The AVC only accepts one MHSUD (mental health/substance use disorder) outpatient cost-share structure. Plan design includes different cost-sharing for MHSUD outpatient professional (Office Visits) versus MHSUD outpatient Other .Substance Use Disorder Services (Non-Office Visit) (Includes outpatient chemical dependency detoxification, and unlimited Acupuncture treatment services when provided for chemical dependency. All are subject to medical necessity criteria.)
84481WA0060007	Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$32.00 Copay	$32.00 Copay	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.
84481WA0060007	Non-Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	40% Coinsurance after Deductible	N/A	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.
84481WA0060005	Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$10.00 Copay	$10.00 Copay	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

84481WA0060005	Non-Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$100.00 Copay	N/A	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.
84481WA0060008	Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$10.00 Copay	$10.00 Copay	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.
84481WA0060008	Non-Preferred Generic Drugs		Plan Schedule of Benefits - Page 6	$200.00 Copay after Deductible	N/A	The AVC and PBT only accommodate a single tier of "Generic Drugs." Our formulary design breaks Generic Drugs into two separate tiers - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The PBT uses "Generic Drugs" and "Non-Preferred Brand Drugs" only - it does not accommodate separate tiers for Generic Drugs - Preferred Generic Drugs and Non-Preferred Generic Drugs.	The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

Unique Plan Design—Supporting Documentation and Justification

Issuers must fill in the following information.

Health Insurance Oversight System (HIOS) Issuer ID:

84481

HIOS Product IDs:

84481WA006

Applicable HIOS Plan IDs (Standard Component):

84481WA0060005, 84481WA0060006, 84481WA0060007,84481WA0060008

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:

Cost-sharing for Generic Drugs is split into two generic drug tiers (preferred generic and non-preferred generic).

Acceptable alternate method used per *Code of Federal Regulations* (CFR) 156.135(b)(2) or 156.135(b)(3):

Method 156.135(b)(3) was used to develop the actuarial values for the plans.

Confirmation that only in-network cost sharing, including multitier networks, was considered:

Only in-network cost sharing was considered.

Description of the standardized plan population data used:

The population data used in the development of the adjusted inputs was from the continuance tables in the AV calculator.

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:

If the method described in CFR 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

The federal AV Calculator was used to calculate two AVs - one AV was calculated using the preferred Generic Drugs cost-share as the input for Generic Drugs in the AVC and the other using the non-preferred Generic Drugs cost-share as the input for Generic Drugs in the AVC. ... (response continued below signature section)

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: Kathryn Hall

Digitally signed by Kathryn Hall
DN: cn=Kathryn Hall gn=Kathryn Hall c=US United States l=US United States o=Molina Healthcare e=Kathryn.Hall@molinahealthcare.com
Reason: I am the author of this document
Location:
Date: 2024-05-12 20:44-04:00

Actuary Printed Name: Kathryn Hall, ASA, MAAA

Date: May 13, 2025

(response continued from CFR 156.135(b)(3) item above)
... All other inputs were held constant in both calculations. A weighted average of the two AVs was calculated using weights based on the company's utilization of preferred and non-preferred generic drugs. Due to the unique plan designs of 84481WA0060006 and 84481WA0060007, Wakely 2025 Standard Plan AV Certification was relied upon in the calculations for these plans. The adjusted AVs prepared by Wakely were calculated in accordance with CFR 156.135(b)(3) to accomodate for certain unique plan design aspects, including MHSUD copays and primary care copays. To accomodate for the Generic Drug Cost-Sharing, the same method described above is used. Then, an adjustment factor was calculated for the standard plans using the original AV compared with the blended AV and is applied to the Adjusted AV prepared by Wakely. The resulting product is the final AV.

April 15, 2025

Christine Gibert
Policy Director
Washington Health Benefit Exchange
Via email: Christine.gibert@wahbexchange.org

RE: CERTIFICATION FOR WAHBE 2026 STANDARD PLAN DESIGNS

At the request of the Washington Health Benefit Exchange (WAHBE), Wakely is providing an actuarial value (AV) certification and unique plan justification for the 2026 standardized plan designs. The 2026 benefit designs were modestly adjusted to fit within the parameters of the revised final 2026 federal AV calculator's (AVC) constraints and to include special cost sharing for office visits for primary care and mental health/substance use disorder (MH/SUD). For 2026, Acumen modified the 2026 standardized plan designs to fit within the actuarial value requirements and made adjustments to the federal AVC for unique plan designs that did not fit into the AVC and could be considered material. Wakely completed a review of Acumen's methodology, conducted reasonability checks, and is certifying the unique plan adjustments and plan actuarial values.

While this memo discusses Acumen's methodology at a high level, it primarily focuses on review completed by Wakely to confirm the reasonability of Acumen's AV estimates. Wakely is providing an actuarial certification for the adjusted actuarial values allowed under 45 CFR §156.135(b) (3) in Appendices A and B. The documentation that Acumen provided on their methodology can be found in the Appendix C.

Our understanding is that WAHBE will use the final certification for plan year 2026. Use of this document for other purposes may not be appropriate. This document, and any accompanying files and correspondence, are intended for WAHBE internal use only and are not meant for broad distribution. The estimates presented here are based on emerging data and information available as of the date of this report.

This memo should only be utilized by qualified individuals with an understanding of the assumptions and limitations of the analysis described in the disclosures section of the memo. If disseminated, the memo should only be shared in its entirety. During the review of the memo, if you should have any questions or would like further clarification, please do not hesitate to contact us via email or phone (contact information available below), and we will be happy to provide assistance.

wakely.com

Washington Health Benefit Exchange

2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification

April 15, 2025

Prepared by:
Wakely Consulting Group, LLC

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
Darren Johnson, FSA, MAAA
Consulting Actuary

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Background

The Affordable Care Act (ACA) requires that non-grandfathered health care coverage provided by issuers in the individual market cover all essential health benefits (EHBs) and have actuarial values that fall under the platinum (90% AV), gold (80% AV), silver (70% AV) or bronze (60% AV) tiers. The ACA allows for a de minimis range around these target AVs. The final 2026 NBPP did not make any changes to the allowable federal AV range relative to the 2025 NBPP, however final 2026 NBPP parameters are listed here for completeness. The final 2026 NBPP finalized a range of -2% to +2% for most plans. For example, any plan design that has an AV from 78% to 82% is considered a gold plan. Similar to the final 2025 NBPP, the final 2026 NBPP is proposing a smaller range on the lower end for on-Exchange silver plans of 0% to +2% (or an AV between 70% and 72%). Off-Exchange silver plans would continue to be subject to the -2% to +2% range. Bronze plan designs meeting certain criteria are eligible for an expanded range of +5% on the higher end, allowing an AV up to 65% compared to a high end at 62%. Plans that meet these criteria include high deductible health plans and plans that cover at least one major service, other than preventive, prior to the deductible.

The ACA also defines AVs for cost-sharing reduction (CSR) plan variations that are available to individuals meeting income and other eligibility criteria and enrolling in a silver level plan in the individual market. These CSR variation AVs are 73%, 87% and 94%. The final 2026 NBPP allows for a 0% to +1% de minimis range around the target AVs for CSR plans (e.g., 73% to 74% AV for a 73% CSR plan). The plan designs developed by Acumen for 2026 comply with this proposed 2026 AV ranges.

The Center for Consumer Information and Insurance Oversight (CCIIO) provides an Actuarial Value Calculator (AVC)[1] that issuers must use to determine the AV of a plan. While CCIIO developed the AVC such to accommodate most plans, some plan designs have features which are not supported by the AVC. In these instances, an actuary can either modify the inputs to most closely represent the plan design, or an actuary can modify the results of the AVC to account for the features not supported by the AVC. An actuarial certification documenting the development of the AV for these plan designs is required.

Washington Health Benefit Exchange (WAHBE) defines standard plan designs that issuers participating on the Exchange must offer. Standard plan designs are defined for the individual market. For 2026, WAHBE is adding one additional gold standard plan design to supplement the existing three individual market designs for gold, silver (with three corresponding CSR plan levels), and expanded bronze levels.

WAHBE contracted with Acumen to assist with the development and validation of the

[1] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

federal AVs for the 2026 standard plan designs. WAHBE contracted with Wakely to assist in reviewing Acumen's development of the 2026 standard plan designs for reasonability and to certify actuarial values of all standard plan designs, including any unique plan designs. Standard expanded bronze, silver and all silver CSR variants are considered to be unique plan designs. Compliance of the benefit designs in relation to other regulatory benefit design constraints has not been evaluated by Wakely.

For the 2026 standard plans, benefit changes were made to the 2025 standard plans to account for the update to trend made to the revised final 2026 federal AV calculator. 2026 standard plan designs reflect design changes requested by WAHBE and necessary updates made to remain compliant with the revised final 2026 federal AV calculator, as well as the addition of a new low cost gold plan called Vital Gold.

A summary of WAHBE's standard plan designs is in Appendix D. Most of the cost sharing features of 2026 standard plan designs can be accommodated by the revised final federal AVC. However, the plan designs have features not supported by the AVC (defined as a "unique" plan design). The unique plan designs features are:

1. Mixed cost sharing applied to Mental Health/Substance Use Disorder (MH/SUD) outpatient services. The expanded bronze and silver standard plan designs (including 73%, 87%, and 94% CSR variants) have variable cost sharing between MH/SUD services provided in an office setting and other outpatient MH/SUD services (non-office visit). As the AVC only allows a single benefit input for all outpatient MH/SUD services, this tiered design also constitutes a unique benefit design.
2. The first two PCP and MH/SUD office visits have a $1 copay. Expanded bronze and silver standard designs (including non-94% CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.

The adjustment made to the AVC by Acumen addresses both unique plan designs features and is described below. A summary of WAHBE's 2026 standard plan designs is included in Appendix D.

Methodology

Wakely is providing an actuarial certification for all standard plan designs, including those that utilize adjusted actuarial values allowed under 45 CFR § 165.135(b)(3) in Appendices A and B. Acumen utilized the revised final 2026 federal AVC to determine the AV for all plans, entering plan designs to the extent that they fit the AVC. Screen shots of the unadjusted AVC inputs and outputs for plan designs that were

accommodated by the AVC and the adjusted AVC screenshots provided and developed by Acumen can both be found in Appendix E. The first set of screenshots displays outputs from the revised final 2026 AVC for each standard plan design. The second set of screenshots, captioned as “Adjusted”, displays output from a custom modified version of the AVC constructed using the methodology described briefly below and in more detail in Appendix C.

Both the complete gold standard and vital gold standard plans have no features deviating from the parameters of the AVC and were entered by Acumen into the AVC with no modifications. Acumen adjusted the other resulting AVs for the plan design features that deviate from the parameters of the AVC. For the expanded bronze standard and silver standard plan designs (including 73%, 87%, and 94% CSR variants), separate cost sharing values will apply for MH/SUD services obtained in an office setting versus other outpatient services. The AVC allows for only a single benefit input for MH/SUD outpatient services. For the expanded bronze and silver standard plans (including the 73% and 87% CSR variants), the AVC does not accommodate plan designs with a specified number of upfront $1 copay visits for MH/SUD visits or for primary care visits. The adjustment that Acumen calculated to account for both unique benefit features is described below.

To modify the AVC to account for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables. In the medical and combined continuance tables in the AVC, Acumen estimated the proportion of utilization and allowed cost attributable to MH/SUD in an office setting and combined the MH/SUD office visits with primary care office visits utilization and allowed cost. Acumen then modified the cost and frequency columns associated with the number of primary care visits exceeding a specified number of visits by applying the original ratio of these quantities to total primary care columns to the modified primary care columns including MH/SUD office visits amounts.

The main assumption made by Acumen is that the number of MH/SUD office visits exceeding a specified number of visits will follow a similar distribution as the primary care visits. Data analyzed by Wakely in the past showed that the large portion of the primary care office visits utilization is between 1-2 visits per year. For MH/SUD office visits services, while utilization is lower due to fewer members seeking the services; however, for members that do use services, the number of services exceed 1-2 per year. The assumption made by Acumen that the distributions are similar results in a larger impact to the AV than it otherwise would, as $1 copay would apply to a higher proportion of the total MH/SUD visits, thus resulting in a higher calculated AV than we think is likely to actually occur.

The sensitivity testing Wakely performed considered the lower and the upper bounds of a reasonable AV range and found the adjusted AV falling in the compliant range for the Silver 87% and 94% plans thus this assumption would not alter the AV categorization of those plans. The Silver 73%, Silver Standard and Bronze plans upper bounds were above the de minimis range and are discussed more later in this certification.

The AVC field "Begin Primary Cost-Sharing After a Set Number of Visits" effectively became "Begin Primary and MH/SUD Cost-Sharing After a Set Number of Visits" with this change, along with revising the $0 copay associated with this feature to a $1 copay. Acumen used the version of the AVC with revised continuance tables to calculate the adjusted AVs. This change was only made for the expanded bronze, silver, and silver CSR variants standard plans since the first two $1 copay PCP and MH/SUD visits feature does not apply to the two gold standard plans.

Table 1 shows the actuarial values determined by the original federal revised final 2026 AVC, including the unadjusted actuarial value for the two standard gold plans that Wakely is certifying and the adjusted actuarial values for the standard silver, standard silver CSR variants, and standard expanded bronze plans, that Acumen calculated and Wakely is certifying after the application of the adjustment factor.

Table 1 – Summary of Original and Adjusted Federal AVs

Standard Plan	AV from Original AVC	AV from Acumen Adjusted AVC	Adjustment Factor
Standard Complete Gold (no adjustment needed)	81.81%		
Standard Vital Gold (no adjustment needed)	78.06%		
Standard Silver*	71.33%	71.84%	1.005
Standard Silver, 73% AV CSR Variation*	73.49%	73.95%	1.005
Standard Silver, 87% AV CSR Variation*	87.78%	87.87%	1.005
Standard Silver, 94% AV CSR Variation	94.76%	94.86%	1.005
Standard Expanded Bronze*	63.64%	64.97%	1.021

** Note that the AVs in these rows were developed with two upfront no-cost PCP visits.*

Wakely believes that the methodology that Acumen used to adjust the AVs is appropriate based on the reasonability testing of Acumen's adjusted AVs. To determine whether the adjusted AVs were reasonable, Wakely tested three alternative plan designs in the original AVC that would serve as the boundary cases for the adjusted AVs. The expectation was that the adjusted AV should fall within the range of AVs produced by these alternative boundary cases. Wakely ran this test for all standard plans that offer the two MH/SUD $1 copay visits (all except the two gold designs). Two boundary designs were needed for all plans other than expanded bronze, where three boundary designs

were considered.

The three alternative boundary plan designs used to test the reasonable AV range were as follows:

1. 2026 standard plan designs for each metal, with the same cost sharing applied to all PCP and outpatient MH/SUD services. For the expanded bronze plan design, two lower boundary designs were included:

    (a) a design with the deductible and coinsurance cost sharing applied to all outpatient MH/SUD services; and

    (b) a design with $40 copay cost sharing applied to all PCP visits and outpatient MH/SUD services.

2. 2026 standard plan designs for each metal, with $0 cost-sharing applied to first two PCP visits and all outpatient MH/SUD services. This is a richer boundary case than $1 copay, but the AVC does not allow for a $1 copay for initial visits. As such, this provides the closest boundary case within the design of AV calculator.

Wakely modeled each of these plan designs in the 2026 federal revised final AV calculator. For the expanded bronze plan, the AV for the mixed cost sharing applied to outpatient MH/SUD services (copay for office visits and deductible and coinsurance for all other services) would be a weighted average of the two AVs produced in (1a) and (1b). The resulting AVs are presented in the Table 2 below.

For all plans above, Acumen's 2026 adjusted AV falls within the AV range produced by the lower and upper boundary plan designs. For expanded bronze plan, the adjusted actuarial value exceeds both lower bound AVs with different types of cost sharing applied to all MH/SUD outpatient services (copays and deductible / coinsurance). Considering the range of AVs created by these two plans was narrow and considering that the adjusted AV logically fell within this range, Wakely deemed the adjusted AVs calculated by Acumen to be reasonable and actuarially sound.

Table 2 – Summary of Original and Adjusted Federal AVs

Standard Plan	2026 Adjusted AV	Low Boundary Plan/s (Standard Copays on all PCP and MH/SUD Visits)	Upper Boundary Plan (Zero Cost Sharing on all MH/SUD Visits and Two PCP Visits)
Standard Silver	71.84%	71.08%	72.13%
Standard Silver, 73% AV CSR Variation	73.95%	73.27%	74.21%
Standard Silver, 87% AV CSR Variation	87.87%	87.74%	87.93%
Standard Silver, 94% AV CSR Variation	94.86%	94.76%	94.91%
Standard Bronze (a) – Ded/Coins for MH/SUD	64.97%	63.08%	65.61%
Standard Expanded Bronze (b) – Copay for MH/SUD	64.97%	64.19%	65.61%

Note that the upper bound of the silver CSR 73% variation, the silver standard, and the standard expanded bronze AVs all fall above the de minimis range. However, the application of normal copays on the PCP and MH/SUD visits after the first two (and for expanded bronze, deductible/coinsurance cost sharing on OP Facility MH/SUD) would decrease the plan richness and the AV below the maximum levels (see below and Table 3 for additional detail).

To test this conclusion, Wakely tested best estimate alternative designs by calculating blended best estimate PCP and MH/SUD copay. We used a percentage of utilization of PCP office visit utilization for the first two visits (56.0% based on silver combined claim probability distribution (CPD) for PCP utilization, 59.2% based on the bronze combined CPD for PCP utilization[2]) and the percentage of OP MH/SUD utilization that is office visits (89.0% based on Acumen estimates and the AV Calculator CPD)[3] as the starting point.

As discussed above, for this plan the Acumen assumption around MH/SUD annual utilization could potentially be impactful, as we think that assumption overstates AVs

[2] These values were calculated by taking the ratio of the final value in the "Silver Combined" or "Bronze combined" sheet PCP Silver Frequency column (J170) and the final value in the "Primary Care >2 Visits" column (CF170) to get the proportion of PCP visits that are the first two visits a member has.

[3] Acumen stated that 90.0% of professional MH/SUD services were office visits and 63.4% of facility MH/SUD services were office visits. Using the AVC Silver Combined sheet cells AV170 and AX170 for MH/SUD facility/professional utilization split, we can see that 96.3% of total MH/SUD visits come from professional services with the remaining 3.7% coming from facility services. Taking the sum-product of those numbers gives us 89.0% of MH/SUD services that are office visits (96.3% x 90.0% + 3.7% x 63.4%).

versus actual experience which will have a lower percentage of office visits be the first two for a member in a given year. We found a revised assumption for that percentage by utilizing our WACA 2019 ACA Data (see Data and Reliance section) to calculate the proportion of MH/SUD office visit utilization that takes place in a member's first two visits (24.1%).

Using these assumptions, a revised blended cost sharing was calculated for a PCP visit for each of the three plans and is presented in Table 3 below. All final calculated AVs are within the de minimis range.

Table 3 – Summary of Calculations for Blended Copay AVs

	Description	Silver 73%	Silver	Expanded Bronze	Calculation
(1)	% of PCP Visits at $1 cost sharing	56.0%	56.0%	59.2%	
(2)	% of PCP Visits at full cost sharing	44.0%	44.0%	40.8%	1-(1)
(3)	Office Visit % of OP MH/SUD Util	89.0%	89.0%	89.0%	
(4)	All Other % of OP MH/SUD Util	11.0%	11.0%	11.0%	1-(3)
(5)	% of OP MH/SUD Office Visits at $1 cost sharing	24.1%	24.1%	24.1%	
(6)	% of OP MH/SUD Office Visits at full cost-sharing	75.9%	75.9%	75.9%	1-(5)
(7)	PCP Copay (after first two visits)	$20	$20	$40	
(8)	OP Office Visit MH/SUD Copay (after first two visits)	$20	$20	$40	
(9)	OP All Other MH/SUD Cost Sharing	$30	$30	Deductible / 40% Coins	
(10)	Estimated Blended PCP Copay	$9.36	$9.36	$16.90	$1x(1) + (7)x(2)
(11)	Estimated Blended OP MH/SUD Office Visit Copay	$15.42	$15.42	$30.60	$1x(5) + (8)x(6)
(12)	Total Blended OP MH/SUD Copay	$17.03	$17.03	NA	(11)x(3) + (9)x(4)
(13)	AV With All Blended Copays (PCP and OP MH/SUD)	**73.8%**	**71.7%**	64.9%	
(14)	Expanded Bronze AV with Ded/Coins for OP MH/SUD	NA	NA	63.6%	
(15)	Expanded Bronze Blended AV	NA	NA	**64.7%**	(13)x(3) + (14)x(4)

Disclosures and Limitations

Responsible Actuary. Ksenia Whittal and Darren Johnson are the actuaries responsible for this communication. We are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the use of WAHBE, Washington Office of the Insurance Commissioner (OIC), Acumen and WAHBE issuers. Wakely does not intend to benefit third parties and assumes no duty or liability to those third parties. Any third parties receiving this work should consult their own experts in interpreting the results. This report, when distributed, must be provided in its entirety and include caveats regarding the variability of results and Wakely's reliance on information provided by WAHBE.

Risks and Uncertainties. The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from any estimates. Wakely does not warrant or guarantee that actual experience will tie to the AV estimated for the placement of plan designs into tiers. The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan or pricing AV used to determine premium rates. Actual AVs will vary based on a plan's specific population, utilization, unit cost, and other variables. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from WAHBE and Acumen.

Data and Reliance. Wakely relied on information supplied by Acumen and WAHBE in this assignment. Wakely has reviewed the data and methodology for reasonableness but has not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, these estimates may be impacted, potentially significantly. Any errors in the data will affect the accuracy of the analysis and the conclusions drawn in this report. When performing financial and actuarial analyses on the current data, assumptions must be made where there is

incomplete data. Improvements in data will allow for more accurate analyses and consistent reporting. Below is a list of data and assumptions provided by others and assumptions required by law.

- The 2026 revised final federal AVC Model was relied on for the AV calculations. While reasonability tests have shown there are some assumptions and methodologies that are not consistent with expectations, the AVC was developed for plan classification and not pricing. Thus, the model is being used as such and Wakely makes no warranties for the accuracy of the AVs that result from the AVC.
- The AVC adjustment methodology provided and developed by Acumen (included in Appendix C).
- The unadjusted and adjusted AVC screenshots provided and developed by Acumen (included in Appendix E).
- 2026 WAHBE standard plan benefit designs provided by WAHBE (included in Appendix D).

In addition, we relied on the Wakely ACA Database (WACA) for our MH/SUD visit assumption. This is an aggregated database based on de-identified EDGE Server input and output files (including enrollment, claims, and pharmacy data) from the 2019 benefit year submitted through April 2020, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 4 million lives from the individual and small group ACA markets. The de-identification applies to identifiers specific to enrollee, issuer, and location. We performed reasonability tests on the data but did not audit or verify the data.

Potential limitations of the WACA data include but are not limited to the following:

- Results will be affected by issuer-specific data management. Omitted claims, erroneously coded claims, erroneous enrollment records, and other data issues may not reflect actual ACA cost and diagnosis experience.
- A subset of issuers nationwide submitted data to the database. We believe the database represents a fair cross-section of nationwide experience, but limitations in this regard will affect results.
- We excluded data for both enrollees in American Indian (limited/no-cost sharing) CSR plans and enrollees in Medicaid Private Option plans (these only occur in a few states).

Contents of Actuarial Report. This document and the supporting exhibits constitute the entirety of the actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in

compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. In developing these standard plan designs and the resulting actuarial certification, Wakely followed applicable Actuarial Standards of Practice (ASOP) including:

ASOP No. 23 Data Quality;
ASOP No. 25 Credibility Procedures;
ASOP No. 41 Actuarial Communications;
ASOP No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act; and
ASOP No. 56 Modeling.

Appendix A contains the formal actuarial certification. If you have any questions regarding this letter or the certification, please contact us.

Sincerely,

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
720-282-4965

Darren Johnson, FSA, MAAA
Consulting Actuary
720-206-1391

Appendix A - Actuarial Value Certification

Washington Health Benefit Exchange Standard Plan Designs Effective January 1, 2026

I, Ksenia Whittal, am associated with the firm of Wakely Consulting Group, LLC, an HMA Company (Wakely), am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by Washington Health Benefit Exchange (WAHBE) to provide a certification of the adjusted actuarial value of the standard plan designs offered through WAHBE that are effective January 1, 2026. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the adjusted actuarial values provided with this certification are considered actuarially sound for purposes of 45 CFR § 156.135(b), according to the following criteria:

- The revised final 2026 federal Actuarial Value Calculator was used to determine the AV for the plan provisions that fit within the calculator parameters;
- Appropriate adjustments were calculated, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator;
- The actuarial values have been developed in accordance with generally accepted actuarial principles and practices; and
- The actuarial values meet the requirements of 45 CFR § 156.135(b).

The assumptions and methodology used to develop the actuarial values have been documented in this report. The actuarial values associated with this certification are for the 2026 WAHBE standard expanded bronze, silver, silver 73% CSR, silver 87% CSR, silver 94% CSR, vital gold and complete gold plan designs that will be effective as of January 1, 2026 for individual coverage sold on the Washington Health Benefit Exchange.

The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan. Actual AVs will vary based on a plan's specific population, utilization, unit cost and other variables.

In developing this opinion, I have relied upon the final federal Actuarial Value calculator and the adjustment methodology provided by Acumen. Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
Wakely Consulting Group, LLC, an HMA Company
April 15, 2025

Appendix B - Unique Plan Design Supporting Documentation and Justification

Applicable Plans: 2026 Standard Silver, the Silver 73% CSR, the Silver 87% CSR, the Silver 94% CSR and the Expanded Bronze Standard Option

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator, and the materiality of those benefits): For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature.

Acceptable alternate method used per 156.135(b) (2) or 156.135(b) (3): Method 156.135(b) (3) was utilized in developing the actuarial values for the plans.

Confirmation that only in-network cost-sharing, including multitier networks, was considered: Only in-network cost sharing was considered in the development of the actuarial values.

Description of the standardized plan population data used: Acumen used the data underlying the continuance tables in the 2026 federal AV calculator.

If the method described in 156.135(b) (2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator: n/a

If the method described in 156.135(b) (3) was used, a description of the data and method used to develop the adjustments: Acumen developed adjustments to the continuance tables in AVC to accommodate the unique plan design features. Wakely did not replicate these changes but rather performed reasonability testing of Acumen's methodology by testing three sets of alternative plan designs in the original AVC that would serve as the boundary cases for the adjusted AVs. The expectation was that the adjusted AV should fall within the range of AVs produced by these alternative boundary cases. Wakely tested all standard plans that offer the first two PCP and two MH/SUD at a $1 copay visits (all except both gold designs).

The three alternative boundary plan designs used to test the reasonable AV range were as follows:

1. 2026 standard plan designs for each metal, with the same cost sharing applied to all PCP and outpatient MH/SUD services. For the expanded bronze plan design, two boundary designs were included:
    (a) a design with the deductible and coinsurance cost sharing applied to all outpatient MH/SUD services; and
    (b) a design with $40 copay cost sharing applied to all PCP visits and outpatient MH/SUD services.
2. 2026 standard plan designs for each metal, with $0 cost-sharing applied to first two PCP

visits and all outpatient MH/SUD services. This is a richer boundary case than $1 copay but the AVC does not allow for a $1 copay for initial visits. As such, this provides the closest boundary case within the design of AV calculator.

Wakely modeled each of these plan designs in the revised final 2026 federal AV calculator. For the expanded bronze plan, the AV for the mixed cost sharing applied to outpatient MH/SUD services (copay for office visits and deductible and coinsurance for all other services) would be a weighted average of the two AVs produced in (1a) and (1b). For all plans above, Acumen's 2026 adjusted AV falls within the AV range produced by the lower and upper boundary plan designs. For the expanded bronze plan, the adjusted actuarial value exceeds both lower bound AVs with different types of cost sharing applied to all MH/SUD outpatient services (copays and deductible / coinsurance). Considering the range of AVs created by these two plans was narrow and considering that the adjusted AV logically fell within this range, Wakely deemed the adjusted AVs calculated by Acumen to be reasonable and actuarially sound.

Note that the upper bound of the silver CSR 73% variation, the silver standard, and the standard expanded bronze AVs all fall above the de minimis range. Wakely tested an alternative design for each of these by calculating a blended best estimate PCP and MH/SUD copay using an alternative assumption for the portion of MH/SUD annual utilization for the first two visits for a member in a given year. For the expanded bronze plan, this result was further blended with the alternative plan design that treated all OP MH/SUD as subject to the deductible and coinsurance. Using these assumptions, a revised blended cost sharing for PCP and MH/SUD yielded close to best estimate actuarial values within the de minimis ranges for each of the three impacted plans. Since both Acumen and Wakely methodologies resulted in compliant AVs we can thus be confident the WAHBE Standard Plans are within the de minimis range.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b) (2) or 156.135(b) (3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV.

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 methodologies.

Actuary signature: 

Actuary Printed Name: Ksenia Whittal, FSA, MAAA

Date: April 15, 2025

Appendix C - Acumen's Actuarial Value Calculator Modification Methodology Memorandum

(Begins on next page)

MEMORANDUM

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TO: Christine Gibert, Kristin Villas, WAHBE
FROM: Acumen, LLC
DATE: April 4, 2025
SUBJECT: 2026 Actuarial Value Calculator Modification Methodology

Acumen utilized a modified version of the Revised Final 2026 Actuarial Value Calculator (AVC) to estimate the actuarial value (AV) of proposed 2026 standard plan designs, some of which feature unique plan designs. The plan designs in question allow issuers to set different cost sharing for mental health/substance use disorder (MHSUD) office visits and MHSUD outpatient visits as well as allow enrollees to have up to two office visits of each type (primary care and MHSUD) with a $1 copay before the enrollee is responsible for a higher copay. While the standard AVC supports plan designs with a specified number of upfront no-copay visits for primary care, it does not support this feature for MHSUD office visits and it does not support $1 visits followed by a different copay. By utilizing the built-in upfront cost-sharing option for primary care as a starting point, Acumen modified the AVC to account for both types of office visits and for differential copays to calculate the AV of this plan design. In a separate workbook titled *"2026Designs_Screenshots_Revised_Final_2026AVC.xlsx"*, Acumen has included the screenshots of all standard plans for all metal levels to show how these plans are entered in the modified version of the Revised Final 2026 AVC and the original Revised Final 2026 AVC.

Modifications for Office Visit Cost-Sharing

There were three steps in the primary care and MHSUD AVC modification that Acumen performed, following the same methodology utilized to make relevant adjustments to the Final AVCs in previous years. First, in each medical and combined continuance table in the AVC, Acumen estimated the proportion of utilization and spending in the MHSUD professional and facility category that was accounted for by office visits, then combined these office visits with the primary care office visits fields. Acumen then allocated this combined field among the "Primary Care > N Visits" fields to create "Primary Care > N Visits & MHSUD > N Visits" fields. Finally, Acumen modified the algorithm underlying the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost sharing option to instead use $1 copays for the inputted number of visits, rather than having the visits be no-cost to the enrollee. Thus, by modifying the underlying fields and algorithm, Acumen leveraged the existing special cost-sharing feature in the AVC to calculate the AV of the plan design. The remainder of this section provides more details on each of these steps.

The MHSUD columns in each medical and combined continuance table in the AVC describe the frequency and cost of outpatient professional and facility services related to

MHSUD. Office visits are just one component of these fields, so Acumen had to first estimate the proportion of these MHSUD columns that were made up of office visits. To do this, Acumen utilized the EDGE 2021 Limited Dataset (EDGE LDS)[1], which is a claims database reflecting the individual and small group markets nationwide, available for purchase on the CMS website.

Using categorization logic similar to that used in the construction of the continuance tables underlying the AVC, Acumen first identified MHSUD-related claims in the EDGE LDS using a combination of revenue codes, place of service, HCPCs, and diagnoses appearing on the claim. Acumen then further identified the office visit claims among these by using both BETOS and Restructured BETOS Classification System (RBCS) codes. Finally, Acumen reweighted the data using the AVC standard population and calculated the proportion of MHSUD outpatient professional and facility claims that consisted of office visits. Proportions were calculated for utilization as well as costs and can be viewed in Table 1 below[2]. These derived proportions were then applied to the "Mental Health – OP Facility", "Avg. Mental Health – OP Facility Freq.", "Mental Health – OP Prof", and "Avg. Mental Health – OP Prof Freq." columns in the AVC medical and combined continuance tables to estimate MHSUD office visit cost and frequency. Once these values were calculated, they were subtracted from the existing MHSUD columns and added to the existing "Primary Care" and "Avg. Primary Care Freq" columns in the continuance table to create modified versions of these columns.

Table 1: Percentage of MHSUD utilization and cost AVC categories calculated to involve office visits

Category	Percentage of Category Considered Office Visit
MHSUD Outpatient Facility Utilization	63.41%
MHSUD Outpatient Professional Utilization	90.02%
MHSUD Outpatient Facility Allowed Cost	54.29%
MHSUD Outpatient Professional Allowed Cost	83.23%

Next, all "Primary Care > N Visits" and "Primary Care > N Visits Freq." columns were modified. These fields are specifically used by the AVC when an AVC user engages the "Begin

[1] Although the 2022 LDS data was the most recent EDGE LDS dataset available at the time the Revised Final 2026 AV Calculator was released, Acumen chose to use the 2021 EDGE LDS data because it corresponds to the same year of EDGE data used in the Revised Final 2026 AV Calculator.

[2] Compared to the 2025 calculator, MHSUD office visit facility utilization increased from 12.65% to 63.41%, and allowed costs increased from 7.6% to 54.29%. This significant increase is attributable to two factors: (1) the 2025 percentages were calculated using the 2019 EDGE LDS data, whereas the 2026 percentages were based on the 2021 EDGE LDS data; and (2), the 2021 EDGE LDS data shows a sharp decline in non-office visit facility claims, causing overall facility utilization to decline from 24.18 claims per 1,000 member-months in 2019 to 3.51 claims per 1,000 member-months in 2021. Therefore, the large increase in the percentage of MHSUD office visit facility utilization is a result of a shrinking denominator. The overall impact of this increase is small since the proportion of MHSUD facility claims is much smaller compared to MHSUD professional claims.

Primary Care Cost-Sharing After a Set Number of Visits?" special cost-sharing option. This was done by calculating the ratio of these columns to the original values of the "Primary Care" and "Avg. Primary Care Freq." columns, respectively, then multiplying this ratio by the modified versions of the "Primary Care" and "Avg. Primary Care Freq." columns calculated in the previous paragraph. The main assumption is that the additional office visits from MHSUD follow a pattern similar to Primary Care visits. This calculation was done separately for all rows of each medical and combined continuance table. See Figure 1 below for an example of the calculations for the combined office visit cost field and the "> 1 Visit" cost field for a single row of the silver combined continuance table from the Revised Final 2026 AVC.

Figure 1: Example Calculations for Allowed Costs for $10,000 Row of Silver Combined Continuance Table (Revised Final 2026 AVC)

Up To	Primary Care	Primary Care >1 Visit
	Col (1)	Col (2)
$10,000	$155.81	$91.95

	= Col (2) / Col (1)
1-Visit Factor:	59.0%

Up To	Mental Health - OP Facility	Mental Health - OP Prof.
$10,000	$2.80	$159.77

Office Visit Factors:	54.29%	83.23%	*Factors from Table 1*
Office Visit Share of Cost:	$1.52	$132.98	

Total MHSUD Office Visit Cost:	$134.50

Final Calculations:

Up To	Primary Care	MHSUD Office Visits	Combined Office Visits	1-Visit Factor	Combined >1 Visit
	Col (1)	Col (2)	Col (3) = Col (1) + Col (2)	Col (4)	= Col (3) * Col (4)
$10,000	$155.81	$134.50	$290.31	59.0%	$171.32

Once the modified versions of all these columns were calculated, Acumen replaced the original columns in the AVC with these new versions. This resulted in the primary care-related AVC special cost-sharing feature thereby being applied to the combined primary care and MHSUD office visit columns. Because the costs added to primary care were removed from the MHSUD-related columns, total cost and utilization—overall and within each row of the continuance tables—did not change. Additionally, a key feature of the Washington standard plan designs is that primary care and MHSUD cost-sharing for office visits is always the same, so no information is lost by combining these categories together.

Finally, the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost sharing feature was modified to instead use $1 copays that are not subject to the deductible for the set number of visits. This feature currently works by utilizing a $0 copay for the first few visits. By simply swapping this $0 copay for a $1 copay, Acumen was able to modify the algorithm to account for this bespoke plan feature.

Appendix D - WAHBE 2026 Standard Plan Designs

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WAHBE Required 2026 Standard Plan Designs

Individual Market Gold, Silver, and Bronze Plans

Benefits	2026 Standard Complete Gold	2026 Standard Vital Gold	2026 Standard Silver	2026 Standard Bronze
Deductible and Out-of-Pocket Maximum				
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$1,000	$1,900	$2,500	$6,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$7,000	$8,800	$9,750	$10,150
Office Visits				
Preventive Care/Screening/Immunization	$0	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$15	$20***	$40***
Specialist Visit	$40	$40	$65	$100
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$15	$15	$20***	$40***
Emergency/Urgent Care Services				
Emergency Care Services	$450	$800	$800	40%
Urgent Care	$35	$35	$65	$100
Ambulance	$375	$375	$375	40%
Outpatient Services				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350	$350	$600	40%
Outpatient Surgery Physician/Surgical Services	$75	$75	$200	40%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$15	$15	$30	40%
Outpatient Diagnostic Tests				
Laboratory Outpatient and Professional Services	$20	$30	$40	40%
X-rays and Diagnostic Imaging	$30	$30	$65	40%
Advanced Imaging (CT/PET Scans, MRIs)	$300	$300	30%	40%
Inpatient Services				
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$525*	$650*	$800*	40%
Skilled Nursing Facility	$350**	$350**	$800**	40%
Pharmacy				
Generics	$10	$10	$25	$32
Preferred Brand Drugs	$60	$75	$75	40%
Non-Preferred Brand Drugs	$100	$200	$250	40%
Specialty Drugs (i.e. high-cost)	$100	$200	$250	40%
All Other Benefits				
Speech Therapy	$25	$30	$40	40%
Occupational and Physical Therapy	$25	$30	$40	40%
Durable Medical Equipment (DME)	20%	20%	30%	40%
Home Health	$15**	$15**	$30**	$50**
Hospice	$15**	$15**	$30**	$50**
All Other Benefits	20%	20%	30%	40%
AV	81.81%	78.06%	71.84%	64.97%

Shaded Items are not Subject to Deductible.

* Per day copay, maximum of five copays per stay; ** Per day copay; *** Eligible for two visits at $1 copay, after which stated cost-sharing applies.

Note: For all plans except the Complete Gold and Vital Gold standard plans, 2026 AV is based on a modified version of the revised federal 2026 AV Calculator that accounts for unique plan features. Complete Gold and Vital Gold standard plan AV is provided directly by the 2026 AV Calculator.

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Individual Market Silver Plan and CSR Variations

Benefits	2026 Standard Silver 94% AV	2026 Standard Silver 87% AV	2026 Standard Silver 73% AV
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$0	$750	$2,500
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$2,400	$2,850	$7,950
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$1	$5***	$20***
Specialist Visit	$15	$30	$65
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office	$1	$5***	$20***
Emergency/Urgent Care Services			
Emergency Care Services	$150	$425	$800
Urgent Care	$15	$30	$65
Ambulance	$75	$175	$325
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$100	$325	$600
Outpatient Surgery Physician/Surgical Services	$25	$120	$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$5	$10	$30
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$5	$20	$40
X-rays and Diagnostic Imaging	$15	$40	$65
Advanced Imaging (CT/PET Scans, MRIs)	15%	20%	30%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$100*	$425*	$800*
Skilled Nursing Facility	$100**	$425**	$800**
Pharmacy			
Generics	$5	$12	$24
Preferred Brand Drugs	$12	$35	$75
Non-Preferred Brand Drugs	$35	$160	$250
Specialty Drugs (i.e. high-cost)	$35	$160	$250
All Other Benefits			
Speech Therapy	$5	$20	$40
Occupational and Physical Therapy	$5	$20	$40
Durable Medical Equipment (DME)	15%	20%	30%
Home Health	$5**	$10**	$30**
Hospice	$5**	$10**	$30**
All Other Benefits	15%	20%	30%
AV	94.86%	87.87%	73.95%

Shaded Items are not Subject to Deductible.
* Per day copay, maximum of five copays per stay
** Per day copay
*** Eligible for two visits at $1 copay, after which stated cost-sharing applies.
Note: For all plans except the Complete Gold and Vital Gold standard plans, 2026 AV is based on a modified version of the revised federal 2026 AV Calculator that accounts for unique plan features. Complete Gold and Vital Gold standard plan AV is provided directly by the 2026 AV Calculator.

2026 Standard Plans Designs Appendix A

This Appendix applies to standard plan designs at all metal levels unless otherwise designated. These requirements apply only for covered services under the plan.

1. The standard plan designs outline the cost-sharing for the consumer for a given benefit category.
2. The standard plan designs do not address cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have the in-network cost-share amount. For example, out of network emergency care services would have an in-network cost-sharing under the Balance Billing Protection Act.
3. For all services with a co-pay that are not subject to the deductible, the co-pay amount does not accumulate toward the deductible, but the full co-pay amount paid for the service will accumulate toward the maximum out-of-pocket amount.
4. For services with a co-pay that are subject to the deductible, the full amount of first-dollar out-of-pocket spending accrues toward the deductible.
5. Per the essential health benefit base-benchmark plan, the following services must be covered for, at minimum, the identified number of visits:
    a. Chiropractic: 10 visits
    b. Home health care services: 130 days
    c. Hospice respite services: 14 days per lifetime
    d. Outpatient rehabilitation, combined physical, occupational, and speech therapy, services: 25 visits
    e. Outpatient habilitation services: 25 visits
    f. Inpatient rehabilitative services: 30 days
    g. Inpatient habilitative services: 30 days
    h. Skilled nursing facility services: 60 days
6. Co-payments charged to a consumer may never exceed the actual cost for the service. For instance, if a co-pay is $45 and the service is $30, the cost-share responsibility of the consumer would be $30.
7. For prescription drugs in any tier, the cost-share defined is for a 30-day supply. Carriers may determine to allow for mail order prescriptions at a reduced per-unit cost (e.g.; a 90-day supply).
8. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the plan's in-network maximum out-of-pocket.
9. Office visits for the treatment of mental health, behavioral health, or substance use disorder conditions shall be categorized as Mental/Behavioral Health and Substance Use Disorder Outpatient - Office Visits, regardless of provider type. Other Practitioner Office Visits (Nurse, Physician Assistant) shall generally be treated as a Primary Care Visit to Treat an Injury or Illness or Preventive Care/Screening Immunization. A carrier may include in the Other Practitioner category: nurse practitioners, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, and applied behavior analysis therapists. A carrier is not precluded from using another comparable benefit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office

Visits or Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other. The copay for Mental/Behavioral Health and Substance Use Disorder Outpatient Office visits may be applied to Mental/Behavioral Health and Substance Use Disorder Outpatient services provided in an urgent care setting.

10. Services with a co-pay should be charged with the following methodology: one co-pay per benefit category per day per provider. For example, a charge for a lab draw and read at a primary care visit by the same provider would result in one lab co-pay and one primary care office visit co-pay for the individual.
11. For outpatient services where a facility fee and physician/surgical services are not billed separately, an issuer may apply the cost-sharing requirements for both the facility fee and the physician/surgical services to the total charge.
12. For outpatient encounters that include multiple services, an issuer may apply the cost-sharing requirements for each service provided. For instance, an outpatient encounter involving a surgeon, radiologist, and anesthesiologist would result in three cost-share payments for the consumer.
13. For instances where there is a co-pay for Skilled Nursing Facility and All Inpatient Hospital Services, it is a per-day co-pay (with a limit of five co-pays for an inpatient stay). For instance, a two-day stay would result in two co-pays for the consumer.
14. The co-pay for All Inpatient Hospital Services is a bundled fee that covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay the $525 co-pay for Inpatient Hospital Services and no charge for the Inpatient Physician and Surgical Services. Similarly, an individual in the Vital Gold standard plan would pay the $650 co-pay before reaching the deductible. For the Silver and Bronze standard plans, any charges would first accrue to the deductible, and after the deductible is met, the individual would pay the applicable co-pay or co-insurance.
15. The cost share amount for Emergency Care Services covers facility fee and professional services.
16. Unless otherwise noted in this appendix, carriers are permitted to assign any service to any benefit category if permissible under state and federal law.
17. 2026 WA Essential Health Benefits (EHBs) additions are as follows:
    a. Hearing Exams shall be categorized as Primary Care Visits.
    b. Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
    c. Artificial Insemination shall be categorized as All Other Benefits.
    d. Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).
18. While these 2026 standard plan designs do not specify any requirements for virtual care, HBE is exploring this option for future years and is planning to collect existing data from carriers to support this work.

2026 Standard Plans Designs Appendix B Plan and Benefit Template Standardization
These are select categories from the CMS Plan and Benefits Template that the Exchange is standardizing for 2026. Carriers shall file standard plan benefits in the (PBT) with the OIC in accordance with the below chart. The Exchange may standardize more categories in the PBT in future years. The Exchange understands different cost shares may apply depending on the specific service, but the intent is for alignment across carriers at the PBT level. Carriers may opt to file lower cost sharing on a benefit with an approved exception from the Exchange.

Benefit	Complete Gold Cost Share	Vital Gold Cost Share	Silver Cost Sharing	Bronze Cost Share
Primary Care Visit to Treat an Injury or Illness*	$15	$15	$20	$40
Specialist Visit	$40	$40	$65	$100
Other Practitioner Office Visit (Nurse, Physician Assistant)	$15	$15	$20	$40
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350 copay after deductible	$350 copay after deductible	$600 copay after deductible	40% coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	$75 copay after deductible	$75 copay after deductible	$200 copay after deductible	40% coinsurance after deductible
Hospice	$15 copay per day	$15 copay per day	$30 copay per day	$50 copay per day
Urgent Care Centers or Facilities	$35	$35	$65	$100
Home Health Care Services	$15 copay per day	$15 copay per day	$30 copay per day	$50 copay per day
Emergency Room Services	$450 copay after deductible	$800 copay after deductible	$800 copay after deductible	40% coinsurance after deductible
Emergency Transportation/Ambulance	$375 copay	$375 copay	$375 copay	40% coinsurance after deductible
Inpatient Hospital Services (e.g., Hospital Stay)**	$525 copay per day	$650 copay per day	$800 copay per day after deductible	40% coinsurance after deductible
Inpatient Physician and Surgical Services	No charge	No charge	No charge	40% coinsurance after deductible

Skilled Nursing Facility	$350 copay per day after deductible	$350 copay per day after deductible	$800 copay per day after deductible	40% coinsurance after deductible
Prenatal and Post Natal Care	No charge	No charge	No charge	No charge
Delivery and All Inpatient Services for Maternity Care**	$525 copay per day	$650 copay per day	$800 copay after deductible	40% coinsurance after deductible
Mental/Behavioral Health Office Visit*	$15 copay	$15 copay	$20 copay	$40 copay
Mental/Behavioral Health Inpatient Services**	$525 copay per day	$650 copay per day	$800 copay per day after deductible	40% coinsurance after deductible
Substance Abuse Disorder Office Visit*	$15 copay	$15 copay	$20 copay	$40 copay
Substance Abuse Disorder Inpatient Services**	$525 copay per day	$650 copay per day	$800 copay per day after deductible	40% coinsurance after deductible
Generic Drugs	$10	$10	$25	$32
Preferred Brand Drugs	$60	$75	$75	40% coinsurance after deductible
Non-Preferred Brand Drugs	$100	$200 copay after deductible	$250 copay after deductible	40% coinsurance after deductible
Specialty Drugs	$100	$200 copay after deductible	$250 copay after deductible	40% coinsurance after deductible
Outpatient Rehabilitation Services	$25	$30	$40	40% coinsurance after deductible
Habilitation Services	$25	$30	$40	40% coinsurance after deductible
Chiropractic Care*	$15	$15	$20	$40
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Hearing Aids	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance

Imaging (CT/PET Scans, MRIs)	$300 copay after deductible	$300 copay after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Preventive Care/Screening/Immunization	No charge	No charge	No charge	No charge
Acupuncture*	$15	$15	$20	$40
Routine Eye Exam for Children	No charge	No charge	No charge	No charge
Eye Glasses for Children	No charge	No charge	No charge	No charge
Rehabilitative Speech Therapy	$25	$30	$40	40% coinsurance after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$25	$30	$40	40% coinsurance after deductible
Well Baby Visits and Care	No charge	No charge	No charge	No charge
Laboratory Outpatient and Professional Services	$20	$30	$40	40% coinsurance after deductible
X-Rays and Diagnostic Imaging	$30	$30	$65	40% coinsurance after deductible
Abortion for Which Public Funding is Prohibited	No charge	No charge	No charge	No charge
Transplant**	$525 copay per day	$650 copay per day	$800 copay after deductible	40% coinsurance after deductible
Diabetes Education	No charge	No charge	No charge	No charge
Prosthetic Devices	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Nutritional Counseling	No charge	No charge	No charge	No charge
Diabetes Care Management	No charge	No charge	No charge	No charge

*Carrier shall administer benefit such that the first two Primary Care Visits and the first two Mental/Behavioral Health Visits are $1 for Silver and Bronze plans.

**Carrier shall administer copay per day up to 5 days like Inpatient Hospitals for Complete Gold, Vital Gold and Silver plans.

Appendix E – WAHBE 2026 Standard Plans AVC Screenshots (Unadjusted and Adjusted)

(Begins on next page)

Wakely
An HMA Company

Individual Market Standard Complete Gold Plan

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:	

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	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$7,000.00			
MOOP if Separate ($)						

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	☑	☐		$450.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$525.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$25.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$25.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$100.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$100.00	☑	☑			☐	☐

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):	5
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:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.81%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1094 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Vital Gold Plan

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:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,900.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$8,800.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$650.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$30.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$200.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$200.00	☑	☑			☑	☐

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):	5
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:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.06%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1523 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver Plan

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,750.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

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):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.33%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1172 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 73% Plan

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:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$7,950.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$24.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

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):	5	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):	2	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.49%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1055 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 87% Plan

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
MOOP ($)			$2,850.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
MOOP ($)			
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	☑	☐		$425.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$425.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$425.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$325.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$120.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$160.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$160.00	☑	☑			☐	☐

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):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.78%
Metal Tier: Gold
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1172 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 94% Plan

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	Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$2,400.00			
MOOP if Separate ($)						

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	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$100.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$5.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$5.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$5.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$15.00	☑	☑			☐	☐
Skilled Nursing Facility	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☐		$25.00	☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$12.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$35.00	☑	☑			☐	☐

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):	5
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:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.76%
Metal Tier:	Platinum
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1055 seconds

Revised Final 2026 AV Calculator

Individual Market Standard Expanded Bronze Plan

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

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)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
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	☐	☐		$32.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

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):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	63.64%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.1055 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver Plan (Adjusted)

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,750.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

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):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.84%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1133 seconds

WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 73% Plan (Adjusted)

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$7,950.00			
MOOP if Separate ($)						

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	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$24.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

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):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 73.95%
Metal Tier: Silver
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1055 seconds
WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 87% Plan (Adjusted)

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$2,850.00			
MOOP if Separate ($)						

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	☑	☐		$425.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$425.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$425.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$325.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$120.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$160.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$160.00	☑	☑			☐	☐

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):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.87%
Metal Tier: Gold
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1016 seconds
WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 94% Plan (Adjusted)

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	Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$2,400.00			
MOOP if Separate ($)						

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	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$100.00	☑	☑			☐	☐
Primary Care & MHSUD Office Visits	☐	☐		$1.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$5.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$5.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$5.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$15.00	☑	☑			☐	☐
Skilled Nursing Facility	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☐		$25.00	☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$12.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$35.00	☑	☑			☐	☐

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):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.86%
Metal Tier: Platinum
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1016 seconds
WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Expanded Bronze Plan (Adjusted)

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:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

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 & MHSUD Office Visits	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☑	☑			☑	☑			☐	☐
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	☐	☐		$32.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

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 & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	64.97%
Metal Tier:	Bronze
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.1055 seconds

WAHBE Revised Final 2026 AV Calculator

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	Molina Healthcare of Washington, Inc.
Address	21540 30th Drive SE, Suite 400 Bothell, WA, 98021
Carrier Identification Number	96270

Rate Renewal Period:	From	1/1/2026	To	12/31/2026
Date Submitted:		5/13/2025		

Proposed Rate Summary

Current community rate:	$599.37	per month
Proposed community rate:	$746.73	per month
Percentage change:	24.59%	%
Portion of carrier's total enrollment affected:	4.68	%
Portion of carrier's total premium revenue affected:	7.68	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims	$620.51	83.10%
b) Expenses	$103.82	13.90%
c) Contribution to surplus contingency charges, or risk charges	$22.40	3.00%
d) Investment earnings	$0.00	0.00%
e) Total (a + b + c - d)	$746.73	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	489287	486415	646581
Earned Premium	$293,930,108.29	$276,235,334.56	$329,468,564.56
Paid Claims	$286,180,690.70	$249,889,529.38	$268,337,168.00
Beginning Claim Reserve	$23,001,473.68	$19,041,149.02	$19,955,630.78
Ending Claim Reserve	$25,931,897.98	$23,001,473.68	$19,041,149.02
Incurred Claims	$289,111,115.00	$253,849,854.03	$267,422,686.25
Expenses	$38,388,623.69	$42,156,119.47	$52,071,396.00
Gain/Loss	-$33,569,630.40	-$19,770,638.94	$9,974,482.31
Loss Ratio Percentage	98.36%	91.90%	81.17%

General Information

1. Trend Factor Summary

Types of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	10.54%	43.94%
Professional	6.87%	26.08%
Prescription Drugs	9.94%	24.60%
Dental	0.00%	0.00%
Other	3.91%	5.38%

2. List the effective date and the rate increase for all rate changes in the past three periods.

	1)	2)	3)
Date	1/1/2025	1/1/2024	1/1/2023
%	5.68%	6.50%	10.02%

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)			Yes	X	No

4. Attach a table showing the base rate for each plan affected by this filing.

See Rate Schedule

5. Attach comments or additional Information

Incurred Claims and Reserve Amounts for 2024 and 2023 have been adjusted to include additional runout.

6. Preparer's Information

Name: Kathryn Hall
Title: Actuarial Manager
Telephone Number: 571.244.5809

Molina Healthcare of Washington, Inc.
Rating Example
1/1/2026-12/31/2026

Family Rating Example

Plan Design: Molina Cascade Silver
Product: 84481WA006
HIOS: 84481WA0060006

				(a)	(b)	(c)	(d)	
				Base Premium				
Member	**Age**	**Smoking Status**	**Rating Area**	**Rate[1]**	**Age Factor[2]**	**Tobacco**	**Area**	**Final Premium[2]**
Subscriber	40	Smoker	Rating Area 2	$526.98	1.2780	1.0000	1.0189	$686.20
Spouse	38	Non-Smoker	Rating Area 2	$526.98	1.2460	1.0000	1.0189	$669.02
Child 1	18	Non-Smoker	Rating Area 2	$526.98	0.9130	1.0000	1.0189	$490.22
Child 2	16	Non-Smoker	Rating Area 2	$526.98	0.8590	1.0000	1.0189	$461.23
Child 3	14	Non-Smoker	Rating Area 2	$526.98	0.7650	1.0000	1.0189	$410.76
Child 4	11	Non-Smoker	Rating Area 2	$526.98	0.0000	1.0000	1.0189	$0.00
Total								**$2,717.43**

The rate schedule includes a table outlining premiums by age, smoking status and rating area by each plan. 'Final Premium' is taken directly from the rate schedule for the appropriate plan, age, smoking status and rating area combination
(1) Corresponds to Calibrated Plan Adjusted Index Rate in URRT
(2) Rates are charged to no more than three oldest covered children under 21 for family coverage

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:	Molina Healthcare of Washington, Inc.
HIOS Issuer ID:	84481
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
84481WA0060004	Constant Care Silver 1	N/A	Terminated	7134
84481WA0060005	Molina Cascade Gold	Molina Cascade Complete Gold	Renewal	10687
84481WA0060006	Molina Cascade Silver	Molina Cascade Silver	Renewal	13965
84481WA0060007	Molina Cascade Bronze	Molina Cascade Bronze	Renewal	11560
84481WA0060008	N/A	Molina Cascade Vital Gold	New	0
Total				**43346**

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:

84481WA0060005

i. The product is issued by Molina, the same health insurance issuer.
ii. The product is offered as an HMO, the same product network type.
iii. The product continues to cover the same service area.
iv. The plan maintains the same cost-sharing structure, except for differences to adjust for changes in cost and utilization of medical and to maintain the same metal level of coverage. These changes are described in further detail in the file named “Benefit Components.pdf”

v. The product provides the same covered benefits, except for changes consistent with State law that are effective uniformly for all individuals, and in benefits that cumulatively impact the rate within an allowable variation of +/-2 percentage points. These changes are described in further detail in UPMJ Q4a and in the URRT Part III “Part III Rate Filing Documentation and Actuarial Memorandum.pdf" in the Section titled: MISCELLANEOUS INSTRUCTIONS / Effective Rate Review Information (specifically "Plan Adjusted Index Rate Factor Comparison: Tables of factors comparing the 2026 values with the 2025 values for the Plan Adjusted Index Rate are provided in tab |17. URRT| in the Actuarial Memorandum Exhibits”).

84481WA0060006

i. The product is issued by Molina, the same health insurance issuer.
ii. The product is offered as an HMO, the same product network type.
iii. The product continues to cover the same service area.
iv. The plan maintains the same cost-sharing structure, except for differences to adjust for changes in cost and utilization of medical and to maintain the same metal level of coverage. These changes are described in further detail in the file named “Benefit Components.pdf”

v. The product provides the same covered benefits, except for changes consistent with State law that are effective uniformly for all individuals, and in benefits that cumulatively impact the rate within an allowable variation of +/-2 percentage points. These changes are described in further detail in UPMJ Q4a and in the URRT Part III "Part III Rate Filing Documentation and Actuarial Memorandum.pdf" in the Section titled: MISCELLANEOUS INSTRUCTIONS / Effective Rate Review Information (specifically "Plan Adjusted Index Rate Factor Comparison: Tables of factors comparing the 2026 values with the 2025 values for the Plan Adjusted Index Rate are provided in tab |17. URRT| in the Actuarial Memorandum Exhibits").

84481WA0060007

i. The product is issued by Molina, the same health insurance issuer.
ii. The product is offered as an HMO, the same product network type.
iii. The product continues to cover the same service area.
iv. The plan maintains the same cost-sharing structure, except for differences to adjust for changes in cost and utilization of medical and to maintain the same metal level of coverage. These changes are described in further detail in the file named "Benefit Components.pdf"

v. The product provides the same covered benefits, except for changes consistent with State law that are effective uniformly for all individuals, and in benefits that cumulatively impact the rate within an allowable variation of +/-2 percentage points. These changes are described in further detail in UPMJ Q4a and in the URRT Part III "Part III Rate Filing Documentation and Actuarial Memorandum.pdf" in the Section titled: MISCELLANEOUS INSTRUCTIONS / Effective Rate Review Information (specifically "Plan Adjusted Index Rate Factor Comparison: Tables of factors comparing the 2026 values with the 2025 values for the Plan Adjusted Index Rate are provided in tab |17. URRT| in the Actuarial Memorandum Exhibits").

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)**
84481WA0060005	Molina Cascade Gold	Molina Cascade Complete Gold		None	Deductible for Medical and Drug Benefits (Total)	$600	$1,000
				Acupuncture - removed 12 visit limit per year (updated EHB for 2026)	N/A	N/A	N/A
				Donor Human Milk - new EHB for 2026 (RCW 48.43.815)	N/A	N/A	N/A
				Hearing Aids - new EHB for 2026 (RCW 48.43.135)	N/A	N/A	N/A
				Infertility Treatment - new EHB for 2026	N/A	N/A	N/A
				Routine Foot Care - new EHB for 2026	N/A	N/A	N/A
				Prescription hormone therapy - 12-month supply (ESHB 1971)	N/A	N/A	N/A
84481WA0060006	Molina Cascade Silver	N/A-Same as 2025		None	MOOP for Medical and Drug Benefits (Total)	$9,200	$9,750
				None	PCP Office Visit Copay	$30	$20
				None	MH/SUD Office Visit Copay	$30	$20
				Acupuncture - removed 12 visit limit per year (updated EHB for 2026)	N/A	N/A	N/A
				Donor Human Milk - new EHB for 2026 (RCW 48.43.815)	N/A	N/A	N/A
				Hearing Aids - new EHB for 2026 (RCW 48.43.135)	N/A	N/A	N/A
				Infertility Treatment - new EHB for 2026	N/A	N/A	N/A
				Routine Foot Care - new EHB for 2026	N/A	N/A	N/A
				Prescription hormone therapy - 12-month supply (ESHB 1971)	N/A	N/A	N/A
84481WA0060007	Molina Cascade Bronze	N/A-Same as 2025		None	MOOP for Medical and Drug Benefits (Total)	$9,200	$10,150
				None	PCP Office Visit Copay	$50	$40
				None	Specialist Office Visit Copay	$100 after deductible	$100
				None	MH/SUD Office Visit Copay	$50	$40
				Acupuncture - removed 12 visit limit per year (updated EHB for 2026)	N/A	N/A	N/A
				Donor Human Milk - new EHB for 2026 (RCW 48.43.815)	N/A	N/A	N/A
				Hearing Aids - new EHB for 2026 (RCW 48.43.135)	N/A	N/A	N/A
				Infertility Treatment - new EHB for 2026	N/A	N/A	N/A
				Routine Foot Care - new EHB for 2026	N/A	N/A	N/A
				Prescription hormone therapy - 12-month supply (ESHB 1971)	N/A	N/A	N/A

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)**
84481WA0060004	Constant Care Silver 1	84481WA0060006	Molina Cascade Silver		Moves from a separate Medical/Rx Deductible to a Combined Medical/Rx Deductible	Medical Deductible (2025) / Combined Deductible (2026)	$0	$2,500
					Moves from a separate Medical/Rx Deductible to a Combined Medical/Rx Deductible	Rx Deductible (2025) / Combined Deductible (2026)	$900	$2,500
					None	MOOP	$7,930	$9,750
					None	Emergency Room Facility	35%	$800 after deductible
					None	Urgent Care	$30	$65
					None	PCP Office Visit Copay	$30	$20 Eligible for two visits at $1 copay, after which stated cost-sharing applies.
					None	Specialist Office Visit Copay	$60	$65
					None	MH/SUD Office Visit Copay	$30	$20 Eligible for two visits at $1 copay, after which stated cost-sharing applies. This two-visit allowance is shared with Mental/Behavioral Health Outpatient Services
					None	Habilitative Services	$60	$40
					None	Rehabilitative Services	$60	$40
					None	Outpatient Facility	$1,500	$600 after deductible
					None	Outpatient Professional	$250	$200 after deductible
					None	Specialized Scanning	$950	30% after deductible
					None	Radiology Services	$95	$65
					None	Laboratory Services	$60	$40
					None	Chemotherapy	50%	$250 after deductible
					None	Inpatient Facility	35%	$800/day after deductible (max 5 copays per stay)
					None	Inpatient Professional	35%	Combined with inpatient facility fee
					None	Skilled Nursing Facility	35%	$800/day after deductible
					None	Hospice	No charge	$30/day
					None	Prefered Generic Drugs	$27	$25
					None	Prefered Brand Drugs	$75	$75
					None	Non-Preferred Drugs	50% after Rx deductible	$250 after deductible
					None	Specialty Drugs	50% after Rx deductible	$250 after deductible
					None	Durable Medical Equipment	50%	30% after deductible
					None	Home Infusion	No charge	30% after deductible
					None	Home Healthcare	No charge	$30/day
					None	Emergency Medical Transportation	50%	$375
					None	Dialysis	$60	30% after deductible

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):	43,346
Overall Average Rate Change (weighted by 03/31/2025 enrollment) 5(l):	24.59%

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
84481WA0060004	Constant Care Silver 1	Terminated	7,134	84481WA0060006	Molina Cascade Silver	36.93%	0.00%	0.04%	36.98%
84481WA0060005	Molina Cascade Gold	Renewal	10,687	N/A	N/A	10.25%	0.00%	-0.87%	9.30%
84481WA0060006	Molina Cascade Silver	Renewal	13,965	N/A	N/A	36.93%	0.00%	0.04%	36.98%
84481WA0060007	Molina Cascade Bronze	Renewal	11,560	N/A	N/A	13.52%	0.00%	2.28%	16.10%

MOLINA HEALTHCARE OF WASHINGTON, INC.
2026 Commission Payment Schedules

Marketplace Line of Business	**Commissions**: Paid on a Per Member Per Month (PMPM) Basis
New and Renewing Benefit Contracts or Policies that take effect from January 1, 2026, thru December 31st, 2026 (OEP and SEP)	Agency override tiered by total book of business: 250-499 members =$2 PMPM 500-999 members = $3 PMPM 1000-4999 members = $4 PMPM 5,000+members = $5 PMPM Agent level commissions: $20 PMPM

Broker bonus program details are provided in the following table:

2026 Agent Bonus	**New Members**	25-49 New members, One-time Bonus Amount of $25 per member 50-99 New members, One-time Bonus Amount of $50 per member 100+ New members, One-time Bonus Amount of $75 per member
	Renewing Members	50+ Renewed members, one-time bonus amount of $50 per member

***The PMPM and Agent Bonus amounts above are based on our initial rating and will be finalized prior to final rate approval**

The individual signing below on behalf of Molina Healthcare of Washington, Inc, certifies that to the best of his or her knowledge, the information provided includes all proposed commission schedules for the Molina Healthcare of Washington Inc. Marketplace Line of Business.

Signature: Signed by: Mark Margiotta BD20E901B9CF465... **Date**: 5/5/2025

Name: Mark Margiotta

Title: Senior Vice President, Molina Healthcare Inc.

Unified Rate Review v6.1

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Company Legal Name:	Molina Healthcare of Washington, Inc.		
HIOS Issuer ID:	84481	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	$334,541,734.48	$683.73
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$289,111,115.00	$590.88
Risk Adjustment	$39,265,304.12	$80.25
Experience Period Premium	$293,930,108.29	$600.73
Experience Period Member Months	489,287	

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	$96.49	1.088	1.055	1.066	1.025	$121.11
Outpatient Hospital	$204.16	1.023	1.095	1.059	1.025	$248.17
Professional	$178.55	1.016	1.055	1.044	1.025	$204.77
Other Medical	$13.92	1.016	1.055	1.044	1.025	$15.96
Capitation	$26.97	1.025	1.000	1.025	1.000	$28.34
Prescription Drug	$163.64	1.025	1.108	1.031	1.029	$197.39
Total	$683.73					**$815.75**

Morbidity Adjustment	0.967
Demographic Shift	1.009
Plan Design Changes	1.121
Other	1.000
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$892.52**

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.00%

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$892.52**	$258,620,165.28
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	$105.13	$30,461,851.98
Exchange User Fees	0.82%	$1,881,076.49
Market Adjusted Index Rate	**$793.89**	**$230,039,389.79**

Projected Member Months	**289,764**

Product-Plan Data Collection

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.
To remove a product, navigate to the corresponding Product Name/Product ID field and select the Remove Product button or Ctrl + Shift + Q.
To remove a plan, navigate to the corresponding Plan Name/Plan ID field and select the Remove Plan button or Ctrl + Shift + A.

Company Legal Name: **Molina Healthcare of Washington, Inc.**
HIOS Issuer ID: **84481** 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		Molina Healthcare				
1.2	Product ID		84481WA006				
1.3	Plan Name		Complete Gold	Silver	Bronze	Vital Gold	Silver 1
1.4	Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
1.5	Metal		Gold	Silver	Bronze	Gold	Silver
1.6	AV Metal Value		0.817	0.718	0.650	0.780	0.718
1.7	Plan Category		Renewing	Renewing	Renewing	New	Terminated
1.8	Plan Type		HMO	HMO	HMO	HMO	HMO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes	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)		9.30%	36.98%	16.10%	0.00%	0.00%
1.12	Product Rate Increase %		22.36%				
1.13	Submission Level Rate Increase %		22.36%				

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information						
	2.1	Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
$334,541,734	2.2	Allowed Claims	$334,541,734	$124,966,258	$93,809,113	$48,346,479	$0	$67,419,884
$0	2.3	Reinsurance	$0	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$45,430,619	$12,367,072	$10,653,230	$14,646,891	$0	$7,763,426
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$289,111,115	2.6	Incurred Claims	$289,111,115	$112,599,186	$83,155,883	$33,699,588	$0	$59,656,459
$39,265,304	2.7	Risk Adjustment Transfer Amount	$39,265,304	$34,124,368	$15,564,739	-$13,851,047	$0	$3,427,244
$293,930,108	2.8	Premium	$293,930,108	$80,139,504	$84,613,801	$63,913,855	$0	$65,262,949
489,287	2.9	Experience Period Member Months	489,287	125,397	137,373	124,626	0	101,891
	2.10	Current Enrollment	43,346	10,687	13,965	11,560	0	7,134
	2.11	Current Premium PMPM	$640.20	$684.82	$662.33	$547.01	$0.00	$681.02
	2.12	Loss Ratio	86.77%	98.54%	83.01%	67.31%	#DIV/0!	86.85%
		Per Member Per Month						
	2.13	Allowed Claims	$683.73	$996.56	$682.88	$387.93	#DIV/0!	$661.69
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
	2.15	Member Cost Sharing	$92.85	$98.62	$77.55	$117.53	#DIV/0!	$76.19
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
	2.17	Incurred Claims	$590.88	$897.94	$605.33	$270.41	#DIV/0!	$585.49
	2.18	Risk Adjustment Transfer Amount	$80.25	$272.13	$113.30	-$111.14	#DIV/0!	$33.64
	2.19	Premium	$600.73	$639.09	$615.94	$512.85	#DIV/0!	$640.52

	Section III: Plan Adjustment Factors						
3.1	Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
3.2	Market Adjusted Index Rate		$793.89				
3.3	AV and Cost Sharing Design of Plan		0.8377	1.0059	0.6184	0.7835	0.0000
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.5	Benefits in Addition to EHB		1.0013	1.0011	1.0017	1.0013	0.0000
	Administrative Costs						
3.6	Administrative Expense		9.68%	8.21%	12.65%	10.28%	0.00%
3.7	Taxes and Fees		2.98%	2.96%	3.02%	2.99%	0.00%
3.8	Profit & Risk Load		3.00%	3.00%	3.00%	3.00%	0.00%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.10	**Plan Adjusted Index Rate**		$789.59	$931.46	$604.64	$743.86	$0.00
3.11	Age Calibration Factor	0.580082251	0.5801				
3.12	Geographic Calibration Factor	0.975310488	0.9753				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$446.72	$526.98	$342.08	$420.85	$0.00

	Section IV: Projected Plan Level Information						
4.1	Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
4.2	Allowed Claims	$258,620,163	$65,342,439	$19,473,252	$40,450,770	$133,353,702	$0
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$54,840,920	$11,952,655	-$601,840	$14,160,216	$29,329,889	$0
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$203,779,242	$53,389,784	$20,075,092	$26,290,554	$104,023,813	$0
4.7	Risk Adjustment Transfer Amount	$23,978,123	$5,901,519	$1,848,316	$3,935,036	$12,293,252	$0
4.8	Premium	$216,375,294	$56,311,427	$20,805,088	$28,752,256	$110,506,523	$0
4.9	Projected Member Months	289,764	71,317	22,336	47,553	148,558	0
4.10	Loss Ratio	84.78%	85.82%	88.62%	80.43%	84.71%	#DIV/0!
	Per Member Per Month						
4.11	Allowed Claims	$892.52	$916.23	$871.83	$850.65	$897.65	#DIV/0!
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.13	Member Cost Sharing	$189.26	$167.60	-$26.94	$297.78	$197.43	#DIV/0!
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.15	Incurred Claims	$703.26	$748.63	$898.78	$552.87	$700.22	#DIV/0!
4.16	Risk Adjustment Transfer Amount	$82.75	$82.75	$82.75	$82.75	$82.75	#DIV/0!
4.17	Premium	$746.73	$789.59	$931.46	$604.64	$743.86	#DIV/0!

Rating Area Data Collection

Specify the total number of Rating Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.
Select only the Rating Areas you are offering plans within and add a factor for each area.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.0189
Rating Area 3	1.1498
Rating Area 4	1.0003
Rating Area 5	1.0003
Rating Area 6	1.0340
Rating Area 8	1.0138

Molina Healthcare of Washington, Inc.

Part II: Explanation of the Rate Increase
Effective January 1, 2026

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services for over 1 million individuals eligible for Medicaid, Medicare, and Marketplace throughout the state of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

1. Scope and range of the rate increase: Molina is requesting on average a 24.6% premium increase for its individual policies sold in the Washington Marketplace effective January 1, 2026. 43,346 Molina Marketplace members would receive changes to their premiums ranging from an 8.6 percent increase to a 39.4 percent increase depending on their geographic location and metal tier. Molina will renew the Molina Cascade Complete Gold, Molina Cascade Silver, and Molina Cascade Bronze plans, terminate the Constant Care Silver 1 plan, and add Molina Cascade Vital Gold as a new plan for 2026. Finally, please note these are averages, by plan and due to members aging, premium changes could be larger or smaller than anticipated.

The key drivers of the rate change are an increase in projected claims costs mentioned in "Section 3. Changes in Medical Service Costs" and a decrease as a result of projected Risk Adjustment contributing toward a 1.9% decrease in rates.

2. Financial experience of the product: Premium of $293,930,108 was received for 2024 compared to incurred claims of $289,111,115, risk transfer receivable of $41,355,022 and federal reimbursement recoveries from the High-Risk Enrollee Reimbursement Pool of $0. The High-Risk Enrollee Reimbursement Pool Charge was -$1,179,182. The HHS-RADV Adjustment was -$910,537. Taxes and fees were $7,579,925. Admin expenses were $30,808,699. Molina's financial experience in 2024 resulted in a gain of 2.2 percent or pretax net income of $6,606,210.

The proposed premium rates yield a medical loss ratio of 87.1 percent. The medical loss ratio represents the percentage of every premium dollar that Molina expects to spend on medical expenses and improving health care quality for our members. The projected medical loss ratio exceeds the Affordable Care Act minimum required loss ratio of 80 percent.

3. Changes in Medical Service Costs: Medical and pharmacy combined trend of 9.2 percent was applied in the development of the rates for expected increases in the utilization and cost of covered services. 5.1 percent of the total trend is due to utilization, driven by a 6.8 percent trend in pharmacy drug utilization and a 5.9% trend in outpatient utilization. 3.9 percent of the total trend is due to unit cost.

4. Changes in benefits:

The Molina Cascade Gold plan is being renewed with changes such as deductible from $600 to $1,000.

The Molina Cascade Silver plan is being renewed with changes to the out-of-pocket maximum on Silver 100, from $1,900 to $2,400, Silver 150, from $2,500 to $2,850, Silver 200, from $7,250 to $7,950, Silver 250 from $9,200 to $9,750.

The Molina Cascade Bronze plan is being renewed with changes to the out-of-pocket maximum from $9,200 to $10,150

The Constant Care Silver 1 plan is terminating in 2026 and the Molina Cascade Vital Gold plan is new in 2026.

The collective plan design changes result in a small decrease to the aggregate rate change.

Additional changes beyond what has been described have also occurred. Please consult our public rate filing for further detail.

5. Administrative costs and anticipated profits: Administrative expenses are expected to contribute toward a 0.3% increase in rates. Taxes and fees are expected to contribute toward a 0.5% increase in rates. The Exchange Fee did not change from prior year. The targeted profit margin is 3.0% after tax and remains unchanged and does not contribute toward a change in rates.

Summary of Pooled Experience with Adjustments:

Summary of Pooled Experience with Adjustments			
	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	489,287	486,415	646581
Earned Premium	$293,930,108	$276,235,335	$329,468,565
Paid Claims	$286,180,691	$249,889,529	$268,337,168
Beginning Claim Reserve	$23,001,474	$19,041,149	$19,955,631
Ending Claim Reserve	$25,931,898	$23,001,474	$19,041,149
Incurred Claims	$289,111,115	$253,849,854	$267,422,686
Expenses	$38,388,624	$42,156,119	$52,071,396
Gain/Loss	-$33,569,630	-$19,770,639	$9,974,482
Loss Ratio Percentage	98.36%	91.90%	81.17%
Risk Adjustment	$41,355,022	$39,648,209	$1,693,969
High Risk Enrollee Reimbursement Pool Recoveries	$0	$1,249,071	$956,859
High Risk Enrollee Reimbursement Pool Charge	-$1,179,182	-$990,369	-$1,193,688
HHS-RADV adjustments	-$910,537	$0	$0
Total Commercial Reimbursements	$0	$0	$1,000
Adjusted Gain Loss with Adjustments	$6,606,210	$20,136,272	$11,432,622
MLR Rebates	$0	$0	$0

Actuarial Memorandum and Certification

Effective January 1, 2026

The purpose of this actuarial memorandum and certification is to provide information related to Molina Healthcare of Washington, Inc.'s (Molina) Part I Unified Rate Review Template submission to the Washington Individual Marketplace (Washington Marketplace).

The actuarial memorandum and certification describe Molina's rating methodology used to develop rates for Individual products offered on the Washington Marketplace effective January 1, 2026. Molina will not market Individual products outside of the Washington Marketplace.

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services individuals eligible for Medicaid, Medicare, and Marketplace throughout the State of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 20 states across the nation, Molina serves more than 5 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern Washington. Today, we continue his mission of providing high quality and cost-effective health care to those who need it most.

200 Oceangate ▪ Suite 100 ▪ Long Beach, CA ▪ 800.526.8196

MolinaHealthcare.com

Contents

GENERAL INFORMATION

The information below documents the company identifying and contact information entered into the general information section of Worksheet 1 of the Unified Rate Review Template (URRT).

The rate methodology and resulting premiums outlined in this Actuarial Memorandum assume current law, which includes the following:

- The expiration of the American Rescue Plan (ARP) enhanced premium tax credit subsidies at the end of 2025.
- Cost-Sharing Reduction (CSR) subsidies remain unfunded.
- The parameters of the HHS Notice of Benefit and Payment Parameters for 2026 (Final 2026 Payment Notice), which became effective on January 15th, 2025.

Notably, the Marketplace Integrity and Affordability Proposed Rule (Program Integrity Rule) was published by CMS in the Federal Register on March 19th, 2025, followed by a comment period that could substantially alter the proposed rule. The rate methodology and resulting premiums outlined in this Actuarial Memorandum were prepared prior to the finalization of the Program Integrity Rule and therefore do not reflect the changes proposed in the Program Integrity Rule.

Molina will seek regulatory approval to file revised rates if material changes to the regulatory environment occur, including, but not limited to, changes to the above mentioned items.

Company Identifying Information

Company Identifying Information	
Legal Name:	Molina Healthcare of Washington, Inc.
State:	Washington
HIOS Issuer ID:	84481
Market:	Washington Individual Marketplace
Effective Date:	January 1, 2026

Company Contact Information

Company Contact Information	
Contact Name	Kathryn Hall
E-mail	Kathryn.Hall@molinahealthcare.com

PROPOSED RATE INCREASE(S)

Molina's rate filing reflects a rate change of 24.59% as calculated by section Q5 of the Uniform Product Modification Justification (UPMJ) template for Molina's 43,346 members enrolled effective March 2025, reported as of April 2025. The UPMJ Q5 rate change is calculated using the average rate change of each plan weighted by membership in each plan.

Molina's rate filing reflects the following rate changes as calculated by Part I of the Unified Rate Review Template in Section 1 of Worksheet 2 for Molina's 36,212 members enrolled in plans that are renewing for 2026. Enrollment data is as of March 2025, reported as of April 2025. The URRT rate change is calculated using the rate change of each renewing plan weighted by the membership and premium in each renewing plan.

The rate changes vary by plan due to changes in the Actuarial Value (AV) Pricing Values assigned to each metal plan that are applied to the Plan Adjusted Index Rate.

14-Digit Plan ID	Plan Name	Metal	202503 Mbrs	2025 PMPM	2026 PMPM	Avg	Min	Max
84481WA0060005	Molina Cascade Complete Gold	Gold	10,687	$685	$748	9.3%	8.6%	11.4%
84481WA0060006	Molina Cascade Silver	Silver	13,965	$662	$907	37.0%	36.0%	39.4%
84481WA0060007	Molina Cascade Bronze	Bronze	11,560	$547	$635	16.1%	15.4%	18.3%
84481WA0060008	Molina Cascade Vital Gold	Gold	0	$0	$0	-	-	-
Total			**36,212**	**$632**	**$773**	**22.4%**	**8.6%**	**39.4%**

Reason for Rate Change(s): The following factors contribute toward the overall change in the proposed rates.

- **Claims:** Projected claims for 2026 are expected to contribute toward a 17.3% increase in rates due to updated base period experience claims, trend, changes in product, acuity, and demographic mix.
- **Taxes and Fees:** Taxes, fees, and retention are expected to contribute toward a 0.5% increase in rates.
- **Margin:** Margins are expected to contribute toward a 0.5% increase in rates at our company standard 3.0% after-tax profit margin.
- **Risk Transfer:** Risk transfer is expected to contribute toward a 1.9% decrease in rates.
- **Administrative Expenses:** Administrative expenses are expected to contribute toward a 0.3% increase in rates.
- **Membership Mix:** The membership mix from the base period to the projection period compared to the membership mix for comparable time periods from the prior year rate filing is expected to contribute toward a 5.7% increase in rates.

Rate changes vary by plan due to changes in Actuarial Value, Cost Share Design (CSD), and Geographic factors.

MARKET EXPERIENCE

The single risk pool was established according to the requirements in 45 CFR 156.80. No transitional products/plans or grandfathered products are included in the development of the single risk pool.

Molina's 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months or 40,774 average members in the period of January 1, 2024 to December 31, 2024.

Experience Period Premium and Claims

Paid Through Date: The market experience reported in Worksheet 1, Section I of the URRT represents 2024 incurred claims paid through March 2025. The completion factors applied to the 2024 claims experience were updated with data through March 2025.

Current Date: The current enrollment and premium are reported as of April 2025.

Premiums (Net of MLR Rebate) in Experience Period: The premiums reported in Worksheet 1, Section I of the URRT represent the earned premium from 2024, excluding risk adjustment transfer payments for the 2024 benefit year. Earned premium does not reflect any MLR rebates. No amounts were subtracted from the earned premium for any reductions prescribed by the federal MLR formula, such as taxes and assessments.

Allowed and Incurred Claims in Experience Period: The following table reports the allowed and incurred claims during the experience period of January 1, 2024 to December 31, 2024.

Description	Medical	Pharmacy	Capitation	Total
Allowed	$237,949,720	$80,067,777	$13,196,321	$331,213,818
IBNR Factor	1.014	1.000	1.000	1.010
Allowed w/ IBNR	**$241,277,636**	**$80,067,777**	**$13,196,321**	**$334,541,734**
Paid	$204,905,854	$71,110,323	$10,164,514	$286,180,691
IBNR Factor	1.014	1.000	1.000	1.010
Paid w/ IBNR	**$207,836,278**	**$71,110,323**	**$10,164,514**	**$289,111,115**

The experience is for all 2024 individual non-grandfathered plans including subsidized populations defined under the Cost Sharing Reduction (CSR) programs. The experience does include data for the American Indian/Alaska Native (AIAN) population which is funded by the federal government and is not tied to any metal level in the Marketplace.

Allowed claims for the experience period were obtained from the claims records by adding the plan incurred paid claims and the member cost-sharing for medical and pharmacy claims net of rebates received from drug manufacturers. The allowed claims calculation applies to both fee-for-service claims and capitation costs.

Completion factors were applied to both the allowed and incurred medical claim amounts. The completion factors were developed separately for inpatient and non-inpatient medical claims based on Molina's Washington Marketplace data. The IBNR factor for medical allowed claims is 1.014. The IBNR factor for medical incurred and paid claims is 1.014. IBNR factors were not applied to capitation and pharmacy claims.

The IBNR reserves were determined based on best estimates. Explicit margin for loss adjustment expenses and provision for adverse deviation are accounted for in the financial system in separate accounts that do not impact the completion factors used for IBNR reserves.

All medical claims are paid through Molina's claims system. Pharmacy claims are processed through Molina's pharmacy benefit manager.

In the experience period 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 not counted toward the annual limitation on cost sharing.

There were no federal or state reinsurance amounts to report in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Experience Period Premium and Experience Period Member Months in 2024 were reported in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Inclusion of Capitation Payments: All capitated payments are included in the experience data and rate development. For pediatric vision coverage Molina has a vision care agreement with Vision Service Plan (VSP), a California not-for-profit corporation, with its principal place of business located in Rancho Cordova, CA and Molina Healthcare of Washington, Inc. which is in Bothell, WA. No changes have occurred to the 2026 agreement terms compared with 2024 and 2025.

Actual to Projected Analysis: Molina tracks Marketplace experience on an ongoing monthly basis through IBNR reserving, claims forecasting based on current and prior year results, and Risk Adjustment estimation. The experience is tracked at the single risk pool level. 2024 experience was used as the baseline experience period for the 2026 rate filing, so the extent that 2024 experience deviated from projected 2024 results is captured in 2026 rates. No extra adjustments were made in 2026 pricing to account for 2024 deviations in claims.

Benefit Categories

Molina assigned all experience claims to benefit categories utilizing Milliman's MedInsight Health Cost Guidelines (HCG) grouper. The following table displays the measurement units related to each benefit category.

Benefit Category	Util Type
Inpatient Hospital	Days
Outpatient Hospital	Visits
Professional	Services
Other Medical	Services
Capitation	Benefit Period
Prescription Drug	Prescriptions

Projection Factors

Trend Factors

Trend Factors: Trend factors were applied separately for unit cost and utilization and by each major benefit category shown in Worksheet 1, Section II of the URRT. The Year 1 and Year 2 trend factors represent the annual trend numbers that were used to trend the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026.

Unit cost trends were measured by calculating average reimbursement rates in the base period and projection period, which consider reimbursement changes and provider mix changes. The unit cost trends include the expected impact of Medicare reimbursement changes from 2024 to 2026 for provider reimbursement contracts that are based on a percentage of the Medicare fee schedule. Pharmacy unit cost trends are based on an analysis of AWP changes over time for a fixed basket of drugs.

The unit cost projections reflect input on likely network and provider contract term changes for the projection year. Provider contracting is already complete for plan year 2026 for counties within Molina's existing footprint. The status of projected reimbursement trend is mostly locked in for plan year 2026.

Utilization trends were developed through a review of trends from the 2025 URRT public use files in Worksheet 1, Section II, with a focus on Individual Market plans with non-zero credibility and nonzero trend factors in states where Molina offers coverage. Year 1 utilization trends include the impact of emerging experience in 2025. Changes in average health status and mix of services are considered in the Acuity and Plan Mix adjustments included in the rate filing and are not considered in utilization trends.

Cost-sharing benefit features such as deductible, copay, out-of-pocket maximum would impact utilization leveraging of trend. However, for pricing purposes allowed trends (utilization before leveraging) were used according to the URR instructions for developing the single risk pool.

Trends were selected based on expectations for a more stable On-Exchange population and were compared to historical and prospective trends for our On-Exchange experience in other states. In general, prospective utilization trends were selected in a way that does not expect abnormally high and abnormally low historical experience to continue.

Please see WA Exhibit 3 for support of the selected trends applied in pricing and WA Exhibits 4 and 5 as support for the historical and adjusted trends described above.

Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment: The morbidity adjustment is comprised of an acuity factor that represents anticipated changes in Molina's single risk pool.

Changes in acuity: The morbidity of Molina's covered population is expected to decrease between the experience period and the projection period.

An acuity adjustment of 1.039 was made to the 2024 experience period data to reflect changes in the population acuity from the experience period to the 2025 current period. The acuity changes from the 2024 experience period to the 2025 current period are measured by calculating the difference in the 2024 risk scores and 2025 risk scores, both weighted by 2026 projected metal mix to avoid double counting with the plan mix adjustment.

The acuity change from the 2025 current period to the 2026 projection period is calculated in the same way, weighting 2025 and 2026 risk scores with 2026 projected metal mix. With the implementation of uniform silver-loading, the majority of Molina's Silver members are expected to move to Gold plans decreasing the projected average risk score for Gold members.

Under current law, Enhanced Premium Tax Credits (ePTCs) are scheduled to expire at the end of 2025. Molina retained Milliman to analyze the impact of expiring premium subsidies on statewide morbidity. We reviewed the study and determined that the best estimate for an acuity adjustment is 1.023. The total acuity adjustment factor for the 2025 current period to the 2026 projection period is 0.930.

The final acuity adjustment factor is 0.967. Please refer to Appendix Exhibit 4.1.

Demographic Shift: A demographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the demographic mix from the 2024 experience data to the 2026 projection period.

The anticipated demographic mix is based on a review of enrollment through March 2025 and projected 2026 enrollment compared to the experience period. Molina anticipates that its 2026 demographics will be consistent with its 2025 demographics for existing membership. The demographic adjustments were developed using allowed claims by age cohort normalized for differences in metal and acuity. The total demographic adjustment made to the 2024 experience period data is 1.007. Please refer to Appendix Exhibit 4.2a.

Geographic Adjustment: A geographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the area membership mix from the 2024 experience data to the 2026 projection period. A geographic adjustment of 1.002 was made to the 2024 experience period data. Please refer to Appendix Exhibit 4.2c.

Plan Mix Adjustment: The plan mix adjustment reflects anticipated changes in the average utilization of services due to differences in average cost-sharing requirements during the experience period and

average cost-sharing requirements in the projection period. This includes changes in induced demand and the effects of selection for the single risk pool.

The 2024 claims experience by Metal and CSR variant was used to weight the 2024 membership mix against the projected membership mix expected in the 2026 projection period to develop a plan mix adjustment factor between the 2024 experience period and 2026 projection period. The Gold allowed claims amount was adjusted to reflect the membership migration to Gold as a result of uniform silver-loading. The adjusted allowed claims are a weighted average calculated using the membership moving from Silver and Bronze to Gold.

The plan mix adjustment made to the 2024 experience period data is 1.121. Please refer to Appendix Exhibit 4.3.

Manual Rate Adjustments

Not Applicable.

Credibility of Experience

A Monte Carlo simulation was used to determine the credibility level to assign to the base period experience. The simulation used a claims probability distribution (CPD) from the Final 2026 Actuarial Value calculator to generate random samples of members and calculated the average annual cost for each sample.

The results showed that 60,000 member months are needed so that the average annual cost is within 10% of the mean (expected claims amount) 95% of the time.

The credibility percentage to apply to the experience data is based on experience period member months and the credibility formula below:

- 0 - 59,999 member months: 100% manual
- 60,000+ member months: 100% experience

The 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months resulting in a credibility percentage that is 100% experience rated. This method is consistent with the applicable American Academy of Actuaries' Actuarial Standards of Practice (ASOP) No. 25 Credibility Procedures.

Establishing the Index Rate

Index Rate: The index rate is developed following the specifications of 45 CFR part 156.80(d)(1). The index rate for the projection period is estimated to be $892.52. The index rate represents the estimated total allowed claims experience for the essential health benefits within the Washington Marketplace. The index rate does not include adjustments for the risk adjustment and reinsurance programs or an adjustment for the Washington Marketplace user fee. Please refer to Appendix Exhibit 5.1a.

Development of the Market-wide Adjusted Index Rate

Reinsurance

Not Applicable.

Risk Adjustment and Payment Change

Experience Period Risk Adjustment PMPM:
Molina used results from the Wakely National Risk Adjustment Reporting (WNRAR) Project to supplement internal estimates of risk scores, statewide premiums, and related risk adjustment transfer amounts. For the 2024 experience period, the risk transfer receivable is $80.25 per member per month (PMPM) or $39,265,304.

Projected Risk Adjustments PMPM: Molina estimated the risk transfer amount for 2026 using the 2024 experience period risk transfer amounts. The 2026 risk transfer estimates were developed by projecting 2025 relative risk scores and transfer payments, then projecting 2026 relative risk scores and transfer payments. The risk transfer payment amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium. The projection is based on the 2026 calibrated model. The population was grouped into the following cohorts:

- *2025 Renewal Members* – Some of Molina's current members previously had coverage in 2024 and renewed in 2025 with Molina. Molina relied on the renewal member's 2024 experience and risk scores to project their 2025 relative risk scores, taking into consideration any applicable changes in enrollment across metal tiers.
- *2025 New Members* – To estimate the relative risk of the 2025 new members, Molina referred to the estimated risk scores and transfer amounts from the 2024 experience period. Estimated risk scores were adjusted in consideration of the metal tier mix between the 2024 members and the 2025 new members.

- *2026 Members* – Molina assumed the 2026 members would have the higher relative risk scores as the 2025 members, with consideration for the metal tier mix between the two years.

The impact of the national high-risk pool fund was incorporated using 2024 claims experience and a white paper report from Wakely on the estimated high-cost risk pooling charges based on information voluntarily provided by issuers. The net impact of estimated charges and recoveries was calculated as $1.45 PMPM payable.

The impact of the risk adjustment data validation program was incorporated using historical error rates from the final CMS RADV results and the RADV error rate report from Wakely based on information voluntarily provided by issuers. The net impact of estimated payment was calculated as $1.97 PMPM receivable.

The resulting 2026 risk transfer receivable estimate is $82.23 PMPM. Molina included $1.45 PMPM payable for projected national high-risk pooling funding and $1.97 PMPM receivable for projected risk adjustment data validation to get a net risk transfer receivable estimate of $82.75 PMPM. This amount was converted from a paid to allowed basis and entered in the URRT Worksheet I, Section II.

The risk transfer receivable amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium.

The 2026 statewide average premium was projected using historical experience and information from Wakely, including the estimated 2025 statewide average premium. An adjustment of was made to the statewide average premium to account for changes due to uniform silver-loading. Using historical experience and the adjustment for silver-loading, the 2026 statewide average premium increase is estimated to be 8.2%.

Please refer to WA Exhibit 10 for further information on projected risk adjustment.

Washington Marketplace Exchange Fee:
Washington Marketplace will charge a fee of $5.11 PMPM which was divided by the total paid to allowed factor of 0.787 to convert to an allowed basis of $6.49 PMPM for the Market Adjusted Index Rate. Please refer to Appendix Exhibit 5.1a to locate the same percentage for the Exchange User Fee entered in Worksheet 1, Section II.

Market Adjusted Index Rate: The market adjusted index rate is developed following the specifications of 45 CFR part 156.80(d)(1). Molina modified the index rate provided in URRT Worksheet I to a market adjusted index rate. Please refer to Appendix Exhibit 5.1a

Plan Adjusted Index Rates

The plan adjusted index rates are developed following the specifications of 45 CFR part 156.80(d)(2). The plan adjusted index rates are entered in Worksheet 2, Section IV, of the URRT. Molina calculated the plan adjusted index rates by applying plan specific level adjustments for actuarial value, cost

sharing utilization, additional benefits, and administrative costs, excluding exchange user fees, to the market adjusted index rate. Please refer to Appendix Exhibit 10.2.

Paid to Allowed Ratio: The Paid to Allowed ratio reflects the estimated cost-sharing in the projected period. The Final 2026 AV Calculator was used to determine metal AVs, but for pricing a different calculator was used. This is detailed in the Pricing AVs section. The Paid to Allowed ratio is the member-weighted average of the Actuarial Values. Please refer to Appendix Exhibit 5.1b.

Benefits in Addition to EHBs:
There are no benefits in addition to EHBs. However, Molina covers the elective termination of pregnancy benefit. Per Checklist Item #10d, abortion services must be treated as non-EHBs in the URRT. Therefore, elective termination of pregnancy costs are included in the Index Rate and field 3.5 in the URRT has been adjusted to account for these costs. An estimated $1.00 PMPM is used to account for abortion services. The percentage of premium by plan is used to calculate the Benefits in Addition to EHB, field 3.5 of Worksheet 2. Please refer to Appendix Exhibit 5.1b.

Retention Loads, excluding Exchange User Fees: All costs related to admin, profit & risk and taxes & fees, excluding the Washington Marketplace Fee, are calculated for each expected plan offering. Please refer to WA Exhibit 11.

Provider Network, Delivery System Characteristics, and Utilization Management Practices: Plan rates do not vary for variation in provider network, delivery system characteristics, or utilization management.

Provider Compensation Statement: Provider compensation does not include bonuses in addition to other payments.

Catastrophic plans: Not applicable.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Administrative expenses for the Marketplace product from 2024 and 2025 were reviewed and projected forward to 2026 to develop the administrative costs required to manage the Washington Marketplace population. An internal administrative cost budget was developed on a PMPM basis and applied to the Washington Marketplace rates. Part of the total administrative expense load is a subcomponent for Quality Expenses which are administrative costs dedicated to improving health care quality for Molina Marketplace members. The Quality Expense load is $10.48 PMPM. Amounts for broker commissions were added to the administrative costs. The expected administrative expense load is 10.3%. Please refer to WA Exhibit 11.

Broker Commissions: Broker commissions of $11.83 PMPM are expected based on historical broker-sold business and a projection of new and renewing members sold through the broker channel.

Profit Margin: The target after-tax margin is 3.0%, which aligns with Molina's company standard target. Molina's current capital and surplus did not impact the filing. The profit and risk load of 3.0% of premium is consistent with the target margin filed and approved for each rating period from 2015 through 2026.

Taxes and Fees: Molina's estimated taxes and fees (excluding Exchange Fee) are 3.0%. The taxes and fees estimates are comprised of the following:

- **Income Tax:** An estimated 0.8% of premiums will be paid in Federal income taxes.
- **WSHIP:** The WSHIP assessment is projected at $0.13 PMPM. Per the most recent information available in the 2023 Annual Report, WSHIP assessments were $12 million in 2023 (an estimated $0.25 PMPM). WSHIP assessments for 2024 were projected to be $6 million. Therefore, Molina has estimated the WSHIP assessment to be $0.13 PMPM for 2026.
- **Regulatory Surcharge:** The regulatory surcharge is an annual cost of operating the Office of the Insurance Commissioner which is charged to insurers like Molina. The 0.08% of premium is based on internal budgetary forecasts. The 2026 regulatory surcharge was assumed to be 0.08% of premium.
- **Risk Adjustment User Fee:** $0.20 PMPM will be paid toward the risk adjustment user fee.
- **Insurance Fraud Surcharge:** The 2026 insurance fraud surcharge is estimated to be .004% of premium.
- **Premium Tax:** Molina has assumed 2.0% for the state premium tax.
- **PCORI:** An estimated $0.33 PMPM ($4.01 PMPY) will be paid toward the PCORI fee. This was estimated by projecting forward the $3.47 PMPY value for members whose plan year ends September 2024 through October 2025 forward two years at a rate of 7.5% per year, the 3-year average annual increase.
- **WAPAL:** An estimated $0.06 PMPM will be paid toward the WAPAL fund. The 2026 estimate is based on the most recent information available from the FY2025 Assessment Rate Notification to Payers.

Calibration

Age Curve Calibration: Molina calibrated the Plan Adjusted Index Rates to an age 21 rate. The average composite age factor was estimated by multiplying the population distribution by the age factors. The calibration factor is 0.580.

Molina estimated the average age of the single risk pool to be 43 years of age by multiplying the expected age distribution percentages by the age. Molina assumed an average age of 7 for the Age 0-14 cohort in the average age estimate and an average age of 71 for the Age 65+ cohort. Premium rates are based on the attained age as of the coverage effective date and will not be re-rated/adjusted when a birthdate occurs during the year after the coverage starts.

Please refer to Appendix Exhibit 4.2b.

Geographic Factor Calibration: Molina applied geographic factors to the index rate in the calculation of region-specific rates. The geographic factors are based on the provider reimbursement expectations in each region.

None of the following items were used in establishing the geographic rating area factors:

(i) Health status of enrollees or the population in an area;
(ii) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health 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.

Adjustments were made to the geographic factors to ensure that the minimum geographic factor and the maximum geographic factor did not deviate by more than 15% per Washington regulations. The calibration factor of 0.975 equals the inverse of the weighted average geographic factor.

Please refer to Appendix Exhibit 7.1.

Tobacco Factor Calibration: Molina does not price in a tobacco surcharge. The calibration factor is set to 1.000. The tobacco calibration factor has been set to 1.000 in 2023, 2024, and 2025 as well.

Base Premium Rate Development

The Base Premium Rates are calibrated to an age 21 premium with an area factor of 1.0. Only the allowable rating factors will be applied to the Base Premium Rates. Please see Appendix Exhibit 6.1.

PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) using the federally prescribed MLR methodology is for calendar year 2026 based on the ratio of projected incurred claims divided by projected revenue. The MLR result was calculated to be 87.1%. Please refer to Appendix Exhibit 11.1 for a full demonstration of the projected loss ratio. In the Part I Unified Rate Review Template, Worksheet 2, item 4.10 Loss Ratio displays a loss ratio in total and by plan adjusted index rates. The loss ratio calculated here follows a different formula than the federally prescribed MLR methodology and will not match that figure. The URRT loss ratio is incurred claims divided the sum of the risk adjustment transfer amount and the plan adjusted index rate premium. The federal MLR considers quality in the numerator and taxes and fees in the denominator.

PLAN PRODUCT INFORMATION

AV Metal Values

All plan offerings have cost-sharing levels that are different for Preferred Generic Drugs and Non-Preferred Generic Drugs. These plans are considered unique benefit design according to the logic used in the Final 2026 Actuarial Value Calculator (AVC). The AV metal values were determined by using a permissible alternative method that complies with 45 CFR 156.135(b)(3).

The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

The Bronze and Silver Standard plans were adjusted according to the same generic drug methodology. An adjustment factor was calculated for the standard plans using the original AV compared with the blended AV and applied to the Adjusted AV prepared by Wakely. Please refer to Appendix Exhibit 11.4.

Please refer to the supporting document "Unique Plan Design Documentation" unique plan design certification for documentation on the generic drug cost-sharing component of the plans.

For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature. The unique plan design certification for the Bronze and Silver plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Silver CSR Loading: In accordance with WAC 284-43-6820, a uniform CSR silver load adjustment factor of 1.435 has been applied to Silver plans for plan year 2026. Please refer to WA Exhibit 8.

AV Pricing Values

AV pricing value of each plan only includes the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). Cost-sharing adjustments ensure that differences due to health status were not included in the adjustment. The modifiers are applied to the index rate. Molina relied on the Final 2026 AV Calculator to evaluate the Actuarial Value of the plan designs.

Plan ID	Plan Name	AV Metal Value	AV Pricing Value
84481WA0060005	Molina Cascade Complete Gold	0.8171	0.8171
84481WA0060006	Molina Cascade Silver	0.7184	0.7184
84481WA0060007	Molina Cascade Bronze	0.6499	0.6499
84481WA0060008	Molina Cascade Vital Gold	0.7801	0.7801

Essential Health Benefits

All benefit plans offered meet essential health benefit (EHB) requirements. Molina plan designs in 2026 are all standard plan designs. The State of Washington has added new EHBs for plan years beginning on or after January 1, 2026. The EHB additions are as follows:

- Hearing Exams shall be categorized as Primary Care Visits.
- Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
- Artificial Insemination shall be categorized as All Other Benefits.
- Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).

Membership Projections

Molina is filing Washington Marketplace rates in 18 counties representing 7 rating regions. The membership projection is based on anticipated renewals of existing members and new members. New membership is based on an estimate of the total number of members enrolled in Washington Marketplace by county. The source of new members is mostly from other carriers.

The enrollment projections by plan, including cost-sharing reduction eligible plans, were based on a projection of 2025 membership calculated early in 2025. The baseline membership projections reflected a decline in membership across all plans as a result of the 2026 rate change. Members are also anticipated to migrate away from Silver plans due to uniform silver-loading. Some of these members are expected to migrate toward Molina Gold plans.

We are anticipating that Molina will not offer one of the lowest cost Silver plans in 2026, and as a result, will continue to decline in Silver membership. This is partially because new members tend to select one of the lowest cost offerings in the market, including Cascade Select plan offerings from other carriers. As a result, Molina modeled a reduction in the proportion of available Silver members in the market compared to current membership. With the anticipated expiration of ePTCs, Molina modeled a reduction in membership. These members may move to other carriers or leave the market.

Molina plans to offer its products in the counties listed by region below.

Region	County List
1	King
2	Cowlitz, Kitsap, Lewis
3	Clark, Klickitat, Skamania
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Mason, Pierce, Thurston
6	Benton, Franklin
8	Snohomish

Terminated Products

Molina is terminating the Constant Care Silver 1 plan design for 2026. Members currently enrolled in this plan will be mapped to the Molina Cascade Silver plan.

A summary of Molina's terminated, renewing, and new products is provided in the following table:

Plan ID	Plan Name	Metal	2026 Status
84481WA0060005	Molina Cascade Complete Gold	Gold	Renewing
84481WA0060006	Molina Cascade Silver	Silver	Renewing
84481WA0060007	Molina Cascade Bronze	Bronze	Renewing
84481WA0060008	Molina Cascade Vital Gold	Gold	New
84481WA0060004	Constant Care Silver 1	Silver	Terminated

PLAN TYPE

All benefit plans are comprehensive HMO individual products.

MISCELLANEOUS INSTRUCTIONS

Effective Rate Review Information

URRT Comparison: Tables comparing the 2026 values with the 2025 values entered in the URRT (Worksheet I, Sections II) are provided in Appendix Exhibit 2.1.

Mental Health / Substance Use Disorder Financial Requirement Checklist: In Molina's mental health parity calculation template, the underlying claim data source is Molina's WA marketplace 2024

experience data projected forward to 2026 as described in the Actuarial Memorandum. No adjustment has been made to the data. The projections reflect the plan level assumptions and are based on the amounts that the Plan allows before reductions for enrollee cost sharing. A reasonable actuarial method was used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Reliance

The unique plan design certification for the Standard plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Milliman's MedInsight Health Cost Guidelines (HCG) grouper was relied upon for categorizing claims data for the experience period.

Wakely's white paper report on the estimated high-cost risk pooling charges (2023, 2024, and 2025 High-Cost Risk Pooling Program – National Estimate) was relied upon for our estimate of High Cost Risk Pool (HCRP) amounts.

Actuarial Certification

I, Kathryn Hall, am an employee of Molina Healthcare and I am a member in good standing with the American Academy of Actuaries meeting its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries. I have the education and experience necessary to the perform the work and hereby certify, to the best of my knowledge and judgment, that this filing complies with applicable State and Federal Statues for individual rate filings. I certify the following:

The projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
b. Developed in compliance with the applicable Actuarial Standards of Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Termination of pregnancy is a WA EHB under the “maternity and newborn services” category [WAC 284-43-5642]. The “Benefits in Addition to EHB” field is the multiplicative inverse of the value entered into the “EHB Percent of Total Premium” field on the Plans & Benefits Template (PBT). For the purposes of filling out the URRT Worksheets, abortion services for which public funding is prohibited was entered as Benefits in Addition to EHB, even though the benefits are considered EHBs in Washington.

The Final 2026 AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. Adjustments were made for unique benefit designs as described in the Reliance and in the Plan Product Information / AV Metal Values sections of this memorandum.

Please refer to the supporting document “Unique Plan Design Documentation” unique plan design certification.

I certify that the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct, including:

- ASOP 5: Incurred Health and Disability Claims
- ASOP 8: Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP 12: Risk Classification
- ASOP 23: Data Quality
- ASOP 25: Credibility Procedures
- ASOP 41: Actuarial Communications
- ASOP 45: The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act
- ASOP 56: Modeling

05/13/2025

Kathryn Hall, ASA, MAAA
Actuarial Manager
Molina Healthcare

Date

Actuarial Memorandum and Certification

Effective January 1, 2026

The purpose of this actuarial memorandum and certification is to provide information related to Molina Healthcare of Washington, Inc.'s (Molina) Part I Unified Rate Review Template submission to the Washington Individual Marketplace (Washington Marketplace).

The actuarial memorandum and certification describe Molina's rating methodology used to develop rates for Individual products offered on the Washington Marketplace effective January 1, 2026. Molina will not market Individual products outside of the Washington Marketplace.

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services individuals eligible for Medicaid, Medicare, and Marketplace throughout the State of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 20 states across the nation, Molina serves more than 5 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern Washington. Today, we continue his mission of providing high quality and cost-effective health care to those who need it most.

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MolinaHealthcare.com

Contents

GENERAL INFORMATION

The information below documents the company identifying and contact information entered into the general information section of Worksheet 1 of the Unified Rate Review Template (URRT).

The rate methodology and resulting premiums outlined in this Actuarial Memorandum assume current law, which includes the following:

- The expiration of the American Rescue Plan (ARP) enhanced premium tax credit subsidies at the end of 2025.
- Cost-Sharing Reduction (CSR) subsidies remain unfunded.
- The parameters of the HHS Notice of Benefit and Payment Parameters for 2026 (Final 2026 Payment Notice), which became effective on January 15th, 2025.

Notably, the Marketplace Integrity and Affordability Proposed Rule (Program Integrity Rule) was published by CMS in the Federal Register on March 19th, 2025, followed by a comment period that could substantially alter the proposed rule. The rate methodology and resulting premiums outlined in this Actuarial Memorandum were prepared prior to the finalization of the Program Integrity Rule and therefore do not reflect the changes proposed in the Program Integrity Rule.

Molina will seek regulatory approval to file revised rates if material changes to the regulatory environment occur, including, but not limited to, changes to the above mentioned items.

Company Identifying Information

Company Identifying Information	
Legal Name:	Molina Healthcare of Washington, Inc.
State:	Washington
HIOS Issuer ID:	84481
Market:	Washington Individual Marketplace
Effective Date:	January 1, 2026

Company Contact Information

Company Contact Information	
Contact Name	Kathryn Hall
E-mail	Kathryn.Hall@molinahealthcare.com

PROPOSED RATE INCREASE(S)

Molina's rate filing reflects a rate change of 24.59% as calculated by section Q5 of the Uniform Product Modification Justification (UPMJ) template for Molina's 43,346 members enrolled effective March 2025, reported as of April 2025. The UPMJ Q5 rate change is calculated using the average rate change of each plan weighted by membership in each plan.

Molina's rate filing reflects the following rate changes as calculated by Part I of the Unified Rate Review Template in Section 1 of Worksheet 2 for Molina's 36,212 members enrolled in plans that are renewing for 2026. Enrollment data is as of March 2025, reported as of April 2025. The URRT rate change is calculated using the rate change of each renewing plan weighted by the membership and premium in each renewing plan.

The rate changes vary by plan due to changes in the Actuarial Value (AV) Pricing Values assigned to each metal plan that are applied to the Plan Adjusted Index Rate.

14-Digit Plan ID	Plan Name	Metal	202503 Mbrs	2025 PMPM	2026 PMPM	Avg	Min	Max
84481WA0060005	Molina Cascade Complete Gold	Gold	10,687	$685	$748	9.3%	8.6%	11.4%
84481WA0060006	Molina Cascade Silver	Silver	13,965	$662	$907	37.0%	36.0%	39.4%
84481WA0060007	Molina Cascade Bronze	Bronze	11,560	$547	$635	16.1%	15.4%	18.3%
84481WA0060008	Molina Cascade Vital Gold	Gold	0	$0	$0	-	-	-
Total			**36,212**	**$632**	**$773**	**22.4%**	**8.6%**	**39.4%**

Reason for Rate Change(s): The following factors contribute toward the overall change in the proposed rates.

- **Claims:** Projected claims for 2026 are expected to contribute toward a 17.3% increase in rates due to updated base period experience claims, trend, changes in product, acuity, and demographic mix.
- **Taxes and Fees:** Taxes, fees, and retention are expected to contribute toward a 0.5% increase in rates.
- **Margin:** Margins are expected to contribute toward a 0.5% increase in rates at our company standard 3.0% after-tax profit margin.
- **Risk Transfer:** Risk transfer is expected to contribute toward a 1.9% decrease in rates.
- **Administrative Expenses:** Administrative expenses are expected to contribute toward a 0.3% increase in rates.
- **Membership Mix:** The membership mix from the base period to the projection period compared to the membership mix for comparable time periods from the prior year rate filing is expected to contribute toward a 5.7% increase in rates.

Rate changes vary by plan due to changes in Actuarial Value, Cost Share Design (CSD), and Geographic factors.

MARKET EXPERIENCE

The single risk pool was established according to the requirements in 45 CFR 156.80. No transitional products/plans or grandfathered products are included in the development of the single risk pool.

Molina's 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months or 40,774 average members in the period of January 1, 2024 to December 31, 2024.

Experience Period Premium and Claims

Paid Through Date: The market experience reported in Worksheet 1, Section I of the URRT represents 2024 incurred claims paid through March 2025. The completion factors applied to the 2024 claims experience were updated with data through March 2025.

Current Date: The current enrollment and premium are reported as of April 2025.

Premiums (Net of MLR Rebate) in Experience Period: The premiums reported in Worksheet 1, Section I of the URRT represent the earned premium from 2024, excluding risk adjustment transfer payments for the 2024 benefit year. Earned premium does not reflect any MLR rebates. No amounts were subtracted from the earned premium for any reductions prescribed by the federal MLR formula, such as taxes and assessments.

Allowed and Incurred Claims in Experience Period: The following table reports the allowed and incurred claims during the experience period of January 1, 2024 to December 31, 2024.

Description	Medical	Pharmacy	Capitation	Total
Allowed	$237,949,720	$80,067,777	$13,196,321	$331,213,818
IBNR Factor	1.014	1.000	1.000	1.010
Allowed w/ IBNR	**$241,277,636**	**$80,067,777**	**$13,196,321**	**$334,541,734**
Paid	$204,905,854	$71,110,323	$10,164,514	$286,180,691
IBNR Factor	1.014	1.000	1.000	1.010
Paid w/ IBNR	**$207,836,278**	**$71,110,323**	**$10,164,514**	**$289,111,115**

The experience is for all 2024 individual non-grandfathered plans including subsidized populations defined under the Cost Sharing Reduction (CSR) programs. The experience does include data for the American Indian/Alaska Native (AIAN) population which is funded by the federal government and is not tied to any metal level in the Marketplace.

Allowed claims for the experience period were obtained from the claims records by adding the plan incurred paid claims and the member cost-sharing for medical and pharmacy claims net of rebates received from drug manufacturers. The allowed claims calculation applies to both fee-for-service claims and capitation costs.

Completion factors were applied to both the allowed and incurred medical claim amounts. The completion factors were developed separately for inpatient and non-inpatient medical claims based on Molina's Washington Marketplace data. The IBNR factor for medical allowed claims is 1.014. The IBNR factor for medical incurred and paid claims is 1.014. IBNR factors were not applied to capitation and pharmacy claims.

The IBNR reserves were determined based on best estimates. Explicit margin for loss adjustment expenses and provision for adverse deviation are accounted for in the financial system in separate accounts that do not impact the completion factors used for IBNR reserves.

All medical claims are paid through Molina's claims system. Pharmacy claims are processed through Molina's pharmacy benefit manager.

In the experience period 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 not counted toward the annual limitation on cost sharing.

There were no federal or state reinsurance amounts to report in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Experience Period Premium and Experience Period Member Months in 2024 were reported in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Inclusion of Capitation Payments: All capitated payments are included in the experience data and rate development. For pediatric vision coverage Molina has a vision care agreement with Vision Service Plan (VSP), a California not-for-profit corporation, with its principal place of business located in Rancho Cordova, CA and Molina Healthcare of Washington, Inc. which is in Bothell, WA. No changes have occurred to the 2026 agreement terms compared with 2024 and 2025.

Actual to Projected Analysis: Molina tracks Marketplace experience on an ongoing monthly basis through IBNR reserving, claims forecasting based on current and prior year results, and Risk Adjustment estimation. The experience is tracked at the single risk pool level. 2024 experience was used as the baseline experience period for the 2026 rate filing, so the extent that 2024 experience deviated from projected 2024 results is captured in 2026 rates. No extra adjustments were made in 2026 pricing to account for 2024 deviations in claims.

Benefit Categories

Molina assigned all experience claims to benefit categories utilizing Milliman's MedInsight Health Cost Guidelines (HCG) grouper. The following table displays the measurement units related to each benefit category.

Benefit Category	Util Type
Inpatient Hospital	Days
Outpatient Hospital	Visits
Professional	Services
Other Medical	Services
Capitation	Benefit Period
Prescription Drug	Prescriptions

Projection Factors

Trend Factors

Trend Factors: Trend factors were applied separately for unit cost and utilization and by each major benefit category shown in Worksheet 1, Section II of the URRT. The Year 1 and Year 2 trend factors represent the annual trend numbers that were used to trend the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026.

Unit cost trends were measured by calculating average reimbursement rates in the base period and projection period, which consider reimbursement changes and provider mix changes. The unit cost trends include the expected impact of Medicare reimbursement changes from 2024 to 2026 for provider reimbursement contracts that are based on a percentage of the Medicare fee schedule. Pharmacy unit cost trends are based on an analysis of AWP changes over time for a fixed basket of drugs.

The unit cost projections reflect input on likely network and provider contract term changes for the projection year. Provider contracting is already complete for plan year 2026 for counties within Molina's existing footprint. The status of projected reimbursement trend is mostly locked in for plan year 2026.

Utilization trends were developed through a review of trends from the 2025 URRT public use files in Worksheet 1, Section II, with a focus on Individual Market plans with non-zero credibility and nonzero trend factors in states where Molina offers coverage. Year 1 utilization trends include the impact of emerging experience in 2025. Changes in average health status and mix of services are considered in the Acuity and Plan Mix adjustments included in the rate filing and are not considered in utilization trends.

Cost-sharing benefit features such as deductible, copay, out-of-pocket maximum would impact utilization leveraging of trend. However, for pricing purposes allowed trends (utilization before leveraging) were used according to the URR instructions for developing the single risk pool.

Trends were selected based on expectations for a more stable On-Exchange population and were compared to historical and prospective trends for our On-Exchange experience in other states. In general, prospective utilization trends were selected in a way that does not expect abnormally high and abnormally low historical experience to continue.

Please see WA Exhibit 3 for support of the selected trends applied in pricing and WA Exhibits 4 and 5 as support for the historical and adjusted trends described above.

Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment: The morbidity adjustment is comprised of an acuity factor that represents anticipated changes in Molina's single risk pool.

Changes in acuity: The morbidity of Molina's covered population is expected to decrease between the experience period and the projection period.

An acuity adjustment of 1.039 was made to the 2024 experience period data to reflect changes in the population acuity from the experience period to the 2025 current period. The acuity changes from the 2024 experience period to the 2025 current period are measured by calculating the difference in the 2024 risk scores and 2025 risk scores, both weighted by 2026 projected metal mix to avoid double counting with the plan mix adjustment.

The acuity change from the 2025 current period to the 2026 projection period is calculated in the same way, weighting 2025 and 2026 risk scores with 2026 projected metal mix. With the implementation of uniform silver-loading, the majority of Molina's Silver members are expected to move to Gold plans decreasing the projected average risk score for Gold members.

Under current law, Enhanced Premium Tax Credits (ePTCs) are scheduled to expire at the end of 2025. Molina retained Milliman to analyze the impact of expiring premium subsidies on statewide morbidity. We reviewed the study and determined that the best estimate for an acuity adjustment is 1.023. The total acuity adjustment factor for the 2025 current period to the 2026 projection period is 0.930.

The final acuity adjustment factor is 0.967. Please refer to Appendix Exhibit 4.1.

Demographic Shift: A demographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the demographic mix from the 2024 experience data to the 2026 projection period.

The anticipated demographic mix is based on a review of enrollment through March 2025 and projected 2026 enrollment compared to the experience period. Molina anticipates that its 2026 demographics will be consistent with its 2025 demographics for existing membership. The demographic adjustments were developed using allowed claims by age cohort normalized for differences in metal and acuity. The total demographic adjustment made to the 2024 experience period data is 1.007. Please refer to Appendix Exhibit 4.2a.

Geographic Adjustment: A geographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the area membership mix from the 2024 experience data to the 2026 projection period. A geographic adjustment of 1.002 was made to the 2024 experience period data. Please refer to Appendix Exhibit 4.2c.

Plan Mix Adjustment: The plan mix adjustment reflects anticipated changes in the average utilization of services due to differences in average cost-sharing requirements during the experience period and

average cost-sharing requirements in the projection period. This includes changes in induced demand and the effects of selection for the single risk pool.

The 2024 claims experience by Metal and CSR variant was used to weight the 2024 membership mix against the projected membership mix expected in the 2026 projection period to develop a plan mix adjustment factor between the 2024 experience period and 2026 projection period. The Gold allowed claims amount was adjusted to reflect the membership migration to Gold as a result of uniform silver-loading. The adjusted allowed claims are a weighted average calculated using the membership moving from Silver and Bronze to Gold.

The plan mix adjustment made to the 2024 experience period data is 1.121. Please refer to Appendix Exhibit 4.3.

Manual Rate Adjustments

Not Applicable.

Credibility of Experience

A Monte Carlo simulation was used to determine the credibility level to assign to the base period experience. The simulation used a claims probability distribution (CPD) from the Final 2026 Actuarial Value calculator to generate random samples of members and calculated the average annual cost for each sample.

The results showed that 60,000 member months are needed so that the average annual cost is within 10% of the mean (expected claims amount) 95% of the time.

The credibility percentage to apply to the experience data is based on experience period member months and the credibility formula below:

- 0 - 59,999 member months: 100% manual
- 60,000+ member months: 100% experience

The 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months resulting in a credibility percentage that is 100% experience rated. This method is consistent with the applicable American Academy of Actuaries' Actuarial Standards of Practice (ASOP) No. 25 Credibility Procedures.

Establishing the Index Rate

Index Rate: The index rate is developed following the specifications of 45 CFR part 156.80(d)(1). The index rate for the projection period is estimated to be $892.52. The index rate represents the estimated total allowed claims experience for the essential health benefits within the Washington Marketplace. The index rate does not include adjustments for the risk adjustment and reinsurance programs or an adjustment for the Washington Marketplace user fee. Please refer to Appendix Exhibit 5.1a.

Development of the Market-wide Adjusted Index Rate

Reinsurance

Not Applicable.

Risk Adjustment and Payment Change

Experience Period Risk Adjustment PMPM:
Molina used results from the Wakely National Risk Adjustment Reporting (WNRAR) Project to supplement internal estimates of risk scores, statewide premiums, and related risk adjustment transfer amounts. For the 2024 experience period, the risk transfer receivable is $80.25 per member per month (PMPM) or $39,265,304.

Projected Risk Adjustments PMPM: Molina estimated the risk transfer amount for 2026 using the 2024 experience period risk transfer amounts. The 2026 risk transfer estimates were developed by projecting 2025 relative risk scores and transfer payments, then projecting 2026 relative risk scores and transfer payments. The risk transfer payment amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium. The projection is based on the 2026 calibrated model. The population was grouped into the following cohorts:

- *2025 Renewal Members* – Some of Molina's current members previously had coverage in 2024 and renewed in 2025 with Molina. Molina relied on the renewal member's 2024 experience and risk scores to project their 2025 relative risk scores, taking into consideration any applicable changes in enrollment across metal tiers.
- *2025 New Members* – To estimate the relative risk of the 2025 new members, Molina referred to the estimated risk scores and transfer amounts from the 2024 experience period. Estimated risk scores were adjusted in consideration of the metal tier mix between the 2024 members and the 2025 new members.

- *2026 Members* – Molina assumed the 2026 members would have the higher relative risk scores as the 2025 members, with consideration for the metal tier mix between the two years.

The impact of the national high-risk pool fund was incorporated using 2024 claims experience and a white paper report from Wakely on the estimated high-cost risk pooling charges based on information voluntarily provided by issuers. The net impact of estimated charges and recoveries was calculated as $1.45 PMPM payable.

The impact of the risk adjustment data validation program was incorporated using historical error rates from the final CMS RADV results and the RADV error rate report from Wakely based on information voluntarily provided by issuers. The net impact of estimated payment was calculated as $1.97 PMPM receivable.

The resulting 2026 risk transfer receivable estimate is $82.23 PMPM. Molina included $1.45 PMPM payable for projected national high-risk pooling funding and $1.97 PMPM receivable for projected risk adjustment data validation to get a net risk transfer receivable estimate of $82.75 PMPM. This amount was converted from a paid to allowed basis and entered in the URRT Worksheet I, Section II.

The risk transfer receivable amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium.

The 2026 statewide average premium was projected using historical experience and information from Wakely, including the estimated 2025 statewide average premium. An adjustment of was made to the statewide average premium to account for changes due to uniform silver-loading. Using historical experience and the adjustment for silver-loading, the 2026 statewide average premium increase is estimated to be 8.2%.

Please refer to WA Exhibit 10 for further information on projected risk adjustment.

Washington Marketplace Exchange Fee:
Washington Marketplace will charge a fee of $5.11 PMPM which was divided by the total paid to allowed factor of 0.787 to convert to an allowed basis of $6.49 PMPM for the Market Adjusted Index Rate. Please refer to Appendix Exhibit 5.1a to locate the same percentage for the Exchange User Fee entered in Worksheet 1, Section II.

Market Adjusted Index Rate: The market adjusted index rate is developed following the specifications of 45 CFR part 156.80(d)(1). Molina modified the index rate provided in URRT Worksheet I to a market adjusted index rate. Please refer to Appendix Exhibit 5.1a

Plan Adjusted Index Rates

The plan adjusted index rates are developed following the specifications of 45 CFR part 156.80(d)(2). The plan adjusted index rates are entered in Worksheet 2, Section IV, of the URRT. Molina calculated the plan adjusted index rates by applying plan specific level adjustments for actuarial value, cost

sharing utilization, additional benefits, and administrative costs, excluding exchange user fees, to the market adjusted index rate. Please refer to Appendix Exhibit 10.2.

Paid to Allowed Ratio: The Paid to Allowed ratio reflects the estimated cost-sharing in the projected period. The Final 2026 AV Calculator was used to determine metal AVs, but for pricing a different calculator was used. This is detailed in the Pricing AVs section. The Paid to Allowed ratio is the member-weighted average of the Actuarial Values. Please refer to Appendix Exhibit 5.1b.

Benefits in Addition to EHBs:
There are no benefits in addition to EHBs. However, Molina covers the elective termination of pregnancy benefit. Per Checklist Item #10d, abortion services must be treated as non-EHBs in the URRT. Therefore, elective termination of pregnancy costs are included in the Index Rate and field 3.5 in the URRT has been adjusted to account for these costs. An estimated $1.00 PMPM is used to account for abortion services. The percentage of premium by plan is used to calculate the Benefits in Addition to EHB, field 3.5 of Worksheet 2. Please refer to Appendix Exhibit 5.1b.

Retention Loads, excluding Exchange User Fees: All costs related to admin, profit & risk and taxes & fees, excluding the Washington Marketplace Fee, are calculated for each expected plan offering. Please refer to WA Exhibit 11.

Provider Network, Delivery System Characteristics, and Utilization Management Practices: Plan rates do not vary for variation in provider network, delivery system characteristics, or utilization management.

Provider Compensation Statement: Provider compensation does not include bonuses in addition to other payments.

Catastrophic plans: Not applicable.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Administrative expenses for the Marketplace product from 2024 and 2025 were reviewed and projected forward to 2026 to develop the administrative costs required to manage the Washington Marketplace population. An internal administrative cost budget was developed on a PMPM basis and applied to the Washington Marketplace rates. Part of the total administrative expense load is a subcomponent for Quality Expenses which are administrative costs dedicated to improving health care quality for Molina Marketplace members. The Quality Expense load is $10.48 PMPM. Amounts for broker commissions were added to the administrative costs. The expected administrative expense load is 10.3%. Please refer to WA Exhibit 11.

Broker Commissions: Broker commissions of $11.83 PMPM are expected based on historical broker-sold business and a projection of new and renewing members sold through the broker channel.

Profit Margin: The target after-tax margin is 3.0%, which aligns with Molina's company standard target. Molina's current capital and surplus did not impact the filing. The profit and risk load of 3.0% of premium is consistent with the target margin filed and approved for each rating period from 2015 through 2026.

Taxes and Fees: Molina's estimated taxes and fees (excluding Exchange Fee) are 3.0%. The taxes and fees estimates are comprised of the following:

- **Income Tax:** An estimated 0.8% of premiums will be paid in Federal income taxes.
- **WSHIP:** The WSHIP assessment is projected at $0.13 PMPM. Per the most recent information available in the 2023 Annual Report, WSHIP assessments were $12 million in 2023 (an estimated $0.25 PMPM). WSHIP assessments for 2024 were projected to be $6 million. Therefore, Molina has estimated the WSHIP assessment to be $0.13 PMPM for 2026.
- **Regulatory Surcharge:** The regulatory surcharge is an annual cost of operating the Office of the Insurance Commissioner which is charged to insurers like Molina. The 0.08% of premium is based on internal budgetary forecasts. The 2026 regulatory surcharge was assumed to be 0.08% of premium.
- **Risk Adjustment User Fee:** $0.20 PMPM will be paid toward the risk adjustment user fee.
- **Insurance Fraud Surcharge:** The 2026 insurance fraud surcharge is estimated to be .004% of premium.
- **Premium Tax:** Molina has assumed 2.0% for the state premium tax.
- **PCORI:** An estimated $0.33 PMPM ($4.01 PMPY) will be paid toward the PCORI fee. This was estimated by projecting forward the $3.47 PMPY value for members whose plan year ends September 2024 through October 2025 forward two years at a rate of 7.5% per year, the 3-year average annual increase.
- **WAPAL:** An estimated $0.06 PMPM will be paid toward the WAPAL fund. The 2026 estimate is based on the most recent information available from the FY2025 Assessment Rate Notification to Payers.

Calibration

Age Curve Calibration: Molina calibrated the Plan Adjusted Index Rates to an age 21 rate. The average composite age factor was estimated by multiplying the population distribution by the age factors. The calibration factor is 0.580.

Molina estimated the average age of the single risk pool to be 43 years of age by multiplying the expected age distribution percentages by the age. Molina assumed an average age of 7 for the Age 0-14 cohort in the average age estimate and an average age of 71 for the Age 65+ cohort. Premium rates are based on the attained age as of the coverage effective date and will not be re-rated/adjusted when a birthdate occurs during the year after the coverage starts.

Please refer to Appendix Exhibit 4.2b.

Geographic Factor Calibration: Molina applied geographic factors to the index rate in the calculation of region-specific rates. The geographic factors are based on the provider reimbursement expectations in each region.

None of the following items were used in establishing the geographic rating area factors:

(i) Health status of enrollees or the population in an area;
(ii) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health 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.

Adjustments were made to the geographic factors to ensure that the minimum geographic factor and the maximum geographic factor did not deviate by more than 15% per Washington regulations. The calibration factor of 0.975 equals the inverse of the weighted average geographic factor.

Please refer to Appendix Exhibit 7.1.

Tobacco Factor Calibration: Molina does not price in a tobacco surcharge. The calibration factor is set to 1.000. The tobacco calibration factor has been set to 1.000 in 2023, 2024, and 2025 as well.

Base Premium Rate Development

The Base Premium Rates are calibrated to an age 21 premium with an area factor of 1.0. Only the allowable rating factors will be applied to the Base Premium Rates. Please see Appendix Exhibit 6.1.

PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) using the federally prescribed MLR methodology is for calendar year 2026 based on the ratio of projected incurred claims divided by projected revenue. The MLR result was calculated to be 87.1%. Please refer to Appendix Exhibit 11.1 for a full demonstration of the projected loss ratio. In the Part I Unified Rate Review Template, Worksheet 2, item 4.10 Loss Ratio displays a loss ratio in total and by plan adjusted index rates. The loss ratio calculated here follows a different formula than the federally prescribed MLR methodology and will not match that figure. The URRT loss ratio is incurred claims divided the sum of the risk adjustment transfer amount and the plan adjusted index rate premium. The federal MLR considers quality in the numerator and taxes and fees in the denominator.

PLAN PRODUCT INFORMATION

AV Metal Values

All plan offerings have cost-sharing levels that are different for Preferred Generic Drugs and Non-Preferred Generic Drugs. These plans are considered unique benefit design according to the logic used in the Final 2026 Actuarial Value Calculator (AVC). The AV metal values were determined by using a permissible alternative method that complies with 45 CFR 156.135(b)(3).

The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

The Bronze and Silver Standard plans were adjusted according to the same generic drug methodology. An adjustment factor was calculated for the standard plans using the original AV compared with the blended AV and applied to the Adjusted AV prepared by Wakely. Please refer to Appendix Exhibit 11.4.

Please refer to the supporting document "Unique Plan Design Documentation" unique plan design certification for documentation on the generic drug cost-sharing component of the plans.

For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature. The unique plan design certification for the Bronze and Silver plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Silver CSR Loading: In accordance with WAC 284-43-6820, a uniform CSR silver load adjustment factor of 1.435 has been applied to Silver plans for plan year 2026. Please refer to WA Exhibit 8.

AV Pricing Values

AV pricing value of each plan only includes the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). Cost-sharing adjustments ensure that differences due to health status were not included in the adjustment. The modifiers are applied to the index rate. Molina relied on the Final 2026 AV Calculator to evaluate the Actuarial Value of the plan designs.

Plan ID	Plan Name	AV Metal Value	AV Pricing Value
84481WA0060005	Molina Cascade Complete Gold	0.8171	0.8171
84481WA0060006	Molina Cascade Silver	0.7184	0.7184
84481WA0060007	Molina Cascade Bronze	0.6499	0.6499
84481WA0060008	Molina Cascade Vital Gold	0.7801	0.7801

Essential Health Benefits

All benefit plans offered meet essential health benefit (EHB) requirements. Molina plan designs in 2026 are all standard plan designs. The State of Washington has added new EHBs for plan years beginning on or after January 1, 2026. The EHB additions are as follows:

- Hearing Exams shall be categorized as Primary Care Visits.
- Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
- Artificial Insemination shall be categorized as All Other Benefits.
- Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).

Membership Projections

Molina is filing Washington Marketplace rates in 18 counties representing 7 rating regions. The membership projection is based on anticipated renewals of existing members and new members. New membership is based on an estimate of the total number of members enrolled in Washington Marketplace by county. The source of new members is mostly from other carriers.

The enrollment projections by plan, including cost-sharing reduction eligible plans, were based on a projection of 2025 membership calculated early in 2025. The baseline membership projections reflected a decline in membership across all plans as a result of the 2026 rate change. Members are also anticipated to migrate away from Silver plans due to uniform silver-loading. Some of these members are expected to migrate toward Molina Gold plans.

We are anticipating that Molina will not offer one of the lowest cost Silver plans in 2026, and as a result, will continue to decline in Silver membership. This is partially because new members tend to select one of the lowest cost offerings in the market, including Cascade Select plan offerings from other carriers. As a result, Molina modeled a reduction in the proportion of available Silver members in the market compared to current membership. With the anticipated expiration of ePTCs, Molina modeled a reduction in membership. These members may move to other carriers or leave the market.

Molina plans to offer its products in the counties listed by region below.

Region	County List
1	King
2	Cowlitz, Kitsap, Lewis
3	Clark, Klickitat, Skamania
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Mason, Pierce, Thurston
6	Benton, Franklin
8	Snohomish

Terminated Products

Molina is terminating the Constant Care Silver 1 plan design for 2026. Members currently enrolled in this plan will be mapped to the Molina Cascade Silver plan.

A summary of Molina's terminated, renewing, and new products is provided in the following table:

Plan ID	Plan Name	Metal	2026 Status
84481WA0060005	Molina Cascade Complete Gold	Gold	Renewing
84481WA0060006	Molina Cascade Silver	Silver	Renewing
84481WA0060007	Molina Cascade Bronze	Bronze	Renewing
84481WA0060008	Molina Cascade Vital Gold	Gold	New
84481WA0060004	Constant Care Silver 1	Silver	Terminated

PLAN TYPE

All benefit plans are comprehensive HMO individual products.

MISCELLANEOUS INSTRUCTIONS

Effective Rate Review Information

URRT Comparison: Tables comparing the 2026 values with the 2025 values entered in the URRT (Worksheet I, Sections II) are provided in Appendix Exhibit 2.1.

Mental Health / Substance Use Disorder Financial Requirement Checklist: In Molina's mental health parity calculation template, the underlying claim data source is Molina's WA marketplace 2024

experience data projected forward to 2026 as described in the Actuarial Memorandum. No adjustment has been made to the data. The projections reflect the plan level assumptions and are based on the amounts that the Plan allows before reductions for enrollee cost sharing. A reasonable actuarial method was used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Reliance

The unique plan design certification for the Standard plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Milliman's MedInsight Health Cost Guidelines (HCG) grouper was relied upon for categorizing claims data for the experience period.

Wakely's white paper report on the estimated high-cost risk pooling charges (2023, 2024, and 2025 High-Cost Risk Pooling Program – National Estimate) was relied upon for our estimate of High Cost Risk Pool (HCRP) amounts.

Actuarial Certification

I, Kathryn Hall, am an employee of Molina Healthcare and I am a member in good standing with the American Academy of Actuaries meeting its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries. I have the education and experience necessary to the perform the work and hereby certify, to the best of my knowledge and judgment, that this filing complies with applicable State and Federal Statues for individual rate filings. I certify the following:

The projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
b. Developed in compliance with the applicable Actuarial Standards of Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Termination of pregnancy is a WA EHB under the “maternity and newborn services” category [WAC 284-43-5642]. The “Benefits in Addition to EHB” field is the multiplicative inverse of the value entered into the “EHB Percent of Total Premium” field on the Plans & Benefits Template (PBT). For the purposes of filling out the URRT Worksheets, abortion services for which public funding is prohibited was entered as Benefits in Addition to EHB, even though the benefits are considered EHBs in Washington.

The Final 2026 AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. Adjustments were made for unique benefit designs as described in the Reliance and in the Plan Product Information / AV Metal Values sections of this memorandum.

Please refer to the supporting document “Unique Plan Design Documentation” unique plan design certification.

I certify that the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct, including:

- ASOP 5: Incurred Health and Disability Claims
- ASOP 8: Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP 12: Risk Classification
- ASOP 23: Data Quality
- ASOP 25: Credibility Procedures
- ASOP 41: Actuarial Communications
- ASOP 45: The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act
- ASOP 56: Modeling

05/13/2025

Kathryn Hall, ASA, MAAA
Actuarial Manager
Molina Healthcare

Date

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060005	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Molina Cascade Complete Gold	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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$1,000	
Default Coinsurance			20%	
MOOP			$7,000	

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	$ 450	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)		No	$ 525	Before and After Deductible	No				Note 3	
Primary Care Visit to Treat an Injury or Illness		No	$ 15	Before and After Deductible	No					
Specialist Visit		No	$ 40	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 15	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		No	$ 15	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)		Yes	$ 300	After Deductible						
Rehabilitative Speech Therapy		No	$ 25	Before and After Deductible	No				Note 1	
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 25	Before and After Deductible	No				Note 1	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 20	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 30	Before and After Deductible	No					
Skilled Nursing Facility		Yes	$ 350	After Deductible					Note 2	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	$ 350	After Deductible						
Outpatient Surgery Physician/Surgical Services		Yes	$ 75	After Deductible						
Urgent Care		No	$ 35	Before and After Deductible	No					
Emergency Transportation		No	$ 375	Before and After Deductible	No					
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)		No	$ 15	Before and After Deductible	No					
Hospice Services		No	$ 15	Before and After Deductible	No				Note 5	
Infertility Treatment		Yes				20%	After Deductible			
Home Health Care Services		No	$ 15	Before and After Deductible	No				Note 5	
Inpatient Physician and Surgical Services		No	$ -	Before and After Deductible					Note 3	
Cosmetic Surgery		No	$ 525	Before and After Deductible	No					
Outpatient Rehabilitation Services		No	$ 25	Before and After Deductible	No				Note 1	
Habilitation Services		No	$ 25	Before and After Deductible	No				Note 1	
Chiropractic Care		No	$ 25	Before and After Deductible	No				Note 1	
Durable Medical Equipment		Yes				20%	After Deductible			
Hearing Aids		No				20%	Before Deductible	No		
Routine Foot Care		No	$ 15	Before and After Deductible	No					
Acupuncture		No	$ 25	Before and After Deductible	No				Note 1	
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Transplant		No	$ 525	Before and After Deductible	No					
Dialysis		Yes				20%	After Deductible			
Chemotherapy		No	$ 100	Before and After Deductible	No				Note 4	
Radiation		Yes	$ 350	After Deductible						
Prosthetic Devices		Yes				20%	After Deductible			
Infusion Therapy		Yes				20%	After Deductible			
Treatment for Temporomandibular Joint Disorders		Yes	$ 75	After Deductible					Note 1	
Nutritional Counseling		No	$ 15	Before and After Deductible	No					
Reconstructive Surgery		No	$ 525	Before and After Deductible	No					
Gender Affirming Care		No	$ 15	Before and After Deductible	No					
Diabetes Care Management		No	$ 15	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU		No	$ 15	Before and After Deductible	No					
Dental Anesthesia		Yes	$ 75	After Deductible					Note 1	
Non-EHB Benefits										
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)		No	$ 10	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 60	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		No	$ 100	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 100	Before and After Deductible	No					

Notes

Note 1 Cost share just for physician/professional services.

Note 2 Per day copay. Cost share just for facility services.

Note 3 Per day copay, maximum of five copays per stay. The copay for all Inpatient Hospital Services covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay only the $525 copay

Note 4 Cost share applies to outpatient facility, professional/administration fees, and the associated drug

Note 5 Per day copay.

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060006
Line 1.2	**Plan Name**	Molina Cascade Silver
Line 1.3	**Metal Level**	Silver
Line 1.4	**Cost-Share Reduction (CSR) Plan?**	No
Line 1.5	**Exchange Status**	On Exchange
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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$2,500	
Default Coinsurance			30%	
MOOP			$9,750	

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	No	Yes	$ 800	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes	$ 800	After Deductible					Note 3	
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 20	Before and After Deductible	No				Note 5	
Specialist Visit	No	No	$ 65	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 20	Before and After Deductible	No				Note 5	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 30	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	Yes				30%	After Deductible			
Rehabilitative Speech Therapy	No	No	$ 40	Before and After Deductible	No				Note 1	
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 40	Before and After Deductible	No				Note 1	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 40	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 65	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 800	After Deductible					Note 6	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes	$ 600	After Deductible					Note 2	
Outpatient Surgery Physician/Surgical Services	No	Yes	$ 200	After Deductible					Note 2	
Urgent Care	No	No	$ 65	Before and After Deductible	No					
Emergency Transportation	No	No	$ 375	Before and After Deductible	No					
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	No	$ 20	Before and After Deductible	No				Note 5	
Hospice Services	No	No	$ 30	Before and After Deductible	No				Note 6	
Infertility Treatment	No	Yes				30%	After Deductible			
Home Health Care Services	No	No	$ 30	Before and After Deductible	No				Note 6	
Inpatient Physician and Surgical Services	No	No	$ -	Before and After Deductible					Note 3	
Cosmetic Surgery	No	Yes	$ 800	After Deductible						
Outpatient Rehabilitation Services	No	No	$ 40	Before and After Deductible	No					
Habilitation Services	No	No	$ 40	Before and After Deductible	No					
Chiropractic Care	No	No	$ 20	Before and After Deductible	No					
Durable Medical Equipment	No	Yes				30%	After Deductible			
Hearing Aids	No	Yes				30%	Before and After Deductible			
Routine Foot Care	No	No	$ 20	Before and After Deductible	No					
Acupuncture	No	No	$ 40	Before and After Deductible	No					
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Transplant	No	Yes	$ 800	After Deductible						
Dialysis	No	Yes				30%	After Deductible			
Chemotherapy	No	Yes	$ 250	After Deductible						
Radiation	No	Yes	$ 600	After Deductible						
Prosthetic Devices	No	Yes				30%	After Deductible			
Infusion Therapy	No	Yes				30%	After Deductible			
Treatment for Temporomandibular Joint Disorders	No	Yes	$ 200	After Deductible						
Nutritional Counseling	No	No	$ 20	Before and After Deductible	No					
Reconstructive Surgery	No	Yes	$ 800	After Deductible						
Gender Affirming Care	No	No	$ 20	Before and After Deductible	No					
Diabetes Care Management	No	No	$ 20	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU	No	No	$ 20	Before and After Deductible	No					
Dental Anesthesia	No	Yes	$ 600	After Deductible					Note 2	
Non-EHB Benefits										
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)		No	$ 25	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 75	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		Yes	$ 250	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 250	After Deductible						

Notes

Note 1 Cost share just for physician/professional services

Note 2 Cost share just for facility services

Note 3 Per day copay, maximum of five copays per stay. The copay for all Inpatient Hospital Services covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay only the $525 copay

Note 4 Cost share applies to outpatient facility, professional/administration fees, and the associated drug

Note 5 Eligible for two visits at $1 copay, after which stated cost-sharing applies

Note 6 Per day copay.

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060006
Line 1.2	**Plan Name**	Molina Cascade Silver 73
Line 1.3	**Metal Level**	Silver
Line 1.4	**Cost-Share Reduction (CSR) Plan?**	73% AV Level Silver Plan
Line 1.5	**Exchange Status**	On Exchange
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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$2,500	
Default Coinsurance			30%	
MOOP			$7,950	

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	No	Yes	$ 800	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes	$ 800	After Deductible					Note 3	
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 20	Before and After Deductible	No				Note 5	
Specialist Visit	No	No	$ 65	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 20	Before and After Deductible	No				Note 5	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 30	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	Yes				30%	After Deductible			
Rehabilitative Speech Therapy	No	No	$ 40	Before and After Deductible	No				Note 1	
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 40	Before and After Deductible	No				Note 1	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 40	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 65	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 800	After Deductible					Note 6	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes	$ 600	After Deductible					Note 2	
Outpatient Surgery Physician/Surgical Services	No	Yes	$ 200	After Deductible					Note 2	
Urgent Care	No	No	$ 65	Before and After Deductible	No					
Emergency Transportation	No	No	$ 325	Before and After Deductible	No					
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	No	$ 20	Before and After Deductible	No				Note 5	
Hospice Services	No	No	$ 30	Before and After Deductible	No				Note 6	
Infertility Treatment	No	Yes				30%	After Deductible			
Home Health Care Services	No	No	$ 30	Before and After Deductible	No				Note 6	
Inpatient Physician and Surgical Services	No	No	$ -	Before and After Deductible					Note 3	
Cosmetic Surgery	No	Yes	$ 800	After Deductible						
Outpatient Rehabilitation Services	No	No	$ 40	Before and After Deductible	No				Note 1	
Habilitation Services	No	No	$ 40	Before and After Deductible	No				Note 1	
Chiropractic Care	No	No	$ 40	Before and After Deductible	No				Note 1	
Durable Medical Equipment	No	Yes				30%	After Deductible			
Hearing Aids	No	Yes				30%	Before and After Deductible			
Routine Foot Care	No	No	$ 20	Before and After Deductible	No					
Acupuncture	No	No	$ 40	Before and After Deductible	No					
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Transplant	No	Yes	$ 800	After Deductible						
Dialysis	No	Yes				30%	After Deductible			
Chemotherapy	No	Yes	$ 250	After Deductible					Note 4	
Radiation	No	Yes	$ 600	After Deductible						
Prosthetic Devices	No	Yes	$ 250	After Deductible					Note 4	
Infusion Therapy	No	Yes				30%	After Deductible			
Treatment for Temporomandibular Joint Disorders	No	Yes	$ 200	After Deductible					Note 1	
Nutritional Counseling	No	No	$ 30	Before and After Deductible	No					
Reconstructive Surgery	No	Yes	$ 800	After Deductible						
Gender Affirming Care	No	No	$ 20	Before and After Deductible	No					
Diabetes Care Management	No	No	$ 20	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU	No	No	$ 20	Before and After Deductible	No					
Dental Anesthesia	No	Yes	$ 200	After Deductible					Note 1	
Non-EHB Benefits										
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)		No	$ 24	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 75	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		Yes	$ 250	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 250	After Deductible						

Notes

Note 1 Cost share just for physician/professional services

Note 2 Cost share just for facility services

Note 3 Per day copay, maximum of five copays per stay. The copay for all Inpatient Hospital Services covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay only the $525 copay

Note 4 Cost share applies to outpatient facility, professional/administration fees, and the associated drug

Note 5 Eligible for two visits at $1 copay, after which stated cost-sharing applies

Note 6 Per day copay.

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060006	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Molina Cascade Silver 87	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	87% AV Level Silver 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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$750	
Default Coinsurance			20%	
MOOP			$2,850	

			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	$ 425	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes	$ 425	After Deductible					Note 3	
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 5	Before and After Deductible	No				Note 5	
Specialist Visit	No	No	$ 30	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 5	Before and After Deductible	No				Note 5	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 10	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	Yes				20%	After Deductible			
Rehabilitative Speech Therapy	No	No	$ 20	Before and After Deductible	No				Note 1	
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 20	Before and After Deductible	No				Note 1	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 20	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 40	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 425	After Deductible					Note 6	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes	$ 325	After Deductible					Note 2	
Outpatient Surgery Physician/Surgical Services	No	Yes	$ 120	After Deductible					Note 2	
Urgent Care	No	No	$ 30	Before and After Deductible	No					
Emergency Transportation	No	No	$ 175	Before and After Deductible	No					
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	No	$ 5	Before and After Deductible	No				Note 5	
Hospice Services	No	No	$ 10	Before and After Deductible	No				Note 6	
Infertility Treatment	No	Yes				20%	After Deductible			
Home Health Care Services	No	No	$ 10	Before and After Deductible	No				Note 6	
Inpatient Physician and Surgical Services	No	No	$ -	Before and After Deductible					Note 3	
Cosmetic Surgery	No	Yes	$ 425	After Deductible						
Outpatient Rehabilitation Services	No	No	$ 20	Before and After Deductible	No					
Habilitation Services	No	No	$ 20	Before and After Deductible	No					
Chiropractic Care	No	No	$ 20	Before and After Deductible	No					
Durable Medical Equipment	No	Yes				20%	After Deductible			
Hearing Aids	No	Yes				20%	Before and After Deductible			
Routine Foot Care	No	No	$ 5	Before and After Deductible	No					
Acupuncture	No	No	$ 20	Before and After Deductible	No					
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Transplant	No	Yes	$ 425	After Deductible						
Dialysis	No	Yes				20%	After Deductible			
Chemotherapy	No	Yes	$ 160	Before and After Deductible						
Radiation	No	Yes	$ 325	After Deductible						
Prosthetic Devices	No	Yes				20%	After Deductible			
Infusion Therapy	No	Yes				20%	After Deductible			
Treatment for Temporomandibular Joint Disorders	No	Yes	$ 120	After Deductible						
Nutritional Counseling	No	No	$ 10	Before and After Deductible	No					
Reconstructive Surgery	No	Yes	$ 425	After Deductible						
Gender Affirming Care	No	No	$ 5	Before and After Deductible	No					
Diabetes Care Management	No	No	$ 10	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU	No	No	$ 10	Before and After Deductible	No					
Dental Anesthesia	No	Yes	$ 120	After Deductible					Note 1	
Non-EHB Benefits										
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)		No	$ 12	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 35	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		No	$ 160	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 160	Before and After Deductible	No					

Notes

Note 1 Cost share just for physician/professional services

Note 2 Cost share just for facility services

Note 3 Per day copay, maximum of five copays per stay. The copay for all Inpatient Hospital Services covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay only the $525 copay

Note 4 Cost share applies to outpatient facility, professional/administration fees, and the associated drug

Note 5 Eligible for two visits at $1 copay, after which stated cost-sharing applies

Note 6 Per day copay.

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060006	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Molina Cascade Silver 94	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	94% AV Level Silver 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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$0	
Default Coinsurance			15%	
MOOP			$2,400	

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	No	No	$ 150	Before and After Deductible	No					
Inpatient Hospital Services (e.g., Hospital Stay)	No	No	$ 100	Before and After Deductible	No				Note 3	
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 1	Before and After Deductible	No				Note 5	
Specialist Visit	No	No	$ 15	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 1	Before and After Deductible	No				Note 5	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 5	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	No				15%	Before and After Deductible	No		
Rehabilitative Speech Therapy	No	No	$ 5	Before and After Deductible	No				Note 1	
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 5	Before and After Deductible	No				Note 1	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 5	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 15	Before and After Deductible	No					
Skilled Nursing Facility	No	No	$ 100	Before and After Deductible	No				Note 6	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	No	$ 100	Before and After Deductible	No				Note 2	
Outpatient Surgery Physician/Surgical Services	No	No	$ 25	Before and After Deductible	No				Note 2	
Urgent Care	No	No	$ 15	Before and After Deductible	No					
Emergency Transportation	No	No	$ 75	Before and After Deductible	No					
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	No	$ 1	Before and After Deductible	No				Note 5	
Hospice Services	No	No	$ 5	Before and After Deductible	No				Note 6	
Infertility Treatment	No	No				15%	Before and After Deductible	No		
Home Health Care Services	No	No	$ 5	Before and After Deductible	No				Note 6	
Inpatient Physician and Surgical Services	No	No	$ -	Before and After Deductible					Note 3	
Cosmetic Surgery	No	No	$ 100	Before and After Deductible	No					
Outpatient Rehabilitation Services	No	No	$ 5	Before and After Deductible	No					
Habilitation Services	No	No	$ 5	Before and After Deductible	No					
Chiropractic Care	No	No	$ 5	Before and After Deductible	No					
Durable Medical Equipment	No	No				15%	Before and After Deductible	No		
Hearing Aids	No	No				15%	Before and After Deductible	No		
Routine Foot Care	No	No	$ 1	Before and After Deductible	No					
Acupuncture	No	No	$ 5	Before and After Deductible	No					
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Transplant	No	No	$ 100	Before and After Deductible	No					
Dialysis	No	No				15%	Before and After Deductible	No		
Chemotherapy	No	No	$ 35	Before and After Deductible	No					
Radiation	No	No	$ 100	Before and After Deductible	No					
Prosthetic Devices	No	No				15%	Before and After Deductible	No		
Infusion Therapy	No	No				15%	Before and After Deductible	No		
Treatment for Temporomandibular Joint Disorders	No	No	$ 25	Before and After Deductible	No					
Nutritional Counseling	No	No	$ 1	Before and After Deductible	No					
Reconstructive Surgery	No	No	$ 100	Before and After Deductible	No					
Gender Affirming Care	No	No	$ 1	Before and After Deductible	No					
Diabetes Care Management	No	No	$ 1	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU	No	No	$ 1	Before and After Deductible	No					
Dental Anesthesia	No	No	$ 100	Before and After Deductible	No					
Non-EHB Benefits										
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)		No	$ 5	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 12	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		No	$ 35	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 35	Before and After Deductible	No					

Notes

Note 1 Cost share just for physician/professional services

Note 2 Cost share just for facility services

Note 3 Per day copay, maximum of five copays per stay. The copay for all Inpatient Hospital Services covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay only the $525 copay

Note 4 Cost share applies to outpatient facility, professional/administration fees, and the associated drug

Note 5 Eligible for two visits at $1 copay, after which stated cost-sharing applies

Note 6 Per day copay.

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060007
Line 1.2	**Plan Name**	Molina Cascade Bronze
Line 1.3	**Metal Level**	Expanded Bronze
Line 1.4	**Cost-Share Reduction (CSR) Plan?**	
Line 1.5	**Exchange Status**	On Exchange
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**	2
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$6,000	
Default Coinsurance			40%	
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	No	Yes				40%	After Deductible			
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes				40%	After Deductible			
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 40	Before and After Deductible	No				Note 2	
Specialist Visit	No	No	$ 100	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 40	Before and After Deductible	No				Note 2	
Mental Health & Substance Use Disorder All Other OP Services	No	Yes				40%	After Deductible		Note 1	
Imaging (CT/PET Scans, MRIs)	No	Yes				40%	After Deductible			
Rehabilitative Speech Therapy	No	Yes				40%	After Deductible			
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	Yes				40%	After Deductible			
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	Yes				40%	After Deductible			
X-rays and Diagnostic Imaging	No	Yes				40%	After Deductible			
Skilled Nursing Facility	No	Yes				40%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes				40%	After Deductible			
Outpatient Surgery Physician/Surgical Services	No	Yes				40%	After Deductible			
Urgent Care	No	No	$ 100	Before and After Deductible	No					
Emergency Transportation	No	Yes				40%	After Deductible			
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	No	$ 40	Before and After Deductible	No				Note 2	
Hospice Services	No	No	$ 50	Before and After Deductible	No				Note 3	
Infertility Treatment	No	Yes				40%	After Deductible			
Home Health Care Services	No	No	$ 50	Before and After Deductible	No				Note 3	
Inpatient Physician and Surgical Services	No	Yes				40%	After Deductible			
Cosmetic Surgery	No	Yes				40%	After Deductible			
Outpatient Rehabilitation Services	No	Yes				40%	After Deductible		Note 1	
Habilitation Services	No	Yes				40%	After Deductible		Note 1	
Chiropractic Care	No	Yes				40%	After Deductible		Note 1	
Durable Medical Equipment	No	Yes				40%	After Deductible			
Hearing Aids	No	No				40%	Before and After Deductible	No		
Routine Foot Care	No	No	$ 40	Before and After Deductible	No					
Acupuncture	No	Yes				40%	After Deductible			
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Transplant	No	Yes				40%	After Deductible			
Dialysis	No	Yes				40%	After Deductible			
Chemotherapy	No	Yes				40%	After Deductible			
Radiation	No	Yes				40%	After Deductible			
Prosthetic Devices	No	Yes				40%	After Deductible			
Infusion Therapy	No	Yes				40%	After Deductible			
Treatment for Temporomandibular Joint Disorders	No	Yes				40%	After Deductible			
Nutritional Counseling	No	No	$ 40	Before and After Deductible	No					
Reconstructive Surgery	No	Yes				40%	After Deductible			
Gender Affirming Care	No	No	$ 40	Before and After Deductible	No					
Diabetes Care Management	No	No	$ 40	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU	No	No	$ 40	Before and After Deductible	No					
Dental Anesthesia	No	Yes				40%	After Deductible			
Non-EHB Benefits										
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)		No	$ 32	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				40%	After Deductible			

Notes

Note 1 Cost share just for physician/professional services

Note 2 Eligible for two visits at $1 copay, after which stated cost-sharing applies

Note 3 Per day copay.

Benefit Components

Worksheet Controls

Company: Molina Healthcare of Washington, Inc. **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	84481WA0060008
Line 1.2	**Plan Name**	Molina Cascade Vital Gold
Line 1.3	**Metal Level**	Gold
Line 1.4	**Cost-Share Reduction (CSR) Plan?**	
Line 1.5	**Exchange Status**	On Exchange
Line 1.6	**New or Renewing**	New

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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

Section 3: Network and Tier Information

Line 3.1	**Network Type**	HMO
Line 3.2	**Network Name**	Molina Marketplace
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: Molina Marketplace

	Medical	Drug	Combined	Errors/Warnings
Deductible			$1,900	
Default Coinsurance			20%	
MOOP			$8,800	

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	$ 800	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)		Yes	$ 650	After Deductible					Note 3	
Primary Care Visit to Treat an Injury or Illness		No	$ 15	Before and After Deductible	No					
Specialist Visit		No	$ 40	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 15	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		No	$ 15	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)		Yes	$ 300	After Deductible						
Rehabilitative Speech Therapy		No	$ 30	Before and After Deductible	No				Note 1	
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 30	Before and After Deductible	No				Note 1	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 30	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 30	Before and After Deductible	No					
Skilled Nursing Facility		Yes	$ 350	After Deductible					Note 2	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	$ 350	After Deductible						
Outpatient Surgery Physician/Surgical Services		Yes	$ 75	After Deductible						
Urgent Care		No	$ 35	Before and After Deductible	No					
Emergency Transportation		No	$ 375	Before and After Deductible	No					
Other EHB Categories										
Other Practitioner Office Visit (Nurse, Physician Assistant)		No	$ 15	Before and After Deductible	No					
Hospice Services		No	$ 15	Before and After Deductible	No				Note 5	
Infertility Treatment		Yes	$ 350	After Deductible						
Home Health Care Services		No	$ 15	Before and After Deductible	No				Note 5	
Inpatient Physician and Surgical Services		No	$ -	Before and After Deductible					Note 3	
Cosmetic Surgery		Yes	$ 650	After Deductible						
Outpatient Rehabilitation Services		No	$ 30	Before and After Deductible	No				Note 1	
Habilitation Services		No	$ 30	Before and After Deductible	No				Note 1	
Chiropractic Care		No	$ 30	Before and After Deductible	No				Note 1	
Durable Medical Equipment		Yes				20%	After Deductible			
Hearing Aids		No				20%	Before and After Deductible	No		
Routine Foot Care		No	$ 15	Before and After Deductible	No					
Acupuncture		No	$ 30	Before and After Deductible	No				Note 1	
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Transplant		Yes	$ 650	After Deductible						
Dialysis		Yes				20%	After Deductible			
Chemotherapy		Yes	$ 200	After Deductible					Note 4	
Radiation		Yes	$ 350	After Deductible						
Prosthetic Devices		Yes				20%	After Deductible			
Infusion Therapy		Yes				20%	After Deductible			
Treatment for Temporomandibular Joint Disorders		Yes	$ 75	After Deductible					Note 1	
Nutritional Counseling		No	$ 15	Before and After Deductible	No					
Reconstructive Surgery		Yes	$ 650	After Deductible						
Gender Affirming Care		No	$ 15	Before and After Deductible	No					
Diabetes Care Management		No	$ 15	Before and After Deductible	No					
Inherited Metabolic Disorder - PKU		No	$ 15	Before and After Deductible	No					
Dental Anesthesia		Yes	$ 75	After Deductible					Note 1	
Non-EHB Benefits										
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)		No	$ 10	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 75	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		Yes	$ 200	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 200	After Deductible						

Notes

Note 1 Cost share just for physician/professional services.

Note 2 Per day copay. Cost share just for facility services.

Note 3 Per day copay, maximum of five copays per stay. The copay for all Inpatient Hospital Services covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay only the $525 copay

Note 4 Cost share applies to outpatient facility, professional/administration fees, and the associated drug

Note 5 Per day copay.

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Complete Gold
HIOS Plan ID: 84481WA0060005
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	335.31	341.65	385.53	335.43	335.42	346.70		339.95		335.31	341.65	385.53	335.43	335.42	346.70		339.95	
15	365.12	372.01	419.80	365.24	365.23	377.52		370.17		365.12	372.01	419.80	365.24	365.23	377.52		370.17	
16	376.52	383.63	432.90	376.64	376.63	389.30		381.72		376.52	383.63	432.90	376.64	376.63	389.30		381.72	
17	387.91	395.24	446.00	388.04	388.03	401.09		393.28		387.91	395.24	446.00	388.04	388.03	401.09		393.28	
18	400.18	407.74	460.11	400.32	400.31	413.78		405.72		400.18	407.74	460.11	400.32	400.31	413.78		405.72	
19	412.46	420.25	474.22	412.60	412.58	426.47		418.16		412.46	420.25	474.22	412.60	412.58	426.47		418.16	
20	425.17	433.20	488.84	425.31	425.30	439.61		431.05		425.17	433.20	488.84	425.31	425.30	439.61		431.05	
21	438.32	446.60	503.96	438.46	438.45	453.20		444.38		438.32	446.60	503.96	438.46	438.45	453.20		444.38	
22	438.32	446.60	503.96	438.46	438.45	453.20		444.38		438.32	446.60	503.96	438.46	438.45	453.20		444.38	
23	438.32	446.60	503.96	438.46	438.45	453.20		444.38		438.32	446.60	503.96	438.46	438.45	453.20		444.38	
24	438.32	446.60	503.96	438.46	438.45	453.20		444.38		438.32	446.60	503.96	438.46	438.45	453.20		444.38	
25	440.07	448.38	505.97	440.22	440.21	455.02		446.16		440.07	448.38	505.97	440.22	440.21	455.02		446.16	
26	448.84	457.31	516.05	448.99	448.97	464.08		455.05		448.84	457.31	516.05	448.99	448.97	464.08		455.05	
27	459.36	468.03	528.15	459.51	459.50	474.96		465.71		459.36	468.03	528.15	459.51	459.50	474.96		465.71	
28	476.45	485.45	547.80	476.61	476.60	492.63		483.04		476.45	485.45	547.80	476.61	476.60	492.63		483.04	
29	490.48	499.74	563.93	490.64	490.63	507.14		497.26		490.48	499.74	563.93	490.64	490.63	507.14		497.26	
30	497.49	506.89	571.99	497.66	497.64	514.39		504.37		497.49	506.89	571.99	497.66	497.64	514.39		504.37	
31	508.01	517.60	584.09	508.18	508.17	525.26		515.04		508.01	517.60	584.09	508.18	508.17	525.26		515.04	
32	518.53	528.32	596.18	518.70	518.69	536.14		525.70		518.53	528.32	596.18	518.70	518.69	536.14		525.70	
33	525.11	535.02	603.74	525.28	525.27	542.94		532.37		525.11	535.02	603.74	525.28	525.27	542.94		532.37	
34	532.12	542.17	611.80	532.30	532.28	550.19		539.48		532.12	542.17	611.80	532.30	532.28	550.19		539.48	
35	535.63	545.74	615.84	535.80	535.79	553.82		543.04		535.63	545.74	615.84	535.80	535.79	553.82		543.04	
36	539.13	549.31	619.87	539.31	539.30	557.44		546.59		539.13	549.31	619.87	539.31	539.30	557.44		546.59	
37	542.64	552.89	623.90	542.82	542.80	561.07		550.15		542.64	552.89	623.90	542.82	542.80	561.07		550.15	
38	546.14	556.46	627.93	546.33	546.31	564.69		553.70		546.14	556.46	627.93	546.33	546.31	564.69		553.70	
39	553.16	563.60	635.99	553.34	553.33	571.94		560.81		553.16	563.60	635.99	553.34	553.33	571.94		560.81	
40	560.17	570.75	644.06	560.36	560.34	579.20		567.92		560.17	570.75	644.06	560.36	560.34	579.20		567.92	
41	570.69	581.47	656.15	570.88	570.86	590.07		578.59		570.69	581.47	656.15	570.88	570.86	590.07		578.59	
42	580.77	591.74	667.74	580.97	580.95	600.50		588.81		580.77	591.74	667.74	580.97	580.95	600.50		588.81	
43	594.80	606.03	683.87	595.00	594.98	615.00		603.03		594.80	606.03	683.87	595.00	594.98	615.00		603.03	
44	612.33	623.89	704.03	612.54	612.52	633.13		620.80		612.33	623.89	704.03	612.54	612.52	633.13		620.80	
45	632.93	644.88	727.71	633.14	633.12	654.43		641.69		632.93	644.88	727.71	633.14	633.12	654.43		641.69	
46	657.48	669.89	755.94	657.70	657.68	679.81		666.57		657.48	669.89	755.94	657.70	657.68	679.81		666.57	
47	685.09	698.03	787.68	685.32	685.30	708.36		694.57		685.09	698.03	787.68	685.32	685.30	708.36		694.57	
48	716.65	730.18	823.97	716.89	716.87	740.99		726.57		716.65	730.18	823.97	716.89	716.87	740.99		726.57	
49	747.77	761.89	859.75	748.02	748.00	773.17		758.12		747.77	761.89	859.75	748.02	748.00	773.17		758.12	
50	782.84	797.62	900.07	783.10	783.08	809.42		793.67		782.84	797.62	900.07	783.10	783.08	809.42		793.67	
51	817.46	832.90	939.88	817.74	817.71	845.23		828.77		817.46	832.90	939.88	817.74	817.71	845.23		828.77	
52	855.60	871.76	983.72	855.88	855.86	884.66		867.43		855.60	871.76	983.72	855.88	855.86	884.66		867.43	
53	894.17	911.06	1028.07	894.47	894.44	924.54		906.54		894.17	911.06	1028.07	894.47	894.44	924.54		906.54	
54	935.81	953.48	1075.95	936.12	936.10	967.59		948.76		935.81	953.48	1075.95	936.12	936.10	967.59		948.76	
55	977.45	995.91	1123.82	977.78	977.75	1010.65		990.97		977.45	995.91	1123.82	977.78	977.75	1010.65		990.97	
56	1022.60	1041.91	1175.73	1022.94	1022.91	1057.33		1036.74		1022.60	1041.91	1175.73	1022.94	1022.91	1057.33		1036.74	
57	1068.18	1088.35	1228.14	1068.54	1068.51	1104.46		1082.96		1068.18	1088.35	1228.14	1068.54	1068.51	1104.46		1082.96	
58	1116.84	1137.93	1284.08	1117.21	1117.18	1154.77		1132.29		1116.84	1137.93	1284.08	1117.21	1117.18	1154.77		1132.29	
59	1140.94	1162.49	1311.80	1141.32	1141.29	1179.69		1156.73		1140.94	1162.49	1311.80	1141.32	1141.29	1179.69		1156.73	
60	1189.60	1212.06	1367.74	1189.99	1189.96	1230.00		1206.05		1189.60	1212.06	1367.74	1189.99	1189.96	1230.00		1206.05	
61	1231.68	1254.94	1416.12	1232.09	1232.05	1273.51		1248.71		1231.68	1254.94	1416.12	1232.09	1232.05	1273.51		1248.71	
62	1259.29	1283.07	1447.87	1259.71	1259.67	1302.06		1276.71		1259.29	1283.07	1447.87	1259.71	1259.67	1302.06		1276.71	
63	1293.92	1318.35	1487.68	1294.35	1294.31	1337.86		1311.82		1293.92	1318.35	1487.68	1294.35	1294.31	1337.86		1311.82	
64 and over	1314.96	1339.79	1511.87	1315.38	1315.35	1359.60		1333.14		1314.96	1339.79	1511.87	1315.38	1315.35	1359.60		1333.14	

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Silver
HIOS Plan ID: 84481WA0060006
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Silver
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	395.49	402.96	454.72	395.62	395.61	408.92		400.96		395.49	402.96	454.72	395.62	395.61	408.92		400.96	
15	430.65	438.78	495.14	430.79	430.78	445.27		436.60		430.65	438.78	495.14	430.79	430.78	445.27		436.60	
16	444.09	452.48	510.59	444.24	444.22	459.17		450.23		444.09	452.48	510.59	444.24	444.22	459.17		450.23	
17	457.53	466.17	526.05	457.68	457.67	473.07		463.86		457.53	466.17	526.05	457.68	457.67	473.07		463.86	
18	472.01	480.92	542.69	472.16	472.15	488.04		478.54		472.01	480.92	542.69	472.16	472.15	488.04		478.54	
19	486.48	495.67	559.33	486.64	486.63	503.00		493.21		486.48	495.67	559.33	486.64	486.63	503.00		493.21	
20	501.47	510.94	576.57	501.64	501.63	518.50		508.41		501.47	510.94	576.57	501.64	501.63	518.50		508.41	
21	516.98	526.75	594.40	517.16	517.14	534.54		524.13		516.98	526.75	594.40	517.16	517.14	534.54		524.13	
22	516.98	526.75	594.40	517.16	517.14	534.54		524.13		516.98	526.75	594.40	517.16	517.14	534.54		524.13	
23	516.98	526.75	594.40	517.16	517.14	534.54		524.13		516.98	526.75	594.40	517.16	517.14	534.54		524.13	
24	516.98	526.75	594.40	517.16	517.14	534.54		524.13		516.98	526.75	594.40	517.16	517.14	534.54		524.13	
25	519.05	528.85	596.78	519.22	519.21	536.68		526.23		519.05	528.85	596.78	519.22	519.21	536.68		526.23	
26	529.39	539.39	608.67	529.57	529.55	547.37		536.71		529.39	539.39	608.67	529.57	529.55	547.37		536.71	
27	541.80	552.03	622.93	541.98	541.96	560.20		549.29		541.80	552.03	622.93	541.98	541.96	560.20		549.29	
28	561.96	572.57	646.11	562.15	562.13	581.05		569.73		561.96	572.57	646.11	562.15	562.13	581.05		569.73	
29	578.50	589.43	665.14	578.70	578.68	598.15		586.51		578.50	589.43	665.14	578.70	578.68	598.15		586.51	
30	586.78	597.86	674.65	586.97	586.95	606.70		594.89		586.78	597.86	674.65	586.97	586.95	606.70		594.89	
31	599.18	610.50	688.91	599.38	599.37	619.53		607.47		599.18	610.50	688.91	599.38	599.37	619.53		607.47	
32	611.59	623.14	703.18	611.80	611.78	632.36		620.05		611.59	623.14	703.18	611.80	611.78	632.36		620.05	
33	619.35	631.04	712.09	619.55	619.53	640.38		627.91		619.35	631.04	712.09	619.55	619.53	640.38		627.91	
34	627.62	639.47	721.60	627.83	627.81	648.93		636.30		627.62	639.47	721.60	627.83	627.81	648.93		636.30	
35	631.75	643.68	726.36	631.96	631.95	653.21		640.49		631.75	643.68	726.36	631.96	631.95	653.21		640.49	
36	635.89	647.90	731.11	636.10	636.08	657.49		644.69		635.89	647.90	731.11	636.10	636.08	657.49		644.69	
37	640.03	652.11	735.87	640.24	640.22	661.76		648.88		640.03	652.11	735.87	640.24	640.22	661.76		648.88	
38	644.16	656.33	740.62	644.38	644.36	666.04		653.07		644.16	656.33	740.62	644.38	644.36	666.04		653.07	
39	652.43	664.75	750.13	652.65	652.63	674.59		661.46		652.43	664.75	750.13	652.65	652.63	674.59		661.46	
40	660.70	673.18	759.65	660.92	660.91	683.14		669.84		660.70	673.18	759.65	660.92	660.91	683.14		669.84	
41	673.11	685.82	773.91	673.34	673.32	695.97		682.42		673.11	685.82	773.91	673.34	673.32	695.97		682.42	
42	685.00	697.94	787.58	685.23	685.21	708.27		694.48		685.00	697.94	787.58	685.23	685.21	708.27		694.48	
43	701.55	714.79	806.60	701.78	701.76	725.37		711.25		701.55	714.79	806.60	701.78	701.76	725.37		711.25	
44	722.23	735.86	830.38	722.47	722.45	746.75		732.22		722.23	735.86	830.38	722.47	722.45	746.75		732.22	
45	746.52	760.62	858.32	746.77	746.75	771.88		756.85		746.52	760.62	858.32	746.77	746.75	771.88		756.85	
46	775.47	790.12	891.60	775.73	775.71	801.81		786.20		775.47	790.12	891.60	775.73	775.71	801.81		786.20	
47	808.04	823.30	929.05	808.31	808.29	835.49		819.22		808.04	823.30	929.05	808.31	808.29	835.49		819.22	
48	845.27	861.23	971.85	845.55	845.52	873.97		856.96		845.27	861.23	971.85	845.55	845.52	873.97		856.96	
49	881.97	898.63	1014.05	882.27	882.24	911.93		894.17		881.97	898.63	1014.05	882.27	882.24	911.93		894.17	
50	923.33	940.77	1061.60	923.64	923.61	954.69		936.11		923.33	940.77	1061.60	923.64	923.61	954.69		936.11	
51	964.17	982.38	1108.56	964.50	964.47	996.92		977.51		964.17	982.38	1108.56	964.50	964.47	996.92		977.51	
52	1009.15	1028.21	1160.27	1009.49	1009.46	1043.42		1023.11		1009.15	1028.21	1160.27	1009.49	1009.46	1043.42		1023.11	
53	1054.65	1074.56	1212.58	1055.00	1054.97	1090.46		1069.24		1054.65	1074.56	1212.58	1055.00	1054.97	1090.46		1069.24	
54	1103.76	1124.60	1269.05	1104.13	1104.09	1141.25		1119.03		1103.76	1124.60	1269.05	1104.13	1104.09	1141.25		1119.03	
55	1152.87	1174.64	1325.52	1153.26	1153.22	1192.03		1168.82		1152.87	1174.64	1325.52	1153.26	1153.22	1192.03		1168.82	
56	1206.12	1228.90	1386.74	1206.52	1206.49	1247.08		1222.81		1206.12	1228.90	1386.74	1206.52	1206.49	1247.08		1222.81	
57	1259.89	1283.68	1448.56	1260.31	1260.27	1302.68		1277.32		1259.89	1283.68	1448.56	1260.31	1260.27	1302.68		1277.32	
58	1317.27	1342.15	1514.54	1317.71	1317.67	1362.01		1335.50		1317.27	1342.15	1514.54	1317.71	1317.67	1362.01		1335.50	
59	1345.71	1371.12	1547.23	1346.16	1346.12	1391.41		1364.32		1345.71	1371.12	1547.23	1346.16	1346.12	1391.41		1364.32	
60	1403.09	1429.59	1613.21	1403.56	1403.52	1450.74		1422.50		1403.09	1429.59	1613.21	1403.56	1403.52	1450.74		1422.50	
61	1452.72	1480.16	1670.27	1453.21	1453.16	1502.06		1472.82		1452.72	1480.16	1670.27	1453.21	1453.16	1502.06		1472.82	
62	1485.29	1513.34	1707.72	1485.79	1485.74	1535.74		1505.84		1485.29	1513.34	1707.72	1485.79	1485.74	1535.74		1505.84	
63	1526.13	1554.95	1754.67	1526.64	1526.60	1577.97		1547.25		1526.13	1554.95	1754.67	1526.64	1526.60	1577.97		1547.25	
64 and over	1550.94	1580.24	1783.20	1551.47	1551.42	1603.62		1572.39		1550.94	1580.24	1783.20	1551.47	1551.42	1603.62		1572.39	

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Bronze
HIOS Plan ID: 84481WA0060007
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Bronze
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	256.82	261.67	295.28	256.91	256.90	265.54		260.37		256.82	261.67	295.28	256.91	256.90	265.54		260.37	
15	279.65	284.93	321.53	279.74	279.73	289.15		283.52		279.65	284.93	321.53	279.74	279.73	289.15		283.52	
16	288.38	293.82	331.56	288.47	288.46	298.17		292.37		288.38	293.82	331.56	288.47	288.46	298.17		292.37	
17	297.10	302.72	341.60	297.20	297.20	307.20		301.21		297.10	302.72	341.60	297.20	297.20	307.20		301.21	
18	306.50	312.29	352.40	306.61	306.60	316.91		310.74		306.50	312.29	352.40	306.61	306.60	316.91		310.74	
19	315.90	321.87	363.21	316.01	316.00	326.63		320.27		315.90	321.87	363.21	316.01	316.00	326.63		320.27	
20	325.64	331.79	374.40	325.75	325.74	336.70		330.15		325.64	331.79	374.40	325.75	325.74	336.70		330.15	
21	335.71	342.05	385.98	335.82	335.81	347.11		340.36		335.71	342.05	385.98	335.82	335.81	347.11		340.36	
22	335.71	342.05	385.98	335.82	335.81	347.11		340.36		335.71	342.05	385.98	335.82	335.81	347.11		340.36	
23	335.71	342.05	385.98	335.82	335.81	347.11		340.36		335.71	342.05	385.98	335.82	335.81	347.11		340.36	
24	335.71	342.05	385.98	335.82	335.81	347.11		340.36		335.71	342.05	385.98	335.82	335.81	347.11		340.36	
25	337.05	343.42	387.53	337.17	337.16	348.50		341.72		337.05	343.42	387.53	337.17	337.16	348.50		341.72	
26	343.77	350.26	395.25	343.88	343.87	355.44		348.52		343.77	350.26	395.25	343.88	343.87	355.44		348.52	
27	351.83	358.47	404.51	351.94	351.93	363.77		356.69		351.83	358.47	404.51	351.94	351.93	363.77		356.69	
28	364.92	371.81	419.57	365.04	365.03	377.31		369.97		364.92	371.81	419.57	365.04	365.03	377.31		369.97	
29	375.66	382.76	431.92	375.79	375.78	388.42		380.86		375.66	382.76	431.92	375.79	375.78	388.42		380.86	
30	381.03	388.23	438.09	381.16	381.15	393.97		386.30		381.03	388.23	438.09	381.16	381.15	393.97		386.30	
31	389.09	396.44	447.36	389.22	389.21	402.30		394.47		389.09	396.44	447.36	389.22	389.21	402.30		394.47	
32	397.15	404.65	456.62	397.28	397.27	410.63		402.64		397.15	404.65	456.62	397.28	397.27	410.63		402.64	
33	402.18	409.78	462.41	402.32	402.30	415.84		407.75		402.18	409.78	462.41	402.32	402.30	415.84		407.75	
34	407.55	415.25	468.59	407.69	407.68	421.40		413.19		407.55	415.25	468.59	407.69	407.68	421.40		413.19	
35	410.24	417.99	471.67	410.38	410.36	424.17		415.91		410.24	417.99	471.67	410.38	410.36	424.17		415.91	
36	412.93	420.72	474.76	413.06	413.05	426.95		418.64		412.93	420.72	474.76	413.06	413.05	426.95		418.64	
37	415.61	423.46	477.85	415.75	415.74	429.73		421.36		415.61	423.46	477.85	415.75	415.74	429.73		421.36	
38	418.30	426.20	480.94	418.44	418.42	432.50		424.08		418.30	426.20	480.94	418.44	418.42	432.50		424.08	
39	423.67	431.67	487.11	423.81	423.80	438.06		429.53		423.67	431.67	487.11	423.81	423.80	438.06		429.53	
40	429.04	437.14	493.29	429.18	429.17	443.61		434.97		429.04	437.14	493.29	429.18	429.17	443.61		434.97	
41	437.10	445.35	502.55	437.24	437.23	451.94		443.14		437.10	445.35	502.55	437.24	437.23	451.94		443.14	
42	444.82	453.22	511.43	444.97	444.95	459.92		450.97		444.82	453.22	511.43	444.97	444.95	459.92		450.97	
43	455.56	464.16	523.78	455.71	455.70	471.03		461.86		455.56	464.16	523.78	455.71	455.70	471.03		461.86	
44	468.99	477.85	539.22	469.15	469.13	484.92		475.48		468.99	477.85	539.22	469.15	469.13	484.92		475.48	
45	484.77	493.92	557.36	484.93	484.92	501.23		491.47		484.77	493.92	557.36	484.93	484.92	501.23		491.47	
46	503.57	513.08	578.98	503.74	503.72	520.67		510.53		503.57	513.08	578.98	503.74	503.72	520.67		510.53	
47	524.72	534.63	603.29	524.89	524.88	542.54		531.98		524.72	534.63	603.29	524.89	524.88	542.54		531.98	
48	548.89	559.25	631.08	549.07	549.06	567.53		556.48		548.89	559.25	631.08	549.07	549.06	567.53		556.48	
49	572.72	583.54	658.49	572.92	572.90	592.17		580.65		572.72	583.54	658.49	572.92	572.90	592.17		580.65	
50	599.58	610.90	689.37	599.78	599.76	619.94		607.88		599.58	610.90	689.37	599.78	599.76	619.94		607.88	
51	626.10	637.93	719.86	626.31	626.29	647.37		634.76		626.10	637.93	719.86	626.31	626.29	647.37		634.76	
52	655.31	667.68	753.44	655.53	655.51	677.56		664.37		655.31	667.68	753.44	655.53	655.51	677.56		664.37	
53	684.85	697.78	787.41	685.08	685.06	708.11		694.33		684.85	697.78	787.41	685.08	685.06	708.11		694.33	
54	716.74	730.28	824.08	716.98	716.96	741.09		726.66		716.74	730.28	824.08	716.98	716.96	741.09		726.66	
55	748.64	762.77	860.75	748.89	748.86	774.06		758.99		748.64	762.77	860.75	748.89	748.86	774.06		758.99	
56	783.21	798.01	900.50	783.48	783.45	809.81		794.05		783.21	798.01	900.50	783.48	783.45	809.81		794.05	
57	818.13	833.58	940.64	818.40	818.38	845.91		829.45		818.13	833.58	940.64	818.40	818.38	845.91		829.45	
58	855.39	871.55	983.49	855.68	855.65	884.44		867.23		855.39	871.55	983.49	855.68	855.65	884.44		867.23	
59	873.86	890.36	1004.72	874.15	874.12	903.54		885.95		873.86	890.36	1004.72	874.15	874.12	903.54		885.95	
60	911.12	928.33	1047.56	911.43	911.40	942.06		923.73		911.12	928.33	1047.56	911.43	911.40	942.06		923.73	
61	943.35	961.16	1084.62	943.66	943.64	975.39		956.40		943.35	961.16	1084.62	943.66	943.64	975.39		956.40	
62	964.50	982.71	1108.93	964.82	964.79	997.26		977.84		964.50	982.71	1108.93	964.82	964.79	997.26		977.84	
63	991.02	1009.74	1139.43	991.35	991.32	1024.68		1004.73		991.02	1009.74	1139.43	991.35	991.32	1024.68		1004.73	
64 and over	1007.13	1026.15	1157.94	1007.46	1007.43	1041.33		1021.07		1007.13	1026.15	1157.94	1007.46	1007.43	1041.33		1021.07	

Molina Healthcare of Washington, Inc.
RATE SCHEDULE

Plan Information

Plan Name: Molina Cascade Vital Gold
HIOS Plan ID: 84481WA0060008
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Cowlitz, Kitsap, Lewis
3	Yes	Clark, Klickitat, Skamania
4	Yes	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin
7	No	
8	Yes	Snohomish
9	No	

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	315.91	321.88	363.22	316.02	316.01	326.64		320.28		315.91	321.88	363.22	316.02	316.01	326.64		320.28	
15	343.99	350.49	395.50	344.11	344.10	355.67		348.75		343.99	350.49	395.50	344.11	344.10	355.67		348.75	
16	354.73	361.43	407.85	354.85	354.84	366.78		359.64		354.73	361.43	407.85	354.85	354.84	366.78		359.64	
17	365.46	372.37	420.19	365.59	365.58	377.88		370.52		365.46	372.37	420.19	365.59	365.58	377.88		370.52	
18	377.03	384.15	433.49	377.15	377.14	389.83		382.24		377.03	384.15	433.49	377.15	377.14	389.83		382.24	
19	388.59	395.93	446.78	388.72	388.71	401.79		393.97		388.59	395.93	446.78	388.72	388.71	401.79		393.97	
20	400.57	408.13	460.55	400.70	400.69	414.17		406.11		400.57	408.13	460.55	400.70	400.69	414.17		406.11	
21	412.95	420.75	474.79	413.09	413.08	426.98		418.67		412.95	420.75	474.79	413.09	413.08	426.98		418.67	
22	412.95	420.75	474.79	413.09	413.08	426.98		418.67		412.95	420.75	474.79	413.09	413.08	426.98		418.67	
23	412.95	420.75	474.79	413.09	413.08	426.98		418.67		412.95	420.75	474.79	413.09	413.08	426.98		418.67	
24	412.95	420.75	474.79	413.09	413.08	426.98		418.67		412.95	420.75	474.79	413.09	413.08	426.98		418.67	
25	414.61	422.44	476.69	414.75	414.73	428.69		420.34		414.61	422.44	476.69	414.75	414.73	428.69		420.34	
26	422.87	430.85	486.19	423.01	422.99	437.23		428.72		422.87	430.85	486.19	423.01	422.99	437.23		428.72	
27	432.78	440.95	497.59	432.92	432.91	447.47		438.76		432.78	440.95	497.59	432.92	432.91	447.47		438.76	
28	448.88	457.36	516.10	449.03	449.02	464.13		455.09		448.88	457.36	516.10	449.03	449.02	464.13		455.09	
29	462.10	470.82	531.30	462.25	462.24	477.79		468.49		462.10	470.82	531.30	462.25	462.24	477.79		468.49	
30	468.70	477.56	538.89	468.86	468.85	484.62		475.19		468.70	477.56	538.89	468.86	468.85	484.62		475.19	
31	478.61	487.65	550.29	478.77	478.76	494.87		485.24		478.61	487.65	550.29	478.77	478.76	494.87		485.24	
32	488.53	497.75	561.68	488.69	488.67	505.12		495.28		488.53	497.75	561.68	488.69	488.67	505.12		495.28	
33	494.72	504.06	568.80	494.88	494.87	511.52		501.56		494.72	504.06	568.80	494.88	494.87	511.52		501.56	
34	501.33	510.79	576.40	501.49	501.48	518.35		508.26		501.33	510.79	576.40	501.49	501.48	518.35		508.26	
35	504.63	514.16	580.20	504.80	504.78	521.77		511.61		504.63	514.16	580.20	504.80	504.78	521.77		511.61	
36	507.93	517.53	584.00	508.10	508.09	525.19		514.96		507.93	517.53	584.00	508.10	508.09	525.19		514.96	
37	511.24	520.89	587.80	511.41	511.39	528.60		518.31		511.24	520.89	587.80	511.41	511.39	528.60		518.31	
38	514.54	524.26	591.59	514.71	514.70	532.02		521.66		514.54	524.26	591.59	514.71	514.70	532.02		521.66	
39	521.15	530.99	599.19	521.32	521.31	538.85		528.36		521.15	530.99	599.19	521.32	521.31	538.85		528.36	
40	527.76	537.72	606.79	527.93	527.92	545.68		535.06		527.76	537.72	606.79	527.93	527.92	545.68		535.06	
41	537.67	547.82	618.18	537.85	537.83	555.93		545.11		537.67	547.82	618.18	537.85	537.83	555.93		545.11	
42	547.17	557.50	629.10	547.35	547.33	565.75		554.73		547.17	557.50	629.10	547.35	547.33	565.75		554.73	
43	560.38	570.96	644.30	560.57	560.55	579.41		568.13		560.38	570.96	644.30	560.57	560.55	579.41		568.13	
44	576.90	587.79	663.29	577.09	577.07	596.49		584.88		576.90	587.79	663.29	577.09	577.07	596.49		584.88	
45	596.31	607.57	685.60	596.51	596.49	616.56		604.56		596.31	607.57	685.60	596.51	596.49	616.56		604.56	
46	619.43	631.13	712.19	619.64	619.62	640.47		628.00		619.43	631.13	712.19	619.64	619.62	640.47		628.00	
47	645.45	657.64	742.10	645.66	645.64	667.37		654.38		645.45	657.64	742.10	645.66	645.64	667.37		654.38	
48	675.18	687.93	776.29	675.41	675.39	698.11		684.52		675.18	687.93	776.29	675.41	675.39	698.11		684.52	
49	704.50	717.81	810.00	704.74	704.72	728.43		714.25		704.50	717.81	810.00	704.74	704.72	728.43		714.25	
50	737.54	751.47	847.98	737.78	737.76	762.59		747.74		737.54	751.47	847.98	737.78	737.76	762.59		747.74	
51	770.16	784.71	885.49	770.42	770.40	796.32		780.81		770.16	784.71	885.49	770.42	770.40	796.32		780.81	
52	806.09	821.31	926.80	806.36	806.33	833.46		817.24		806.09	821.31	926.80	806.36	806.33	833.46		817.24	
53	842.43	858.34	968.58	842.71	842.68	871.04		854.08		842.43	858.34	968.58	842.71	842.68	871.04		854.08	
54	881.66	898.31	1013.69	881.95	881.93	911.60		893.86		881.66	898.31	1013.69	881.95	881.93	911.60		893.86	
55	920.89	938.28	1058.79	921.20	921.17	952.16		933.63		920.89	938.28	1058.79	921.20	921.17	952.16		933.63	
56	963.42	981.62	1107.70	963.75	963.72	996.14		976.75		963.42	981.62	1107.70	963.75	963.72	996.14		976.75	
57	1006.37	1025.38	1157.08	1006.71	1006.68	1040.55		1020.29		1006.37	1025.38	1157.08	1006.71	1006.68	1040.55		1020.29	
58	1052.21	1072.08	1209.78	1052.56	1052.53	1087.94		1066.76		1052.21	1072.08	1209.78	1052.56	1052.53	1087.94		1066.76	
59	1074.92	1095.22	1235.89	1075.28	1075.25	1111.43		1089.79		1074.92	1095.22	1235.89	1075.28	1075.25	1111.43		1089.79	
60	1120.76	1141.92	1288.59	1121.13	1121.10	1158.82		1136.26		1120.76	1141.92	1288.59	1121.13	1121.10	1158.82		1136.26	
61	1160.40	1182.32	1334.17	1160.79	1160.76	1199.81		1176.46		1160.40	1182.32	1334.17	1160.79	1160.76	1199.81		1176.46	
62	1186.42	1208.82	1364.09	1186.82	1186.78	1226.71		1202.83		1186.42	1208.82	1364.09	1186.82	1186.78	1226.71		1202.83	
63	1219.04	1242.06	1401.59	1219.45	1219.41	1260.44		1235.91		1219.04	1242.06	1401.59	1219.45	1219.41	1260.44		1235.91	
64 and over	1238.85	1262.25	1424.37	1239.27	1239.24	1280.94		1256.00		1238.85	1262.25	1424.37	1239.27	1239.24	1280.94		1256.00	

Unified Rate Review v6.1

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Company Legal Name:	Molina Healthcare of Washington, Inc.		
HIOS Issuer ID:	84481	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	$334,541,734.48	$683.73
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$289,111,115.00	$590.88
Risk Adjustment	$39,265,304.12	$80.25
Experience Period Premium	$293,930,108.29	$600.73
Experience Period Member Months	489,287	

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	$96.49	1.088	1.055	1.066	1.025	$121.11
Outpatient Hospital	$204.16	1.023	1.095	1.059	1.025	$248.17
Professional	$178.55	1.016	1.055	1.044	1.025	$204.77
Other Medical	$13.92	1.016	1.055	1.044	1.025	$15.96
Capitation	$26.97	1.025	1.000	1.025	1.000	$28.34
Prescription Drug	$163.64	1.025	1.108	1.031	1.029	$197.39
Total	$683.73					**$815.75**

Morbidity Adjustment	0.944
Demographic Shift	1.009
Plan Design Changes	1.121
Other	1.000
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$871.58**

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.00%

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$871.58**	$315,689,762.32
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	$100.78	$36,502,947.53
Exchange User Fees	0.84%	$2,351,338.63
Market Adjusted Index Rate	**$777.29**	**$281,538,153.42**

Projected Member Months	**362,204**

Product-Plan Data Collection

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.
To remove a product, navigate to the corresponding Product Name/Product ID field and select the Remove Product button or Ctrl + Shift + Q.
To remove a plan, navigate to the corresponding Plan Name/Plan ID field and select the Remove Plan button or Ctrl + Shift + A.

Company Legal Name: **Molina Healthcare of Washington, Inc.**
HIOS Issuer ID: **84481** 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		Molina Healthcare				
1.2	Product ID		84481WA006				
1.3	Plan Name		Complete Gold	Silver	Bronze	Vital Gold	Silver 1
1.4	Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
1.5	Metal		Gold	Silver	Bronze	Gold	Silver
1.6	AV Metal Value		0.817	0.718	0.650	0.780	0.718
1.7	Plan Category		Renewing	Renewing	Renewing	New	Terminated
1.8	Plan Type		HMO	HMO	HMO	HMO	HMO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes	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)		7.24%	34.38%	13.94%	0.00%	0.00%
1.12	Product Rate Increase %		20.06%				
1.13	Submission Level Rate Increase %		20.06%				

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information						
	2.1	Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
$334,541,734	2.2	Allowed Claims	$334,541,734	$124,966,258	$93,809,113	$48,346,479	$0	$67,419,884
$0	2.3	Reinsurance	$0	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$45,430,619	$12,367,072	$10,653,230	$14,646,891	$0	$7,763,426
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$289,111,115	2.6	Incurred Claims	$289,111,115	$112,599,186	$83,155,883	$33,699,588	$0	$59,656,459
$39,265,304	2.7	Risk Adjustment Transfer Amount	$39,265,304	$34,124,368	$15,564,739	-$13,851,047	$0	$3,427,244
$293,930,108	2.8	Premium	$293,930,108	$80,139,504	$84,613,801	$63,913,855	$0	$65,262,949
489,287	2.9	Experience Period Member Months	489,287	125,397	137,373	124,626	0	101,891
	2.10	Current Enrollment	43,346	10,687	13,965	11,560	0	7,134
	2.11	Current Premium PMPM	$640.20	$684.82	$662.33	$547.01	$0.00	$681.02
	2.12	Loss Ratio	86.77%	98.54%	83.01%	67.31%	#DIV/0!	86.85%
		Per Member Per Month						
	2.13	Allowed Claims	$683.73	$996.56	$682.88	$387.93	#DIV/0!	$661.69
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
	2.15	Member Cost Sharing	$92.85	$98.62	$77.55	$117.53	#DIV/0!	$76.19
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00
	2.17	Incurred Claims	$590.88	$897.94	$605.33	$270.41	#DIV/0!	$585.49
	2.18	Risk Adjustment Transfer Amount	$80.25	$272.13	$113.30	-$111.14	#DIV/0!	$33.64
	2.19	Premium	$600.73	$639.09	$615.94	$512.85	#DIV/0!	$640.52

	Section III: Plan Adjustment Factors						
3.1	Plan ID (Standard Component ID)		84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
3.2	Market Adjusted Index Rate		$777.29				
3.3	AV and Cost Sharing Design of Plan		0.8377	1.0059	0.6184	0.7835	0.0000
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.5	Benefits in Addition to EHB		1.0013	1.0011	1.0017	1.0014	0.0000
	Administrative Costs						
3.6	Administrative Expense		9.87%	8.38%	12.86%	10.47%	0.00%
3.7	Taxes and Fees		2.97%	2.96%	3.00%	2.98%	0.00%
3.8	Profit & Risk Load		3.00%	3.00%	3.00%	3.00%	0.00%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.10	**Plan Adjusted Index Rate**		$774.74	$913.78	$593.38	$729.91	$0.00
3.11	Age Calibration Factor	0.580082251	0.5801				
3.12	Geographic Calibration Factor	0.975310488	0.9753				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$438.32	$516.98	$335.71	$412.95	$0.00

	Section IV: Projected Plan Level Information						
4.1	Plan ID (Standard Component ID)	Total	84481WA0060005	84481WA0060006	84481WA0060007	84481WA0060008	84481WA0060004
4.2	Allowed Claims	$315,689,752	$79,761,520	$23,770,471	$49,376,951	$162,780,810	$0
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$66,942,615	$14,590,241	-$734,649	$17,284,919	$35,802,104	$0
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$248,747,137	$65,171,279	$24,505,120	$32,092,032	$126,978,706	$0
4.7	Risk Adjustment Transfer Amount	$28,733,386	$7,071,889	$2,214,874	$4,715,412	$14,731,211	$0
4.8	Premium	$265,391,542	$69,065,199	$25,512,866	$35,271,167	$135,542,310	$0
4.9	Projected Member Months	362,204	89,146	27,920	59,441	185,697	0
4.10	Loss Ratio	84.57%	85.60%	88.38%	80.26%	84.50%	#DIV/0!
	Per Member Per Month						
4.11	Allowed Claims	$871.58	$894.73	$851.38	$830.69	$876.59	#DIV/0!
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.13	Member Cost Sharing	$184.82	$163.67	-$26.31	$290.79	$192.80	#DIV/0!
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.15	Incurred Claims	$686.76	$731.06	$877.69	$539.90	$683.80	#DIV/0!
4.16	Risk Adjustment Transfer Amount	$79.33	$79.33	$79.33	$79.33	$79.33	#DIV/0!
4.17	Premium	$732.71	$774.74	$913.78	$593.38	$729.91	#DIV/0!

Rating Area Data Collection

Specify the total number of Rating Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.
Select only the Rating Areas you are offering plans within and add a factor for each area.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.0189
Rating Area 3	1.1498
Rating Area 4	1.0003
Rating Area 5	1.0003
Rating Area 6	1.0340
Rating Area 8	1.0138

Actuarial Memorandum and Certification

Effective January 1, 2026

The purpose of this actuarial memorandum and certification is to provide information related to Molina Healthcare of Washington, Inc.'s (Molina) Part I Unified Rate Review Template submission to the Washington Individual Marketplace (Washington Marketplace).

The actuarial memorandum and certification describe Molina's rating methodology used to develop rates for Individual products offered on the Washington Marketplace effective January 1, 2026. Molina will not market Individual products outside of the Washington Marketplace.

Molina Healthcare of Washington, Inc. is a managed care organization that provides healthcare services individuals eligible for Medicaid, Medicare, and Marketplace throughout the State of Washington. Molina Healthcare of Washington, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 20 states across the nation, Molina serves more than 5 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern Washington. Today, we continue his mission of providing high quality and cost-effective health care to those who need it most.

200 Oceangate ▪ Suite 100 ▪ Long Beach, CA ▪ 800.526.8196

MolinaHealthcare.com

Contents

GENERAL INFORMATION

The information below documents the company identifying and contact information entered into the general information section of Worksheet 1 of the Unified Rate Review Template (URRT).

The rate methodology and resulting premiums outlined in this Actuarial Memorandum assume current law, which includes the following:

- The expiration of the American Rescue Plan (ARP) enhanced premium tax credit subsidies at the end of 2025.
- Cost-Sharing Reduction (CSR) subsidies remain unfunded.
- The parameters of the HHS Notice of Benefit and Payment Parameters for 2026 (Final 2026 Payment Notice), which became effective on January 15th, 2025.

Notably, the Marketplace Integrity and Affordability Proposed Rule (Program Integrity Rule) was published by CMS in the Federal Register on March 19th, 2025, followed by a comment period that could substantially alter the proposed rule. The rate methodology and resulting premiums outlined in this Actuarial Memorandum were prepared prior to the finalization of the Program Integrity Rule and therefore do not reflect the changes proposed in the Program Integrity Rule.

Molina will seek regulatory approval to file revised rates if material changes to the regulatory environment occur, including, but not limited to, changes to the above mentioned items.

Company Identifying Information

Company Identifying Information	
Legal Name:	Molina Healthcare of Washington, Inc.
State:	Washington
HIOS Issuer ID:	84481
Market:	Washington Individual Marketplace
Effective Date:	January 1, 2026

Company Contact Information

Company Contact Information	
Contact Name	Kathryn Hall
E-mail	Kathryn.Hall@molinahealthcare.com

PROPOSED RATE INCREASE(S)

Molina's rate filing reflects a rate change of 22.24% as calculated by section Q5 of the Uniform Product Modification Justification (UPMJ) template for Molina's 43,346 members enrolled effective March 2025, reported as of April 2025. The UPMJ Q5 rate change is calculated using the average rate change of each plan weighted by membership in each plan.

Molina's rate filing reflects the following rate changes as calculated by Part I of the Unified Rate Review Template in Section 1 of Worksheet 2 for Molina's 36,212 members enrolled in plans that are renewing for 2026. Enrollment data is as of March 2025, reported as of April 2025. The URRT rate change is calculated using the rate change of each renewing plan weighted by the membership and premium in each renewing plan.

The rate changes vary by plan due to changes in the Actuarial Value (AV) Pricing Values assigned to each metal plan that are applied to the Plan Adjusted Index Rate.

14-Digit Plan ID	Plan Name	Metal	202503 Mbrs	2025 PMPM	2026 PMPM	Avg	Min	Max
84481WA0060005	Molina Cascade Complete Gold	Gold	10,687	$685	$734	7.2%	6.6%	9.3%
84481WA0060006	Molina Cascade Silver	Silver	13,965	$662	$890	34.4%	33.4%	36.8%
84481WA0060007	Molina Cascade Bronze	Bronze	11,560	$547	$623	13.9%	13.2%	16.1%
84481WA0060008	Molina Cascade Vital Gold	Gold	0	$0	$0	-	-	-
Total			**36,212**	**$632**	**$759**	**20.1%**	**6.6%**	**36.8%**

Reason for Rate Change(s): The following factors contribute toward the overall change in the proposed rates.

- **Claims:** Projected claims for 2026 are expected to contribute toward a 14.7% increase in rates due to updated base period experience claims, trend, changes in product, acuity, and demographic mix.
- **Taxes and Fees:** Taxes, fees, and retention are expected to contribute toward a 0.4% increase in rates.
- **Margin:** Margins are expected to contribute toward a 0.4% increase in rates at our company standard 3.0% after-tax profit margin.
- **Risk Transfer:** Risk transfer is expected to contribute toward a 1.3% decrease in rates.
- **Administrative Expenses:** Administrative expenses are expected to contribute toward a 0.3% increase in rates.
- **Membership Mix:** The membership mix from the base period to the projection period compared to the membership mix for comparable time periods from the prior year rate filing is expected to contribute toward a 5.6% increase in rates.

Rate changes vary by plan due to changes in Actuarial Value, Cost Share Design (CSD), and Geographic factors.

MARKET EXPERIENCE

The single risk pool was established according to the requirements in 45 CFR 156.80. No transitional products/plans or grandfathered products are included in the development of the single risk pool.

Molina's 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months or 40,774 average members in the period of January 1, 2024 to December 31, 2024.

Experience Period Premium and Claims

Paid Through Date: The market experience reported in Worksheet 1, Section I of the URRT represents 2024 incurred claims paid through March 2025. The completion factors applied to the 2024 claims experience were updated with data through March 2025.

Current Date: The current enrollment and premium are reported as of April 2025.

Premiums (Net of MLR Rebate) in Experience Period: The premiums reported in Worksheet 1, Section I of the URRT represent the earned premium from 2024, excluding risk adjustment transfer payments for the 2024 benefit year. Earned premium does not reflect any MLR rebates. No amounts were subtracted from the earned premium for any reductions prescribed by the federal MLR formula, such as taxes and assessments.

Allowed and Incurred Claims in Experience Period: The following table reports the allowed and incurred claims during the experience period of January 1, 2024 to December 31, 2024.

Description	Medical	Pharmacy	Capitation	Total
Allowed	$237,949,720	$80,067,777	$13,196,321	$331,213,818
IBNR Factor	1.014	1.000	1.000	1.010
Allowed w/ IBNR	**$241,277,636**	**$80,067,777**	**$13,196,321**	**$334,541,734**
Paid	$204,905,854	$71,110,323	$10,164,514	$286,180,691
IBNR Factor	1.014	1.000	1.000	1.010
Paid w/ IBNR	**$207,836,278**	**$71,110,323**	**$10,164,514**	**$289,111,115**

The experience is for all 2024 individual non-grandfathered plans including subsidized populations defined under the Cost Sharing Reduction (CSR) programs. The experience does include data for the American Indian/Alaska Native (AIAN) population which is funded by the federal government and is not tied to any metal level in the Marketplace.

Allowed claims for the experience period were obtained from the claims records by adding the plan incurred paid claims and the member cost-sharing for medical and pharmacy claims net of rebates received from drug manufacturers. The allowed claims calculation applies to both fee-for-service claims and capitation costs.

Completion factors were applied to both the allowed and incurred medical claim amounts. The completion factors were developed separately for inpatient and non-inpatient medical claims based on Molina's Washington Marketplace data. The IBNR factor for medical allowed claims is 1.014. The IBNR factor for medical incurred and paid claims is 1.014. IBNR factors were not applied to capitation and pharmacy claims.

The IBNR reserves were determined based on best estimates. Explicit margin for loss adjustment expenses and provision for adverse deviation are accounted for in the financial system in separate accounts that do not impact the completion factors used for IBNR reserves.

All medical claims are paid through Molina's claims system. Pharmacy claims are processed through Molina's pharmacy benefit manager.

In the experience period 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 not counted toward the annual limitation on cost sharing.

There were no federal or state reinsurance amounts to report in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Experience Period Premium and Experience Period Member Months in 2024 were reported in Worksheet 1, Section I and Section II, Worksheet 2 of the URRT.

Inclusion of Capitation Payments: All capitated payments are included in the experience data and rate development. For pediatric vision coverage Molina has a vision care agreement with Vision Service Plan (VSP), a California not-for-profit corporation, with its principal place of business located in Rancho Cordova, CA and Molina Healthcare of Washington, Inc. which is in Bothell, WA. No changes have occurred to the 2026 agreement terms compared with 2024 and 2025.

Actual to Projected Analysis: Molina tracks Marketplace experience on an ongoing monthly basis through IBNR reserving, claims forecasting based on current and prior year results, and Risk Adjustment estimation. The experience is tracked at the single risk pool level. 2024 experience was used as the baseline experience period for the 2026 rate filing, so the extent that 2024 experience deviated from projected 2024 results is captured in 2026 rates. No extra adjustments were made in 2026 pricing to account for 2024 deviations in claims.

Benefit Categories

Molina assigned all experience claims to benefit categories utilizing Milliman's MedInsight Health Cost Guidelines (HCG) grouper. The following table displays the measurement units related to each benefit category.

Benefit Category	Util Type
Inpatient Hospital	Days
Outpatient Hospital	Visits
Professional	Services
Other Medical	Services
Capitation	Benefit Period
Prescription Drug	Prescriptions

Projection Factors

Trend Factors

Trend Factors: Trend factors were applied separately for unit cost and utilization and by each major benefit category shown in Worksheet 1, Section II of the URRT. The Year 1 and Year 2 trend factors represent the annual trend numbers that were used to trend the experience period claims forward 24 months from the midpoint of the base period, July 2024, to the midpoint of the projection period, July 2026.

Unit cost trends were measured by calculating average reimbursement rates in the base period and projection period, which consider reimbursement changes and provider mix changes. The unit cost trends include the expected impact of Medicare reimbursement changes from 2024 to 2026 for provider reimbursement contracts that are based on a percentage of the Medicare fee schedule. Pharmacy unit cost trends are based on an analysis of AWP changes over time for a fixed basket of drugs.

The unit cost projections reflect input on likely network and provider contract term changes for the projection year. Provider contracting is already complete for plan year 2026 for counties within Molina's existing footprint. The status of projected reimbursement trend is mostly locked in for plan year 2026.

Utilization trends were developed through a review of trends from the 2025 URRT public use files in Worksheet 1, Section II, with a focus on Individual Market plans with non-zero credibility and nonzero trend factors in states where Molina offers coverage. Year 1 utilization trends include the impact of emerging experience in 2025. Changes in average health status and mix of services are considered in the Acuity and Plan Mix adjustments included in the rate filing and are not considered in utilization trends.

Cost-sharing benefit features such as deductible, copay, out-of-pocket maximum would impact utilization leveraging of trend. However, for pricing purposes allowed trends (utilization before leveraging) were used according to the URR instructions for developing the single risk pool.

Trends were selected based on expectations for a more stable On-Exchange population and were compared to historical and prospective trends for our On-Exchange experience in other states. In general, prospective utilization trends were selected in a way that does not expect abnormally high and abnormally low historical experience to continue.

Please see WA Exhibit 3 for support of the selected trends applied in pricing and WA Exhibits 4 and 5 as support for the historical and adjusted trends described above.

Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment: The morbidity adjustment is comprised of an acuity factor that represents anticipated changes in Molina's single risk pool.

Changes in acuity: The morbidity of Molina's covered population is expected to decrease between the experience period and the projection period.

An acuity adjustment of 1.038 was made to the 2024 experience period data to reflect changes in the population acuity from the experience period to the 2025 current period. The acuity changes from the 2024 experience period to the 2025 current period are measured by calculating the difference in the 2024 risk scores and 2025 risk scores, both weighted by 2026 projected metal mix to avoid double counting with the plan mix adjustment.

The acuity change from the 2025 current period to the 2026 projection period is calculated in the same way, weighting 2025 and 2026 risk scores with 2026 projected metal mix. With the implementation of uniform silver-loading, the majority of Molina's Silver members are expected to move to Gold plans decreasing the projected average risk score for Gold members. The total acuity adjustment factor for the 2025 current period to the 2026 projection period is 0.910.

The final acuity adjustment factor is 0.944. Please refer to Appendix Exhibit 4.1.

Demographic Shift: A demographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the demographic mix from the 2024 experience data to the 2026 projection period.

The anticipated demographic mix is based on a review of enrollment through March 2025 and projected 2026 enrollment compared to the experience period. Molina anticipates that its 2026 demographics will be consistent with its 2025 demographics for existing membership. The demographic adjustments were developed using allowed claims by age cohort normalized for differences in metal and acuity. The total demographic adjustment made to the 2024 experience period data is 1.007. Please refer to Appendix Exhibit 4.2a.

Geographic Adjustment: A geographic adjustment factor was applied to the experience period claims to reflect the anticipated change in the area membership mix from the 2024 experience data to the 2026 projection period. A geographic adjustment of 1.002 was made to the 2024 experience period data. Please refer to Appendix Exhibit 4.2c.

Plan Mix Adjustment: The plan mix adjustment reflects anticipated changes in the average utilization of services due to differences in average cost-sharing requirements during the experience period and average cost-sharing requirements in the projection period. This includes changes in induced demand and the effects of selection for the single risk pool.

The 2024 claims experience by Metal and CSR variant was used to weight the 2024 membership mix against the projected membership mix expected in the 2026 projection period to develop a plan mix adjustment factor between the 2024 experience period and 2026 projection period. The Gold

allowed claims amount was adjusted to reflect the membership migration to Gold as a result of uniform silver-loading. The adjusted allowed claims are a weighted average calculated using the membership moving from Silver and Bronze to Gold.

The plan mix adjustment made to the 2024 experience period data is 1.121. Please refer to Appendix Exhibit 4.3.

Manual Rate Adjustments

Not Applicable.

Credibility of Experience

A Monte Carlo simulation was used to determine the credibility level to assign to the base period experience. The simulation used a claims probability distribution (CPD) from the Final 2026 Actuarial Value calculator to generate random samples of members and calculated the average annual cost for each sample.

The results showed that 60,000 member months are needed so that the average annual cost is within 10% of the mean (expected claims amount) 95% of the time.

The credibility percentage to apply to the experience data is based on experience period member months and the credibility formula below:

- 0 - 59,999 member months: 100% manual
- 60,000+ member months: 100% experience

The 2024 experience in Part I of the Unified Rate Review Template (URRT) is based on 489,287 member months resulting in a credibility percentage that is 100% experience rated. This method is consistent with the applicable American Academy of Actuaries' Actuarial Standards of Practice (ASOP) No. 25 Credibility Procedures.

Establishing the Index Rate

Index Rate: The index rate is developed following the specifications of 45 CFR part 156.80(d)(1). The index rate for the projection period is estimated to be $871.58. The index rate represents the estimated total allowed claims experience for the essential health benefits within the Washington Marketplace. The index rate does not include adjustments for the risk adjustment and reinsurance programs or an adjustment for the Washington Marketplace user fee. Please refer to Appendix Exhibit 5.1a.

Development of the Market-wide Adjusted Index Rate

Reinsurance

Not Applicable.

Risk Adjustment and Payment Change

Experience Period Risk Adjustment PMPM:
Molina used results from the Wakely National Risk Adjustment Reporting (WNRAR) Project to supplement internal estimates of risk scores, statewide premiums, and related risk adjustment transfer amounts. For the 2024 experience period, the risk transfer receivable is $80.25 per member per month (PMPM) or $39,265,304.

Projected Risk Adjustments PMPM: Molina estimated the risk transfer amount for 2026 using the 2024 experience period risk transfer amounts. The 2026 risk transfer estimates were developed by projecting 2025 relative risk scores and transfer payments, then projecting 2026 relative risk scores and transfer payments. The risk transfer payment amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium. The projection is based on the 2026 calibrated model. The population was grouped into the following cohorts:

- *2025 Renewal Members* – Some of Molina's current members previously had coverage in 2024 and renewed in 2025 with Molina. Molina relied on the renewal member's 2024 experience and risk scores to project their 2025 relative risk scores, taking into consideration any applicable changes in enrollment across metal tiers.
- *2025 New Members* – To estimate the relative risk of the 2025 new members, Molina referred to the estimated risk scores and transfer amounts from the 2024 experience period. Estimated risk scores were adjusted in consideration of the metal tier mix between the 2024 members and the 2025 new members.

- *2026 Members* – Molina assumed the 2026 members would have the higher relative risk scores as the 2025 members, with consideration for the metal tier mix between the two years.

The impact of the national high-risk pool fund was incorporated using 2024 claims experience and a white paper report from Wakely on the estimated high-cost risk pooling charges based on information voluntarily provided by issuers. The net impact of estimated charges and recoveries was calculated as $1.45 PMPM payable.

The impact of the risk adjustment data validation program was incorporated using historical error rates from the final CMS RADV results and the RADV error rate report from Wakely based on information voluntarily provided by issuers. The net impact of estimated payment was calculated as $1.97 PMPM receivable.

The resulting 2026 risk transfer receivable estimate is $78.81 PMPM. Molina included $1.45 PMPM payable for projected national high-risk pooling funding and $1.97 PMPM receivable for projected risk adjustment data validation to get a net risk transfer receivable estimate of $79.33 PMPM. This amount was converted from a paid to allowed basis and entered in the URRT Worksheet I, Section II.

The risk transfer receivable amounts in the projection period reflect expected changes in the relative risk of the population and changes to the statewide premium.

The 2026 statewide average premium was projected using historical experience and information from Wakely, including the estimated 2025 statewide average premium. An adjustment of was made to the statewide average premium to account for changes due to uniform silver-loading. Using historical experience and the adjustment for silver-loading, the 2026 statewide average premium increase is estimated to be 8.2%.

Please refer to WA Exhibit 10 for further information on projected risk adjustment.

Washington Marketplace Exchange Fee:
Washington Marketplace will charge a fee of $5.11 PMPM which was divided by the total paid to allowed factor of 0.787 to convert to an allowed basis of $6.49 PMPM for the Market Adjusted Index Rate. Please refer to Appendix Exhibit 5.1a to locate the same percentage for the Exchange User Fee entered in Worksheet 1, Section II.

Market Adjusted Index Rate: The market adjusted index rate is developed following the specifications of 45 CFR part 156.80(d)(1). Molina modified the index rate provided in URRT Worksheet I to a market adjusted index rate. Please refer to Appendix Exhibit 5.1a

Plan Adjusted Index Rates

The plan adjusted index rates are developed following the specifications of 45 CFR part 156.80(d)(2). The plan adjusted index rates are entered in Worksheet 2, Section IV, of the URRT. Molina calculated the plan adjusted index rates by applying plan specific level adjustments for actuarial value, cost

sharing utilization, additional benefits, and administrative costs, excluding exchange user fees, to the market adjusted index rate. Please refer to Appendix Exhibit 10.2.

Paid to Allowed Ratio: The Paid to Allowed ratio reflects the estimated cost-sharing in the projected period. The Final 2026 AV Calculator was used to determine metal AVs, but for pricing a different calculator was used. This is detailed in the Pricing AVs section. The Paid to Allowed ratio is the member-weighted average of the Actuarial Values. Please refer to Appendix Exhibit 5.1b.

Benefits in Addition to EHBs:
There are no benefits in addition to EHBs. However, Molina covers the elective termination of pregnancy benefit. Per Checklist Item #10d, abortion services must be treated as non-EHBs in the URRT. Therefore, elective termination of pregnancy costs are included in the Index Rate and field 3.5 in the URRT has been adjusted to account for these costs. An estimated $1.00 PMPM is used to account for abortion services. The percentage of premium by plan is used to calculate the Benefits in Addition to EHB, field 3.5 of Worksheet 2. Please refer to Appendix Exhibit 5.1b.

Retention Loads, excluding Exchange User Fees: All costs related to admin, profit & risk and taxes & fees, excluding the Washington Marketplace Fee, are calculated for each expected plan offering. Please refer to WA Exhibit 11.

Provider Network, Delivery System Characteristics, and Utilization Management Practices: Plan rates do not vary for variation in provider network, delivery system characteristics, or utilization management.

Provider Compensation Statement: Provider compensation does not include bonuses in addition to other payments.

Catastrophic plans: Not applicable.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Administrative expenses for the Marketplace product from 2024 and 2025 were reviewed and projected forward to 2026 to develop the administrative costs required to manage the Washington Marketplace population. An internal administrative cost budget was developed on a PMPM basis and applied to the Washington Marketplace rates. Part of the total administrative expense load is a subcomponent for Quality Expenses which are administrative costs dedicated to improving health care quality for Molina Marketplace members. The Quality Expense load is $10.48 PMPM. Amounts for broker commissions were added to the administrative costs. The expected administrative expense load is 10.3%. Please refer to WA Exhibit 11.

Broker Commissions: Broker commissions of $11.83 PMPM are expected based on historical broker-sold business and a projection of new and renewing members sold through the broker channel.

Profit Margin: The target after-tax margin is 3.0%, which aligns with Molina's company standard target. Molina's current capital and surplus did not impact the filing. The profit and risk load of 3.0% of premium is consistent with the target margin filed and approved for each rating period from 2015 through 2026.

Taxes and Fees: Molina's estimated taxes and fees (excluding Exchange Fee) are 3.0%. The taxes and fees estimates are comprised of the following:

- **Income Tax:** An estimated 0.8% of premiums will be paid in Federal income taxes.
- **WSHIP:** The WSHIP assessment is projected at $0.13 PMPM. Per the most recent information available in the 2023 Annual Report, WSHIP assessments were $12 million in 2023 (an estimated $0.25 PMPM). WSHIP assessments for 2024 were projected to be $6 million. Therefore, Molina has estimated the WSHIP assessment to be $0.13 PMPM for 2026.
- **Regulatory Surcharge:** The regulatory surcharge is an annual cost of operating the Office of the Insurance Commissioner which is charged to insurers like Molina. The 0.08% of premium is based on internal budgetary forecasts. The 2026 regulatory surcharge was assumed to be 0.08% of premium.
- **Risk Adjustment User Fee:** $0.20 PMPM will be paid toward the risk adjustment user fee.
- **Insurance Fraud Surcharge:** The 2026 insurance fraud surcharge is estimated to be .004% of premium.
- **Premium Tax:** Molina has assumed 2.0% for the state premium tax.
- **PCORI:** An estimated $0.33 PMPM ($4.01 PMPY) will be paid toward the PCORI fee. This was estimated by projecting forward the $3.47 PMPY value for members whose plan year ends September 2024 through October 2025 forward two years at a rate of 7.5% per year, the 3-year average annual increase.
- **WAPAL:** An estimated $0.06 PMPM will be paid toward the WAPAL fund. The 2026 estimate is based on the most recent information available from the FY2025 Assessment Rate Notification to Payers.

Calibration

Age Curve Calibration: Molina calibrated the Plan Adjusted Index Rates to an age 21 rate. The average composite age factor was estimated by multiplying the population distribution by the age factors. The calibration factor is 0.580.

Molina estimated the average age of the single risk pool to be 43 years of age by multiplying the expected age distribution percentages by the age. Molina assumed an average age of 7 for the Age 0-14 cohort in the average age estimate and an average age of 71 for the Age 65+ cohort. Premium rates are based on the attained age as of the coverage effective date and will not be re-rated/adjusted when a birthdate occurs during the year after the coverage starts.

Please refer to Appendix Exhibit 4.2b.

Geographic Factor Calibration: Molina applied geographic factors to the index rate in the calculation of region-specific rates. The geographic factors are based on the provider reimbursement expectations in each region.

None of the following items were used in establishing the geographic rating area factors:

(i) Health status of enrollees or the population in an area;
(ii) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health 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.

Adjustments were made to the geographic factors to ensure that the minimum geographic factor and the maximum geographic factor did not deviate by more than 15% per Washington regulations. The calibration factor of 0.975 equals the inverse of the weighted average geographic factor.

Please refer to Appendix Exhibit 7.1.

Tobacco Factor Calibration: Molina does not price in a tobacco surcharge. The calibration factor is set to 1.000. The tobacco calibration factor has been set to 1.000 in 2023, 2024, and 2025 as well.

Base Premium Rate Development

The Base Premium Rates are calibrated to an age 21 premium with an area factor of 1.0. Only the allowable rating factors will be applied to the Base Premium Rates. Please see Appendix Exhibit 6.1.

PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) using the federally prescribed MLR methodology is for calendar year 2026 based on the ratio of projected incurred claims divided by projected revenue. The MLR result was calculated to be 87.0%. Please refer to Appendix Exhibit 11.1 for a full demonstration of the projected loss ratio. In the Part I Unified Rate Review Template, Worksheet 2, item 4.10 Loss Ratio displays a loss ratio in total and by plan adjusted index rates. The loss ratio calculated here follows a different formula than the federally prescribed MLR methodology and will not match that figure. The URRT loss ratio is incurred claims divided the sum of the risk adjustment transfer amount and the plan adjusted index rate premium. The federal MLR considers quality in the numerator and taxes and fees in the denominator.

PLAN PRODUCT INFORMATION

AV Metal Values

All plan offerings have cost-sharing levels that are different for Preferred Generic Drugs and Non-Preferred Generic Drugs. These plans are considered unique benefit design according to the logic used in the Final 2026 Actuarial Value Calculator (AVC). The AV metal values were determined by using a permissible alternative method that complies with 45 CFR 156.135(b)(3).

The AVC assumes one cost-sharing amount for all generic drugs. The AVC was used to calculate two AVs for each plan. The first was calculated using the preferred generic drug cost-share as the input for Generic Drugs line in the AVC. The second using the non-preferred generic drug cost-share as the input for Generic Drugs line in the AVC with all other inputs the same. The two AVs were blended using weights calculated from Molina's historical generic drug utilization to obtain the final AV.

The Bronze and Silver Standard plans were adjusted according to the same generic drug methodology. An adjustment factor was calculated for the standard plans using the original AV compared with the blended AV and applied to the Adjusted AV prepared by Wakely. Please refer to Appendix Exhibit 11.4.

Please refer to the supporting document "Unique Plan Design Documentation" unique plan design certification for documentation on the generic drug cost-sharing component of the plans.

For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature. The unique plan design certification for the Bronze and Silver plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Silver CSR Loading: In accordance with WAC 284-43-6820, a uniform CSR silver load adjustment factor of 1.435 has been applied to Silver plans for plan year 2026. Please refer to WA Exhibit 8.

AV Pricing Values

AV pricing value of each plan only includes the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). Cost-sharing adjustments ensure that differences due to health status were not included in the adjustment. The modifiers are applied to the index rate. Molina relied on the Final 2026 AV Calculator to evaluate the Actuarial Value of the plan designs.

Plan ID	Plan Name	AV Metal Value	AV Pricing Value
84481WA0060005	Molina Cascade Complete Gold	0.8171	0.8171
84481WA0060006	Molina Cascade Silver	0.7184	0.7184
84481WA0060007	Molina Cascade Bronze	0.6499	0.6499
84481WA0060008	Molina Cascade Vital Gold	0.7801	0.7801

Essential Health Benefits

All benefit plans offered meet essential health benefit (EHB) requirements. Molina plan designs in 2026 are all standard plan designs. The State of Washington has added new EHBs for plan years beginning on or after January 1, 2026. The EHB additions are as follows:

- Hearing Exams shall be categorized as Primary Care Visits.
- Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
- Artificial Insemination shall be categorized as All Other Benefits.
- Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).

Membership Projections

Molina is filing Washington Marketplace rates in 18 counties representing 7 rating regions. The membership projection is based on anticipated renewals of existing members and new members. New membership is based on an estimate of the total number of members enrolled in Washington Marketplace by county. The source of new members is mostly from other carriers.

The enrollment projections by plan, including cost-sharing reduction eligible plans, were based on a projection of 2025 membership calculated early in 2025. The baseline membership projections reflected a decline in membership across all plans as a result of the 2026 rate change. Members are also anticipated to migrate away from Silver plans due to uniform silver-loading. Some of these members are expected to migrate toward Molina Gold plans.

We are anticipating that Molina will not offer one of the lowest cost Silver plans in 2026, and as a result, will continue to decline in Silver membership. This is partially because new members tend to select one of the lowest cost offerings in the market, including Cascade Select plan offerings from other carriers. As a result, Molina modeled a reduction in the proportion of available Silver members in the market compared to current membership.

Molina plans to offer its products in the counties listed by region below.

Region	County List
1	King
2	Cowlitz, Kitsap, Lewis
3	Clark, Klickitat, Skamania
4	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
5	Mason, Pierce, Thurston
6	Benton, Franklin
8	Snohomish

Terminated Products

Molina is terminating the Constant Care Silver 1 plan design for 2026. Members currently enrolled in this plan will be mapped to the Molina Cascade Silver plan.

A summary of Molina's terminated, renewing, and new products is provided in the following table:

Plan ID	Plan Name	Metal	2026 Status
84481WA0060005	Molina Cascade Complete Gold	Gold	Renewing
84481WA0060006	Molina Cascade Silver	Silver	Renewing
84481WA0060007	Molina Cascade Bronze	Bronze	Renewing
84481WA0060008	Molina Cascade Vital Gold	Gold	New
84481WA0060004	Constant Care Silver 1	Silver	Terminated

PLAN TYPE

All benefit plans are comprehensive HMO individual products.

MISCELLANEOUS INSTRUCTIONS

Effective Rate Review Information

URRT Comparison: Tables comparing the 2026 values with the 2025 values entered in the URRT (Worksheet I, Sections II) are provided in Appendix Exhibit 2.1.

Mental Health / Substance Use Disorder Financial Requirement Checklist: In Molina's mental health parity calculation template, the underlying claim data source is Molina's WA marketplace 2024

experience data projected forward to 2026 as described in the Actuarial Memorandum. No adjustment has been made to the data. The projections reflect the plan level assumptions and are based on the amounts that the Plan allows before reductions for enrollee cost sharing. A reasonable actuarial method was used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Reliance

The unique plan design certification for the Standard plans was performed by Ksenia Whittal of Wakely Consulting. Please refer to Appendix B of the supporting document "Actuarial Value Certification for WAHBE 2026 Standard Medical Plan Designs".

Milliman's MedInsight Health Cost Guidelines (HCG) grouper was relied upon for categorizing claims data for the experience period.

Wakely's white paper report on the estimated high-cost risk pooling charges (2023, 2024, and 2025 High-Cost Risk Pooling Program – National Estimate) was relied upon for our estimate of High Cost Risk Pool (HCRP) amounts.

Actuarial Certification

I, Kathryn Hall, am an employee of Molina Healthcare and I am a member in good standing with the American Academy of Actuaries meeting its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries. I have the education and experience necessary to the perform the work and hereby certify, to the best of my knowledge and judgment, that this filing complies with applicable State and Federal Statues for individual rate filings. I certify the following:

The projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
b. Developed in compliance with the applicable Actuarial Standards of Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Termination of pregnancy is a WA EHB under the “maternity and newborn services” category [WAC 284-43-5642]. The “Benefits in Addition to EHB” field is the multiplicative inverse of the value entered into the “EHB Percent of Total Premium” field on the Plans & Benefits Template (PBT). For the purposes of filling out the URRT Worksheets, abortion services for which public funding is prohibited was entered as Benefits in Addition to EHB, even though the benefits are considered EHBs in Washington.

The Final 2026 AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. Adjustments were made for unique benefit designs as described in the Reliance and in the Plan Product Information / AV Metal Values sections of this memorandum.

Please refer to the supporting document “Unique Plan Design Documentation” unique plan design certification.

I certify that the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct, including:

- ASOP 5: Incurred Health and Disability Claims
- ASOP 8: Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP 12: Risk Classification
- ASOP 23: Data Quality
- ASOP 25: Credibility Procedures
- ASOP 41: Actuarial Communications
- ASOP 45: The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act
- ASOP 56: Modeling

Kathryn Hall, ASA, MAAA
Actuarial Manager
Molina Healthcare

05/13/2025
Date