State: *Washington* ***Filing Company:*** *Providence Health Plan*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 NonGrandfathered Individual Rate filing*
Project Name/Number: */*

Filing at a Glance

Company:	Providence Health Plan
Product Name:	2026 NonGrandfathered Individual Rate filing
State:	Washington
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Rate
Date Submitted:	05/15/2025
SERFF Tr Num:	PROV-134500631
SERFF Status:	Assigned
State Tr Num:	484719
State Status:	Review Pending
Co Tr Num:	2026 NONGRANDFATHERED INDIVIDUAL RATE FILING
Effective Date Requested:	01/01/2026
Author(s):	Jill Long, Traci Rooks, Jason Lee, Joseph Rubin, Sarah Pettey
Reviewer(s):	Amy Peach (primary), Jeff Oberle
Disposition Date:	
Disposition Status:	
Effective Date:	
Destruction Date:	

State Filing Description:

State: Washington **Filing Company:** Providence Health Plan
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 NonGrandfathered Individual Rate filing
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type:
Overall Rate Impact: 10.59%

Deemer Date:
Submitted By: Jason Lee

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/15/2025
State Status Changed: 05/15/2025
Created By: Jill Long
Corresponding Filing Tracking Number: PROV-134500629, PROV-WA26-125119896

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions:

Outside Market Only

Filing Description:
Description/ Metal Tier/ AV

Columbia 1500 Gold - pediatric vision, Direct/Gold/80.38
Columbia 5000 Silver - pediatric vision, Direct/Silver/71.70
Columbia 9200 Bronze - pediatric vision, Direct/Bronze/64.95

Form-PROV-134500629
Rates-PROV-134500631
Binder-PROV-WA26-125119896

This filing was prepared with the intention of following the STM tools. If you have any questions, please feel free to contact me at the phone number listed below. Thank you for your consideration, we look forward to your favorable review.

Sincerely,
Jill Long
Compliance Consultant
Telephone:l 503-866-3544
E-mail: jill.long@providence.org

Company and Contact

Filing Contact Information

Jill Long, Sr Regulatory Affairs Consultant
4400 NE Halsey Street, Building 2,
Ste. 690
Portland, OR 97213

jill.long@providence.org
503-574-7814 [Phone]

State: *Washington* ***Filing Company:*** *Providence Health Plan*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 NonGrandfathered Individual Rate filing*
Project Name/Number: */*

Filing Company Information

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Portland, OR 97005
(503) 574-7500 ext. [Phone]

CoCode: 95005
Group Code:
Group Name:
FEIN Number: 93-0863097

State of Domicile: Oregon
Company Type: HCSC
State ID Number:

State: Washington **Filing Company:** Providence Health Plan
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 NonGrandfathered Individual Rate filing
Project Name/Number: /

Filing Fees

State Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

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

SERFF Tracking #:	*PROV-134500631*	***State Tracking #:***	*484719*	***Company Tracking #:***	*2026 NONGRANDFATHERED INDIVIDUAL RATE ...*

State:	*Washington*	***Filing Company:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
Project Name/Number:	*/*		

Correspondence Summary

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Re: Notice for Second Set of Rates Review Process	Note To Reviewer	Jill Long	05/20/2025	05/20/2025
Notice for Second Set of Rates Review Process	Note To Filer	Rocky Patterson II	05/19/2025	05/19/2025
Rate Request Summary	Reviewer Note	Kelli Armfield	05/23/2025	

State: Washington **Filing Company:** Providence Health Plan
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 NonGrandfathered Individual Rate filing
Project Name/Number: /

Note To Reviewer

Created By:

Jill Long on 05/20/2025 10:44 AM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 11:08 AM

Subject:

Re: Notice for Second Set of Rates Review Process

Comments:

Message acknowledged. Thank you.

State: Washington **Filing Company:** Providence Health Plan
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 NonGrandfathered Individual Rate filing
Project Name/Number: /

Note To Filer

Created By:

Rocky Patterson II on 05/19/2025 05:54 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 11:08 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:** Providence Health Plan
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 NonGrandfathered Individual Rate filing
Project Name/Number: /

Reviewer Note

Created By:

Kelli Armfield on 05/23/2025 06:48 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 11:08 AM

Subject:

Rate Request Summary

Comments:

See attached

Providence Health Plan – 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:	10.59% *average**
Requested effective date:	Jan. 1, 2026
Plans impacted:	Providence Health Plan's Individual plans
People impacted:	254
Counties:	Benton, Clark, Franklin, Spokane, Thurston, and Walla Walla

Key information used to develop the rate request

(Jan. 2024 - Dec. 2024)

Premiums	$1,878,223
Claims	$1,886,840
Administrative expenses	$669,671
Risk adjustment	$1,237,093
Company made	**$558,805**

The company expects its annual medical costs to increase 11.6%.

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:

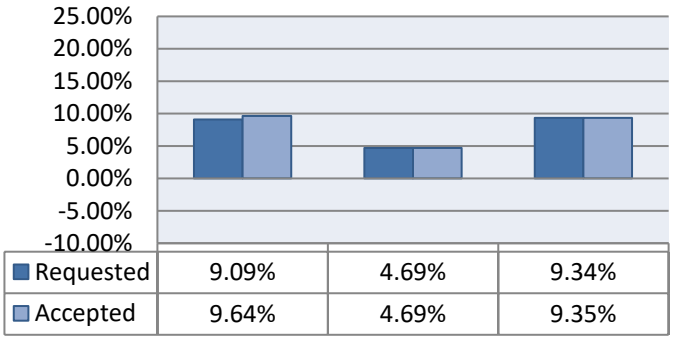
Claims:	83.98**%**
Administration:	12.52**%**
Profit:	3.50**%**

Are there any benefit changes?

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

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

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



Requested	9.09%	4.69%	9.34%
Accepted	9.64%	4.69%	9.35%

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:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	9.300%
Effective Date of Last Rate Revision:	01/01/2025
Filing Method of Last Filing:	SERFF
SERFF Tracking Number of Last Filing:	PROV-134088293

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):
Providence Health Plan	Increase	10.590%	10.590%	$242,562	254	$2,595,817	13.110%	7.430%

State: Washington **Filing Company:** Providence Health Plan
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 NonGrandfathered Individual Rate filing
Project Name/Number: /

Rate Review Detail

COMPANY:

Company Name: Providence Health Plan
HHS Issuer Id: 45834

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Columbia Individual	45834WA049		254

Trend Factors: Inpatient Hospital 10.9%, Outpatient Hospital 10.9%, Professional 10.9%, Other Medical 10.9%, Capitation 10.9%, Composite Medical 10.9%, Prescription Drug 14.0%, Aggregate Trend 11.6%

FORMS:

New Policy Forms: PIC-WA 0126 IND PROV COL CTR
Affected Forms: N/A
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 3,121
Benefit Change: None
Percent Change Requested: Min: 7.4 Max: 13.1 Avg: 10.6

PRIOR RATE:

Total Earned Premium: 2,195,911.00
Total Incurred Claims: 2,758,459.00
Annual $: Min: 277.45 Max: 1,706.12 Avg: 746.65

REQUESTED RATE:

Projected Earned Premium: 2,595,817.00
Projected Incurred Claims: 3,070,052.00
Annual $: Min: 302.93 Max: 1,908.78 Avg: 831.73

SERFF Tracking #:	*PROV-134500631*	***State Tracking #:***	*484719*	***Company Tracking #:***	*2026 NONGRANDFATHERED INDIVIDUAL RATE ...*

State:	*Washington*	***Filing Company:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
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: PROV-134088293 Percent Rate Change Request: 10.59	Sample Consumer Adjusted Premium Rate Table (Exhibit 11).pdf, Rate Schedule Duplicate.xlsm, Rate Schedule.pdf,

EXHIBIT 11: SAMPLE CONSUMER ADJUSTED PREMIUM RATE

Plan Name: Providence Columbia 5000 Silver
Exchange Plan: Outside the exchange

Family Member	Rating Area	Tobacco Use	Tobacco Load	Age on 1/1/2026	Monthly Premium	Age Band	Child Count
Subscriber	5	No	1	52	$963.00	52	0
Spouse	5	Yes	1.1	44	$758.12	44	0
Child 1	5	No	1	14	$377.41	0-14	1
Child 2	5	No	1	11	$377.41	0-14	2
Child 3	5	No	1	8	$377.41	0-14	3
Child 4	5	No	1	3	$0.00	0-14	4
Total					$2,853.35		

**Rates are charged to no more than the three oldest covered children under 21 for family coverage*

Providence Health Plan
RATE SCHEDULE

Plan Information

Plan Name: Providence Columbia 1500 Gold
HIOS Plan ID: 45834WA0490001
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the exchange
Metal Level: Gold
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	No	
2	No	
3	Yes	Clark
4	Yes	Spokane
5	Yes	Thurston
6	Yes	Benton, Franklin
7	No	
8	No	
9	Yes	Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14			442.49	391.67	433.49	422.18			412.18			442.49	391.67	433.49	422.18			412.18
15			481.83	426.49	472.03	459.71			448.82			481.83	426.49	472.03	459.71			448.82
16			496.86	439.80	486.76	474.06			462.83			496.86	439.80	486.76	474.06			462.83
17			511.90	453.11	501.49	488.41			476.83			511.90	453.11	501.49	488.41			476.83
18			528.10	467.45	517.36	503.86			491.92			528.10	467.45	517.36	503.86			491.92
19			544.29	481.78	533.22	519.31			507.01			544.29	481.78	533.22	519.31			507.01
20			561.07	496.63	549.66	535.32			522.63			561.07	496.63	549.66	535.32			522.63
21			578.42	511.99	566.66	551.87			538.80			636.26	563.19	623.33	607.06			592.68
22			578.42	511.99	566.66	551.87			538.80			636.26	563.19	623.33	607.06			592.68
23			578.42	511.99	566.66	551.87			538.80			636.26	563.19	623.33	607.06			592.68
24			578.42	511.99	566.66	551.87			538.80			636.26	563.19	623.33	607.06			592.68
25			580.74	514.04	568.92	554.08			540.95			638.81	565.44	625.81	609.49			595.05
26			592.30	524.28	580.26	565.12			551.73			651.53	576.71	638.29	621.63			606.90
27			606.19	536.57	593.86	578.36			564.66			666.81	590.23	653.25	636.20			621.13
28			628.74	556.53	615.96	599.89			585.67			691.61	612.18	677.56	659.88			644.24
29			647.25	572.92	634.09	617.55			602.91			711.98	630.21	697.50	679.31			663.20
30			656.51	581.11	643.16	626.38			611.53			722.16	639.22	707.48	689.02			672.68
31			670.39	593.40	656.76	639.62			624.47			737.43	652.74	722.44	703.58			686.92
32			684.27	605.69	670.36	652.87			637.40			752.70	666.26	737.40	718.16			701.14
33			692.95	613.37	678.86	661.15			645.48			762.25	674.71	746.75	727.27			710.03
34			702.20	621.56	687.92	669.98			654.10			772.42	683.72	756.71	736.98			719.51
35			706.83	625.65	692.46	674.39			658.41			777.51	688.22	761.71	741.83			724.25
36			711.46	629.75	696.99	678.81			662.72			782.61	692.73	766.69	746.69			728.99
37			716.09	633.84	701.52	683.22			667.03			787.70	697.22	771.67	751.54			733.73
38			720.71	637.94	706.06	687.64			671.34			792.78	701.73	776.67	756.40			738.47
39			729.97	646.13	715.12	696.47			679.96			802.97	710.74	786.63	766.12			747.96
40			739.22	654.32	724.19	705.30			688.58			813.14	719.75	796.61	775.83			757.44
41			753.11	666.61	737.79	718.54			701.51			828.42	733.27	811.57	790.39			771.66
42			766.41	678.39	750.82	731.23			713.91			843.05	746.23	825.90	804.35			785.30
43			784.92	694.77	768.95	748.89			731.15			863.41	764.25	845.85	823.78			804.27
44			808.06	715.25	791.62	770.97			752.70			888.87	786.78	870.78	848.07			827.97
45			835.24	739.31	818.25	796.91			778.02			918.76	813.24	900.08	876.60			855.82
46			867.63	767.99	849.99	827.81			808.19			954.39	844.79	934.99	910.59			889.01
47			904.07	800.24	885.69	862.58			842.14			994.48	880.26	974.26	948.84			926.35
48			945.72	837.11	926.49	902.31			880.93			1040.29	920.82	1019.14	992.54			969.02
49			986.79	873.46	966.72	941.50			919.19			1085.47	960.81	1063.39	1035.65			1011.11
50			1033.06	914.42	1012.05	985.65			962.29			1136.37	1005.86	1113.26	1084.22			1058.52
51			1078.76	954.86	1056.82	1029.25			1004.86			1186.64	1050.35	1162.50	1132.18			1105.35
52			1129.08	999.41	1106.12	1077.26			1051.73			1241.99	1099.35	1216.73	1184.99			1156.90
53			1179.98	1044.46	1155.98	1125.82			1099.15			1297.98	1148.91	1271.58	1238.40			1209.07
54			1234.93	1093.10	1209.81	1178.25			1150.33			1358.42	1202.41	1330.79	1296.08			1265.36
55			1289.88	1141.74	1263.65	1230.68			1201.52			1418.87	1255.91	1390.02	1353.75			1321.67
56			1349.46	1194.47	1322.01	1287.52			1257.01			1484.41	1313.92	1454.21	1416.27			1382.71
57			1409.61	1247.72	1380.94	1344.92			1313.05			1550.57	1372.49	1519.03	1479.41			1444.36
58			1473.82	1304.55	1443.84	1406.18			1372.85			1621.20	1435.01	1588.22	1546.80			1510.14
59			1505.63	1332.71	1475.01	1436.53			1402.49			1656.19	1465.98	1622.51	1580.18			1542.74
60			1569.84	1389.54	1537.91	1497.79			1462.29			1726.82	1528.49	1691.70	1647.57			1608.52
61			1625.37	1438.69	1592.31	1550.77			1514.02			1787.91	1582.56	1751.54	1705.85			1665.42
62			1661.81	1470.95	1628.01	1585.54			1547.96			1827.99	1618.05	1790.81	1744.09			1702.76
63			1707.50	1511.40	1672.77	1629.13			1590.53			1878.25	1662.54	1840.05	1792.04			1749.58
64 and over			1735.26	1535.97	1699.97	1655.61			1616.39			1908.78	1689.57	1869.97	1821.17			1778.03

Providence Health Plan
RATE SCHEDULE

Plan Information

Plan Name: Providence Columbia 5000 Silver
HIOS Plan ID: 45834WA0490002
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the exchange
Metal Level: Silver
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	No	
2	No	
3	Yes	Clark
4	Yes	Spokane
5	Yes	Thurston
6	Yes	Benton, Franklin
7	No	
8	No	
9	Yes	Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14			385.24	341.00	377.41	367.56			358.85			385.24	341.00	377.41	367.56			358.85
15			419.48	371.31	410.95	400.23			390.75			419.48	371.31	410.95	400.23			390.75
16			432.58	382.90	423.78	412.72			402.94			432.58	382.90	423.78	412.72			402.94
17			445.67	394.49	436.61	425.22			415.14			445.67	394.49	436.61	425.22			415.14
18			459.77	406.97	450.42	438.67			428.27			459.77	406.97	450.42	438.67			428.27
19			473.87	419.45	464.23	452.12			441.41			473.87	419.45	464.23	452.12			441.41
20			488.48	432.37	478.54	466.06			455.01			488.48	432.37	478.54	466.06			455.01
21			503.58	445.75	493.34	480.47			469.08			553.94	490.33	542.67	528.52			515.99
22			503.58	445.75	493.34	480.47			469.08			553.94	490.33	542.67	528.52			515.99
23			503.58	445.75	493.34	480.47			469.08			553.94	490.33	542.67	528.52			515.99
24			503.58	445.75	493.34	480.47			469.08			553.94	490.33	542.67	528.52			515.99
25			505.60	447.53	495.31	482.39			470.96			556.16	492.28	544.84	530.63			518.06
26			515.67	456.45	505.18	492.00			480.34			567.24	502.10	555.70	541.20			528.37
27			527.75	467.14	517.02	503.53			491.60			580.53	513.85	568.72	553.88			540.76
28			547.39	484.53	536.26	522.27			509.89			602.13	532.98	589.89	574.50			560.88
29			563.51	498.79	552.05	537.65			524.91			619.86	548.67	607.26	591.42			577.40
30			571.57	505.92	559.94	545.33			532.41			628.73	556.51	615.93	599.86			585.65
31			583.65	516.62	571.78	556.87			543.67			642.02	568.28	628.96	612.56			598.04
32			595.74	527.32	583.62	568.40			554.93			655.31	580.05	641.98	625.24			610.42
33			603.29	534.01	591.02	575.60			561.96			663.62	587.41	650.12	633.16			618.16
34			611.35	541.14	598.92	583.29			569.47			672.49	595.25	658.81	641.62			626.42
35			615.38	544.70	602.86	587.13			573.22			676.92	599.17	663.15	645.84			630.54
36			619.41	548.27	606.81	590.98			576.97			681.35	603.10	667.49	650.08			634.67
37			623.44	551.83	610.76	594.82			580.73			685.78	607.01	671.84	654.30			638.80
38			627.46	555.40	614.70	598.67			584.48			690.21	610.94	676.17	658.54			642.93
39			635.52	562.53	622.60	606.35			591.98			699.07	618.78	684.86	666.99			651.18
40			643.58	569.66	630.49	614.04			599.49			707.94	626.63	693.54	675.44			659.44
41			655.66	580.36	642.33	625.57			610.75			721.23	638.40	706.56	688.13			671.83
42			667.25	590.61	653.68	636.62			621.54			733.98	649.67	719.05	700.28			683.69
43			683.36	604.88	669.46	652.00			636.55			751.70	665.37	736.41	717.20			700.21
44			703.51	622.71	689.20	671.22			655.31			773.86	684.98	758.12	738.34			720.84
45			727.17	643.66	712.38	693.80			677.36			799.89	708.03	783.62	763.18			745.10
46			755.37	668.62	740.01	720.71			703.63			830.91	735.48	814.01	792.78			773.99
47			787.10	696.70	771.09	750.98			733.18			865.81	766.37	848.20	826.08			806.50
48			823.36	728.80	806.61	785.57			766.95			905.70	801.68	887.27	864.13			843.65
49			859.11	760.44	841.64	819.68			800.26			945.02	836.48	925.80	901.65			880.29
50			899.40	796.10	881.11	858.12			837.78			989.34	875.71	969.22	943.93			921.56
51			939.18	831.32	920.08	896.08			874.84			1033.10	914.45	1012.09	985.69			962.32
52			982.99	870.10	963.00	937.88			915.65			1081.29	957.11	1059.30	1031.67			1007.22
53			1027.31	909.32	1006.42	980.16			956.93			1130.04	1000.25	1107.06	1078.18			1052.62
54			1075.15	951.67	1053.28	1025.80			1001.50			1182.67	1046.84	1158.61	1128.38			1101.65
55			1122.99	994.02	1100.15	1071.45			1046.06			1235.29	1093.42	1210.17	1178.60			1150.67
56			1174.86	1039.93	1150.96	1120.94			1094.37			1292.35	1143.92	1266.06	1233.03			1203.81
57			1227.23	1086.29	1202.27	1170.91			1143.16			1349.95	1194.92	1322.50	1288.00			1257.48
58			1283.13	1135.76	1257.03	1224.24			1195.23			1411.44	1249.34	1382.73	1346.66			1314.75
59			1310.83	1160.28	1284.17	1250.66			1221.03			1441.91	1276.31	1412.59	1375.73			1343.13
60			1366.72	1209.76	1338.93	1304.00			1273.10			1503.39	1330.74	1472.82	1434.40			1400.41
61			1415.07	1252.55	1386.29	1350.12			1318.13			1556.58	1377.81	1524.92	1485.13			1449.94
62			1446.79	1280.63	1417.37	1380.39			1347.68			1591.47	1408.69	1559.11	1518.43			1482.45
63			1486.58	1315.85	1456.34	1418.35			1384.74			1635.24	1447.44	1601.97	1560.19			1523.21
64 and over			1510.74	1337.24	1480.02	1441.41			1407.24			1661.81	1470.96	1628.01	1585.55			1547.96

Providence Health Plan
RATE SCHEDULE

Plan Information

Plan Name: Providence Columbia 9200 Bronze
HIOS Plan ID: 45834WA0490003
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	No	
2	No	
3	Yes	Clark
4	Yes	Spokane
5	Yes	Thurston
6	Yes	Benton, Franklin
7	No	
8	No	
9	Yes	Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14			342.23	302.93	335.27	326.52			318.79			342.23	302.93	335.27	326.52			318.79
15			372.65	329.85	365.07	355.55			347.12			372.65	329.85	365.07	355.55			347.12
16			384.28	340.15	376.47	366.65			357.96			384.28	340.15	376.47	366.65			357.96
17			395.92	350.45	387.86	377.74			368.79			395.92	350.45	387.86	377.74			368.79
18			408.44	361.53	400.13	389.70			380.46			408.44	361.53	400.13	389.70			380.46
19			420.97	372.62	412.41	401.65			392.13			420.97	372.62	412.41	401.65			392.13
20			433.94	384.10	425.12	414.03			404.21			433.94	384.10	425.12	414.03			404.21
21			447.36	395.98	438.26	426.83			416.72			492.10	435.58	482.09	469.51			458.39
22			447.36	395.98	438.26	426.83			416.72			492.10	435.58	482.09	469.51			458.39
23			447.36	395.98	438.26	426.83			416.72			492.10	435.58	482.09	469.51			458.39
24			447.36	395.98	438.26	426.83			416.72			492.10	435.58	482.09	469.51			458.39
25			449.15	397.57	440.02	428.54			418.38			494.07	437.33	484.02	471.39			460.22
26			458.10	405.49	448.78	437.07			426.72			503.91	446.04	493.66	480.78			469.39
27			468.84	414.99	459.30	447.32			436.72			515.72	456.49	505.23	492.05			480.39
28			486.28	430.43	476.39	463.96			452.97			534.91	473.47	524.03	510.36			498.27
29			500.60	443.11	490.42	477.62			466.30			550.66	487.42	539.46	525.38			512.93
30			507.76	449.44	497.43	484.45			472.97			558.54	494.38	547.17	532.90			520.27
31			518.49	458.94	507.95	494.70			482.97			570.34	504.83	558.75	544.17			531.27
32			529.23	468.45	518.47	504.94			492.97			582.15	515.30	570.32	555.43			542.27
33			535.94	474.39	525.04	511.34			499.22			589.53	521.83	577.54	562.47			549.14
34			543.10	480.72	532.05	518.17			505.89			597.41	528.79	585.26	569.99			556.48
35			546.68	483.89	535.56	521.59			509.23			601.35	532.28	589.12	573.75			560.15
36			550.26	487.06	539.06	525.00			512.56			605.29	535.77	592.97	577.50			563.82
37			553.83	490.23	542.57	528.42			515.89			609.21	539.25	596.83	581.26			567.48
38			557.41	493.40	546.08	531.83			519.23			613.15	542.74	600.69	585.01			571.15
39			564.57	499.73	553.09	538.66			525.89			621.03	549.70	608.40	592.53			578.48
40			571.73	506.07	560.10	545.49			532.56			628.90	556.68	616.11	600.04			585.82
41			582.47	515.57	570.62	555.73			542.56			640.72	567.13	627.68	611.30			596.82
42			592.75	524.68	580.70	565.55			552.15			652.03	577.15	638.77	622.11			607.37
43			607.07	537.35	594.72	579.21			565.48			667.78	591.09	654.19	637.13			622.03
44			624.96	553.19	612.25	596.28			582.15			687.46	608.51	673.48	655.91			640.37
45			645.99	571.80	632.85	616.34			601.74			710.59	628.98	696.14	677.97			661.91
46			671.04	593.97	657.40	640.24			625.07			738.14	653.37	723.14	704.26			687.58
47			699.23	618.92	685.01	667.14			651.33			769.15	680.81	753.51	733.85			716.46
48			731.44	647.43	716.56	697.87			681.33			804.58	712.17	788.22	767.66			749.46
49			763.20	675.55	747.68	728.17			710.92			839.52	743.11	822.45	800.99			782.01
50			798.99	707.23	782.74	762.32			744.25			878.89	777.95	861.01	838.55			818.68
51			834.33	738.51	817.36	796.04			777.17			917.76	812.36	899.10	875.64			854.89
52			873.25	772.96	855.49	833.17			813.43			960.58	850.26	941.04	916.49			894.77
53			912.62	807.81	894.06	870.73			850.10			1003.88	888.59	983.47	957.80			935.11
54			955.12	845.42	935.69	911.28			889.69			1050.63	929.96	1029.26	1002.41			978.66
55			997.62	883.04	977.33	951.83			929.27			1097.38	971.34	1075.06	1047.01			1022.20
56			1043.70	923.83	1022.47	995.79			972.20			1148.07	1016.21	1124.72	1095.37			1069.42
57			1090.22	965.01	1068.05	1040.18			1015.53			1199.24	1061.51	1174.86	1144.20			1117.08
58			1139.88	1008.97	1116.70	1087.56			1061.79			1253.87	1109.87	1228.37	1196.32			1167.97
59			1164.48	1030.74	1140.80	1111.04			1084.71			1280.93	1133.81	1254.88	1222.14			1193.18
60			1214.14	1074.70	1189.45	1158.42			1130.96			1335.55	1182.17	1308.40	1274.26			1244.06
61			1257.09	1112.71	1231.52	1199.39			1170.97			1382.80	1223.98	1354.67	1319.33			1288.07
62			1285.27	1137.66	1259.13	1226.28			1197.22			1413.80	1251.43	1385.04	1348.91			1316.94
63			1320.61	1168.94	1293.75	1260.00			1230.14			1452.67	1285.83	1423.13	1386.00			1353.15
64 and over			1342.08	1187.94	1314.78	1280.49			1250.15			1476.29	1306.73	1446.26	1408.53			1375.17

SERFF Tracking #:	*PROV-134500631*	***State Tracking #:***	*484719*	***Company Tracking #:***	*2026 NONGRANDFATHERED INDIVIDUAL RATE ...*

State:	*Washington*	***Filing Company:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
Project Name/Number:	*/*		

URRT

State Determination

Review Status:	Incomplete

SERFF Tracking #:	*PROV-134500631*	***State Tracking #:***	*484719*	***Company Tracking #:***	*2026 NONGRANDFATHERED INDIVIDUAL RATE ...*

State:	*Washington*	***Filing Company:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
Project Name/Number:	*/*		

URRT Items

Item Name	Attachment(s)
Unified Rate Review Template	*UnifiedRateReviewSubmission_20250512125417.xml*
Actuarial Memorandum	*Part_III_Rate_Filing_Documentation_and_Actuarial_Memorandum.pdf*
Actuarial Memorandum - Redacted	*Part_III_Rate_Filing_Documentation_and_Actuarial_Memorandum_Redacted.pdf*
Consumer Justification Narrative	*Part_II_Written_Description_Justifying_the_Rate_Increase.pdf*
Other Supporting Documents	*Part_I_Unified_Rate_Review_Template.pdf*

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Actuarial Memorandum

Providence Health Plan

Issuer ID #45834

Washington Individual Health Insurance 2026 Premium Rate Filing

Date: May 14, 2025
Rates Effective: January 1, 2026

Developed by:

Wakely Consulting Group, LLC, an HMA Company

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Table of Contents

1. Executive Summary

This document contains the Part III Actuarial Memorandum documentation to support the filing of premium rates for Providence Health Plan's (PHP's) individual Washington ACA products, effective January 1, 2026. This information is intended for use by the Washington Office of the Insurance Commissioner (OIC) to assist in the review of PHP's individual rate filing. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT). Additional information supporting this rate filing can be found in accompanying exhibits.

The purpose of the actuarial memorandum is to provide certain information related to the submission of premium rate filings, including support for the values entered in the Part I URRT. This information may not be appropriate for other purposes. Note that the URRT does not demonstrate the process by which the rates were developed.

We believe the premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory based on the provisions of the ACA as currently implemented; however, future modifications in legislation, regulation, and/or court decisions may affect the appropriateness of the premium rates. The values in this report, unless stated otherwise, reflect the scenario in which enhanced premium tax credits (ePTCs) expire at the end of calendar year 2025. No adjustments were made for other proposed regulation, including CSR appropriation. Wakely and PHP would like to reserve the right to change assumptions that become materially impacted due to a change in the regulatory environment up until filings are approved in order to ensure rates are as accurate as possible, to the extent the Washington OIC and federal rules allow.

PHP will be renewing their Washington individual market products effective January 1, 2026. The PHP plans will be offered off-Exchange only and include gold, silver, and bronze plans. In total, PHP is filing 3 plans offered in Rating Areas 3-6 and 9. Plan designs include 2026 EHBs, state mandated benefits, and two additional non-EHBs (allergy testing and fertility preservation).

General Information

2.1.1 COMPANY IDENTIFYING INFORMATION

Company Legal Name: Providence Health Plan

State: Washington

HIOS Issuer ID: 45834

Market: Individual

Effective Date of Rate Change: January 1, 2026

2.1.2 COMPANY CONTACT INFORMATION

Primary Contact Name: Jessica Sonk

Primary Contact Telephone Number: (503) 866-3372

Primary Contact Email Address: Jessica.Sonk@providence.org

2.1.3 RESPONSIBLE ACTUARY INFORMATION

Responsible Actuary Name: Michelle Anderson and Lisa Winters

Company: Wakely Consulting Group, LLC, an HMA Company

Phone Number: (720) 506-1022 and (720) 226-9805

Email Address: Michelle.Anderson@Wakely.com and Lisa.Winters@Wakely.com

2.1.4 SERFF RATE REVIEW DETAIL

Projected Earned Premium: $2,595,817

Projected Incurred Claims: $3,070,052

Proposed Rate Premium PMPM: Min: $302.93. Max: $1,908.78. Weighted Average: $831.73.

Please note that the premium PMPMs are indicative of age-specific rates.

2.1.5 OTHER GENERAL INFORMATION

Type of Filing: Renewing

Type of Plan: EPO Off-Exchange

Months of Rate Guarantee: These rates will be guaranteed until December 31, 2026.

2. Proposed Rates

This filing represents an average increase of 10.6% based on current 2025 membership and projected 2026 rate levels.

The table below summarizes proposed rate changes, effective January 1, 2026, by plan, as reported within URRT Worksheet 2. These changes represent average rate changes across PHP's Washington service area. Premiums will vary by plan, age, area, and tobacco use, although, the percentage change is the same for all ages.

Table 1: Proposed Rates by Plan

Plan	Proposed Change
Providence Columbia 1500 Gold	13.11%
Providence Columbia 5000 Silver	10.89%
Providence Columbia 9200 Bronze	7.43%

When the proposed changes are weighted by 2025 current enrollment, the average rate increase comes out to 10.59%, shown in the Unified Product Modification Justification. However, when the proposed changes are weighted by both 2025 current enrollment and 2025 current premiums, the average rate increase comes out to 10.62%, shown in the Unified Rate Review Template.

3. Reason for Proposed Change

The primary driver of the rate change is due to medical and pharmacy trend. Utilization and provider reimbursement changes are both estimated to increase costs.

4. Market Experience

4.1 Experience Period Premiums and Claims

In the experience period, there was $1,878,223 in premium collected. These premiums are reported on Worksheet 1, Section 1 of the URRT. This value does not include the receivable of $1,237,092 through the Risk Adjustment program. Claims expense, shown in the table below, is incurred from 1/1/2024 to 12/31/2024 and paid through 3/31/2025.

Allowed Claims	$2,500,626
Reinsurance	$0
Incurred Claims in Experience Period	$1,886,840
Risk Adjustment	$1,237,092
Experience Period Premium	$1,878,223

Experience Period Member Months	2,899

4.2 Benefit Categories

PHP assigned the experience data utilization and cost information to benefit categories as shown in Worksheet 1, Section II of the Part I URRT based on the Milliman Health Cost Guidelines categorization:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation: Includes all services provided under one or more capitated arrangements.

Prescription Drug: Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

4.3 Projection Factors

PHP's first year in the Washington individual market was 2020. In 2022, PHP shifted plan offerings to only off-Exchange. Due to low membership, the 2024 experience was determined to not be an accurate prediction of the 2026 estimated costs. As a result, PHP's Washington 2024 claims experience was assigned a credibility of 0.00%. This is in compliance with ASOP #25 which grants the Actuary the ability to use professional judgement over a precise mathematical formula. Credibility will be assessed in future years depending on stability and size of experience.

Therefore, projection factors for purposes of moving the experience forward to the projection period are not applicable. In the Credibility Manual Rate Development section of this report, we discuss the development of claim costs used within the base period and factors applied to project the base period to the projection period for the development of the index rate and base rate.

The projected risk adjustment receivable paid PMPM is expected to be $285.18. Please see Exhibit 14 for details on the risk adjustment transfer payment calculation by metal tier and Exhibit 8 for details on converting the transfer payment to an allowed basis.

5. Credibility Manual Rate Development

The development of the proposed 2026 index rate and base rate for PHP is outlined below. Please see the accompanying exhibits for details regarding the factors used within the development of the index rate.

5.1 Base Period Claims

Allowed PMPM medical costs were developed using 2023 Washington ACA individual statewide EHB incurred claims data, summarized from URRTs submitted in 2025. This represents the most recent year of Washington ACA data available publicly. Pharmacy payments within the URRTs are assumed to be reduced for rebates. An adjustment was made to remove abortion from the statewide data since PHP will not cover this benefit.

5.2 Adjustments made to the base data

The base period allowed PMPMs were adjusted for items including differences in membership mix by metal, average age, risk, geographic service areas, trend, and provider contract reimbursement differences between base and projected periods. Below is a summary of the methodology and source information for the adjustments.

See Exhibit 7 for details of the index rate development.

INCLUSION OF CAPITATION PAYMENTS

No modifications to capitation payments within the base period manual data were made.

5.3 Allowed Claim Cost Adjustments

5.3.1 CHANGES IN MEMBERSHIP MIX

The age and metal mix adjustment applied to the allowed claims represents utilization differences based on variance between Washington's 2023 individual ACA statewide age and metal distribution and the PHP expected age and metal mix in Washington in 2026. Utilization differences by age band and metal tier were derived using Wakely's proprietary database which consists of a nationally-representative sample of approximately 50.5 million member months

comprised of individual data for ACA-compliant plans. This data set is considered fully credible at each metal level.

We further adjusted based on PHP‘s assumed propensity to enroll members with more HCC’s than an equivalent, average population. This assumption was based on a comparison between the PHP Washington experience population and a similar population in the Wakely ACA proprietary database with the same age and metal mix.

See Exhibit 28 for more details regarding the allowed claim cost adjustment.

5.3.2 CHANGES IN MORBIDITY OF THE POPULATION INSURED

No additional morbidity adjustments were deemed necessary. Due to PHP’s unique population, the expiration of the enhanced premium tax credits (ePTC) at the end of 2025 is not expected to impact PHP’s enrollment or population morbidity. The statewide impact is accounted for within the risk adjustment buildup.

5.3.3 TREND FACTORS

Total trend estimates used in the PHP 2026 rate development were based on a review of trends from prospective claim cost trend information published in the 2025 Washington URRT individual rate filings and PHP known and estimated changes in provider reimbursements. A range of reasonable trend assumptions was identified and ultimately, an annual trend, inclusive of utilization and unit cost increases, of 11.6% was selected. See Exhibit 24 for further details on the trend adjustments.

5.3.4 PROVIDER CONTRACTING

Wakely analyzed PHP medical provider contracted rates within each rating area to determine their market position in 2026 relative to the base data underlying contracts. Other assumptions, including pharmacy unit cost trends and PBM rebates, were provided by PHP and incorporated into the index rate. An increase of 10.5% was applied to the base period allowed claims. See Exhibit 3 for more details.

5.3.5 GEOGRAPHIC ADJUSTMENT (TO PHP’S SERVICE AREA)

PHP’s service areas will be within Rating Areas 3-6 and 9. The geographic adjustment reflects the estimated difference in allowed costs between statewide Washington (on which the base period experience is based) and PHP’s expected enrollment distribution in its service area.

5.3.6 GEOGRAPHIC FACTORS APPLIED TO BASE RATE

Please refer to Exhibit 23 in the accompanying exhibits for geographic factors used in the Rate Manual.

5.3.7 CHANGES IN BENEFITS

Wakely made a 1.001 adjustment to allowed claims to account for the new EHB requirements in 2026. This estimate aligns with the allowed cost impacts estimated by Wakely and published by the OIC for the benchmark plan redesign. These new requirements include:

1. Hearing Aids – includes an annual hearing exam and one hearing aid per ear with hearing loss every three years
2. Donor Human Milk – includes medically necessary donor human milk in an inpatient setting for an infant who is medically or physically unable to receive maternal human milk
3. Artificial Insemination – includes artificial insemination in vivo, covering placement of sperm into the cervix or uterus to achieve a pregnancy

5.3.8 NON-ESSENTIAL HEALTH BENEFITS (EHBS)

PHP will be offering two non-EHBs: allergy treatment and fertility preservation. These services were applied in addition to the Market Adjusted Index Rate for premium development purposes, as instructed within the URRT.

Fertility preservation was a new benefit in 2022. The 2026 projected amount reflects actual experience in 2024. It is based on experience in the state of Oregon as the Washington experience was not fully credible. The small reduction in projected allowed claims reflects that the actual experience was lower in 2024 than in 2023.

The allergy testing estimate was calculated based on actual experience in 2024. It is based on experience in the state of Oregon as the Washington experience was not fully credible. The small reduction in projected allowed claims reflects that the actual experience was lower in 2024 than in 2023.

5.3.9 PEDIATRIC DENTAL COSTS

No adjustments were made to account for pediatric dental costs.

5.4 Risk Adjustment Transfers

The risk adjustment transfer amount was calculated to arrive at an estimated transfer amount for PHP’s population. Various adjustments such as age and metal mix distribution shifts, geographic

differences, and premium increases from the base period to 2026 were incorporated to obtain an estimated 2026 risk adjustment transfer.

We took the following steps to arrive at a projected risk adjustment transfer:

- At the metal level, each factor of the risk transfer formula was calculated separately for PHP's expected population and the statewide Washington 2026 estimates.
- **ARF** - Age Rating Factors for PHP and Washington statewide were calculated based on the same enrollment mix by age band as was assumed in the claims buildup.
- **AV** - Actuarial Value for Washington statewide was based on the same statewide Washington metal mix as was assumed in the claims buildup.
- **PLRS** - Plan Liability Risk Score for statewide Washington and PHP started from the average PLRS in the Wakely proprietary national ACA database, specifically for members with the same age and metal mix as either statewide Washington or PHP's expected population in 2026. For PHP, this initial PLRS was then further adjusted based on the assumed propensity for PHP to enroll a greater portion of members with HCC's than an equivalent population with the same metal and age mix, given historical experience and premium levels.
- **GCF** – The Geographic Calibration Factor for PHP was based on the relative cost factor for rating areas within the risk transfer formula, and PHP's distribution within their rating area, relative to statewide Washington enrollment and geographic spread.
- For the primary filing, each of the statewide components was additionally adjusted for the projected impact of the expiration of ePTCs. Using public data sources, the Wakely claims ACA database, and 2024 WNRAR results provided by the client, Wakely estimated the impact of changes in member net premiums (defined as gross premiums net of advanced premium tax credits) by age bracket, plan metal/CSR tier, and income bracket as a percentage of the Federal Poverty Level (FPL) to determine the range of ACA individual market impacts in 2026 due to the expiration of ePTCs. For a consumer of a given age, plan metal/CSR tier, and income, the change in the net premium post-expiration of ePTC was combined with a price elasticity of demand for health insurance to estimate the proportion of members dropping coverage and the proportion of members switching to a less expensive plan metal tier ("buying down" or "buydown"). Adjustments were made to account for shifts in PLRS, AV, IDF, and the statewide average premium. The resulting adjustments were set to 1.000 for the secondary set of rates.

- Using the above factors and an estimated statewide average premium, an estimated risk transfer for PHP is calculated at the metal level. This transfer amount is then weighted by PHP's expected metal mix in Washington in 2026.
- Then, a load was added to the risk adjustment transfer to account for the estimated high-cost risk pooling charge in 2026 from a Wakely National Risk Adjustment Reporting (WNRAR) study, calculated as a percent of premium.
- Finally, the risk adjustment transfer PMPM was converted from a paid to an allowed amount (dividing by expected actuarial value) necessary to capture sufficient premiums to cover anticipated transfer payments.

See Exhibit 14 for the development of risk adjustment transfers by metal level.

Market Adjusted Index Rate

After each of these adjustments is applied, we arrived at an allowed claim cost estimate for EHBs for the average age of PHP's population in the Washington market. Then, the PHP risk adjustment transfer estimate is added to arrive at a total allowed cost (claims and risk adjustment).

This results in projected allowed claims costs of $925 PMPM (claims and risk transfer), consisting of $1,303 PMPM in estimated claims and $378 PMPM in risk adjustment receivable (also on an allowed basis).

6. Credibility of Experience

The credibility of PHP's Washington experience is 0%.

7. Paid to Allowed Ratio

Plan designs were modeled within the Wakely Plan Valuation Model (WPVM), based on detailed claim data from the Wakely proprietary national ACA database, to develop paid-to-allowed pricing estimates (as opposed to the actuarial values from the federal AV calculator). The Wakely ACA database is a nationally-representative sample of approximately 50.5 million member months comprised of individual data for ACA-compliant plans. The model uses actuarially sound pricing methods to value the impact of deductibles, copays, coinsurance, and maximum out-of-pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions in the model to the plan's prospective allowed costs, adjusted for induced demand by metal tier. The purpose of this is to calculate variation of actuarial values for pricing based on plan-specific cost-sharing.

We then applied the pricing actuarial value for each plan to the PHP 2026 index rate for premium rate development. See Exhibit 4 for projected pricing AVs.

8. Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

PHP 2024 experience was reported in URRT Worksheet 1; no credibility was applied to the experience costs.

Projected Risk Adjustment PMPM

The projected index rate was developed based on our best estimate of the market-wide average risk. Projected risk adjustment transfers, net of fees, have an impact of decreasing premiums by $378 PMPM and are reported in the URRT Worksheet 1 (on an allowed basis). Risk adjustment transfers were applied at the market level in the development of the market adjusted index rate.

The risk adjustment fee of $0.20 PMPM was incorporated into 2026 rates and was included within the taxes and fees.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

No adjustments were made in the development of 2026 premiums to account for federal or state reinsurance programs.

9. Non-benefit Expenses and Profit & Risk

Administrative Expense Load

Administrative expenses were developed based on PHP’s current Individual business. In total, 10.3% administrative expenses and commissions were included in the 2026 rate development.

Profit / Contribution to Surplus & Risk Margin

3.5% of proposed 2026 premiums was allocated to profit and risk margin.

Given the WA ACA business only accounts for 0.13% of premium across the business, there is negligible impact on the issuer's capital & surplus levels. We believe that the overall loaded profit margin is sufficient.

Taxes and Fees

Taxes and regulatory fees included in the development of 2026 rates, equal to 2.17% of premium, include the following:

1. Risk Adjustment User Fee = $0.20 PMPM
2. Premium tax = 2.0% of premiums
3. PCORI Fee = $0.32 PMPM
4. WSHIP Fee = $0.13 PMPM
5. Mitigating Inequity Fee = $0.75 PMPM
6. WAPAL Fee = $0.06 PMPM

The retention (administrative expense load + taxes and fees) of 12.5% ties to the WAC 284-43-6660. See Exhibit 5a for details regarding retention components.

10. Projected Loss Ratio

The Anticipated Loss Ratio (ALR) is defined as being the present value of expected benefits over the present value of expected premiums for the time period that the premiums are effective. Wakely estimates the ALR to be 84.0%. This calculation does not exclude any regulatory fees or taxes from premiums, which is why it is lower than the federal MLR calculations.

Based on the federal MLR methodology, the loss ratio is estimated to be 85.8%; therefore, PHP does not anticipate paying consumer rebates for the 2026 plan year. Regulatory fees and taxes were excluded from premium in the calculation of this value.

11. Application of Market Reform Rating Rules

Single Risk Pool

PHP has established a single risk pool for all individual market business. All of PHP's individual business will be non-grandfathered, non-transitional, and ACA-compliant.

Index Rate Development

INDEX RATE FOR PROJECTION PERIOD

The projection period claims portion of the index rate is estimated to be $1,302.60 PMPM. This was calculated based on projected allowed claims for essential health benefits for the single risk pool population during the projection period. Allowed claims in the projection period equal the projection period index rate plus the cost of non-EHBs being offered in the projection period.

MARKET ADJUSTED INDEX RATE FOR PROJECTION PERIOD

We then included the impact of risk adjustment, converted to an allowed basis, and the 'equivalent Marketplace User Fee' (which is $0 for PHP), to calculate the 2026 market adjusted index rate. The market adjusted index rate is $924.80 PMPM.

PLAN ADJUSTED INDEX RATE FOR PROJECTION PERIOD

Plan adjusted index rates were developed by applying allowable plan level adjustments to the market adjusted index rate. The following describes how each component of the adjustment was developed.

AV and Cost Sharing Adjustment

Paid to allowed ratios were developed for each plan based on the WPVM, described elsewhere in this report, and meet the 2% AV pricing value guardrails as described in the Emergency Rule (CR-103E).

Additional adjustments were made to account for induced utilization, driven by cost sharing differences across each plan. Utilization factors reflect the impact of differences in cost sharing on utilization. The factors are consistent with the federal risk transfer formula published by Centers for Medicare and Medicaid Services (CMS) as required by the Emergency Rule (CR-103E).

Provider Network, Delivery System and Utilization Management Adjustment

PHP will only have one network and therefore the network factor for all plans is 1.000.

Adjustments for benefits in addition to EHB

PHP will be offering two benefits in addition to EHBs: allergy testing and fertility preservation. The projected PMPM costs for allergy testing and fertility preservation were calculated using PHP's commercial experience trended to 2026. The total allowed cost of non-EHB benefits is projected to be $0.42 PMPM in 2026.

Impact of Specific Eligibility Categories for Catastrophic Plan

PHP does not offer catastrophic plans.

TOBACCO RATING

The tobacco adjustment factor for ages 21 and above is 1.10. The average tobacco factor is based on the prevalence of smokers in PHP's current membership in the Washington individual market.

CALIBRATION

Per the instructions, plan adjusted index rates were next calibrated to age 21. To bring the experience to an age 21 rate, we divided the plan adjusted index rate by the weighted average age factor. The age factor was calculated as the weighted average of the Federal ACA age factors, as adopted by Washington, and the estimated enrollment by age for PHP's Washington population in 2026. The age associated with this factor is between 48 and 49 years. Once calibrated, the standard federal age factors can be applied on a multiplicative basis to get to the rates for other ages.

The calibrated index rate represents an average monthly premium for a 21-year-old non-tobacco user individual in Rating Area 3.

GEOGRAPHIC FACTORS

The 2025 filed geographic area factors were deemed appropriate for the 2026 rating period; this ensures less fluctuation year over year and mitigates consumer disruption due to premium changes. The 2025 PHP filed rating area factors only reflect differences in the cost of delivering health care services and do not reflect any difference in morbidity by area, nor reflect local demographic and risk profiles. Therefore, we believe population health risk differences by geography are not reflected in geographic factors.

Age and geographic factor calibration are applied uniformly to all plans.

CONSUMER ADJUSTED INDEX RATE

The consumer adjusted index rates were calculated by multiplying the calibrated plan adjusted index rates by the consumer's specific age factor (subject to maximum allowable rating of 3 dependents under age 21), area factor, and tobacco load as applicable.

We used the Federal ACA age factors, as adopted by Washington, for all members and geographic factors that were discussed previously. For tobacco factors, we used a level rating factor of 1.10 for all adult ages.

The consumer adjusted index rates are provided in the rate templates.

12. AV Metal Levels

The 2026 Federal Actuarial Value Calculator (AVC) was used to generate the AV metal tiers (URRT, Worksheet 2).

All plans received adjustments to their actuarial value that were developed outside of the AV calculator and are considered unique benefit designs. For the following categories, the AV Calculator did not provide for as much specificity as the plan's benefits and it was necessary to make adjustments to account for the plan benefits correctly.

- Pharmacy: We developed an effective coinsurance rate for the two tier specialty drugs and generic drugs. Generic drugs were also blended for usage of preventive drugs.
- Emergency Room: An effective coinsurance rate was developed for services that had a copay followed by coinsurance.
- Free Virtual Visits: Effective copays were developed for primary and specialty care visits by blending the copays and utilization of free virtual visits, other virtual visits, and office visits.
- Effective copays were also required for plans that had cost sharing of coinsurance and no deductible.

These adjustments were developed in accordance with ASOP 50, CFR 45 156.135 and generally accepted actuarial principles. Detail of the AV adjustments can be found in Exhibit 18. The AV metal values can be found in Exhibit 12.

13. AV Pricing Values

The methodology for development of the AV Pricing Values is included in the plan adjusted index rate section. Only allowable modifiers were used in the development of these values. Benefit richness utilization adjustments were applied to stratify the market adjusted index rate to levels suitable for each of the metal tiers.

Differences in morbidity across metal tiers were not included in the pricing development for each metal tier plan.

The pricing AVs differ from the Federal AVC outputs primarily because the estimated allowed PMPMs used in developing pricing AVs are different than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements (e.g. copays, deductibles and MOOPs). The other variance is differences in the methodology of the pricing models and underlying data of the modeling.

14. Membership Projections

The membership projections for 2026 were provided by PHP based on their current membership in the Washington individual market and an understanding of the current and projected Washington market in 2026. PHP is anticipating stable membership between 2025 and 2026. Actual enrollment is highly dependent on consumer decisions and the competitiveness of rates in the market.

Exhibit 13 shows 2026 PHP individual enrollment projections by plan and rating area.

15. CSR Load and Payments

All PHP plans will be offered off-exchange only in 2026. PHP has been offering off-exchange only plans since 2022. No CSR load was applied for 2024 and there is no CSR load for 2026. There were no CSR payments for plan year 2024.

16. Terminated Plans and Products

There are no terminated plans for 2026.

17. Plan Type

The plan types listed in the drop-down box in Worksheet 2, Section I of the URRT describe the plans exactly.

18. URRT Warnings

There are no warnings appearing in the URRT.

19. Effective Rate Review Information

Additional information available upon request.

20. Reliance

Providence Health Plan has provided Wakely Consulting Group, LLC, an HMA Company, 8000 South Chester Street, Suite 650, Centennial, CO 80112 (Wakely) with information used to develop the 2026 Washington individual commercial product premium rates. This information includes, but is not limited to, the following:

- Estimated 2026 enrollment figures by rating area, metal, variant, plan, and Exchange status; and
- Geographic regions to be covered in 2026; and
- Benefit designs for Federal AVC inputs and pricing AV inputs; and
- General administrative expenses, profit margin, taxes & fees, and other retention components; and
- Quality initiatives (QI) allowed to be treated as QI under regulatory rules; and
- Product design information including a statement that 2026 coverage will include EHBs and state mandated benefits, with the exception of abortion, and non-EHBs for allergy testing and fertility preservation; and
- Assumptions around reimbursements for in and out-of-network medical and pharmacy contracts; and
- PHP Washington claims and enrollment experience, by plan, incurred in 2024, including estimated reimbursements as a percentage of Medicare; and
- The 2026 filed premium rates are consistent with PHP's internal business plans; and
- IBNR calculations, and other needed adjustments, as applied to the PHP Washington medical claim experience, and other financial information needed for reporting purposes.

21. Actuarial Certification

We, Michelle Anderson and Lisa Winters, are members of the American Academy of Actuaries and meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries for preparing premium rate filings for insurers. Michelle is a Fellow of the Society of Actuaries and Lisa is an Associate of the Society of Actuaries.

This actuarial certification applies to the Providence Health Plan Washington Individual products.

1. The premium rates filed are in compliance with applicable laws, rules and guidelines of the State of Washington.
2. The premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory based on the provisions of the ACA as currently implemented. The actuarial soundness of the block of business is dependent on projected membership distribution by plan, which we received from PHP.
3. The premium rates are calculated on the basis of sound actuarial principles.
4. The premium rates are reasonable when related to the applicable coverage and characteristics of the applicable class of enrollees.
5. The projected index rates are developed in accordance with all applicable state and federal statutes and regulations (45 CFR 156.80 and 147.102) and with allowable modifiers used in the development of plan specific premium rates.
6. The premium rates filed are in compliance with the Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board that are listed below:

   ASOP No. 5, Incurred Health and Disability Claims

   ASOP No. 8, Regulatory Filings for Health Plan Entities

   ASOP No. 12, Risk Classification

   ASOP No. 23, Data Quality

   ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

   ASOP No. 41, Actuarial Communication

ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

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

ASOP No. 56, Modeling

In our opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are not estimated to be either excessive or deficient based on the provisions of the ACA as currently implemented. Actual experience will vary from the estimates given the inherent uncertainty in developing premium rates under the ACA and potential morbidity shifts in the market due to PHE changes and state policies.

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

The Federal AV Calculator (with some modification) was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Michelle Anderson
Director and Senior Consulting Actuary

Lisa Winters
Consulting Actuary

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Associate, Society of Actuaries
Member, American Academy of Actuaries

Date: May 14, 2025

www.wakely.com

Actuarial Memorandum

Providence Health Plan

Issuer ID #45834

Washington Individual Health Insurance 2026 Premium Rate Filing

Date: May 14, 2025
Rates Effective: January 1, 2026

Developed by:

Wakely Consulting Group, LLC, an HMA Company

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Table of Contents

1. Executive Summary

This document contains the Part III Actuarial Memorandum documentation to support the filing of premium rates for Providence Health Plan's (PHP's) individual Washington ACA products, effective January 1, 2026. This information is intended for use by the Washington Office of the Insurance Commissioner (OIC) to assist in the review of PHP's individual rate filing. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT). Additional information supporting this rate filing can be found in accompanying exhibits.

The purpose of the actuarial memorandum is to provide certain information related to the submission of premium rate filings, including support for the values entered in the Part I URRT. This information may not be appropriate for other purposes. Note that the URRT does not demonstrate the process by which the rates were developed.

We believe the premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory based on the provisions of the ACA as currently implemented; however, future modifications in legislation, regulation, and/or court decisions may affect the appropriateness of the premium rates. The values in this report, unless stated otherwise, reflect the scenario in which enhanced premium tax credits (ePTCs) expire at the end of calendar year 2025. No adjustments were made for other proposed regulation, including CSR appropriation. Wakely and PHP would like to reserve the right to change assumptions that become materially impacted due to a change in the regulatory environment up until filings are approved in order to ensure rates are as accurate as possible, to the extent the Washington OIC and federal rules allow.

PHP will be renewing their Washington individual market products effective January 1, 2026. The PHP plans will be offered off-Exchange only and include gold, silver, and bronze plans. In total, PHP is filing 3 plans offered in Rating Areas 3-6 and 9. Plan designs include 2026 EHBs, state mandated benefits, and two additional non-EHBs (allergy testing and fertility preservation).

General Information

2.1.1 COMPANY IDENTIFYING INFORMATION

Company Legal Name: Providence Health Plan

State: Washington

HIOS Issuer ID: 45834

Market: Individual

Effective Date of Rate Change: January 1, 2026

2.1.2 COMPANY CONTACT INFORMATION

Primary Contact Name: Jessica Sonk

Primary Contact Telephone Number: (503) 866-3372

Primary Contact Email Address: Jessica.Sonk@providence.org

2.1.3 RESPONSIBLE ACTUARY INFORMATION

Responsible Actuary Name: Michelle Anderson and Lisa Winters

Company: Wakely Consulting Group, LLC, an HMA Company

Phone Number: (720) 506-1022 and (720) 226-9805

Email Address: Michelle.Anderson@Wakely.com and Lisa.Winters@Wakely.com

2.1.4 SERFF RATE REVIEW DETAIL

Projected Earned Premium: $2,595,817

Projected Incurred Claims: $3,070,052

Proposed Rate Premium PMPM: Min: $302.93. Max: $1,908.78. Weighted Average: $831.73.

Please note that the premium PMPMs are indicative of age-specific rates.

2.1.5 OTHER GENERAL INFORMATION

Type of Filing: Renewing

Type of Plan: EPO Off-Exchange

Months of Rate Guarantee: These rates will be guaranteed until December 31, 2026.

2. Proposed Rates

This filing represents an average increase of 10.6% based on current 2025 membership and projected 2026 rate levels.

The table below summarizes proposed rate changes, effective January 1, 2026, by plan, as reported within URRT Worksheet 2. These changes represent average rate changes across PHP's Washington service area. Premiums will vary by plan, age, area, and tobacco use, although, the percentage change is the same for all ages.

Table 1: Proposed Rates by Plan

Plan	Proposed Change
Providence Columbia 1500 Gold	13.11%
Providence Columbia 5000 Silver	10.89%
Providence Columbia 9200 Bronze	7.43%

When the proposed changes are weighted by 2025 current enrollment, the average rate increase comes out to 10.59%, shown in the Unified Product Modification Justification. However, when the proposed changes are weighted by both 2025 current enrollment and 2025 current premiums, the average rate increase comes out to 10.62%, shown in the Unified Rate Review Template.

3. Reason for Proposed Change

The primary driver of the rate change is due to medical and pharmacy trend. Utilization and provider reimbursement changes are both estimated to increase costs.

4. Market Experience

4.1 Experience Period Premiums and Claims

In the experience period, there was $1,878,223 in premium collected. These premiums are reported on Worksheet 1, Section 1 of the URRT. This value does not include the receivable of $1,237,092 through the Risk Adjustment program. Claims expense, shown in the table below, is incurred from 1/1/2024 to 12/31/2024 and paid through 3/31/2025.

Allowed Claims	$2,500,626
Reinsurance	$0
Incurred Claims in Experience Period	$1,886,840
Risk Adjustment	$1,237,092
Experience Period Premium	$1,878,223

Experience Period Member Months	2,899

4.2 Benefit Categories

PHP assigned the experience data utilization and cost information to benefit categories as shown in Worksheet 1, Section II of the Part I URRT based on the Milliman Health Cost Guidelines categorization:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation: Includes all services provided under one or more capitated arrangements.

Prescription Drug: Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

4.3 Projection Factors

PHP's first year in the Washington individual market was 2020. In 2022, PHP shifted plan offerings to only off-Exchange. Due to low membership, the 2024 experience was determined to not be an accurate prediction of the 2026 estimated costs. As a result, PHP's Washington 2024 claims experience was assigned a credibility of 0.00%. This is in compliance with ASOP #25 which grants the Actuary the ability to use professional judgement over a precise mathematical formula. Credibility will be assessed in future years depending on stability and size of experience.

Therefore, projection factors for purposes of moving the experience forward to the projection period are not applicable. In the Credibility Manual Rate Development section of this report, we discuss the development of claim costs used within the base period and factors applied to project the base period to the projection period for the development of the index rate and base rate.

The projected risk adjustment receivable paid PMPM is expected to be $285.18. Please see Exhibit 14 for details on the risk adjustment transfer payment calculation by metal tier and Exhibit 8 for details on converting the transfer payment to an allowed basis.

5. Credibility Manual Rate Development

The development of the proposed 2026 index rate and base rate for PHP is outlined below. Please see the accompanying exhibits for details regarding the factors used within the development of the index rate.

5.1 Base Period Claims

Allowed PMPM medical costs were developed using 2023 Washington ACA individual statewide EHB incurred claims data, summarized from URRTs submitted in 2025. This represents the most recent year of Washington ACA data available publicly. Pharmacy payments within the URRTs are assumed to be reduced for rebates. An adjustment was made to remove abortion from the statewide data since PHP will not cover this benefit.

5.2 Adjustments made to the base data

The base period allowed PMPMs were adjusted for items including differences in membership mix by metal, average age, risk, geographic service areas, trend, and provider contract reimbursement differences between base and projected periods. Below is a summary of the methodology and source information for the adjustments.

See Exhibit 7 for details of the index rate development.

INCLUSION OF CAPITATION PAYMENTS

No modifications to capitation payments within the base period manual data were made.

5.3 Allowed Claim Cost Adjustments

5.3.1 CHANGES IN MEMBERSHIP MIX

The age and metal mix adjustment applied to the allowed claims represents utilization differences based on variance between Washington's 2023 individual ACA statewide age and metal distribution and the PHP expected age and metal mix in Washington in 2026. Utilization differences by age band and metal tier were derived using Wakely's proprietary database which consists of a nationally-representative sample of approximately 50.5 million member months

comprised of individual data for ACA-compliant plans. This data set is considered fully credible at each metal level.

We further adjusted based on PHP‘s assumed propensity to enroll members with more HCC’s than an equivalent, average population. This assumption was based on a comparison between the PHP Washington experience population and a similar population in the Wakely ACA proprietary database with the same age and metal mix.

See Exhibit 28 for more details regarding the allowed claim cost adjustment.

5.3.2 CHANGES IN MORBIDITY OF THE POPULATION INSURED

No additional morbidity adjustments were deemed necessary. Due to PHP’s unique population, the expiration of the enhanced premium tax credits (ePTC) at the end of 2025 is not expected to impact PHP’s enrollment or population morbidity. The statewide impact is accounted for within the risk adjustment buildup.

5.3.3 TREND FACTORS

Total trend estimates used in the PHP 2026 rate development were based on a review of trends from prospective claim cost trend information published in the 2025 Washington URRT individual rate filings and PHP known and estimated changes in provider reimbursements. A range of reasonable trend assumptions was identified and ultimately, an annual trend, inclusive of utilization and unit cost increases, of 11.6% was selected. See Exhibit 24 for further details on the trend adjustments.

5.3.4 PROVIDER CONTRACTING

Wakely analyzed PHP medical provider contracted rates within each rating area to determine their market position in 2026 relative to the base data underlying contracts. Other assumptions, including pharmacy unit cost trends and PBM rebates, were provided by PHP and incorporated into the index rate. An increase of 10.5% was applied to the base period allowed claims. See Exhibit 3 for more details.

5.3.5 GEOGRAPHIC ADJUSTMENT (TO PHP’S SERVICE AREA)

PHP’s service areas will be within Rating Areas 3-6 and 9. The geographic adjustment reflects the estimated difference in allowed costs between statewide Washington (on which the base period experience is based) and PHP’s expected enrollment distribution in its service area.

5.3.6 GEOGRAPHIC FACTORS APPLIED TO BASE RATE

Please refer to Exhibit 23 in the accompanying exhibits for geographic factors used in the Rate Manual.

5.3.7 CHANGES IN BENEFITS

Wakely made a 1.001 adjustment to allowed claims to account for the new EHB requirements in 2026. This estimate aligns with the allowed cost impacts estimated by Wakely and published by the OIC for the benchmark plan redesign. These new requirements include:

1. Hearing Aids – includes an annual hearing exam and one hearing aid per ear with hearing loss every three years
2. Donor Human Milk – includes medically necessary donor human milk in an inpatient setting for an infant who is medically or physically unable to receive maternal human milk
3. Artificial Insemination – includes artificial insemination in vivo, covering placement of sperm into the cervix or uterus to achieve a pregnancy

5.3.8 NON-ESSENTIAL HEALTH BENEFITS (EHBS)

PHP will be offering two non-EHBs: allergy treatment and fertility preservation. These services were applied in addition to the Market Adjusted Index Rate for premium development purposes, as instructed within the URRT.

Fertility preservation was a new benefit in 2022. The 2026 projected amount reflects actual experience in 2024. It is based on experience in the state of Oregon as the Washington experience was not fully credible. The small reduction in projected allowed claims reflects that the actual experience was lower in 2024 than in 2023.

The allergy testing estimate was calculated based on actual experience in 2024. It is based on experience in the state of Oregon as the Washington experience was not fully credible. The small reduction in projected allowed claims reflects that the actual experience was lower in 2024 than in 2023.

5.3.9 PEDIATRIC DENTAL COSTS

No adjustments were made to account for pediatric dental costs.

5.4 Risk Adjustment Transfers

The risk adjustment transfer amount was calculated to arrive at an estimated transfer amount for PHP’s population. Various adjustments such as age and metal mix distribution shifts, geographic

differences, and premium increases from the base period to 2026 were incorporated to obtain an estimated 2026 risk adjustment transfer.

We took the following steps to arrive at a projected risk adjustment transfer:

- At the metal level, each factor of the risk transfer formula was calculated separately for PHP's expected population and the statewide Washington 2026 estimates.
- **ARF** - Age Rating Factors for PHP and Washington statewide were calculated based on the same enrollment mix by age band as was assumed in the claims buildup.
- **AV** - Actuarial Value for Washington statewide was based on the same statewide Washington metal mix as was assumed in the claims buildup.
- **PLRS** - Plan Liability Risk Score for statewide Washington and PHP started from the average PLRS in the Wakely proprietary national ACA database, specifically for members with the same age and metal mix as either statewide Washington or PHP's expected population in 2026. For PHP, this initial PLRS was then further adjusted based on the assumed propensity for PHP to enroll a greater portion of members with HCC's than an equivalent population with the same metal and age mix, given historical experience and premium levels.
- **GCF** – The Geographic Calibration Factor for PHP was based on the relative cost factor for rating areas within the risk transfer formula, and PHP's distribution within their rating area, relative to statewide Washington enrollment and geographic spread.
- For the primary filing, each of the statewide components was additionally adjusted for the projected impact of the expiration of ePTCs. Using public data sources, the Wakely claims ACA database, and 2024 WNRAR results provided by the client, Wakely estimated the impact of changes in member net premiums (defined as gross premiums net of advanced premium tax credits) by age bracket, plan metal/CSR tier, and income bracket as a percentage of the Federal Poverty Level (FPL) to determine the range of ACA individual market impacts in 2026 due to the expiration of ePTCs. For a consumer of a given age, plan metal/CSR tier, and income, the change in the net premium post-expiration of ePTC was combined with a price elasticity of demand for health insurance to estimate the proportion of members dropping coverage and the proportion of members switching to a less expensive plan metal tier ("buying down" or "buydown"). Adjustments were made to account for shifts in PLRS, AV, IDF, and the statewide average premium. The resulting adjustments were set to 1.000 for the secondary set of rates.

- Using the above factors and an estimated statewide average premium, an estimated risk transfer for PHP is calculated at the metal level. This transfer amount is then weighted by PHP's expected metal mix in Washington in 2026.
- Then, a load was added to the risk adjustment transfer to account for the estimated high-cost risk pooling charge in 2026 from a Wakely National Risk Adjustment Reporting (WNRAR) study, calculated as a percent of premium.
- Finally, the risk adjustment transfer PMPM was converted from a paid to an allowed amount (dividing by expected actuarial value) necessary to capture sufficient premiums to cover anticipated transfer payments.

See Exhibit 14 for the development of risk adjustment transfers by metal level.

Market Adjusted Index Rate

After each of these adjustments is applied, we arrived at an allowed claim cost estimate for EHBs for the average age of PHP's population in the Washington market. Then, the PHP risk adjustment transfer estimate is added to arrive at a total allowed cost (claims and risk adjustment).

This results in projected allowed claims costs of $925 PMPM (claims and risk transfer), consisting of $1,303 PMPM in estimated claims and $378 PMPM in risk adjustment receivable (also on an allowed basis).

6. Credibility of Experience

The credibility of PHP's Washington experience is 0%.

7. Paid to Allowed Ratio

Plan designs were modeled within the Wakely Plan Valuation Model (WPVM), based on detailed claim data from the Wakely proprietary national ACA database, to develop paid-to-allowed pricing estimates (as opposed to the actuarial values from the federal AV calculator). The Wakely ACA database is a nationally-representative sample of approximately 50.5 million member months comprised of individual data for ACA-compliant plans. The model uses actuarially sound pricing methods to value the impact of deductibles, copays, coinsurance, and maximum out-of-pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions in the model to the plan's prospective allowed costs, adjusted for induced demand by metal tier. The purpose of this is to calculate variation of actuarial values for pricing based on plan-specific cost-sharing.

We then applied the pricing actuarial value for each plan to the PHP 2026 index rate for premium rate development. See Exhibit 4 for projected pricing AVs.

8. Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

PHP 2024 experience was reported in URRT Worksheet 1; no credibility was applied to the experience costs.

Projected Risk Adjustment PMPM

The projected index rate was developed based on our best estimate of the market-wide average risk. Projected risk adjustment transfers, net of fees, have an impact of decreasing premiums by $378 PMPM and are reported in the URRT Worksheet 1 (on an allowed basis). Risk adjustment transfers were applied at the market level in the development of the market adjusted index rate.

The risk adjustment fee of $0.20 PMPM was incorporated into 2026 rates and was included within the taxes and fees.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

No adjustments were made in the development of 2026 premiums to account for federal or state reinsurance programs.

9. Non-benefit Expenses and Profit & Risk

Administrative Expense Load

Administrative expenses were developed based on PHP’s current Individual business. In total, 10.3% administrative expenses and commissions were included in the 2026 rate development.

Profit / Contribution to Surplus & Risk Margin

3.5% of proposed 2026 premiums was allocated to profit and risk margin.

Given the WA ACA business only accounts for 0.13% of premium across the business, there is negligible impact on the issuer's capital & surplus levels. We believe that the overall loaded profit margin is sufficient.

Taxes and Fees

Taxes and regulatory fees included in the development of 2026 rates, equal to 2.17% of premium, include the following:

1. Risk Adjustment User Fee = $0.20 PMPM
2. Premium tax = 2.0% of premiums
3. PCORI Fee = $0.32 PMPM
4. WSHIP Fee = $0.13 PMPM
5. Mitigating Inequity Fee = $0.75 PMPM
6. WAPAL Fee = $0.06 PMPM

The retention (administrative expense load + taxes and fees) of 12.5% ties to the WAC 284-43-6660. See Exhibit 5a for details regarding retention components.

10. Projected Loss Ratio

The Anticipated Loss Ratio (ALR) is defined as being the present value of expected benefits over the present value of expected premiums for the time period that the premiums are effective. Wakely estimates the ALR to be 84.0%. This calculation does not exclude any regulatory fees or taxes from premiums, which is why it is lower than the federal MLR calculations.

Based on the federal MLR methodology, the loss ratio is estimated to be 85.8%; therefore, PHP does not anticipate paying consumer rebates for the 2026 plan year. Regulatory fees and taxes were excluded from premium in the calculation of this value.

11. Application of Market Reform Rating Rules

Single Risk Pool

PHP has established a single risk pool for all individual market business. All of PHP's individual business will be non-grandfathered, non-transitional, and ACA-compliant.

Index Rate Development

INDEX RATE FOR PROJECTION PERIOD

The projection period claims portion of the index rate is estimated to be $1,302.60 PMPM. This was calculated based on projected allowed claims for essential health benefits for the single risk pool population during the projection period. Allowed claims in the projection period equal the projection period index rate plus the cost of non-EHBs being offered in the projection period.

MARKET ADJUSTED INDEX RATE FOR PROJECTION PERIOD

We then included the impact of risk adjustment, converted to an allowed basis, and the 'equivalent Marketplace User Fee' (which is $0 for PHP), to calculate the 2026 market adjusted index rate. The market adjusted index rate is $924.80 PMPM.

PLAN ADJUSTED INDEX RATE FOR PROJECTION PERIOD

Plan adjusted index rates were developed by applying allowable plan level adjustments to the market adjusted index rate. The following describes how each component of the adjustment was developed.

AV and Cost Sharing Adjustment

Paid to allowed ratios were developed for each plan based on the WPVM, described elsewhere in this report, and meet the 2% AV pricing value guardrails as described in the Emergency Rule (CR-103E).

Additional adjustments were made to account for induced utilization, driven by cost sharing differences across each plan. Utilization factors reflect the impact of differences in cost sharing on utilization. The factors are consistent with the federal risk transfer formula published by Centers for Medicare and Medicaid Services (CMS) as required by the Emergency Rule (CR-103E).

Provider Network, Delivery System and Utilization Management Adjustment

PHP will only have one network and therefore the network factor for all plans is 1.000.

Adjustments for benefits in addition to EHB

PHP will be offering two benefits in addition to EHBs: allergy testing and fertility preservation. The projected PMPM costs for allergy testing and fertility preservation were calculated using PHP's commercial experience trended to 2026. The total allowed cost of non-EHB benefits is projected to be $0.42 PMPM in 2026.

Impact of Specific Eligibility Categories for Catastrophic Plan

PHP does not offer catastrophic plans.

TOBACCO RATING

The tobacco adjustment factor for ages 21 and above is 1.10. The average tobacco factor is based on the prevalence of smokers in PHP's current membership in the Washington individual market.

CALIBRATION

Per the instructions, plan adjusted index rates were next calibrated to age 21. To bring the experience to an age 21 rate, we divided the plan adjusted index rate by the weighted average age factor. The age factor was calculated as the weighted average of the Federal ACA age factors, as adopted by Washington, and the estimated enrollment by age for PHP's Washington population in 2026. The age associated with this factor is between 48 and 49 years. Once calibrated, the standard federal age factors can be applied on a multiplicative basis to get to the rates for other ages.

The calibrated index rate represents an average monthly premium for a 21-year-old non-tobacco user individual in Rating Area 3.

GEOGRAPHIC FACTORS

The 2025 filed geographic area factors were deemed appropriate for the 2026 rating period; this ensures less fluctuation year over year and mitigates consumer disruption due to premium changes. The 2025 PHP filed rating area factors only reflect differences in the cost of delivering health care services and do not reflect any difference in morbidity by area, nor reflect local demographic and risk profiles. Therefore, we believe population health risk differences by geography are not reflected in geographic factors.

Age and geographic factor calibration are applied uniformly to all plans.

CONSUMER ADJUSTED INDEX RATE

The consumer adjusted index rates were calculated by multiplying the calibrated plan adjusted index rates by the consumer's specific age factor (subject to maximum allowable rating of 3 dependents under age 21), area factor, and tobacco load as applicable.

We used the Federal ACA age factors, as adopted by Washington, for all members and geographic factors that were discussed previously. For tobacco factors, we used a level rating factor of 1.10 for all adult ages.

The consumer adjusted index rates are provided in the rate templates.

12. AV Metal Levels

The 2026 Federal Actuarial Value Calculator (AVC) was used to generate the AV metal tiers (URRT, Worksheet 2).

All plans received adjustments to their actuarial value that were developed outside of the AV calculator and are considered unique benefit designs. For the following categories, the AV Calculator did not provide for as much specificity as the plan's benefits and it was necessary to make adjustments to account for the plan benefits correctly.

- Pharmacy: We developed an effective coinsurance rate for the two tier specialty drugs and generic drugs. Generic drugs were also blended for usage of preventive drugs.
- Emergency Room: An effective coinsurance rate was developed for services that had a copay followed by coinsurance.
- Free Virtual Visits: Effective copays were developed for primary and specialty care visits by blending the copays and utilization of free virtual visits, other virtual visits, and office visits.
- Effective copays were also required for plans that had cost sharing of coinsurance and no deductible.

These adjustments were developed in accordance with ASOP 50, CFR 45 156.135 and generally accepted actuarial principles. Detail of the AV adjustments can be found in Exhibit 18. The AV metal values can be found in Exhibit 12.

13. AV Pricing Values

The methodology for development of the AV Pricing Values is included in the plan adjusted index rate section. Only allowable modifiers were used in the development of these values. Benefit richness utilization adjustments were applied to stratify the market adjusted index rate to levels suitable for each of the metal tiers.

Differences in morbidity across metal tiers were not included in the pricing development for each metal tier plan.

The pricing AVs differ from the Federal AVC outputs primarily because the estimated allowed PMPMs used in developing pricing AVs are different than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements (e.g. copays, deductibles and MOOPs). The other variance is differences in the methodology of the pricing models and underlying data of the modeling.

14. Membership Projections

The membership projections for 2026 were provided by PHP based on their current membership in the Washington individual market and an understanding of the current and projected Washington market in 2026. PHP is anticipating stable membership between 2025 and 2026. Actual enrollment is highly dependent on consumer decisions and the competitiveness of rates in the market.

Exhibit 13 shows 2026 PHP individual enrollment projections by plan and rating area.

15. CSR Load and Payments

All PHP plans will be offered off-exchange only in 2026. PHP has been offering off-exchange only plans since 2022. No CSR load was applied for 2024 and there is no CSR load for 2026. There were no CSR payments for plan year 2024.

16. Terminated Plans and Products

There are no terminated plans for 2026.

17. Plan Type

The plan types listed in the drop-down box in Worksheet 2, Section I of the URRT describe the plans exactly.

18. URRT Warnings

There are no warnings appearing in the URRT.

19. Effective Rate Review Information

Additional information available upon request.

20. Reliance

Providence Health Plan has provided Wakely Consulting Group, LLC, an HMA Company, 8000 South Chester Street, Suite 650, Centennial, CO 80112 (Wakely) with information used to develop the 2026 Washington individual commercial product premium rates. This information includes, but is not limited to, the following:

- Estimated 2026 enrollment figures by rating area, metal, variant, plan, and Exchange status; and
- Geographic regions to be covered in 2026; and
- Benefit designs for Federal AVC inputs and pricing AV inputs; and
- General administrative expenses, profit margin, taxes & fees, and other retention components; and
- Quality initiatives (QI) allowed to be treated as QI under regulatory rules; and
- Product design information including a statement that 2026 coverage will include EHBs and state mandated benefits, with the exception of abortion, and non-EHBs for allergy testing and fertility preservation; and
- Assumptions around reimbursements for in and out-of-network medical and pharmacy contracts; and
- PHP Washington claims and enrollment experience, by plan, incurred in 2024, including estimated reimbursements as a percentage of Medicare; and
- The 2026 filed premium rates are consistent with PHP's internal business plans; and
- IBNR calculations, and other needed adjustments, as applied to the PHP Washington medical claim experience, and other financial information needed for reporting purposes.

21. Actuarial Certification

We, Michelle Anderson and Lisa Winters, are members of the American Academy of Actuaries and meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries for preparing premium rate filings for insurers. Michelle is a Fellow of the Society of Actuaries and Lisa is an Associate of the Society of Actuaries.

This actuarial certification applies to the Providence Health Plan Washington Individual products.

1. The premium rates filed are in compliance with applicable laws, rules and guidelines of the State of Washington.
2. The premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory based on the provisions of the ACA as currently implemented. The actuarial soundness of the block of business is dependent on projected membership distribution by plan, which we received from PHP.
3. The premium rates are calculated on the basis of sound actuarial principles.
4. The premium rates are reasonable when related to the applicable coverage and characteristics of the applicable class of enrollees.
5. The projected index rates are developed in accordance with all applicable state and federal statutes and regulations (45 CFR 156.80 and 147.102) and with allowable modifiers used in the development of plan specific premium rates.
6. The premium rates filed are in compliance with the Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board that are listed below:

   ASOP No. 5, Incurred Health and Disability Claims

   ASOP No. 8, Regulatory Filings for Health Plan Entities

   ASOP No. 12, Risk Classification

   ASOP No. 23, Data Quality

   ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

   ASOP No. 41, Actuarial Communication

ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

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

ASOP No. 56, Modeling

In our opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are not estimated to be either excessive or deficient based on the provisions of the ACA as currently implemented. Actual experience will vary from the estimates given the inherent uncertainty in developing premium rates under the ACA and potential morbidity shifts in the market due to PHE changes and state policies.

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

The Federal AV Calculator (with some modification) was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Michelle Anderson
Director and Senior Consulting Actuary

Lisa Winters
Consulting Actuary

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Associate, Society of Actuaries
Member, American Academy of Actuaries

Date: May 14, 2025

Part II: Written Description Justifying the Rate Increase

The 2026 monthly health insurance premium is made up of four pieces: estimated claim costs, administrative costs, taxes and fees, and risk/profit margin.

Scope and range of the rate increase: The premium rate change from 2025 to 2026 is 10.6% for renewing members. The number of individuals impacted by the rate increase is 254. The increase varies by plan from 7.4% to 13.1%.

Financial experience of the product: Providence has experienced financial losses in this product in 2023 and a profit in 2022 and 2024. However, these losses and gains are from a very small membership base and inherently difficult to predict year over year due to the lack of credibility and stability of membership. The 2026 rate increase is expected to produce a 3.5% margin.

Changes in medical service costs: The main contributor to the change in rates is a year of medical and pharmacy trend, driven by utilization increases and provider reimbursement changes.

Changes in benefits: The following new Essential Health Benefits (EHBs) have been added to all plans:

- Hearing Aids – includes an annual hearing exam and one hearing aid per ear with hearing loss every three years
- Donor Human Milk – includes medically necessary donor human milk in an inpatient setting for an infant who is medically or physically unable to receive maternal human milk
- Artificial Insemination – includes artificial insemination in vivo, covering placement of sperm into the cervix or uterus to achieve a pregnancy

Additionally, the deductible and MOOP on the Bronze plan have been increased from $8,900 to $9,200.

Administrative costs and anticipated margins: Administrative costs per member are decreasing in 2026 by 1.5% of premium over the prior filing. There are negligible differences to taxes and fees included within the 2025 and 2026 premium rates. Anticipated margin for this filing is 3.5%.

A copy of the "Summary of Pooled Experience with Adjustments" table is included below.

	Experience Period	First Prior Period	Second Prior Period	Combined 3 Years's Outcome
	From 1/1/2024 To 12/31/2024	From 1/1/2023 To 12/31/2023	From 1/1/2022 To 12/31/2022	From 1/1/2019 To 12/31/2021
Member Months	2,899	2,685	2,536	8,120.00
Earned Premium	$1,878,222.98	$1,570,193.68	$1,391,466.34	4,839,883.00
Paid Claims	$1,865,462.36	$2,206,744.53	$1,983,063.16	6,055,270.04
Beginning Claim Reserve	$23,114.10	$21,803.44	$77,847.59	122,765.13
Ending Claim Reserve	$21,377.17	$23,114.10	$21,803.44	66,294.71
Incurred Claims	$1,886,839.53	$2,229,858.63	$2,004,866.59	6,121,564.75
Expenses	$669,670.58	$773,265.37	$692,010.41	2,134,946.36
Gain/Loss	($678,287.13)	($1,432,930.32)	($1,305,410.66)	(3,416,628.11)
Loss Ratio Percentage	100.5%	142.0%	144.1%	386.6%
Commercial Reinsurance	0.00	0.00	0.00	-
Risk Adjustment	1,243,853.61	1,031,631.91	1,776,283.53	4,051,769.05
HCRP reimbursement	0.00	0.00	0.00	
HCRP assessment amounts	($6,761.60)	(5,663.87)	(5,042.70)	
Risk Corridor	0.00	0.00	0.00	0.00
RADV*	TBD	TBD	0.00	
Gain/Loss	$558,804.88	(406,962.28)	465,830.17	617,672.77
Gain/Loss as % of Premium	29.8%	-25.9%	33.5%	
MLR Refunds	$0.00	$0.00	$0.00	$0.00
Net Gain After MLR Refunds	$558,804.88	(406,962.28)	465,830.17	617,672.77
Reinsurance Assessment and Risk Adjustment Fee are components of "Expenses" in the table above.				
Reinsurance Assessment	$0.00	$0.00	$0.00	$0.00
Risk Adjustment Fee	$591.70	$640.66	$1,465.47	$2,697.83

*RADV amounts were released for 2022 transfers on May 29, 2024. The adjustments to transfer years 2023 and 2024 are not yet released.

Unified Rate Review v6.0

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: **Providence Health Plan**
HIOS Issuer ID: **45834** 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	$2,500,626.45	$862.58
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$1,886,839.53	$650.86
Risk Adjustment	$1,237,092.01	$426.73
Experience Period Premium	$1,878,222.98	$647.89
Experience Period Member Months	2,899	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend Cost	Year 1 Trend Utilization	Year 2 Trend Cost	Year 2 Trend Utilization	Trended EHB Allowed Claims PMPM
Inpatient Hospital	$114.86	1.000	1.000	1.000	1.000	$114.86
Outpatient Hospital	$168.70	1.000	1.000	1.000	1.000	$168.70
Professional	$265.04	1.000	1.000	1.000	1.000	$265.04
Other Medical	$20.60	1.000	1.000	1.000	1.000	$20.60
Capitation	$0.86	1.000	1.000	1.000	1.000	$0.86
Prescription Drug	$289.36	1.000	1.000	1.000	1.000	$289.36
Total	$859.41					**$859.41**

Morbidity Adjustment	1.000
Demographic Shift	1.000
Plan Design Changes	1.000
Other	1.000
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$859.41**

Manual EHB Allowed Claims PMPM	$1,302.60
Applied Credibility %	0.00%

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$1,302.60**	$4,065,414.60
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	$377.80	$1,179,103.70
Exchange User Fees	0.00%	$0.00
Market Adjusted Index Rate	**$924.80**	**$2,886,310.90**

Projected Member Months	**3,121**

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: **Providence Health Plan**
HIOS Issuer ID: **45834** 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		Columbia Individual		
1.2	Product ID		45834WA049		
1.3	Plan Name		Providence	Providence	Providence
1.4	Plan ID (Standard Component ID)		45834WA0490001	45834WA0490002	45834WA0490003
1.5	Metal		Gold	Silver	Bronze
1.6	AV Metal Value		0.804	0.717	0.650
1.7	Plan Category		Renewing	Renewing	Renewing
1.8	Plan Type		EPO	EPO	EPO
1.9	Exchange Plan?		No	No	No
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		13.11%	10.89%	7.43%
1.12	Product Rate Increase %		10.62%		
1.13	Submission Level Rate Increase %		10.62%		

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information				
	2.1	Plan ID (Standard Component ID)	Total	45834WA0490001	45834WA0490002	45834WA0490003
$2,500,626	2.2	Allowed Claims	$2,500,626	$1,213,560	$415,237	$871,829
$0	2.3	Reinsurance	$0	$0	$0	$0
	2.4	Member Cost Sharing	$613,787	$262,544	$149,864	$201,379
	2.5	Cost Sharing Reduction	$0	$0	$0	$0
$1,886,840	2.6	Incurred Claims	$1,886,840	$951,016	$265,373	$670,451
$1,237,092	2.7	Risk Adjustment Transfer Amount	$1,237,092	$676,099	$168,936	$392,057
$1,878,223	2.8	Premium	$1,878,223	$867,061	$473,439	$537,723
2,899	2.9	Experience Period Member Months	2,899	1,270	729	900
	2.10	Current Enrollment	254	106	58	90
	2.11	Current Premium PMPM	$751.51	$779.18	$701.18	$751.35
	2.12	Loss Ratio	60.57%	61.63%	41.31%	72.11%
		Per Member Per Month				
	2.13	Allowed Claims	$862.58	$955.56	$569.60	$968.70
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00
	2.15	Member Cost Sharing	$211.72	$206.73	$205.58	$223.75
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00
	2.17	Incurred Claims	$650.86	$748.83	$364.02	$744.95
	2.18	Risk Adjustment Transfer Amount	$426.73	$532.36	$231.74	$435.62
	2.19	Premium	$647.89	$682.72	$649.44	$597.47

	Section III: Plan Adjustment Factors				
3.1	Plan ID (Standard Component ID)		45834WA0490001	45834WA0490002	45834WA0490003
3.2	Market Adjusted Index Rate		$924.80		
3.3	AV and Cost Sharing Design of Plan		0.8497	0.7277	0.6360
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB		1.0005	1.0006	1.0007
	Administrative Costs				
3.6	Administrative Expense		9.30%	10.69%	12.03%
3.7	Taxes and Fees		2.17%	2.17%	2.17%
3.8	Profit & Risk Load		3.50%	3.50%	3.50%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**		$924.74	$805.09	$715.21
3.11	Age Calibration Factor	0.5959	0.5959		
3.12	Geographic Calibration Factor	1.0509	1.0509		
3.13	Tobacco Calibration Factor	0.9987	0.9987		
3.14	**Calibrated Plan Adjusted Index Rate**		$578.42	$503.58	$447.36

	Section IV: Projected Plan Level Information				
4.1	Plan ID (Standard Component ID)	Total	45834WA0490001	45834WA0490002	45834WA0490003
4.2	Allowed Claims	$4,067,169	$2,319,329	$855,243	$892,597
4.3	Reinsurance	$0	$0	$0	$0
4.4	Member Cost Sharing	$997,117	$459,274	$236,715	$301,128
4.5	Cost Sharing Reduction	$0	$0	$0	$0
4.6	Incurred Claims	$3,070,052	$1,860,055	$618,528	$591,470
4.7	Risk Adjustment Transfer Amount	$890,035	$718,444	$173,426	-$1,834
4.8	Premium	$2,595,817	$1,342,720	$532,165	$720,931
4.9	Projected Member Months	3,121	1,452	661	1,008
4.10	Loss Ratio	88.07%	90.24%	87.66%	82.25%
	Per Member Per Month				
4.11	Allowed Claims	$1,303.16	$1,597.33	$1,293.86	$885.51
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$319.49	$316.30	$358.12	$298.74
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$983.68	$1,281.03	$935.75	$586.78
4.16	Risk Adjustment Transfer Amount	$285.18	$494.80	$262.37	-$1.82
4.17	Premium	$831.73	$924.74	$805.09	$715.21

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 3	1.0000
Rating Area 4	0.8852
Rating Area 5	0.9797
Rating Area 6	0.9541
Rating Area 9	0.9315

SERFF Tracking #:	*PROV-134500631*	***State Tracking #:***	*484719*	***Company Tracking #:***	*2026 NONGRANDFATHERED INDIVIDUAL RATE ...*

State:	*Washington*	***Filing Company:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Written Description Justifying the Rate Increase
Comments:	loaded into urrt tab
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certification
Comments:	
Attachment(s):	WA INDV 2024 ADS Tie Out.pdf Appendix 1 2026 filing WA INDV.pdf WA State Exhibits.pdf WA State Exhibits Duplicate.xlsx Benefit Components.pdf Benefit Components (duplicate).xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Certification-Rates-2025 Individual Mental Health and Substance Use Disorder Financial Requirements
Comments:	
Attachment(s):	MHSUD Parity Calculations.pdf MHSUD Parity Calculations_Duplicate.xlsm Mental Health and Substance Use Disorder Financial Requirement Parity Certification.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
Item Status:	
Status Date:	

Satisfied - Item:	Certification to 2026 Commission Schedule
Comments:	
Attachment(s):	2026 WA Producer Compensation Attachment C.pdf
Item Status:	

Status Date:	

Satisfied - Item:	Uniform Product Modification Justification Documentation
Comments:	
Attachment(s):	Uniform Product Modification Justification Duplicate.xlsx Uniform Product Modification Justification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unique Plan Design Justification
Comments:	
Attachment(s):	Unique Plan Design Justification_signed.pdf
Item Status:	
Status Date:	

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

Satisfied - Item:	AV Calc Screenshot
Comments:	
Attachment(s):	Federal AV Screenshots.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Filing Checklist
Comments:	
Attachment(s):	Checklist Rates 2026 WA INDV.pdf
Item Status:	
Status Date:	

Satisfied - Item:	WAC 284-43-6590
Comments:	
Attachment(s):	Mitigating Inequity Certification.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*PROV-134500631*	***State Tracking #:***	*484719*	***Company Tracking #:***	*2026 NONGRANDFATHERED INDIVIDUAL RATE ...*

State:	*Washington*	***Filing Company:***	*Providence Health Plan*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 NonGrandfathered Individual Rate filing*		
Project Name/Number:	*/*		

Satisfied - Item:	1332 Supplemental Checklist
Comments:	
Attachment(s):	Supplemental Checklist 2026 WA INDV.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Secondary Filing with ARPA Extension
Comments:	
Attachment(s):	Rate Schedule with ARPA extension (duplicate).xlsm Rate Schedule with ARPA extension.pdf Part I Unified Rate Review Template with ARPA extension (duplicate).xlsm Part I Unified Rate Review Template with ARPA extension.pdf
Item Status:	
Status Date:	

Individual ADS Premium to Rate Filing			
			Source
a	ADS Premium	$2,698,969.00	Page 2 Column 2a Line 1
b	Risk Adjustment	-$820,745.95	General Ledger
c = a + b	Adjusted ADS Total	$1,878,223.05	
d	Filing Premium	$1,878,222.98	URRT
e = d -c	Variance (Dollars)	-$0.07	Calculation
f = e/d	Variance (%)	0.00%	Calculation

Individual ADS Benefit Expense to Rate Filing			
			Source
a	ADS Benefit Expense	$1,721,781.00	Page 2 Column 2a Line 17
b	Timing Adjustments	$166,429.00	
c = a + b	Adjusted ADS Total	$1,888,210.00	
d	Filing Expense	$1,886,839.53	URRT
e = c - d	Variance (Dollars)	-$1,370.47	Calculation
f = e/d	Variance (%)	-0.07%	Calculation

Individual ADS Admin Expense to Rate Filing			
			Source
a	ADS Admin Expense	$656,148.00	Page 2 Column 2a Line 19 & 20
b	Timing Adjustments	$13,522.28	
c = a + b	Adjusted ADS Total	$669,670.28	
d	Filing Expense	$669,670.58	WAC 284-43-6660.
e = c - d	Variance (Dollars)	$0.30	Calculation
f = e/d	Variance (%)	0.00%	Calculation

Individual ADS Membership to Rate Filing			
			Source
a	ADS Membership Q1 2024	246	Page 3 Column 2a, line 2
b	ADS Membership Q2 2024	245	Page 3 Column 2a, line 3
c	ADS Membership Q3 2024	243	Page 3 Column 2a, line 4
d	ADS Membership Q4 2024	237	Page 3 Column 2a, line 5
e = avg (a:d)	ADS Average membership	243	Calculation
f	Filing 2024 Member Month	2,899	URRT WS2, line 2.9
g = f/12	Filing Average Membership	242	Calculation
h = g-f	Variance (Members)	-1	Calculation
I = h/g	Variance (%)	-0.48%	Calculation

Insurer's Financial Position:

The most recent Statement (YE 2024) reports net operating loss of $100.6 M[1] on $2,477 M[2] in total revenue before net investment gains of $46.6 M[3]. Capital and surplus is reported at $683.3 M[4] as of 31 December 2024.

Providence Health Plan (PHP) reserves are adequate to meet the Net Worth requirements as required by the State Insurance Division. As a matter of practice, Providence Health Plan has a goal that each major line of business (Group Commercial, Medicare, Medicaid, ASO, Individual Commercial, etc.) is able to support the cost of capital required for ongoing participation in each market.

The accompanying rate filing is calculated to produce a margin at a level required to maintain reasonable rate stability and insurer solvency over an extended period of time. The accompanying rate change is intended to help balance anticipated increases in benefit costs (what the Health Plan pays to health care providers) with member cost sharing (what the member pays in copays, coinsurance, and deductibles).

PHP's surplus is necessary to provide financial security to policy holders and the long-term commitment to our members.

[1] Statement of Revenue and Expenses col 2 row 24
[2] Statement of Revenue and Expenses col 2 row 2
[3] Statement of Revenue and Expenses col 2 line 27
[4] Liabilities Capital and Surplus col 3 line 33

ASSETS

		Current Year			Prior Year
		1	2	3	4
		Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1.	Bonds (Schedule D)	658,844,309	0	658,844,309	733,757,216
2.	Stocks (Schedule D):				
	2.1 Preferred stocks	0	0	0	0
	2.2 Common stocks	182,523,929	0	182,523,929	179,919,781
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens	0	0	0	0
	3.2 Other than first liens	0	0	0	0
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $.....0 encumbrances)	33,136,289	0	33,136,289	36,299,040
	4.2 Properties held for the production of income (less $.....0 encumbrances)	0	0	0	0
	4.3 Properties held for sale (less $.....0 encumbrances)	0	0	0	0
5.	Cash ($.....207,774,103, Schedule E - Part 1), cash equivalents ($.....11,398,529, Schedule E - Part 2) and short-term investments ($.....0, Schedule DA)	219,172,632	0	219,172,632	248,303,018
6.	Contract loans (including $.....0 premium notes)	0	0	0	0
7.	Derivatives (Schedule DB)	0	0	0	0
8.	Other invested assets (Schedule BA)	0	0	0	0
9.	Receivables for securities	9,435	0	9,435	7,327,680
10.	Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11.	Aggregate write-ins for invested assets	23,419,218	23,419,218	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	1,117,105,812	23,419,218	1,093,686,594	1,205,606,735
13.	Title plants less $.....0 charged off (for Title insurers only)	0	0	0	0
14.	Investment income due and accrued	4,107,005	0	4,107,005	5,542,254
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	97,781,825	256,739	97,525,086	80,468,947
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $.....0 earned but unbilled premiums)	0	0	0	0
	15.3 Accrued retrospective premiums ($.....0) and contracts subject to redetermination ($.....24,337,745)	24,337,745	0	24,337,745	24,677,000
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers	487,594	0	487,594	2,722,866
	16.2 Funds held by or deposited with reinsured companies	0	0	0	0
	16.3 Other amounts receivable under reinsurance contracts	24,897,000	0	24,897,000	27,363,000
17.	Amounts receivable relating to uninsured plans	7,895,418	0	7,895,418	10,480,563
18.1	Current federal and foreign income tax recoverable and interest thereon	4,114,706	0	4,114,706	2,879,445
18.2	Net deferred tax asset	12,919,750	10,981,788	1,937,962	301,181
19.	Guaranty funds receivable or on deposit	0	0	0	0
20.	Electronic data processing equipment and software	17,387,482	17,387,482	0	0
21.	Furniture and equipment, including health care delivery assets ($.....0)	374,777	374,777	0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23.	Receivables from parent, subsidiaries and affiliates	19,736,995	19,736,995	0	0
24.	Health care ($.....25,144,537) and other amounts receivable	40,602,557	15,458,019	25,144,538	23,558,290
25.	Aggregate write-ins for other-than-invested assets	70,593	70,593	0	0
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	1,371,819,259	87,685,611	1,284,133,648	1,383,600,280
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28.	Total (Lines 26 and 27)	1,371,819,259	87,685,611	1,284,133,648	1,383,600,280
Details of Write-Ins					
1101.	LAND OPTION & PUT AGREEMENT ESCROW ACCOUNT	23,419,218	23,419,218	0	0
1102.		0	0	0	0
1103.		0	0	0	0
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199.	Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	23,419,218	23,419,218	0	0
2501.	Unclaimed Property	70,593	70,593	0	0
2502.		0	0	0	0
2503.		0	0	0	0
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	70,593	70,593	0	0

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1	2	3	4
		Covered	Uncovered	Total	Total
1.	Claims unpaid (less $.....302,500 reinsurance ceded)	223,013,153	11,954,327	234,967,480	224,923,908
2.	Accrued medical incentive pool and bonus amounts	4,882,161	0	4,882,161	3,062,364
3.	Unpaid claims adjustment expenses	11,447,655	0	11,447,655	9,742,921
4.	Aggregate health policy reserves, including the liability of $.....0 for medical loss ratio rebate per the Public Health Service Act	54,562,000	0	54,562,000	77,179,000
5.	Aggregate life policy reserves	0	0	0	0
6.	Property/casualty unearned premium reserves	0	0	0	0
7.	Aggregate health claim reserves	0	0	0	0
8.	Premiums received in advance	30,403,942	0	30,403,942	26,254,161
9.	General expenses due or accrued	4,639,017	0	4,639,017	9,600,969
10.1	Current federal and foreign income tax payable and interest thereon (including $.....0 on realized capital gains (losses))	0	0	0	0
10.2	Net deferred tax liability	0	0	0	0
11.	Ceded reinsurance premiums payable	0	0	0	0
12.	Amounts withheld or retained for the account of others	0	0	0	0
13.	Remittances and items not allocated	0	0	0	0
14.	Borrowed money (including $.....0 current) and interest thereon $.....0 (including $.....0 current)	0	0	0	0
15.	Amounts due to parent, subsidiaries and affiliates	91,671,913	0	91,671,913	110,892,971
16.	Derivatives	0	0	0	0
17.	Payable for securities	4,942,020	0	4,942,020	18,172,348
18.	Payable for securities lending	0	0	0	0
19.	Funds held under reinsurance treaties (with $.....0 authorized reinsurers, $.....0 unauthorized reinsurers and $.....0 certified reinsurers)	0	0	0	0
20.	Reinsurance in unauthorized and certified ($.....0) companies	0	0	0	0
21.	Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22.	Liability for amounts held under uninsured plans	99,570,063	0	99,570,063	81,909,700
23.	Aggregate write-ins for other liabilities (including $.....0 current)	63,789,962	0	63,789,962	93,585,843
24.	Total liabilities (Lines 1 to 23)	588,921,886	11,954,327	600,876,213	655,324,185
25.	Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26.	Common capital stock	XXX	XXX	0	0
27.	Preferred capital stock	XXX	XXX	0	0
28.	Gross paid in and contributed surplus	XXX	XXX	0	0
29.	Surplus notes	XXX	XXX	0	0
30.	Aggregate write-ins for other-than-special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	683,257,435	728,276,095
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $.....0)	XXX	XXX	0	0
	32.2 0 shares preferred (value included in Line 27 $.....0)	XXX	XXX	0	0
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	683,257,435	728,276,095
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	1,284,133,648	1,383,600,280
Details of Write-Ins					
2301.	ASSUMED REINSURANCE PAYABLE	59,884,609	0	59,884,609	90,946,680
2302.	ACCRUED LEASE PAYABLE	921,511	0	921,511	1,148,035
2303.	OTHER LIABILITIES	5,341	0	5,341	28,621
2398.	Summary of remaining write-ins for Line 23 from overflow page	2,978,501	0	2,978,501	1,462,507
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	63,789,962	0	63,789,962	93,585,843
2501.		XXX	XXX	0	0
2502.		XXX	XXX	0	0
2503.		XXX	XXX	0	0
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	0
3001.		XXX	XXX	0	0
3002.		XXX	XXX	0	0
3003.		XXX	XXX	0	0
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year		Prior Year
		1	2	3
		Uncovered	Total	Total
1.	Member Months	XXX	2,077,316	2,165,486
2.	Net premium income (including $.....0 non-health premium income)	XXX	2,477,105,815	2,332,494,052
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	0
4.	Fee-for-service (net of $.....0 medical expenses)	XXX	0	0
5.	Risk revenue	XXX	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	2,477,105,815	2,332,494,052
Hospital and Medical:				
9.	Hospital/medical benefits	0	603,660,992	617,062,387
10.	Other professional services	0	266,423,479	238,225,544
11.	Outside referrals	44,731,728	44,731,728	45,195,264
12.	Emergency room and out-of-area	4,852,968	48,025,425	41,486,833
13.	Prescription drugs	0	166,293,378	168,536,982
14.	Aggregate write-ins for other hospital and medical	0	1,833,930	2,179,594
15.	Incentive pool, withhold adjustments and bonus amounts	0	7,021,199	15,125,724
16.	Subtotal (Lines 9 to 15)	49,584,696	1,137,990,131	1,127,812,328
Less:				
17.	Net reinsurance recoveries	0	(1,121,876,209)	(958,387,403)
18.	Total hospital and medical (Lines 16 minus 17)	49,584,696	2,259,866,340	2,086,199,730
19.	Non-health claims (net)	0	0	0
20.	Claims adjustment expenses, including $.....34,760,278 cost containment expenses	0	69,195,716	58,079,767
21.	General administrative expenses	0	269,666,223	258,628,392
22.	Increase in reserves for life and accident and health contracts (including $.....0 increase in reserves for life only)	0	(21,000,000)	11,000,000
23.	Total underwriting deductions (Lines 18 through 22)	49,584,696	2,577,728,279	2,413,907,889
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(100,622,464)	(81,413,837)
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)	0	35,363,581	38,998,088
26.	Net realized capital gains (losses) less capital gains tax of $.....0	0	11,272,848	(1,105,399)
27.	Net investment gains (losses) (Lines 25 plus 26)	0	46,636,429	37,892,689
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $.....0) (amount charged off $.....240,978)]	0	(240,978)	(578,720)
29.	Aggregate write-ins for other income or expenses	0	0	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	(54,227,013)	(44,099,868)
31.	Federal and foreign income taxes incurred	XXX	0	0
32.	Net income (loss) (Lines 30 minus 31)	XXX	(54,227,013)	(44,099,868)
Details of Write-Ins				
0601.		XXX	0	0
0602.		XXX	0	0
0603.		XXX	0	0
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX	0	0
0701.		XXX	0	0
0702.		XXX	0	0
0703.		XXX	0	0
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798) (Line 7 above)	XXX	0	0
1401.	OTHER PAYMENTS TO PROVIDERS	0	1,833,930	2,179,594
1402.		0	0	0
1403.		0	0	0
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)	0	1,833,930	2,179,594
2901.		0	0	0
2902.		0	0	0
2903.		0	0	0
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)	0	0	0

STATEMENT OF REVENUE AND EXPENSES (CONTINUED)

	CAPITAL & SURPLUS ACCOUNT	1 Current Year	2 Prior Year
33.	Capital and surplus prior reporting year	728,276,095	783,855,125
34.	Net income or (loss) from Line 32	(54,227,013)	(44,099,868)
35.	Change in valuation basis of aggregate policy and claim reserves	0	0
36.	Change in net unrealized capital gains (losses) less capital gains tax of $.....0	2,898,368	7,940,216
37.	Change in net unrealized foreign exchange capital gain or (loss)	0	0
38.	Change in net deferred income tax	10,911,879	1,278,803
39.	Change in nonadmitted assets	(18,157,437)	(19,741,885)
40.	Change in unauthorized and certified reinsurance	0	0
41.	Change in treasury stock	0	0
42.	Change in surplus notes	0	0
43.	Cumulative effect of changes in accounting principles	0	0
44.	Capital Changes:		
	44.1 Paid in	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0
	44.3 Transferred to surplus	0	0
45.	Surplus adjustments:		
	45.1 Paid in	0	0
	45.2 Transferred to capital (Stock Dividend)	0	0
	45.3 Transferred from capital	0	0
46.	Dividends to stockholders	0	0
47.	Aggregate write-ins for gains or (losses) in surplus	13,555,543	(956,296)
48.	Net change in capital and surplus (Lines 34 to 47)	(45,018,660)	(55,579,030)
49.	Capital and surplus end of reporting year (Line 33 plus 48)	683,257,435	728,276,095
Details of Write-Ins			
4701.	Custodian Cash written off	13,556,797	0
4702.	PSA Balance written back	(1,254)	0
4703.	Depreciation Acceleration	0	(956,296)
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)	13,555,543	(956,296)

FIVE-YEAR HISTORICAL DATA

	1 2024	2 2023	3 2022	4 2021	5 2020
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	1,284,133,648	1,383,600,280	1,338,278,274	1,754,556,959	1,191,181,456
2. Total liabilities (Page 3, Line 24)	600,876,213	655,324,185	554,423,149	930,428,774	423,955,897
3. Statutory minimum capital and surplus requirement	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000
4. Total capital and surplus (Page 3, Line 33)	683,257,435	728,276,095	783,855,125	824,128,185	767,225,559
Income Statement (Page 4)					
5. Total revenues (Line 8)	2,477,105,815	2,332,494,052	2,158,990,552	2,003,870,378	1,189,801,265
6. Total medical and hospital expenses (Line 18)	2,259,866,340	2,086,199,730	1,838,998,323	1,785,086,429	877,725,132
7. Claims adjustment expenses (Line 20)	69,195,716	58,079,767	44,066,860	73,402,526	39,575,294
8. Total administrative expenses (Line 21)	269,666,223	258,628,392	223,532,582	153,975,979	109,181,510
9. Net underwriting gain (loss) (Line 24)	(100,622,464)	(81,413,837)	23,392,787	34,405,444	109,319,329
10. Net investment gain (loss) (Line 27)	46,636,429	37,892,689	(49,944,599)	10,176,978	21,958,461
11. Total other income (Lines 28 plus 29)	(240,978)	(578,720)	(795,980)	(401,827)	(43,538,090)
12. Net income or (loss) (Line 32)	(54,227,013)	(44,099,868)	(28,066,861)	44,180,595	87,739,700
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	(124,371,177)	52,500,195	83,717,439	166,557,446	131,533,835
Risk-Based Capital Analysis					
14. Total adjusted capital	683,257,435	728,276,095	783,855,125	824,128,185	767,225,559
15. Authorized control level risk-based capital	94,095,593	86,034,970	80,667,906	78,034,116	72,257,278
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	169,607	179,351	173,307	169,476	179,019
17. Total members months (Column 6, Line 7)	2,077,316	2,165,486	2,081,718	2,060,141	2,229,094
Operating Percentage (Page 4) **(Item divided by Page 4, sum of Lines 2, 3, and 5) x 100.0**					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	91.2	89.4	85.2	89.1	73.8
20. Cost containment expenses	1.4	1.2	1.0	1.9	1.7
21. Other claims adjustment expenses	1.4	1.3	1.0	1.7	1.7
22. Total underwriting deductions (Line 23)	104.1	103.5	98.9	98.3	90.8
23. Total underwriting gain (loss) (Line 24)	(4.1)	(3.5)	1.1	1.7	9.2
Unpaid Claims Analysis **(U&I Exhibit, Part 2B)**					
24. Total claims incurred for prior years (Line 17, Col. 5)	87,313,174	165,844,302	177,914,564	51,149,462	60,775,709
25. Estimated liability of unpaid claims-[prior year (Line 17, Col. 6)]	114,550,198	179,565,127	217,874,608	82,259,918	100,351,280
Investments in Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)	0	0	0	0	0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)	0	0	0	0	0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	60,966,104	62,145,867	62,487,247	64,460,094	206,019,092
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10)	0	0	0	0	0
30. Affiliated mortgage loans on real estate	0	0	0	0	0
31. All other affiliated	0	0	0	0	0
32. Total of above Lines 26 to 31	60,966,104	62,145,867	62,487,247	64,460,094	206,019,092
33. Total investment in parent included in Lines 26 to 31 above	0	0	0	0	0

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of *SSAP No. 3—Accounting Changes and Correction of Errors*?
If no, please explain

OVERFLOW PAGE FOR WRITE-INS

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1	2	3	4
	Covered	Uncovered	Total	Total
2304. CLAIMS REFUNDS IN PROCESS	1,103,399	0	1,103,399	279,226
2305. UNCLAIMED PROPERTY	1,875,102	0	1,875,102	1,069,726
2306. ALTERNATIVE FUNDING	0	0	0	113,556
2397. Summary of remaining write-ins for Line 23 from overflow page	2,978,501	0	2,978,501	1,462,507
2597. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
3097. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0

9 5 0 0 5 2 0 2 4 2 1 6 4 8 1 0 0

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

(To Be Filed By April 1 – Not for Rebate Purposes – See Cautionary Statement at https://content.naic.org/sites/default/files/inline-files/committees_e_app_blanks_related_shce_cautionary_statement.pdf)

Report For: 1. Corporation PROVIDENCE HEALTH PLAN 2. Location: 4400 N.E. HALSEY BLDG # 2. STE. # 690 PORTLAND, OR, US 97213-1545

NAIC Group Code: 4788 | Business in the State of Washington | During the Year: 2024 | NAIC Company Code: 95005

		Business Subject to MLR									10	11	12	13	14	15
		Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
		1	2	3	4	5	6	7	8							
		Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (excluded by statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols 1 thru 12)	Uninsured Plans	Total 13 + 14
1.	Premium:															
	1.1 Health premiums earned (From Part 2, Line 1.11)	2,698,969	0	14,860,853	0	0	0	0	0	0	0	0	0	17,559,822	XXX	17,559,822
	1.2 Federal high risk pools	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
	1.3 State high risk pools	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
	1.4 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)	2,698,969	0	14,860,853	0	0	0	0	0	0	0	0	0	17,559,822	XXX	17,559,822
	1.5 Federal taxes and federal assessments	769	0	(219,426)	0	0	0	0	0	0	0	0	0	(218,657)	0	(218,657)
	1.6 State insurance, premium and other taxes (Similar local taxes of $0)	37,883	0	274,548	0	0	0	0	0	0	0	0	0	312,431	0	312,431
	1.6a Community Benefit Expenditures (informational only)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.7 Regulatory authority licenses and fees	(2,522)	0	(5,873)	0	0	0	0	0	0	0	0	0	(8,395)	0	(8,395)
	1.8 Adjusted premiums earned (Lines 1.4 – 1.5 – 1.6 – 1.7)	2,662,839	0	14,811,604	0	0	0	0	0	0	0	0	0	17,474,443	XXX	17,474,443
	1.9 Net assumed less ceded reinsurance premiums earned	0	0	(67,359)	0	0	0	0	0	0	0	0	48,879,865	48,812,506	XXX	48,812,506
	1.10 Other adjustments due to MLR calculations – Premiums	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
	1.11 Risk revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
	1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)	2,662,839	0	14,744,245	0	0	0	0	0	0	0	0	48,879,865	66,286,949	XXX	66,286,949
2.	Claims:															
	2.1 Incurred claims excluding prescription drugs	1,460,770	0	10,023,790	0	0	0	0	0	0	0	0	0	11,484,560	XXX	11,484,560
	2.2 Prescription drugs	979,747	0	2,342,173	0	0	0	0	0	0	0	0	0	3,321,920	XXX	3,321,920
	2.3 Pharmaceutical rebates	384,554	0	1,016,827	0	0	0	0	0	0	0	0	0	1,401,381	XXX	1,401,381
	2.4 State stop loss, market stabilization and claim/census based assessments (informational only)	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
3.	Incurred medical incentive pools and bonuses	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
4.	Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5.	5.0 Total incurred claims (Lines 2.1 + 2.2 – 2.3 + 3) (From Part 2, Line 2.15)	2,055,963	0	11,349,136	0	0	0	0	0	0	0	0	0	13,405,099	XXX	13,405,099
	5.1 Net assumed less ceded reinsurance claims incurred	0	0	0	0	0	0	0	0	0	0	0	37,034,355	37,034,355	XXX	37,034,355
	5.2 Other adjustments due to MLR calculations – Claims	(1,000,000)	0	0	0	0	0	0	0	0	0	0	0	(1,000,000)	XXX	(1,000,000)
	5.3 Rebates paid	0	0	0	0	0	0	0	0	0	XXX	XXX	0	0	XXX	0
	5.4 Estimated rebates unpaid prior year	0	0	0	0	0	0	0	0	0	XXX	XXX	0	0	XXX	0
	5.5 Estimated rebates unpaid current year	0	0	0	0	0	0	0	0	0	XXX	XXX	0	0	XXX	0
	5.6 Fee for service and co-pay revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX	0
	5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)	1,055,963	0	11,349,136	0	0	0	0	0	0	0	0	37,034,355	49,439,454	XXX	49,439,454
6.	Improving Health Care Quality Expenses Incurred:															
	6.1 Improve Health Outcomes	21,473	0	73,703	0	0	0	0	0	0	0	0	492,806	587,982	0	587,982
	6.2 Activities to prevent hospital readmissions	528	0	2,317	0	0	0	0	0	0	0	0	72,385	75,230	0	75,230
	6.3 Improve patient safety and reduce medical errors	306	0	1,467	0	0	0	0	0	0	0	0	617	2,390	0	2,390
	6.4 Wellness and health promotion activities	4,975	0	32,009	0	0	0	0	0	0	0	0	194,511	231,495	0	231,495
	6.5 Health Information Technology expenses related to health improvement	744	0	4,666	0	0	0	0	0	0	0	0	7,002	12,412	0	12,412
	6.6 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 + 6.2 + 6.3 + 6.4 + 6.5)	28,026	0	114,162	0	0	0	0	0	0	0	0	767,321	909,509	0	909,509
7.	Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6 – Footnote 2.0) / Line 1.8	0.783	0	0.774	0	0	0	0	0	0	XXX	XXX	0	XXX	XXX	XXX
8.	Claims Adjustment Expenses:															
	8.1 Cost containment expenses not included in quality of care expenses in Line 6.6	242,820	0	381,349	0	0	0	0	0	0	0	0	1,487,098	2,111,267	0	2,111,267
	8.2 All other claims adjustment expenses	148,683	0	306,471	0	0	0	0	0	0	0	0	400,264	855,418	0	855,418
	8.3 Total claims adjustment expenses (Lines 8.1 + 8.2)	391,503	0	687,820	0	0	0	0	0	0	0	0	1,887,362	2,966,685	0	2,966,685
9.	Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)	0.147	0	0.046	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (CONTINUED)

(To Be Filed By April 1 – Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1	2	3	4	5	6	7	8				Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA			
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (excluded by statute)	Other Health Business		Subtotal (Cols 1 thru 12)	Uninsured Plans	Total 13 + 14
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits	13,817	0	325,650	0	0	0	0	0	0	0	0	1,138,153	1,477,620	0	1,477,620
10.2 Agents and brokers fees and commissions	14,888	0	198,063	0	0	0	0	0	0	0	0	511,408	724,359	0	724,359
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)	789	0	243,778	0	0	0	0	0	0	0	0	70,440	315,007	0	315,007
10.4 Other general and administrative expenses	173,858	0	519,797	0	0	0	0	0	0	0	0	1,114,042	1,807,697	330,460	2,138,157
10.4a Community Benefit Expenditures (informational only)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10.5 Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)	203,352	0	1,287,288	0	0	0	0	0	0	0	0	2,834,043	4,324,683	330,460	4,655,143
11. Underwriting Gain/(Loss) (Lines 1.12 – 5.7 – 6.6 – 8.3 – 10.5)	983,995	0	1,305,839	0	0	0	0	0	0	0	0	6,356,784	8,646,618	XXX	8,316,158
12. Income from Fees of Uninsured Plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0	0
13. Net Investment and Other Gain/(Loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0	XXX	0
14. Federal Income Taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0	XXX	0
15. Net Gain or (Loss) (Lines 11 + 12 + 13 – 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	8,646,618	XXX	8,316,158
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 10.4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16a ICD-10 Implementation Expenses (informational only: already included in Line 10.4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OTHER INDICATORS:															
1. Number of Certificates/Policies	146	0	561	0	0	0	0	0	0	0	0	0	707	62,809	63,516
2. Number of Covered Lives	237	0	1,740	0	0	0	0	0	0	0	0	0	1,977	0	1,977
3. Number of Groups	XXX	0	39	XXX	0	0	0	0	0	0	0	0	39	0	39
4. Member Months	2,906	0	21,248	0	0	0	0	0	0	0	0	0	24,154	0	24,154

Is run-off business reported in Columns 1 through 9 or 12? If yes, show the amount of premiums and claims included: Premiums $0 Claims $0

AFFORDABLE CARE ACT (ACA) RECEIPTS, PAYMENTS, RECEIVABLES AND PAYABLES

	Current Year		Prior Year	
	Comprehensive Health Coverage		Comprehensive Health Coverage	
	1	2	3	4
	Individual Plans	Small Group Employer Plans	Individual Plans	Small Group Employer Plans
ACA Receivables and Payables				
1. Permanent ACA Risk Adjustment Program				
1.0 Premium adjustments receivable/(payable)	820,746	0	2,905,314	0
2. Transitional ACA Reinsurance Program				
2.0 Total amounts recoverable for claims (paid & unpaid)	0	XXX	0	XXX
3. Temporary ACA Risk Corridors Program				
3.1 Accrued retrospective premium	0	0	0	0
3.2 Reserve for rate credits or policy experience refunds	0	0	0	0
ACA Receipts and Payments				
4. Permanent ACA Risk Adjustment Program				
4.0 Premium adjustments receipts/(payments)	820,746	0	0	0
5. Transitional ACA Reinsurance Program				
5.0 Amounts received for claims	0	XXX	0	XXX
6. Temporary ACA Risk Corridors Program				
6.1 Retrospective premium received	0	0	0	0
6.2 Rate credits or policy experience refunds paid	0	0	0	0

Table of Contents

EXHIBIT 1: PROPOSED RATES

The table below summarizes proposed rates effective January 1, 2026 based on calibrated plan adjusted index rates.

Plan	2025 Rate	2026 Rate	Proposed Change
Providence Columbia 1500 Gold	$511.39	$578.42	13.11%
Providence Columbia 5000 Silver	$454.12	$503.58	10.89%
Providence Columbia 9200 Bronze	$416.42	$447.36	7.43%

EXHIBIT 2: GEOGRAPHIC NORMALIZATION

WA Rating Area	Projected Member Months	Area Factors Relative to WA Rating Area 3
Rating Area 3	1,476	1.0000
Rating Area 4	1,080	0.8852
Rating Area 5	120	0.9797
Rating Area 6	252	0.9541
Rating Area 9	193	0.9315
Total	3,121	0.9515
Cost Ratio		1.1297
Geographic Calibration Factor		1.0509

EXHIBIT 3: GEOGRAPHIC ADJUSTMENT AND PROVIDER CONTRACTING

Estimated ACA Market Allowed Costs Distribution	
Medical	78.1%
Rx	21.9%
Providence Provider Relativities to ACA Market	
Medical	116.8%
Rx	100.0%
Estimated Providence Provider Relativities to ACA Market	**1.131**
PBM Rebate Savings	**0.977**

Manual Provider Contracting Adjustment:	**1.105**

Geographic Adjustment to Providence Service Area	1.006
WA URRT Average	1.000
Providence Service Area Cost Factor	1.006

Rating Area	Geographic Adjustment Factor	Providence Membership Distribution
Rating Area 3	1.0838	47.3%
Rating Area 4	0.9250	34.6%
Rating Area 5	0.9887	3.8%
Rating Area 6	0.9321	8.1%
Rating Area 9	0.9793	6.2%

EXHIBIT 4: PROJECTED PAID TO ALLOWED RATIO

Paid to Allowed and Federal AV

A	Average Pricing AV, Excluding CSR Plans	75.5%
B	Average Federal AV, Excluding CSR Plans	73.6%
C	Variance (A - B)	1.9%

Plan	AV Metal Value	Induced Demand Factor (IDF)
Providence Columbia 1500 Gold	0.8038	1.0332
Providence Columbia 5000 Silver	0.7170	0.9879
Providence Columbia 9200 Bronze	0.6495	0.9600

Plan	AV Metal Value X IDF	Pricing AV X IDF
Providence Columbia 1500 Gold	0.8305	0.8497
Providence Columbia 5000 Silver	0.7084	0.7277
Providence Columbia 9200 Bronze	0.6235	0.6360

Plan	AV Metal Value - Normalized	Pricing AV - Normalized	Variance
Providence Columbia 1500 Gold	1.0000	1.0000	0.0000
Providence Columbia 5000 Silver	0.8529	0.8564	0.0035
Providence Columbia 9200 Bronze	0.7508	0.7485	-0.0023

EXHIBIT 5A: COMPONENTS OF RETENTION

General Admin		Providence Columbia 1500 Gold	Providence Columbia 5000 Silver	Providence Columbia 9200 Bronze
2026 Projected Admin	$82.03	$82.03	$82.03	$82.03
2026 Projected Commission	$4.00	$4.00	$4.00	$4.00
2026 Projected Premium	$831.73	$924.74	$805.09	$715.21
Admin % of Premium	9.86%	8.87%	10.19%	11.47%
Commission % of Premium	0.48%	0.43%	0.50%	0.56%
URRT WS2 Administrative Expense		9.30%	10.69%	12.03%

Fees	
2026 WSHIP PMPM	$0.13
2026 PCORI PMPM	$0.32

2026 WSHIP Calculation			
Year	Assessment	Member Months	PMPM
2023	$12,000,000	48,000,000	$0.25
2024	$6,000,000	48,000,000	$0.13
2025	$6,000,000	48,000,000	$0.13
2026	$6,000,000	48,000,000	$0.13

2026 PCORI Calculation		
Policy End Date	Assessment	Source
December 2024	$3.47	IRS
NHE Projected Trend	11.8%	NHE Trend Projections
December 2026	$3.88	

	PMPM	% Premium
General Admin	**$82.03**	**9.86%**
Commission	**$4.00**	**0.48%**
Target Post-Tax Profit and Risk	**$29.11**	**3.50%**
State Premium Tax	**$16.63**	**2.00%**
Total	$131.77	15.84%
PMPM		
WSHIP	**$0.13**	**0.02%**
PCORI	**$0.32**	**0.04%**
Risk Adjustment Fee	**$0.20**	**0.02%**
Market Place User Fee *	**$0.00**	**0.00%**
Insurance Fraud Surcharge **	**$0.00**	**0.00%**
WAPAL	**$0.06**	**0.01%**
Mitigating Inequity	**$0.75**	**0.09%**
Total	$1.45	0.17%
Projected Incurred Claims after Risk Adjustment **	$698.50	
Premium	**$831.73**	

** The Exchange (Market Place) User Fee is not included in the Taxes and Fees load since it is included in the MAIR*
*** Due to rounding in the URRT Insurance Fraud Surcharge was not considered material enough to include in rating*

EXHIBIT 5B: COMPONENTS OF RETENTION

Components of Retention		
Description	**PMPM**	**% Premium**
General Admin	$82.03	9.86%
Commission	$4.00	0.48%
Target Post-Tax Profit and Risk	$29.11	3.50%
WSHIP	$0.13	0.02%
PCORI	$0.32	0.04%
State Premium Tax	$16.63	2.00%
Risk Adjustment Fee	$0.20	0.02%
*Market Place User Fee **	$0.00	0.00%
WAPAL	$0.06	0.01%
Mitigating Inequity	$0.75	0.09%
Total Retention	**$133.23**	**16.02%**

Prior Washington Individual Filings (For Reference Only)

2025 Washington Individual Filing		
Description	**PMPM**	**% Premium**
General Admin	$84.34	11.31%
Commission	$4.00	0.54%
Target Post-Tax Profit and Risk	$22.38	3.00%
WSHIP	$0.15	0.02%
PCORI	$0.30	0.04%
State Premium Tax	$14.92	2.00%
Risk Adjustment Fee	$0.18	0.02%
*Market Place User Fee **	$0.00	0.00%
WAPAL	$0.07	0.01%
Mitigating Inequity	$0.72	0.10%
Total Retention	**$127.05**	**17.03%**

2024 Washington Individual Filing		
Description	**PMPM**	**% Premium**
General Admin	$76.32	10.96%
Commission	$4.00	0.57%
Target Post-Tax Profit and Risk	$20.89	3.00%
WSHIP	$0.35	0.05%
PCORI	$0.28	0.04%
State Premium Tax	$13.93	2.00%
Risk Adjustment Fee	$0.21	0.03%
*Market Place User Fee **	$0.00	0.00%
WAPAL	$0.06	0.01%
Mitigating Inequity	$0.72	0.10%
Total Retention	**$116.77**	**16.77%**

2023 Washington Individual Filing		
Description	**PMPM**	**% Premium**
General Admin	$64.65	9.89%
Commission	$10.00	1.53%
Target Post-Tax Profit and Risk	$19.61	3.00%
WSHIP	$0.38	0.06%
PCORI	$0.23	0.04%
State Premium Tax	$13.07	2.00%
Risk Adjustment Fee	$0.22	0.03%
*Market Place User Fee **	$0.00	0.00%
Mitigating Inequity	$0.71	0.11%
Total Retention	**$108.87**	**16.66%**

2022 Washington Individual Filing		
Description	**PMPM**	**% Premium**
General Admin	$49.19	8.85%
Commission	$10.00	1.80%
Target Post-Tax Profit and Risk	$16.67	3.00%
WSHIP	$0.59	0.11%
PCORI	$0.23	0.04%
State Premium Tax	$11.11	2.00%
Risk Adjustment Fee	$0.25	0.04%
*Market Place User Fee **	$0.00	0.00%
Mitigating Inequity	$0.50	0.09%
Total Retention	**$88.54**	**15.94%**

Components of Retention *

Percent

	2022	2023	2024	2025	2026
Admin Expense	8.85%	9.89%	10.96%	11.31%	9.86%
Commission	1.80%	1.53%	0.57%	0.54%	0.48%
Taxes and Fees	2.28%	2.24%	2.23%	2.19%	2.17%
Profit & Risk Load	3.00%	3.00%	3.00%	3.00%	3.50%
Total	15.94%	16.66%	16.77%	17.03%	16.02%

PMPM

	2022	2023	2024	2025	2026
Admin Expense	$49.19	$64.65	$76.32	$84.34	$82.03
Commission	$10.00	$10.00	$4.00	$4.00	$4.00
Taxes and Fees	$12.68	$14.61	$15.56	$16.34	$18.09
Profit & Risk Load	$16.67	$19.61	$20.89	$22.38	$29.11
Total	$88.54	$108.87	$116.77	$127.05	$133.23

** The Exchange (Market Place) User Fee is not included in the Taxes and Fees load since it is included in the MAIR*

EXHIBIT 6: FEDERAL MLR

Projected Federal Medical Loss Ratio		
	Federal ACA MLR	**Financial MLR**
Member Months	3,121	3,121
Numerator		
Incurred Claims PMPM	$983.68	$983.68
Risk Adjustment	$285.18	$285.18
MLR Numerator	**$698.50**	**$698.50**
Denominator		
Premium PMPM	$831.73	$831.73
*Taxes and Fees **	$18.09	$0.00
MLR Denominator	**$813.64**	**$831.73**
Medical Loss Ratio	**85.8%**	**84.0%**

**Taxes and Fess included: WSHIP, State Premium Tax, Risk Adjustment Fee, Market Place User Fee, PCORI, WAPAL, Mitigating Inequity*

EXHIBIT 7: INDEX RATE TABLE

PROJECTION PERIOD INDEX RATE DEVELOPMENT

Statewide WA 2023 URRT EHB Allowed Claims PMPM, with IBNR, Net of Rx Rebates	$584.77	Removed abortion state mandated benefits
Allowed Claim Cost and Geographic Adjustment (to PHP Projected Age, Metal, and Risk, in PHP Service Area)	1.4503	
Geographic: Statewide WA 2023 to 2026 PHP Service Area	1.0065	Per Exhibit 3
Metal, Age, Risk: Statewide WA 2023 to 2026 PHP Service Area	1.4410	Per Exhibit 28
Trend Adjustment	1.3890	
Average Annual Trend, Medical + Rx	11.6%	Per Exhibit 24
Years of Trend	3	
Provider Contracting	1.1047	Per Exhibit 3
Change in WA EHBs from 2023 to 2026	1.0010	
Projection Period Index Rate PMPM, Excluding Non-EHBs	**$1,302.60**	
Infertility Allowed Claims PMPM	$0.13	
Allergy Testing Allowed Claims PMPM	$0.43	
Non-EHB Allowed Claims PMPM	$0.56	
Projection Period Index Rate PMPM, Including Non-EHBs	**$1,303.16**	Ties to URRT WS2 4.11

The index rate reflects the mix of tobacco users, area, plan, and morbidity risk in PHP's manual rate. The Index Rate has not been adjusted for risk adjustment, reinsurance or marketplace user fees.

EXHIBIT 8: MARKET ADJUSTED INDEX RATE

The following table summarizes the factors applied to the Index Rate in the projection period to develop the Market Adjusted Index Rate.

PROJECTION PERIOD INDEX RATE DEVELOPMENT

2026 Index Rate PMPM	$1,302.60

Market Adjustments (Paid Basis)	
Net Risk Adjustment	$285.18
Risk Adjustment Transfer	$289.36
High Cost Risk Pool Assessment*	$4.18
High Cost Risk Pool Reimbursement	$0.00
Net Federal Transitional Reinsurance	$0.00
Marketplace User Fees	$0.00

Paid/Allowed Ratio	0.7548

Market Adjustments (Allowed Basis)	
Net Risk Adjustment	$377.80
Net Federal Transitional Reinsurance	$0.00
Marketplace User Fees	$0.00

2026 Market Adjusted Index Rate (MAIR) PMPM	**$924.80**

* Factor Source: WNRAR estimate of assessment as a percentage of premium

EXHIBIT 9: PROJECTION PERIOD PLAN ADJUSTED INDEX RATE DEVELOPMENT

Plan	MAIR	AV & Cost Sharing	Network	Non-EHB	Retention	PAIR	Projected Member Months
Providence Columbia 1500 Gold	$924.80	0.8497	1.0000	1.0005	1.1762	$924.74	1,452
Providence Columbia 5000 Silver	$924.80	0.7277	1.0000	1.0006	1.1956	$805.09	661
Providence Columbia 9200 Bronze	$924.80	0.6360	1.0000	1.0007	1.2151	$715.21	1,008
Composite Portfolio	$924.80	0.7548	1.0000	1.0006	1.1907	$831.73	3,121

Development of Administrative Expense Factor

	Percent of Premium				
	Providence Columbia 1500 Gold	Providence Columbia 5000 Silver	Providence Columbia 9200 Bronze	Total	
Administrative Expense	9.30%	10.69%	12.03%	10.34%	A
Taxes and Fees	2.17%	2.17%	2.17%	2.17%	B
Profit & Risk Load	3.50%	3.50%	3.50%	3.50%	C
Total	14.98%	16.36%	17.70%	16.02%	D = A + B + C
Admin Factor	1.1762	1.1956	1.2151	1.1907	E = 1/(1-D)

Development of Non-EHB Factors

	Providence Columbia 1500 Gold	Providence Columbia 5000 Silver	Providence Columbia 9200 Bronze
Non-EHB Paid Claims PMPM	$0.42	$0.42	$0.42
Non-EHB Factor	1.0005	1.0006	1.0007

EXHIBIT 10: CALIBRATED PLAN ADJUSTED INDEX RATE

Plan	PAIR	Age Calibration	Geographic Calibration	Tobacco Calibration	Calibrated Plan Adjusted Index Rate	Calibrated Plan Adjusted Index Rate URRT
Providence Columbia 1500 Gold	$924.74	0.5959	1.0509	0.9987	$578.42	$578.42
Providence Columbia 5000 Silver	$805.09	0.5959	1.0509	0.9987	$503.58	$503.58
Providence Columbia 9200 Bronze	$715.21	0.5959	1.0509	0.9987	$447.36	$447.36

EXHIBIT 11: SAMPLE CONSUMER ADJUSTED PREMIUM RATE

Plan Name: Providence Columbia 5000 Silver
Exchange Plan: Outside the exchange

Family Member	Rating Area	Tobacco Use	Tobacco Load	Age on 1/1/2026	Monthly Premium	Age Band	Child Count
Subscriber	5	No	1	52	$963.00	52	0
Spouse	5	Yes	1.1	44	$758.12	44	0
Child 1	5	No	1	14	$377.41	0-14	1
Child 2	5	No	1	11	$377.41	0-14	2
Child 3	5	No	1	8	$377.41	0-14	3
Child 4	5	No	1	3	$0.00	0-14	4
Total					$2,853.35		

**Rates are charged to no more than the three oldest covered children under 21 for family coverage*

EXHIBIT 12: AV METAL VALUES

HIOS	Plan	Actuarial Value	Source	Projected Member Months
45834WA0490001	Providence Columbia 1500 Gold	0.8038	AV Calculator	1,452
45834WA0490002	Providence Columbia 5000 Silver	0.7170	AV Calculator	661
45834WA0490003	Providence Columbia 9200 Bronze	0.6495	AV Calculator	1,008
Membership-Weighted Composite Values		**0.7356**		**3,121**

EXHIBIT 13: MEMBERSHIP PROJECTION

2025 Emerging PHP WA Membership - Members

	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 9	Total
Providence Columbia 1500 Gold	55	34	7	12	13	121
Providence Columbia 5000 Silver	29	24	1	1	-	55
Providence Columbia 9200 Bronze	39	32	2	8	3	84
Total	123	90	10	21	16	260
Total %	47.3%	34.6%	3.8%	8.1%	6.2%	100.0%

PHP 2026 WA Projected Membership - Member Months

	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 9	Total
Providence Columbia 1500 Gold	660	408	84	144	156	1,452
Providence Columbia 5000 Silver	348	288	12	12	1	661
Providence Columbia 9200 Bronze	468	384	24	96	36	1,008
Total	1,476	1,080	120	252	193	3,121
Total %	47.3%	34.6%	3.8%	8.1%	6.2%	100.0%

EXHIBIT 14: DEVELOPMENT OF 2026 RISK ADJUSTMENT TRANSFER

2026 Washington Statewide Premium, Non-Catastrophic

2024 Statewide Premium (Adjusted), Non-Cat [1]	$507.09	P	
2024-2025 Rate Increase	1.1240	Q	*Per approved rate increase*
2025-2026 Projected Rate Increase	1.0514	R	*Per requested rate increase*
2026 Statewide Premium (Adjusted), Non-Cat	$599.26	S = P * Q * R	

1) 2024 Interim Risk Adjustment Report, non-Catastrophic

2026 PHP Metal-Level Risk Transfer Calculations

At the metal level, each factor of the risk transfer formula was calculated separately for PHP's expected population and the statewide Washington 2026 estimates.
• ARF - Age Rating Factors for PHP and Washington statewide were calculated based on the same enrollment mix by age band as was assumed in the claims buildup.
• AV - Actuarial Value for Washington statewide was based on the same statewide Washington metal mix as was assumed in the claims buildup.
• PLRS - Plan Liability Risk Score for statewide Washington and PHP started from the average PLRS in the Wakely proprietary national ACA database, specifically for members with the same age and metal mix as either statewide Washington or PHP's expected population in 2026.
• GCF – The Geographic Calibration Factor for PHP was based on the relative cost factor for rating areas within the risk transfer formula, and PHP's distribution within their rating area, relative to statewide Washington enrollment and geographic spread.

Using the above factors and the estimated statewide average premium (calculation shown above), an estimated risk transfer for PHP is calculated at the metal level. This transfer amount is then weighted by PHP's expected metal mix in Washington in 2026.

EXHIBIT 14: DEVELOPMENT OF 2026 RISK ADJUSTMENT TRANSFER

PHP Calculations			
Component	**Bronze**	**Silver**	**Gold**
PLRS iincl. EDF	0.978	1.558	1.995
ARFi	1.774	1.709	1.597
GCFi	1.014	1.014	1.014
IDFi	1.000	1.030	1.080
AVi	0.600	0.700	0.800
With Risk	0.992	1.627	2.185
Without Risk	1.079	1.250	1.399

Statewide Average Calculations			
Component	**Total**	**Total**	**Total**
PLRS iincl. EDF	1.057	1.057	1.057
PLRS Adjustments	1.001	1.001	1.001
ARFi	1.699	1.699	1.699
GCFi	1.000	1.000	1.000
IDFi	1.029	1.029	1.029
AVi	0.680	0.680	0.680
With Risk	1.087	1.087	1.087
Without Risk	1.188	1.188	1.188
Risk Transfer	$2.36	$266.55	$498.98

2026 PHP Total Risk Transfer Calculation

Plan	**Risk Transfer*, no HCRP**	**HCRP Assessment**	**HCRP Reimbursement**	**Risk Transfer PMPM*, with HCRP Assessment and Reimbursement**	**Projected Membership**	**Total Risk Transfer*, with HCRP Assessment and Reimbursement**
Providence Columbia 1500 Gold	$498.98	-$4.18	$0.00	$494.80	1,452	$718,444
Providence Columbia 5000 Silver	$266.55	-$4.18	$0.00	$262.37	661	$173,426
Providence Columbia 9200 Bronze	$2.36	-$4.18	$0.00	-$1.82	1,008	-$1,834
Total	$289.36	-$4.18	$0.00	$285.18	3,121	$890,035

*Positive = receivable; Negative = payable

EXHIBIT 15: COMMISSIONS

Expected Commission Usage	20%
Commission Rate PMPM	$20.00
2026 Commission PMPM	**$4.00**

EXHIBIT 16: SUMMARY OF POOLED EXPERIENCE WITH ADJUSTMENTS

The following information is for PHP's Washington Individual Experience.

	Experience Period	First Prior Period	Second Prior Period	Combined 3 Years's Outcome
	From 1/1/2024 To 12/31/2024	From 1/1/2023 To 12/31/2023	From 1/1/2022 To 12/31/2022	From 1/1/2019 To 12/31/2021
Member Months	2,899	2,685	2,536	8,120.00
Earned Premium	$1,878,222.98	$1,570,193.68	$1,391,466.34	4,839,883.00
Paid Claims	$1,865,462.36	$2,206,744.53	$1,983,063.16	6,055,270.04
Beginning Claim Reserve	$23,114.10	$21,803.44	$77,847.59	122,765.13
Ending Claim Reserve	$21,377.17	$23,114.10	$21,803.44	66,294.71
Incurred Claims	$1,886,839.53	$2,229,858.63	$2,004,866.59	6,121,564.75
Expenses	$669,670.58	$773,265.37	$692,010.41	2,134,946.36
Gain/Loss	($678,287.13)	($1,432,930.32)	($1,305,410.66)	(3,416,628.11)
Loss Ratio Percentage	100.5%	142.0%	144.1%	386.6%
Commercial Reinsurance	0.00	0.00	0.00	-
Risk Adjustment	1,243,853.61	1,031,631.91	1,776,283.53	4,051,769.05
HCRP reimbursement	0.00	0.00	0.00	
HCRP assessment amounts	($6,761.60)	(5,663.87)	(5,042.70)	
Risk Corridor	0.00	0.00	0.00	0.00
RADV*	TBD	TBD	0.00	
Gain/Loss	$558,804.88	(406,962.28)	465,830.17	617,672.77
Gain/Loss as % of Premium	29.8%	-25.9%	33.5%	

MLR Refunds	$0.00	$0.00	$0.00	$0.00
Net Gain After MLR Refunds	$558,804.88	(406,962.28)	465,830.17	617,672.77

Reinsurance Assessment and Risk Adjustment Fee are components of "Expenses" in the table above.

Reinsurance Assessment	$0.00	$0.00	$0.00	$0.00
Risk Adjustment Fee	$591.70	$640.66	$1,465.47	$2,697.83

**RADV amounts were released for 2022 transfers on May 29, 2024. The adjustments to transfer years 2023 and 2024 are not yet released.*

EXHIBIT 16: SUMMARY OF POOLED EXPERIENCE WITH ADJUSTMENTS

The following information is for PHP's Washington Individual Experience - from Prior WAC submitted for 1/1/25 Rates

	Experience Period	First Prior Period
	From 1/1/2023 To 12/31/2023	From 1/1/2022 To 12/31/2022
Member Months	2,685	2,536.00
Earned Premium	$1,570,193.68	$1,391,466.34
Paid Claims	$2,206,744.53	$1,983,063.16
Beginning Claim Reserve	$21,803.44	$77,847.59
Ending Claim Reserve	$23,114.10	$21,803.44
Incurred Claims	$2,229,858.63	$2,004,866.59
Expenses	$773,265.37	$692,010.41
Gain/Loss	($1,432,930.32)	($1,305,410.66)
Loss Ratio Percentage	142.0%	144.1%
Commercial Reinsurance	0.00	0.00
Risk Adjustment*	1,031,631.91	1,776,283.53
HCRP reimbursement	0.00	0.00
HCRP assessment amounts	(5,663.87)	(5,042.70)
Risk Corridor	0.00	0.00
Gain/Loss	(406,962.28)	465,830.17

MLR Refunds	$0.00	$0.00
Net Gain After MLR Refunds	-	-

Reinsurance Assessment and Risk Adjustment Fee are components of "Expenses" in the table above.

Reinsurance Assessment	$0.00	$0.00
Risk Adjustment Fee	$0.00	$0.00

EXHIBIT 17: TOBACCO LOAD

Tobacco Rating Factor, Muted by Projected Age 21+ Membership	1.0885
*% of People Who Can be Rated for Tobacco, Ages 21+	1.5%
Total Rate-Up Based on Admitted Tobacco Usage	1.0013

Average Tobacco Factor	1.0013
Tobacco Calibration	0.9987

	Load	Calibration
2026 Tobacco Factors	1.1000	0.9987
2025 Tobacco Factors	1.1000	0.9979
2024 Tobacco Factors	1.1000	0.9985
2023 Tobacco Factors	1.0973	0.9974
2022 Tobacco Factors	1.1200	0.9970

Age Group	2026 Projected Membership	Tobacco Factor
0-20	11.5%	1.0000
21+	88.5%	1.1000
		1.0885

*Source: Providence 2025 Open Enrollment

EXHIBIT 18: UNIQUE BENEFIT DESIGNS, FEDERAL AV CALCULATOR ADJUSTMENTS

FEDERAL AV CALCULATOR ADJUSTMENT #1: Effective Coinsurance Rate for Specialty Drugs.

Experience: PHP Commercial Group and Individual 2024 experience, paid through January

Providence's 6 Tier Formulary	Mapping for AV Calculator Adjustments	True Definition as per Form Filing
Tier 1	Generic	Mainly Generic
Tier 2	Generic	Mainly Generic
Tier 3	Brand	Mainly Lower Cost Brand
Tier 4	Non-Preferred Brand	Mainly Higher Cost Brand
Tier 5	Specialty	Specialty
Tier 6	Specialty	Specialty

2026 Costs	2026 Script Distribution	Average Cost Per Script 2026	Member Cost Share	Expected Member Cost Share, Per Script
Tier 4: Non-Preferred Brand Drugs	76.87%	$96.49	50% Coinsurance, with $200 Cap	$48.24
Tier 4: Non-Preferred Brand Drugs	6.98%	$1,303.81	50% Coinsurance, with $200 Cap	$200.00
Tier 5: Preferred Specialty Drugs	0.27%	$208.56	50% Coinsurance, with $300 Cap	$104.28
Tier 5: Preferred Specialty Drugs	13.07%	$8,366.16	50% Coinsurance, with $300 Cap	$300.00
Tier 6: Non-Preferred Specialty Drugs	2.81%	$12,704.82	50% Coinsurance	$6,352.41

Average 2026 Member Cost Share per Script	$268.95
Average 2026 Allowed Dollars per Script	$1,616.27
Insurer's Coinsurance for AVC	**83.36%**

FEDERAL AV CALCULATOR ADJUSTMENT #2: Effective Copay for Cost Sharing of Coinsurance and No Deductible.

Experience: AV Calculator Continuance Tables

Columbia 1500 Gold				
	Laboratory Outpatient Facility	**Laboratory Professional**	**Laboratory Combined**	**X-rays Combined**
Avg Cost @ Deductible	$6.91	$27.89		$19.95
Coinsurance Rate Prior To Deductible	20.00%	100.00%		20.00%
Expected MCS - Prior to Deductible	$1.38	$27.89	$29.28	$3.99
Expected Frequency @ Deductible	0.1568	1.1893	1.3461	0.1779
Effective Copay - for Coin Prior to Deductible			**$21.75**	**$22.43**
***Insurer Coinsurance after Deductible**			**80.00%**	**80.00%**

Columbia 5000 Silver				
	Laboratory Outpatient Facility	**Laboratory Professional**	**Laboratory Combined**	**X-rays Combined**
Avg Cost @ Deductible	$20.72	$71.30		$76.19
Coinsurance Rate Prior To Deductible	35.00%	100.00%		35.00%
Expected MCS - Prior to Deductible	$7.25	$71.30	$78.56	$26.66
Expected Frequency @ Deductible	0.3925	2.4821	2.8746	0.4602
Effective Copay - Prior to Deductible			**$27.33**	**$57.95**
***Insurer Coinsurance after Deductible**			**65.00%**	**65.00%**

**No adjustment is needed to Insurer's Coinsurance after Deductible as coinsurance after the deducible is calculated within the AV calculator*

FEDERAL AV CALCULATOR ADJUSTMENT #3: Emergency Room: Effective Coinsurance Rate for Services with Copay Followed by Coinsurance.

Description of Benefit

Before the deductible, the member pays the full allowed charge, and the entire amount paid by the member accrues towards meeting the deductible. After the deductible has been met, a $250 copay applies, and then any remaining allowed charge (i.e., allowed charge minus copay) is subject to the coinsurance.

Columbia 1500 Gold

Plan Details	
Copay	$250
Deductible	$1,500
MOOP	$8,200
Member Coinsurance	20%
Claims Max before member hits MOOP	$35,000

	ER Levels (Col E &F)		
	At Deductible	**At Claims Max**	**In Coin Range**
Average Cost	$7.64	$358.33	$350.69
Frequency	0.0109	0.1211	0.1103

Expected Member Cost for Copay	$27.57
Expected Cost Paid by Insurer	$258.49
Percent Paid in Insurer	**73.71%**

Columbia 5000 Silver

Plan Details	
Copay	$250
Deductible	$5,000
MOOP	$8,900
Member Coinsurance	35%
Claims Max before member hits MOOP	$16,143

	ER Levels (Col E &F)		
	At $15,000	**At $20,000**	**At Claims Max**
Average Cost	$204.43	$243.48	$213.36
Frequency	0.0822	0.0901	0.0840
Weight for Claims Max	77.14%	22.86%	

	ER Levels (Col E &F)		
	At Deductible	**At Claims Max**	**In Coin Range**
Average Cost	$67.82	$213.36	$145.54
Frequency	0.0433	0.0840	0.0407

Expected Member Cost for Copay	$10.18
Expected Cost Paid by Insurer	$87.98
Percent Paid in Insurer	**60.45%**

FEDERAL AV CALCULATOR ADJUSTMENT #4: Effective Generic Copay for 6 Tier Formulary. [1]

Experience: PHP Small Group and Individual 2024 experience, paid through January

1) See Adjustment #1 above for details on Providence's 6 tier formulary

Providence's 6 Tier Formulary	Mapping for AV Calculator Adjustments	True Definition as per Form Filing
Tier 1	Generic	Mainly Generic
Tier 2	Generic	Mainly Generic
Tier 3	Brand	Mainly Lower Cost Brand
Tier 4	Non-Preferred Brand	Mainly Higher Cost Brand
Tier 5	Specialty	Specialty
Tier 6	Specialty	Specialty

	A	B	C	E = B*C + A*(1-C)
Plan	**Tier 1: Copay***	**Tier 2: Copay**	**Weight Tier 2**	**Effective Generic Copay, AV Calculator**
Providence Columbia 1500 Gold	$0.00	$10.00	57.15%	**$5.72**
Providence Columbia 5000 Silver	$0.00	$25.00	57.15%	**$14.29**
Providence Columbia 9200 Bronze	$0.00	$35.00	57.15%	**$20.00**

*Tier 1 includes ACA preventive drugs

FEDERAL AV CALCULATOR ADJUSTMENT #5: Blended Facility Fee

Percent Outpatient Facility Allowed Dollars	
Outpatient Facility Fee at Ambulatory Surgery Center	18.00%
Outpatient Facility Fee at all other Facilities	82.00%

Coinsurance Rate After Deductible	Providence Columbia 1500 Gold	Providence Columbia 5000 Silver
Outpatient Facility Fee at Ambulatory Surgery Center	10.00%	25.00%
Outpatient Facility Fee at all other Facilities	20.00%	35.00%
Blended	**18.20%**	**33.20%**
Insurer's Coinsurance	**81.80%**	**66.80%**

FEDERAL AV CALCULATOR ADJUSTMENT #6: Mental Health Outpatient Services

Columbia 1500 Gold		
Plan Details		
Deductible	$1,500	
Out of Pocket Max	$8,200	
Mental Health Office Visit Professional	$30	*Copay in Front of DED*
Member Cost Share: Mental Health - OP Facility	20%	*Coin After DED*

Mental Health Member Cost Before Hitting the Deducible			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Avg Cost @ Deductible	$35.03	$0.21	$35.23
Expected Frequency @ Deductible	0.4588	0.0024	0.4611
Member Cost Share	$30 Copay	100% Before Ded	
Expected MCS - Prior to Deductible	$13.76	$0.21	$13.97
Effective Copay for Ded Range		**$30.29**	

Mental Health Member Costs at Out of Pocket Max			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Max Claims	$35,000	$35,000	$35,000
Avg Cost	$263.86	$9.68	$273.54
Frequency	2.2908	0.0516	2.3423

Mental Health Member Costs after Deducible			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Avg Cost	$228.83	$9.48	$238.31
Frequency	1.8320	0.0492	
Member Cost Share	$54.96	$1.90	$56.86
Effective Coinsurance in Coinsurance Range		**23.86%**	
Insures Coinsurance in Coinsurance Range for AVC		**76.14%**	

Columbia 5000 Silver

Plan Details		
DED	$5,000	
OPX	$8,900	
Mental Health Office Visit Professional	$45	*Copay in Front of DED*
Member Cost Share: Mental Health - OP Facility	35%	*Coin After DED*

Mental Health Member Cost Before Hitting the Deducible			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Avg Cost @ Deductible	$104.82	$1.23	$106.05
Expected Frequency @ Deductible	1.0818	0.0102	1.0920
Member Cost Share	$45 Copay	100% Before Ded	
Expected MCS - Prior to Deductible	$48.68	$1.23	$49.91
Effective Copay for Ded Range		**$45.71**	

Mental Health Member Costs at Claims up to $15,000			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Weight For Claims Max	77%	77%	
Avg Cost	$183.82	$4.31	
Frequency	1.6960	0.0279	

Mental Health Member Costs at Claims up to $20,000			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Weight For Claims Max	23%	23%	
Avg Cost	$195.80	$5.68	
Frequency	1.7803	0.0339	

Mental Health Member Costs at Out of Pocket Max			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Max Claims	$16,143	$16,143	$16,143
Avg Cost	$186.55	$4.62	$191.18
Frequency	1.7152	0.0293	1.7445

Mental Health Member Costs after Deducible			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Avg Cost	$81.74	$3.39	$85.13
Frequency	0.6334	0.0191	
Member Cost Share	$28.50	$1.19	$29.69
Effective Coinsurance in Coinsurance Range		**34.88%**	
Insures Coinsurance in Coinsurance Range for AVC		**65.12%**	

Columbia 9200 Bronze

Plan Details		
DED	$9,200	
OPX	$9,200	
Mental Health Office Visit Professional	$70	*Copay in Front of DED*
Mental Health - OP Facility	0%	*Coin After DED*

Mental Health Member Cost Before Hitting the Deducible			
	Mental Health Office Visit Professions	**Mental Health - OP Facility**	**Total**
Avg Cost @ Deductible	$104.40	$1.87	$106.27
Expected Frequency @ Deductible	0.9871	0.0148	1.0018
Member Cost Share	$70 Copay	100% Before Ded	
Expected MCS - Prior to Deductible	$69.10	$1.87	$70.96
Effective Copay for Ded Range		**$70.83**	

FEDERAL AV CALCULATOR ADJUSTMENT #7: Effective Copay for PCP/SCP Visits

Visit Type	ExpressCare Virtual Visits	Other Virtual Visits	Office Visits
PCP	1.4%	13.4%	85.3%
SCP	0.0%	37.6%	62.4%

PCP Visits				
Plan	ExpressCare Virtual Visits	Other Virtual Visits	Office Visits	Effective Copay
Providence Columbia 1500 Gold	$0.00	$30.00	$30.00	**$29.58**
Providence Columbia 5000 Silver	$0.00	$45.00	$45.00	**$44.38**
Providence Columbia 9200 Bronze	$0.00	$70.00	$70.00	**$69.03**

SCP Visits				
Plan	ExpressCare Virtual Visits	Other Virtual Visits	Office Visits	Effective Copay
Providence Columbia 1500 Gold	$0.00	$50.00	$50.00	**$50.00**
Providence Columbia 5000 Silver	$0.00	$65.00	$65.00	**$65.00**
Providence Columbia 9200 Bronze	$0.00	$100.00	$100.00	**$100.00**

EXHIBIT 19: DEMOGRAPHIC CALIBRATION

Age Factor 21 Year Old	1.0000	A
2026 Age Factor	1.6780	B
2026 Age Calibration	0.5959	C = A / B

	Age Below	Age Above
2026 Average Age	48	49

2025 Age Calibration	0.5953
2024 Age Calibration	0.5836
2023 Age Calibration	0.5879
2022 Age Calibration	0.6255

2026 Projected Membership

Membership distribution by age was developed from the 2024 CMS Open Enrollment Report Data by age band.

Age	% Membership	Age Factor
0	0.4494%	0.765
1	0.4494%	0.765
2	0.4494%	0.765
3	0.4494%	0.765
4	0.4494%	0.765
5	0.4494%	0.765
6	0.4494%	0.765
7	0.4494%	0.765
8	0.4494%	0.765
9	0.4494%	0.765
10	0.4494%	0.765
11	0.4494%	0.765
12	0.4494%	0.765
13	0.4494%	0.765
14	0.4494%	0.765
15	0.4494%	0.833
16	0.4494%	0.859
17	0.4494%	0.885
18	1.1282%	0.913
19	1.1282%	0.941
20	1.1282%	0.970

Age	% Membership	Age Factor
21	1.1282%	1.000
22	1.1282%	1.000
23	1.1282%	1.000
24	1.1282%	1.000
25	1.1282%	1.004
26	1.9515%	1.024
27	1.9515%	1.048
28	1.9515%	1.087
29	1.9515%	1.119
30	1.9515%	1.135
31	1.9515%	1.159
32	1.9515%	1.183
33	1.9515%	1.198
34	1.9515%	1.214
35	1.8533%	1.222
36	1.8533%	1.230
37	1.8533%	1.238
38	1.8533%	1.246
39	1.8533%	1.262
40	1.8533%	1.278
41	1.8533%	1.302
42	1.8533%	1.325
43	1.8533%	1.357
44	1.8533%	1.397
45	1.7571%	1.444
46	1.7571%	1.500
47	1.7571%	1.563
48	1.7571%	1.635
49	1.7571%	1.706
50	1.7571%	1.786
51	1.7571%	1.865
52	1.7571%	1.952
53	1.7571%	2.040
54	1.7571%	2.135
55	2.7547%	2.230
56	2.7547%	2.333
57	2.7547%	2.437
58	2.7547%	2.548
59	2.7547%	2.603
60	2.7547%	2.714
61	2.7547%	2.810
62	2.7547%	2.873
63	2.7547%	2.952
64	2.7547%	3.000

Age	% Membership	Age Factor
65	0.0464%	3.000
66	0.0464%	3.000
67	0.0464%	3.000
68	0.0464%	3.000
69	0.0464%	3.000
70	0.0464%	3.000
71	0.0464%	3.000
72	0.0464%	3.000
73	0.0464%	3.000
74	0.0464%	3.000
75	0.0464%	3.000
76	0.0464%	3.000
77	0.0464%	3.000
78	0.0464%	3.000
79	0.0464%	3.000
80	0.0464%	3.000
81	0.0464%	3.000
82	0.0464%	3.000
83	0.0464%	3.000
84	0.0464%	3.000
85	0.0464%	3.000
86	0.0464%	3.000
87	0.0464%	3.000
88	0.0464%	3.000
89	0.0464%	3.000
90	0.0464%	3.000
91	0.0464%	3.000
92	0.0464%	3.000
93	0.0464%	3.000
94	0.0464%	3.000
95	0.0464%	3.000
96	0.0464%	3.000
97	0.0464%	3.000
98	0.0464%	3.000
99	0.0464%	3.000
100	0.0464%	3.000

EXHIBIT 20: IMPACTS OF RATING ASSUMPTION CHANGES

	2026	2025*	Change
(i) The impact of medical cost trend	7.99%	6.86%	**1.13%**
Inpatient Hospital	7.58%	5.91%	1.67%
Outpatient Hospital	7.58%	5.91%	1.67%
Professional	7.58%	5.91%	1.67%
Other Medical	7.58%	5.91%	1.67%
Prescription Drug	9.59%	10.50%	-0.91%
Capitation	7.58%	5.91%	1.67%
(ii) The impact of utilization changes	3.31%	2.21%	**1.10%**
Inpatient Hospital	3.13%	1.78%	1.35%
Outpatient Hospital	3.13%	1.78%	1.35%
Professional	3.13%	1.78%	1.35%
Other Medical	3.13%	1.78%	1.35%
Prescription Drug	4.05%	3.90%	0.14%
Capitation	3.13%	1.78%	1.35%
(iii) The impact of cost-sharing changes, including actuarial values.	75.48%	82.37%	**-6.89%**
(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.	$0.42	$0.45	**-$0.03**
(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.	0%	0%	**0%**
(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.	0%	0%	**0%**
(vii) The impact of changes in reserve needs.	3.50%	3.00%	**0.50%**
(ix) The impact of changes in other administrative costs.	9.86%	11.31%	**-1.45%**
(x) The impact of changes in applicable taxes, licensing or regulatory fees.	$18.09	$16.34	**$1.75**

** 2025 Factors Consistent with Providence's 2025 filing*

EXHIBIT 21: COMPARISON OF URRT WORKSHEET 1 - 2026 VS. 2025

	2026	2025	Change
Trended EHB Allowed Claims PMPM (Experience)	$859.41	$1,036.98	-$177.57
Morbidity Adjustment	1.0000	1.0000	0.0%
Demographic Shift	1.0000	1.0000	0.0%
Plan Design Changes	1.0000	1.0000	0.0%
Other	1.0000	1.0000	0.0%
Adjusted Trended EHB Allowed Claims PMPM	$859.41	$1,036.98	-$177.57
Applied Credibility % (Experience)	0.00%	0.00%	0.00%
Credibility Adjusted EHB Allowed Claims PMPM	**$1,302.60**	**$1,138.07**	**$164.53**
Projected Index Rate	**$1,302.60**	**$1,138.07**	**$164.53**
Reinsurance	$0.00	$0.00	$0.00
Risk Adjustment Payment/Charge	$377.80	$387.40	-$9.60
Exchange User Fees	0.00%	0.00%	0.00%
Market Adjusted Index Rate	**$924.80**	**$750.67**	**$174.13**

EXHIBIT 22: EXCHANGE USER FEE

	Projected Membership		
	On-Exchange	Off-Exchange	Combined
Providence Columbia 1500 Gold	-	1,452	1,452
Providence Columbia 5000 Silver	-	661	661
Providence Columbia 9200 Bronze	-	1,008	1,008
Total	-	3,121	3,121

% 2026 Projected Membership On-Exchange	0%
2026 Exchange User Fee	0.00
2026 Exchange User Fee, Load PMPM	0.00

EXHIBIT 23: COMPARISON OF AREA RATING FACTORS

There was no change in the geographic factors between 2025 and 2026 filed premium rates. The factors were last changed within the 2023 premium rate filing. While we did review a potential change in rating area factors within the 2026 premium rates, it was not deemed necessary or credible; the 2023 premium rate geographic factors are still reflective of geographic cost variances.

Rating Area	County	2023 Rating Factor	2024 Rating Factor	2025 Rating Factor	2026 Rating Factor	2025-2026 Change	2026 Rating Factor, URRT Worksheet 3
Rating Area 3	Clark	1.0000	1.0000	1.0000	1.0000	0.0%	1.0000
Rating Area 4	Spokane	0.8852	0.8852	0.8852	0.8852	0.0%	0.8852
Rating Area 5	Thurston	0.9797	0.9797	0.9797	0.9797	0.0%	0.9797
Rating Area 6	Benton	0.9541	0.9541	0.9541	0.9541	0.0%	0.9541
Rating Area 6	Franklin	0.9541	0.9541	0.9541	0.9541	0.0%	0.9541
Rating Area 9	Walla Walla	0.9315	0.9315	0.9315	0.9315	0.0%	0.9315

Calibration Factors

2023	1.0482
2024	1.0544
2025	1.0556
2026	1.0509

EXHIBIT 24: TREND INFORMATION AND PROJECTION

Trend factors used in this filing are based on a combination of Providence's expected changes in contract reimbursements within Washington as well as expected industry carrier trends from WA URRTs and actuarial judgement. The trends are on a rolling 12 month basis and therefore are not adjusted for seasonality.

Medical trends are driven by: changes in the mix of intensity of services within a major service category and movement of utilization between service categories as anticipated within the WA ACA market; changes in negotiated reimbursement levels between PHP and providers.

Pharmacy trends are driven by: changes in script utilization as anticipated within the WA ACA market. PHP unit costs are based on expected changes in PBM costs.

The trends used in this filing reflect the expectation for the single risk pool only. No trend margin or fluctuation factors have been included in the development of these trends. The impact of deductible leveraging has been incorporated into the development of plan relativity factors.

The table below shows the trend factors by major service category. While medical utilization and unit costs were reviewed at a more granular level, they were applied to total medical costs. The categories shown below are not consistent with the URRT PHP experience, and instead are based on manual ACA data that was deemed to be more credible, as applied to the base period data.

Expense Category	Portion of Claim Dollars	Cost - 3 Year	Utilization - 3 Year	Overall - Annualized 3 Year
Inpatient Hospital	20.23%	24.51%	9.68%	36.56%
Outpatient Hospital	29.72%	24.51%	9.68%	36.56%
Professional	24.74%	24.51%	9.68%	36.56%
Other Medical	5.35%	24.51%	9.68%	36.56%
Prescription Drug	19.96%	31.62%	12.65%	48.26%
Capitation	0.00%	24.51%	9.68%	36.56%
Overall	100.00%	25.93%	10.27%	38.90%

EXHIBIT 25: INDUCED DEMAND AND AV AND COST SHARING

	A	B	C	D	E = B*D	F = Product(B:D)
Marketing Name	**Projected Membership**	**Paid/Allowed**	**CSR Load**	**Induced Utilization**	**AV and Cost Sharing Pre CSR Load ***	**AV and Cost Sharing**
Providence Columbia 1500 Gold	121	0.8224	1.0000	1.0332	0.8497	0.8497
Providence Columbia 5000 Silver	55	0.7366	1.0000	0.9879	0.7277	0.7277
Providence Columbia 9200 Bronze	84	0.6625	1.0000	0.9600	0.6360	0.6360
Total (Membership Weighted)	260	0.7526	1.0000	1.0000	0.7548	0.7548

* This is the percentage used as the paid-to-allowed factor in the calculation of the Risk Adjustment and the Exchange User Fee on Worksheet 1, Section II

EXHIBIT 26: PAID TO ALLOWED CLAIMS RATIO EXPERIENCE BY METAL LEVEL

Marketing Name	HIOS	2024 Allowed Claims	2024 Paid Claims	Paid To Allowed
Providence Columbia 1500 Gold	45834WA0490001	$1,213,560	$951,016	0.7837
Providence Columbia 5000 Silver	45834WA0490002	$415,237	$265,373	0.6391
Providence Columbia 9200 Bronze	45834WA0490003	$871,829	$670,451	0.7690

EXHIBIT 27: WEIGHTED-AVERAGE PLAN ADJUSTED INDEX RATE

Marketing Name	Plan Adjusted Index Rate	Projected Member Months
Providence Columbia 1500 Gold	$924.74	1,452
Providence Columbia 5000 Silver	$805.09	661
Providence Columbia 9200 Bronze	$715.21	1,008

Weighted PAIR	$831.73

URRT Premium	$831.73

Marginal difference due to rounding	*$0.00*

EXHIBIT 28: MANUAL RATE MORBIDITY ADJUSTMENT

Allowed PMPM by Age and Metal (ILLUSTRATIVE PURPOSES ONLY - NOT ACTUAL Wakely Proprietary ACA DATA)

Membership by metal >	1%	25%	49%	25%	0%	
Age Ranges	**Catastrophic**	**Bronze**	**Silver**	**Gold**	**Platinum**	**Age Dist**
Age_0_17	$100	$125	$150	$200	$250	5%
Age_18_25	$110	$135	$160	$210	$260	15%
Age_26_34	$120	$145	$170	$220	$270	10%
Age_35_44	$130	$155	$180	$230	$280	15%
Age_45_54	$140	$165	$190	$240	$290	25%
Age_55_64	$150	$175	$200	$250	$300	25%
Age_GE65	$160	$185	$210	$260	$310	5%
Total	$134	$159	$184	$234	$284	

Illustrative Average Allowed Calculation	$189.25

The table above is an illustrative example of how the allowed claim cost adjustment was developed. The numbers in this table are not real (these are not actual allowed claims from the Wakely national ACA proprietary data set). The purpose of this table is to supply insight into our process.

Allowed claims were summarized from the Wakely national individual ACA proprietary data set by metal and age. Then, using age/metal enrollment information from the manual data set and Providence's projected 2026 enrollment, an average allowed claim estimate was developed for each respective population (i.e., Washington's 2023 statewide population or Providence's 2026 projected population). The ratio of the two populations' allowed claim costs represents the adjustment factor between the two respective populations.

We further adjusted based on Providences‘s assumed propensity to enroll members with more HCC’s than an equivalent, average population. This assumption was based on a comparison between the PHP Washington experience population and a similar population in the Wakely ACA propriety database with the same age and metal mix. A similar adjustment was applied to PLRS in the risk adjustment calculation.

Please note that the allowed claim cost PMPMs aren't indicative of true allowed claims for these populations, but are used to understand the relativity between the populations. The ratio is then applied to true allowed claim costs.

EXHIBIT 29: HCRP RECEIPT AND ASSESSMENT AMOUNTS

	Actual		Projected*	
Year	**HCRP Receipt**	**Assessment Amount**	**HCRP Receipt**	**Assessment Amount**
2022	$0	$5,043	$4,867	$4,867
2023	$0	$5,664	$0	$7,236
2024	$0	$6,762	$0	$9,893
2025			$0	$9,031
2026			$0	$13,044

* Factor Source 2024-2026: WNRAR estimate of assessment as a percentage of premium

EXHIBIT 30A: 2024 MEDICAL ALLOWED - WASHINGTON INDIVIDUAL EXPERIENCE

Lag	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	
0	$58,752	$40,984	$43,365	$31,692	$43,893	$41,722	$83,163	$41,636	$57,430	$94,980	$38,869	$47,162	
1	$67,833	$39,965	$59,291	$52,400	$88,362	$31,262	$57,954	$55,910	$38,413	$32,052	$27,335	$32,022	
2	$3,866	$11,152	$11,388	$4,654	$25,255	$27,666	$7,934	$32,121	$15,448	$13,478	$2,905	$653	
3	$1,591	$592	$1,484	$6,404	$5,215	$3,881	$22,593	$39,780	$8,794	$2,130	$7,106	$1,617	
4	($17)	$1,212	$3,487	$5,895	$3,761	$12,855	$13,954	$1,002	$552	$2,590	$34,442		
5	$736	$667	$3,895	$6,087	$11,918	$25,470	$2,241	$0	$258	$556			
6	$394	$153	$9,155	$6,885	$2,108	$1,392	$0	$0	$228				
7	$325	$2,172	$3,004	$3,511	($1,232)	($2,425)	$581	$0					
8	$283	$106	$1,932	$784	$0	$1,084	$0						
9	$0	$637	$37	$384	$0	$156							
10	$0	$1,112	$118	$0	$737								
11	$0	$337	$538	$47									
12	$853	$497	$117										
13	$0	$311											
14	$311												
Total	**$134,926**	**$99,898**	**$137,809**	**$118,745**	**$180,017**	**$143,062**	**$188,420**	**$170,449**	**$121,124**	**$145,787**	**$110,656**	**$81,455**	**$1,632,347**
MMs	231	245	246	245	245	245	240	244	243	246	241	230	2,901

** Incurred 1-1-2024 thru 12-31-2024*
** Paid 1-1-2024 thru 3-31-2025*
** Does not include reserves*

EXHIBIT 30B: 2024 MEDICAL PAID - WASHINGTON INDIVIDUAL EXPERIENCE

Lag	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	
0	$31,493	$18,849	$27,009	$23,407	$26,051	$29,255	$69,889	$33,276	$39,691	$72,894	$26,023	$36,022	
1	$48,190	$31,351	$42,593	$45,192	$76,918	$22,965	$48,188	$49,955	$34,491	$22,829	$20,882	$25,953	
2	$3,462	$5,087	$8,008	$2,363	$22,200	$21,913	$5,220	$28,927	$8,286	$10,900	$2,294	$849	
3	$328	$523	$1,205	$2,346	$3,313	$3,218	$18,251	$38,944	$7,499	$902	$6,883	$1,166	
4	($13)	$1,069	$2,797	$2,164	$2,570	$11,225	$11,177	$793	$472	$1,987	$34,442		
5	$594	$462	$3,274	$2,411	$10,498	$21,614	$1,623	$25	$56	$406			
6	$219	$143	$7,105	$6,476	$1,168	$1,250	$4	$0	$158				
7	$295	$1,511	$2,434	$1,176	$18	($2,360)	$428	$0					
8	$289	$53	$1,413	$755	$0	$899	$0						
9	$0	$637	$37	$235	$0	$156							
10	$0	$890	$95	$0	$590								
11	$0	$219	$0	$38									
12	$853	$497	$117										
13	$0	$311											
14	$311												
Total	**$86,020**	**$61,603**	**$96,086**	**$86,563**	**$143,325**	**$110,135**	**$154,780**	**$151,920**	**$90,652**	**$109,918**	**$90,524**	**$63,990**	**$1,245,515**
MMs	231	245	246	245	245	245	240	244	243	246	241	230	2,901

** Incurred 1-1-2024 thru 12-31-2024*
** Paid 1-1-2024 thru 3-31-2025*
** Does not include reserves*

EXHIBIT 30C: 2024 PHARMACY ALLOWED - WASHINGTON INDIVIDUAL EXPERIENCE

Lag	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	
0	$87,278	$51,705	$126,297	$75,281	$97,806	$46,814	$77,804	$75,645	$92,280	$76,487	$65,972	$93,595	
1	$29,802	$31,852	$9,099	$7,732	$3,275	$6,066	$43,849	$3,036	$39,030	($7,132)	$7,766	$29,368	
2	$0	$0	$0	$0	$0	$19	$0	$0	$0	$0	$0	$0	
3	$36	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		
5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			
6	$0	$0	$0	$0	$0	$0	$0	$0	$0				
7	$0	$0	$0	$0	$0	$0	$0	$0					
8	$0	$0	$0	$0	$0	$0	$0						
9	$0	$0	$0	$0	$0	$0							
10	$0	$0	$0	$0	$0								
11	$0	$0	$0	$0									
12	$0	$0	$0										
13	$0	$0											
14	$0												
Total	**$117,115**	**$83,556**	**$135,395**	**$83,014**	**$101,081**	**$52,898**	**$121,653**	**$78,681**	**$131,310**	**$69,355**	**$73,738**	**$122,963**	**$1,170,759**
MMs	231	245	246	245	245	245	240	244	243	246	241	230	2,901

** Incurred 1-1-2024 thru 12-31-2024*
** Paid 1-1-2024 thru 3-31-2025*
** Does not include reserves*

EXHIBIT 30D: 2024 PHARMACY PAID - WASHINGTON INDIVIDUAL EXPERIENCE

Lag	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	
0	$50,935	$35,447	$108,785	$66,520	$85,033	$36,278	$69,601	$68,759	$80,222	$71,618	$63,499	$87,646	
1	$11,624	$29,139	$8,036	$6,520	$2,480	$7,240	$40,988	$2,662	$35,531	($7,391)	$7,428	$28,716	
2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
3	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		
5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			
6	$0	$0	$0	$0	$0	$0	$0	$0	$0				
7	$0	$0	$0	$0	$0	$0	$0	$0					
8	$0	$0	$0	$0	$0	$0	$0						
9	$0	$0	$0	$0	$0	$0							
10	$0	$0	$0	$0	$0								
11	$0	$0	$0	$0									
12	$0	$0	$0										
13	$0	$0											
14	$10												
Total	**$62,569**	**$64,586**	**$116,821**	**$73,040**	**$87,513**	**$43,517**	**$110,589**	**$71,421**	**$115,752**	**$64,227**	**$70,928**	**$116,362**	**$997,326**
MMs	231	245	246	245	245	245	240	244	243	246	241	230	2,901

** Incurred 1-1-2024 thru 12-31-2024*
** Paid 1-1-2024 thru 3-31-2025*
** Does not include reserves*

EXHIBIT 31: 2024 SUMMARY OF MEDICAL AND PHARMACY TOTALS

	Paid	Allowed
Medical	$1,245,515	$1,632,347
Capitation *	$1,996	$2,495
Pharmacy	$997,326	$1,170,759
Pharmacy Rebates *	($379,375)	($331,914)
IBNR *	$21,377	$26,940
Total	$1,886,840	$2,500,626

** Not included in Exhibits 30A-30D*

EXHIBIT 32: FILED VS ACTUAL EXPENSES

2024		
	Filed	**Actual**
General Admin	$76.32	$209.45
Commission	$4.00	$5.14
Taxes and Fees	$15.56	$16.41
Total PMPM	$95.88	$231.00

The admin allocation is based on PMPMs, similar to other commercial filings. The difference in actual versus expected is due to low membership.

EXHIBIT 33: 2024 WASHINGTON INDIVIDUAL CLAIMS BY BENEFIT CATEGORY

EHB

Item	Total Allowed	IBNR	January	February	March	April	May	June	July	August	September	October	November	December
Inpatient Hospital	$332,972	$6,794	$17,359	$0	$38,446	$1,119	$20,602	$30,378	$53,135	$64,337	$13,205	$30,087	$46,222	$11,287
Outpatient Hospital	$489,063	$9,979	$51,896	$48,568	$41,086	$47,977	$74,669	$25,447	$45,715	$20,583	$36,592	$49,227	$17,969	$19,357
Professional	$768,348	$9,298	$63,569	$45,432	$52,678	$61,462	$73,995	$74,945	$85,737	$81,245	$67,056	$61,213	$43,586	$48,130
Other Medical	$59,712	$723	$1,661	$5,457	$5,136	$7,956	$8,755	$10,295	$3,370	$3,822	$3,220	$4,798	$2,300	$2,219
Pharmacy	$1,170,759	$0	$117,115	$83,556	$135,395	$83,014	$101,081	$52,898	$121,653	$78,681	$131,310	$69,355	$73,738	$122,963
Pharmacy Rebates *	($331,914)	$0	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659	-$27,659
Capitation *	$2,495	$0	$208	$208	$208	$208	$208	$208	$208	$208	$208	$208	$208	$208
Total	$2,491,435	$26,794	$224,149	$155,563	$245,290	$174,076	$251,649	$166,512	$282,159	$221,216	$223,931	$187,228	$156,364	$176,504

Total: Non-EHB	$9,191

Grand Total	$2,500,626

Benefit Category	Experience Period Index Rate PMPM
Inpatient Hospital	$114.86
Outpatient Hospital	$168.70
Professional	$265.04
Other Medical	$20.60
Capitation	$0.86
Prescription Drug	$289.36

EHB Total PMPM	$859.41
URRT	$859.41

** These amounts are determined on an annual basis*

EXHIBIT 34: DETAIL OF UPMJ RATE CHANGE CALCULATION

HIOS Plan ID	2025 Plan Name	2026 Plan Name	Pricing AV 2025	Pricing AV 2026
45834WA0490001	Providence Columbia 1500 Gold	Providence Columbia 1500 Gold	0.9007	0.8497
45834WA0490002	Providence Columbia 5000 Silver	Providence Columbia 5000 Silver	0.7997	0.7277
45834WA0490003	Providence Columbia 8900 Bronze	Providence Columbia 9200 Bronze	0.7333	0.6360

HIOS Plan ID	2025 Plan Name	2026 Plan Name	Experience Rate Change	Benefit Rate Change	Cost-Share Rate Change	Overall Average Rate Change
45834WA0490001	Providence Columbia 1500 Gold	Providence Columbia 1500 Gold	12.94%	0.14%	0.00%	13.11%
45834WA0490002	Providence Columbia 5000 Silver	Providence Columbia 5000 Silver	10.74%	0.14%	0.00%	10.89%
45834WA0490003	Providence Columbia 8900 Bronze	Providence Columbia 9200 Bronze	6.75%	0.13%	0.50%	7.43%

Rating Area	Plan ID	2025 OEP Member Months	2025 Premium*	2026 Premium*
Rating Area 3	45834WA0490001	55	$511.39	$578.42
Rating Area 3	45834WA0490002	29	$454.12	$503.58
Rating Area 3	45834WA0490003	39	$416.42	$447.36
Rating Area 4	45834WA0490001	34	$452.66	$511.99
Rating Area 4	45834WA0490002	24	$401.97	$445.75
Rating Area 4	45834WA0490003	32	$368.60	$395.98
Rating Area 5	45834WA0490001	7	$500.99	$566.66
Rating Area 5	45834WA0490002	1	$444.89	$493.34
Rating Area 5	45834WA0490003	2	$407.95	$438.26
Rating Area 6	45834WA0490001	12	$487.92	$551.87
Rating Area 6	45834WA0490002	1	$433.28	$480.47
Rating Area 6	45834WA0490003	8	$397.31	$426.83
Rating Area 9	45834WA0490001	13	$476.36	$538.80
Rating Area 9	45834WA0490002	0	$423.01	$469.08
Rating Area 9	45834WA0490003	3	$387.90	$416.72

* 2025 and 2026 premiums are sourced from the respective Rate Schedules.

EXHIBIT 35: URRT SUPPORT

	Overall	Providence Columbia 1500 Gold	Providence Columbia 5000 Silver	Providence Columbia 9200 Bronze
2024 Experience Allowed	2,500,626.45	1,213,560	415,237	871,829
2024 Experience Paid	1,886,839.52	951,016	265,373	670,451
Paid to Allowed	75.5%	78.4%	63.9%	76.9%

Expected Member Months in the Rating Period	3,121	1,452	661	1,008
x Benefit Richness Adjustments	1.0000	1.0332	0.9879	0.9600
x Projected Average Paid to Allowed Ratio	75.3%	82.2%	73.7%	66.2%

URRT Section IV: Projected Plan Level Information

Plan ID (Standard Component ID)	Total	45834WA0490001	45834WA0490002	45834WA0490003
Allowed Claims	$4,067,169	$2,319,329	$855,243	$892,597
Reinsurance	$0	$0	$0	$0
Member Cost Sharing	$997,117	$459,274	$236,715	$301,128
Cost Sharing Reduction	$0	$0	$0	$0
Incurred Claims	$3,070,052	$1,860,055	$618,528	$591,470
Risk Adjustment Transfer Amount	$890,035	$718,444	$173,426	-$1,834
Premium	$2,595,817	$1,342,720	$532,165	$720,931
Projected Member Months	3,121	1,452	661	1,008
Loss Ratio	88.07%	90.24%	87.66%	82.25%

Side Calcs

Total Allowed Claims + Risk Adjustment		$956.08	$914.21	$888.44
Market Adjusted Index Rate		$924.80	$924.80	$924.80
Induced Demand		1.033	0.988	0.960
Non-EHB Allowed PMPM by Plan		$0.53	$0.56	$0.61

Average Paid to Allowed Ratio		75.5%	75.5%	75.5%
Allowed Risk Adjustment		$641.26	$379.65	-$2.93
IU Factor in AV RA Gross Up		106.6%	106.6%	106.6%
Allowed Claims		$1,597.33	$1,293.86	$885.51

Market Adjusted Index Rate		$924.80	$924.80	$924.80
Pricing AV		82.2%	73.7%	66.2%
Induced Demand		1.033	0.988	0.960
Retention		15.0%	16.4%	17.7%
Non-EHB Adj		1.0005	1.0006	1.0007
Plan Adjusted Index Rate		$924.74	$805.09	$715.21

	Retention	Admin	Taxes & Fees	Profit
45834WA0490001	14.98%	9.30%	2.17%	3.50%
45834WA0490002	16.36%	10.69%	2.17%	3.50%
45834WA0490003	17.70%	12.03%	2.17%	3.50%

EXHIBIT 36: ENROLLMENT CHECKS

2025 Current Enrollment

	March 2025 Membership
(i) RRD Number of Covered Lives;	254
(ii) URRT Worksheet 2, field 2.10 Current Enrollment;	254
(iii) UPMJ Q1 Enrollment as of 3/31/2025;	254
(iv) Part III supporting exhibits.	N/A

2026 Enrollment Projections

	Projected Member Months
(i) RRD (Projected Earned Premium) / (Requested Rate Weighted Avg. PMPM);	3,121
(ii) URRT Worksheet 2, field 4.9 Projected Member Months;	3,121
(iii) Part II written explanation;	3,121
(iv) Part III supporting exhibits.	3,121

EXHIBIT 37: FINANCIAL DATA CHECKS

URRT Worksheet 1, Section I

Allowed Claims	$2,500,626
Reinsurance	$0
Incurred Claims in Experience Period	$1,886,840
Risk Adjustment	$1,237,092
Experience Period Premium	$1,878,223
Experience Period Member Months	2,899

URRT Worksheet 2, Section II

Allowed Claims	$2,500,626
Reinsurance	$0
Incurred Claims in Experience Period	$1,886,840
Risk Adjustment	$1,237,092
Experience Period Premium	$1,878,223
Experience Period Member Months	2,899

WAC 284-43-6660 Summary

Allowed Claims	N/A
Reinsurance	$0
Incurred Claims in Experience Period	$1,886,840
Risk Adjustment	$1,237,092
Experience Period Premium	$1,878,223
Experience Period Member Months	2,899

EXHIBIT 38: 2024 ACTUAL AND PROJECTED EXPERIENCE

Total	Projected $$	Actual $$	Projected PMPM	Actual PMPM
Allowed Claims	$2,889,780	$2,500,626	$1,124.87	$862.58
Reinsurance	$0	$0	$0.00	$0.00
Incurred Claims	$2,387,114	$1,886,840	$929.20	$650.86
Risk Adjustment	$898,223	$1,237,092	$349.64	$426.73
Total Claims + Risk Adjustment	$1,488,891	$649,748	$579.56	$224.13
Administrative Expenses	$206,341	$599,924	$80.32	$206.94
Taxes & Fees	$39,965	$69,747	$15.56	$24.06
Profit Margin	$53,666	$558,805	$20.89	$192.76
Premium	$1,788,845	$1,878,223	$696.32	$647.89
Paid-to-Allowed Claim Ratio	82.6%	75.5%	82.6%	75.5%
Member Months	2,569	2,899		

Gold	Projected $$	Actual $$	Projected PMPM	Actual PMPM
Allowed Claims	$1,465,916	$1,213,560	$1,388.18	$955.56
Reinsurance	$0	$0	$0.00	$0.00
Incurred Claims	$1,258,269	$951,016	$1,191.54	$748.83
Risk Adjustment	$591,565	$676,099	$560.19	$532.36
Total Claims + Risk Adjustment	$666,704	$274,917	$631.35	$216.47
Administrative Expenses*	$100,084	$276,948	$94.78	$218.07
Taxes & Fees*	$16,428	$32,198	$15.56	$25.35
Profit Margin*	$22,060	$257,966	$20.89	$203.12
Premium	$809,131	$867,061	$766.22	$682.72
Paid-to-Allowed Claim Ratio	85.8%	78.4%	85.8%	78.4%
Member Months	1,056	1,270		

Silver	Projected $$	Actual $$	Projected PMPM	Actual PMPM
Allowed Claims	$986,882	$415,237	$1,190.45	$569.60
Reinsurance	$0	$0	$0.00	$0.00
Incurred Claims	$789,470	$265,373	$952.32	$364.02
Risk Adjustment	$324,769	$168,936	$391.76	$231.74
Total Claims + Risk Adjustment	$464,701	$96,437	$560.56	$132.29
Administrative Expenses*	$64,587	$151,221	$77.91	$207.44
Taxes & Fees*	$12,897	$17,581	$15.56	$24.12
Profit Margin*	$17,318	$140,857	$20.89	$193.22
Premium	$558,516	$473,439	$673.72	$649.44
Paid-to-Allowed Claim Ratio	80.0%	63.9%	80.0%	63.9%
Member Months	829	729		

Bronze	Projected $$	Actual $$	Projected PMPM	Actual PMPM
Allowed Claims	$436,983	$871,829	$638.86	$968.70
Reinsurance	$0	$0	$0.00	$0.00
Incurred Claims	$339,375	$670,451	$496.16	$744.95
Risk Adjustment	-$18,110	$392,057	-$26.48	$435.62
Total Claims + Risk Adjustment	$357,485	$278,393	$522.64	$309.33
Administrative Expenses*	$41,671	$171,754	$60.92	$190.84
Taxes & Fees*	$10,641	$19,968	$15.56	$22.19
Profit Margin*	$14,289	$159,982	$20.89	$177.76
Premium	$421,197	$537,723	$615.79	$597.47
Paid-to-Allowed Claim Ratio	77.7%	76.9%	77.7%	76.9%
Member Months	684	900		

*Actual Administrative Expenses, Taxes & Fees, and Profit Margin at the metal level were distributed from the total based on premium.

Differences in actual versus expected are due to 2024 filed premium rates being manually rated and actual experience reflecting low membership.

EXHIBIT 39: RISK ADJUSTMENT & HCRP ON ALLOWED BASIS

Risk Adjustment Payment/Charge (Paid Basis)	$285.18
Projection Period AV	75.48%
Risk Adjustment Payment/Charge (Allowed Basis)	$377.80

URRT Worksheet 2, Field 4.15	$983.68
URRT Worksheet 2, Field 4.11	$1,303.16
Field 4.15 / Field 4.11	75.48%

EXHIBIT 40: PRIOR ACTUAL ADMINISTRATIVE EXPENSES & TAXES/FEES

	2022		2023		2024	
	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium
Admin Expense	$234.17	42.7%	$232.60	39.8%	$206.94	31.9%
Commissions	$3.81	0.7%	$3.63	0.6%	$5.14	0.8%
Quality improvement	$11.28	2.1%	$13.33	2.3%	$9.67	1.5%
Investment income credit (enter as a negative number)	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
Commercial reinsurance premium	$1.76	0.3%	$0.78	0.1%	$0.94	0.1%
Other administrative expenses	$217.32	39.6%	$214.86	36.7%	$191.20	29.5%
Taxes/Fees Expense	$38.70	7.1%	$55.39	8.2%	$24.06	3.7%
Premium tax	$28.21	5.1%	$45.16	7.7%	$14.90	2.3%
Federal income tax	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
WA OIC regulatory surcharge	$6.51	1.2%	$6.61	1.1%	$5.99	0.9%
WA OIC fraud surcharge	$1.07	0.2%	$0.40	0.1%	$1.45	0.2%
Risk adjustment user fee	$0.25	0.0%	$0.22	0.0%	$0.21	0.0%
PCORI fee	$0.24	0.0%	$0.27	0.0%	$0.26	0.0%
Mitigating inequity fee	$0.01	0.0%	$0.00	0.0%	$0.00	0.0%
WSHIP assessment	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
WAPAL assessment	$0.24	0.0%	$0.22	0.0%	$0.27	0.0%
Exchange user fee	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
Insurance commissioner fees	$2.17	0.4%	$2.51	0.4%	$0.98	0.2%
Total Expenses	$272.87	49.7%	$287.99	48.0%	$231.00	35.6%
WAC Total Expenses	$272.87	**TRUE**	$287.99	**TRUE**	$231.00	**TRUE**

EXHIBIT 41: PROFIT AND RISK LOAD DEVELOPMENT

The accompanying rate filing is calculated to produce a margin at a level required to maintain reasonable rate stability and insurer solvency over an extended period of time. The accompanying rate change is intended to help balance anticipated increases in benefit costs (what the Health Plan pays to health care providers) with member cost sharing (what the member pays in copays, coinsurance, and deductibles). PHP's surplus is necessary to provide financial security to policy holders and the long-term commitment to our members. A 3.5% margin load is used to achieve long term rate stability. No other assumptions or rating factors include their own margin provisions. Unpaid claim liability reflects our best estimate. As this filing is manually rated the unpaid claim liability does not flow into rates.

Year	PMPM Premium Load	URRT WS2 Percent of Premium Load (Field 3.8)	Observed Margins
2022	$16.67	3.0%	33.5%
2023	$19.61	3.0%	-25.9%
2024	$20.89	3.0%	29.8%
2025	$22.38	3.0%	
2026	$29.11	3.5%	

EXHIBIT 42: MONTHS OF SURPLUS

2024 Surplus (Liabilities Capital and Surplus col 3 line 33)	$683,257,435	A
2024 Claims Expense (Page 4, Line 18: Total hospital and medical claims)	$2,259,866,340	B
Months of Surplus	3.63	C = (A / B) * 12

Exhibit 43: EXPERIENCE RISK TRANSFER

State Average Premium	$507.46

Plan ID	Rating Area	Billable Member Months	PLRS	IDF	GCF	AV	ARF	WA INDV FIRS	WA INDV FERS	PHP FIRS	PHP FERS	Factor	Transfer PMPM	Total Transfer
45834WA0490001	3	520	3.803	1.080	1.102	0.800	1.614	1.233	1.208	4.525	1.536	2.397	$1,216.23	$632,401
45834WA0490001	4	374	2.013	1.080	0.927	0.800	1.416	1.233	1.208	2.016	1.134	0.695	$352.72	$131,881
45834WA0490001	5	102	0.301	1.080	0.959	0.800	1.055	1.233	1.208	0.311	0.874	-0.471	-$239.18	-$24,317
45834WA0490001	6	152	0.710	1.080	0.914	0.800	1.540	1.233	1.208	0.701	1.216	-0.438	-$222.51	-$33,807
45834WA0490001	9	143	0.919	1.080	0.965	0.800	1.662	1.233	1.208	0.958	1.385	-0.370	-$187.90	-$26,938
45834WA0490002	9	-	0.000	0.000	0.000	0.000	0.000	1.233	1.208	0.000	0.000			
45834WA0490002	3	388	1.527	1.030	1.102	0.700	1.483	1.233	1.208	1.732	1.178	0.429	$217.71	$84,572
45834WA0490002	4	304	2.084	1.030	0.927	0.700	2.001	1.233	1.208	1.990	1.338	0.506	$256.67	$78,028
45834WA0490002	5	25	1.555	1.030	0.959	0.700	1.131	1.233	1.208	1.536	0.782	0.598	$303.37	$7,716
45834WA0490002	6	11	0.790	1.030	0.914	0.700	1.000	1.233	1.208	0.744	0.659	0.057	$29.10	$325
45834WA0490003	3	351	1.934	1.000	1.102	0.600	1.707	1.233	1.208	2.131	1.128	0.793	$402.66	$141,198
45834WA0490003	4	424	0.318	1.000	0.927	0.600	1.672	1.233	1.208	0.295	0.930	-0.531	-$269.36	-$114,135
45834WA0490003	5	24	0.199	1.000	0.959	0.600	2.389	1.233	1.208	0.191	1.374	-0.983	-$498.90	-$12,173
45834WA0490003	6	43	0.100	1.000	0.914	0.600	1.513	1.233	1.208	0.091	0.830	-0.613	-$311.05	-$13,282
45834WA0490003	9	73	14.346	1.000	0.965	0.600	1.374	1.233	1.208	13.842	0.796	10.563	$5,360.45	$392,385

*From TPIR Final CMS Results

	Estimated 2024 Transfer Amount by Plan			
	Providence Health Plan			
	Total	45834WA0490001	45834WA0490002	45834WA0490003
2024 Actual Transfer Amount per CMS, Total	$1,243,854	$679,220	$170,640	$393,993
Experience Period Estimate of 2024 HCRP Assessment	-$6,762	-$3,121	-$1,704	-$1,936
2024 HCRP Reimbursement	$0	$0	$0	$0
2024 Calculated Risk Adjustment Amount	$1,237,092	$676,099	$168,936	$392,057

Benefit Components Template for Individual and Small Group Medical Filings
Instructions

Version 3.2

Purpose

The purpose of this document is to enable carriers to summarize the benefits of each of their plans in a consistent way while capturing all the information needed to assess the plan designs for compliance. Compared to the Plans and Benefits Template and Actuarial Value Calculator, this template allows significantly more flexibility in both the benefit categories and cost-sharing structures that can be entered. Carriers should enter their plan designs as best as the template will accommodate and make notes of plan features that do not fit into the template (see instructions below).

Understanding the Template

You are currently on the Instructions sheet of this document. Please read this sheet fully before beginning the process of completing the templates. Once you are ready to begin, you can use the "Add Plan Worksheet" button (above) to add exactly one sheet for each plan (and each CSR variation) you are offering. Under the added sheets, you will see six more buttons, which allow you to add or subtract lines from the benefits table as needed to accommodate your plan design. You will need to fill out the plan information at the top of the template and then fill out the table below to display a summary of your plan's benefits and cost sharing structure. Note that the "Update Plan Worksheet Names" button (above) is used to update all of the plan sheet names to the HIOS Plan IDs entered under Line 1.1 in each of the corresponding sheets (which should be done before this document is submitted in the rate filing).

Plan Worksheet Cell Legend	
Cell Format	**Cell Color and Further Explanation**
Entry Required	These cells require a user entry or selection.
"Yes" Entry	Cells with a value of "Yes" will take on a yellow-orange color.
	These cells are not applicable based on user entries or selections in the corresponding plan sheet. If you believe an entry should be made, consider why this cell is deemed not applicable based on your other entries in the sheet. Make a note in the sheet if necessary.
Delete Text	Some cells start out like this when the template is first copied. After you enter a plan design into the template, you must delete the text from any remaining cells formatted this way (grey cells with red text). As indicated above, grey cells are not applicable and therefore should have no entries.
Unique Plan Design	These cells indicate that the cost-sharing structure you entered in the plan sheet creates a unique plan design for the purpose of calculating the actuarial value (AV) based on the functionality of the federal AV calculator or that the entry is an error. The format of these cells changes from the "Entry Required" format above to the format shown to the left based on the user's entry in the cells. Please see the "Automatic Checks" table below for details. Note that if your plan design is unique, you must submit an exhibit in the rate filing showing and justifying your adjustment to the AV calculation.

Instructions

Sheet	Guidance
Instructions	Fully read through these instructions before beginning. This will almost surely save you time in the long run. There are specific ways in which the plans must be entered, as explained below. If, as you are entering a plan, there seems to be ambiguity about how it should be entered, please recheck these instructions, contact the OIC with your question, and/or make a note (as allowed in the template).

Instructions	Add one sheet with the "Add Plan Sheet" button (found at the top of this sheet) for each plan you are offering (and one of each CSR variation). You may not include two plans on one sheet. If you have plans that are identical (or nearly so) you may find that it is faster to fill out one sheet and then duplicate it, making any changes necessary from that starting point. To do this, right click the sheet found at the bottom of the Excel application and click "More or Copy...", then check "Create a Copy", highlight (i.e., click) the sheet you want this new sheet to come before in the "Before Sheet" box, then click "OK". If you choose to duplicate sheets to save time, be very careful not to miss plan differences when adjusting the duplicated sheets. We recommend you duplicate tabs sparingly.

Plan Sheets (Section 1)	In Section 1, enter the HIOS Plan ID, Plan Name, Metal Level, and whether this is a CSR plan variant. Ensure that the Plan Name matches the forms, binder and rate filing documents exactly.
Plan Sheets (Section 2)	In Section 2, enter the Plan Design Information. Lines 2.2-2.10 should be entered the same way as they are entered in the AV Calculator. On Line 2.11, if you enter "Yes" to indicate different cost-sharing between virtual care and non-virtual care, add a note ("Note 1") under the underlined "Notes" header at the bottom of the page. In this note, explain how the cost-sharing is different and how you are accounting for those differences in this template, in the Plans and Benefits template, and in the AV Calculator. Be aware that the instructions for Section 4 (below) include that you should add rows to the benefit table to reflect any differing virtual cost shares.
Plan Sheets (Section 3)	In Section 3, enter the network and tier information. Based on your selection in Line 3.3 and Line 3.7, the table below will allow up to four tiers (including one for out-of-network benefits). The tiers will be part of the table in Section 4.
Plan Sheets (Section 4)	In Section 4, enter a tier name or description in Line 4.1. Do this for all tiers. The entries should describe the tiers in enough detail so that the tiers can be understood. For example, you might write "In-Network Tier," "Without-Referral Tier," or "Virtual Tier."
Plan Sheets (Section 4)	Customize the table to match the benefits you offer for the plan. The six buttons at the top of the sheet can be used to add or subtract rows from the table. There are 4 sections of the table: (1) Medical Benefits: Most of these categories are identical to those in the AV Calculator, with a few additions. Fill in all of these rows unless the benefit is not offered. (2) Other EHB Categories: If the plan offers EHBs not shown in the Medical Benefits section above, add a row for each such benefit. This section should also be used whenever the Medical Benefit categories above do not adequately describe the cost-sharing structure; for example, if you split the Outpatient Facility Fee benefits into multiple categories, you can add rows to display the different subcategory cost shares. Make sure to title the categories appropriately and add notes as necessary for the sake of clarity. (3) Non-EHB Benefits: Add rows for non-EHB benefits that the plan offers. (4) Drug Benefit Tiers: These drug tiers are the 4 standard tiers, as seen in the AV Calculator. If your plan design has more than 4 tiers, add more rows and title them appropriately. *** It is assumed that your plan designs cover virtual visits at the same cost shares as in-person visits. If this is not the case for one or more categories of services, add rows to the table as necessary to reflect the differing cost shares.
Plan Sheets (Section 4)	Enter the cost-sharing information in the table. Guidance is provided below: (1) Upfront Visits or Copays?: Enter “Yes” if the upfront visits or upfront copays are applicable to the benefit category; otherwise, enter “No.” Upfront visits are associated with the “Begin Primary Care Cost-Sharing After a Set Number of Visits” field, and upfront copays are associated with the “Begin Primary Care Deductible/Coinsurance After a Set Number of Copays” field. (2) Subject to Deductible?: If the member's cost-share for the benefit category depends on whether a deductible is met, select "Yes"; otherwise, select "No." (3) Amount (Copays): Enter the amount of the copay, if applicable. Otherwise, leave the cell blank to indicate that a copay is not applicable. (4) Applies (Copays): If there is a copay, enter whether the copay applies before, after, or before and after the deductible. Note that if the benefit is subject to the deductible and copay applies before the deductible, first the copay applies to the allowed charge, and then the rest of the charge applies toward the deductible. In this case, the copay does not accumulate toward the deductible. If the whole amount that the member pays (the allowed charge) accumulates toward the deductible, you should select "After Deductible." (5) Amount (Coinsurance): Enter the member's coinsurance (%) rate, not the carrier's portion. Otherwise, leave the cell blank to indicate that a coinsurance is not applicable.

Plan Sheets (Section 4)	(6) Applies (Coinsurance): Enter whether the coinsurance applies before, after, or before and after the deductible. Note that a coinsurance applying before the deductible has been met is a unique plan design (see below). (7) Accrues Toward Deductible (Copays or Coinsurance): If applicable, enter whether or not the copay or coinsurance paid by the member accrues toward meeting the deductible. (8) Comments: Whenever the plan design is not accommodated by the template (or other clarification is deemed necessary), add a note in the "Comments" column. You will select a note number, which you will then need to also select below, in the Notes section. Add your written comment in this Notes section, explaining what about your plan design is not captured in the template (or otherwise providing clarity). *** If the benefit is fully covered (no member cost share), enter "No" under "Subject to Deductible?" Enter "0" for the Copay "Amount" and "Before and After Deductible" in the "Applies" column. *** If there is no copay or no coinsurance applicable to a particular benefit, leave all three column entries under the particular header ("Copays" or "Coinsurance") blank. Make sure to delete any existing text from those columns. *** If the benefit is not covered by the plan, enter "No" under "Subject to Deductible?," "100%" for the Coinsurance "Amount," "Before and After Deductible" in the "Applies" column, and "No" in the "Accrues Toward Deductible?" column. Also, add a note to clarify that the benefit is not covered. *** If an individual benefit does not have tiered cost sharing within a plan with multiple tiers, enter the cost sharing features (e.g., copays, coinsurances, whether the deductible applies, etc.) identically to how they were entered in tier 1 when filling out other tiers.

Plan Sheets (Final Notes)	Review the unique plan design elements. The table below describes some (but not necessarily all) of the unique plan design elements that a plan may have. If any of these unique design elements is applicable to your plan, you will need to adjust your Actuarial Value Calculation in an actuarially justifiable way and provide the justification in a unique plan design justification rate filing exhibit. In such an exhibit, you must include all calculations, data or data sources, plan design descriptions, etc., necessary for thorough review.

Automatic Checks (Automatically Highlighted in Orange)	
Column Header	**Explanation (What Does Orange Highlighting Mean?)**
Upfront Visits or Copays?	Cells in this column are highlighted whenever "Yes" is entered for a benefit other than "Primary Care Visit to Treat an Injury or Illness."
Subject to Deductible?	[Only for the "Primary Care Visit to Treat an Injury or Illness" benefit category] If "Subject to Deductible?" is "No" and "Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?" (Line 2.8) is not "N/A," the Cell will be highlighted. This sort of design is not logically consistent and therefore should be corrected. Note that this combination of entries also causes an error in the AV Calculator.
Copays: Applies	Cells in this column are highlighted whenever both a copay and coinsurance apply after the deductible (including when either or both apply before and after the deductible).
Copays: Accrues toward Deductible?	Cells in this column are highlighted whenever "No" is entered under "Subject to Deductible?" and "Yes" is entered under "Accrues Toward Deductible?"
Coinsurance: Applies	Cells in this column are highlighted whenever it is indicated that a coinsurance applies before (or before and after) the deductible.

Manual Checks (Not Automatically Highlighted and Not Always Accommodated by the Template)	
Column Header	**Explanation**
More Than 4 Drug Tiers	If the plan incorporates more than 4 tiers of drug cost shares, this is a unique design.
Maximum Coinsurance	If a coinsurance is applied up to a limit for a benefit other than Specialty Drugs (Tier 4 Drugs), this is a unique plan design.
Multiple Cost Share Tiers for One Benefit Category	The AV Calculator has certain benefit categories and allows one copay and/or coinsurance for each. If your plan involves subdividing the AV Calculator's benefit categories and providing different cost shares for each subcategory, this is a unique plan design. A unique plan design AV adjustment will be required; for example, a utilization-weighted blended copay and/or coinsurance may be appropriate.

Plan Sheets	Review the cells that are greyed out. Text in such cells will be red. Delete all such text. If you believe something is missing from the representation of the plan as shown in the template, please add a note explaining why. Also, review the "Errors/Warnings" columns. If there are any numbers in these columns, use the guidance in the "Errors/Warnings" section below to correct the issues.
Instructions	Press the "Update Plan Worksheet Names" button (found at the top of this sheet) to automatically rename all of the sheets to the HIOS Plan IDs entered on Line 1.1 in the plans' sheets. Note that you may press this button multiple times as you work through the templates if doing so make it easier for you to navigate throughout the document.
All	Delete any extra sheets before submitting the document in the rate filing. There should be exactly one sheet added for each plan you will be offering and one sheet for each CSR variation. Remove the Illustrative Example sheet before submitting both the Excel version and PDF version of this document. Note that we do not recommend that you delete this Instructions worksheet, because doing so will also remove your ability to use the two buttons at the top in the case that any corrections are required.

All	Make a PDF copy of this document. Make sure that the PDF shows each and every sheet and cell in this document. You should check the PDF to be sure that this is the case and that no text is cut off due to formatting. If necessary, adjust the print area in the plan sheets to allow the text to show in the PDF.
All	Submit both the Excel version and PDF version of this document. Name the PDF version "Benefit Components.pdf" and name the Excel version "Benefit Components Duplicate.xlsm."

Errors/Warnings

The "Errors/Warnings" columns in Section 4 of the plan sheets are designed to check for common mistakes in each row. Please review these columns and correct all errors. Specific guidance for each error is provided in the table below. If you receive an error and do not believe it should be an error, please add a note to clarify the plan design.

Errors/Warnings	
Error/Warning Number	**Explanation**
1	Why is this error showing? This error is shown whenever the "Preventive Care/Screening/Immunization" benefit category's cost sharing information is entered incorrectly. How do I fix this error? This benefit category should be entered to have a copay of $0 that applies "Before and After the Deductible." No coinsurance information should be entered.
2	Why is this error showing? This error is shown whenever a logically inconsistent plan design was entered, whenever there is text in a cell that should be blank, and whenever an entry was expected in a cell but not entered. How do I fix this error? Make sure that the row is filled out completely and that there is no red text in any grey cell. If only a copay or only a coinsurance is applicable to the benefit category, do not enter anything for the other cost share (i.e., leave all three corresponding columns blank). Make sure that all of the entries in the row follow the data validation rules (i.e., that they are options from the dropdown, numbers when they are supposed to be numbers, etc.).
3	Why is this error showing? This error is shown whenever you have indicated that a benefit category is not subject to the deductible but have not indicated what cost share applies in both phases of cost sharing (i.e., before the deductible and after the deductible). How do I fix this error? One of the copay or the coinsurance must apply before and after the deductible, or one must apply before and one must apply after. Otherwise, you have not specified the cost share in all phases. For example, if a copay applies before the deductible and there is no member cost share after the deductible, enter the copay amount and select "Before Deductible" and enter a 0% coinsurance and select "After Deductible." Common plan designs include the following: Copay (Before and After Deductible) Coinsurance (Before and After Deductible) Copay (Before Deductible) and Coinsurance (After Deductible)

4	Why is this error showing? This error is shown whenever the Deductible, Default Coinsurance, or MOOP entries are missing or inconsistent with the entries in Line 2.2 or Line 2.5. How do I fix this error? Make sure that all yellow cells have entries and all grey cells are blank (i.e., no red text). If this would result in a misrepresentation of the plan's actual design, review the entries in Line 2.2 and Line 2.5. For out-of-network tiers, if there is no applicable deductible, enter $0. If there is no applicable default coinsurance, enter 100%. If there is no applicable MOOP, enter "UNLIMITED".

Benefit Components

Worksheet Controls

Company: Providence Health Plan **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	45834WA0490001	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Providence Columbia 1500 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?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Choice
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: Medical Home

	Medical	Drug	Combined	Errors/Warnings
Deductible			$1,500	
Default Coinsurance			20%	
MOOP			$8,200	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services		Yes	$ 250	After Deductible		20%	After Deductible			
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				20%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		No	$ 30	Before and After Deductible	No					
Specialist Visit		No	$ 50	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 30	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		Yes				20%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				20%	After Deductible			
Rehabilitative Speech Therapy		Yes				20%	After Deductible			
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				20%	After Deductible			
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No				20%	Before and After Deductible	No	Note 1	
X-rays and Diagnostic Imaging		No				20%	Before and After Deductible	No		
Skilled Nursing Facility		Yes				20%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				20%	After Deductible		Note 2	
Outpatient Surgery Physician/Surgical Services		Yes				20%	After Deductible			
Urgent Care		No	$ 50	Before and After Deductible	No					
Emergency Transportation		Yes				20%	After Deductible			
Other EHB Categories										
Virtual Visits		No	$ -	Before and After Deductible					Note 3	
Non-EHB Benefits										
Allergy Testing		Yes				20%	After Deductible			
Fertility Preservation		Yes				20%	After Deductible			
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Preferred Generic Drugs (Tier 1)		No	$ -	Before and After Deductible					Note 4	
Generic Drugs (Tier 2)		No	$ 10	Before and After Deductible	No				Note 4	
Brand Drugs (Tier 3)		No	$ 50	Before and After Deductible	No					
Non-Preferred Drugs (Tier 4)	$200	Yes				50%	After Deductible			
Preferred Specialty Drugs (Tier 5)	$300	Yes				50%	After Deductible			
Specialty Drugs (Tier 6)		Yes				50%	After Deductible			

Notes

Note 1 Laboratory Outpatient and Professional Services have different cost shares. Laboratory Outpatient is 20% coinsurance prior to deductible and Professional Services are 20% after deductible.

Note 2 Outpatient facility fee is 10% in an ambulatory surgery center, 20% in all other facilities.

Note 3 Providence ExpressCare Virtual is zero cost share, other virtual visits same costshare as a PCP or Specialist visit as applicable.

Note 4 Tier 1 contains our preferred generic medications, which are those found to be most cost-effective for chronic disease management. Tier 2 generics are other generic medications that are low cost and typically first-line agents for many different diseases.

Benefit Components

Worksheet Controls

Company: Providence Health Plan **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	45834WA0490002	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Providence Columbia 5000 Silver	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	No	Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Choice
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: Medical Home

	Medical	Drug	Combined	Errors/Warnings
Deductible			$5,000	
Default Coinsurance			35%	
MOOP			$8,900	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services		Yes	$ 250	After Deductible		35%	After Deductible			
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				35%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		No	$ 45	Before and After Deductible	No					
Specialist Visit		No	$ 65	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 45	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		Yes				35%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				35%	After Deductible			
Rehabilitative Speech Therapy		Yes				35%	After Deductible			
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				35%	After Deductible			
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No				35%	Before and After Deductible	No	Note 1	
X-rays and Diagnostic Imaging		No				35%	Before and After Deductible	No		
Skilled Nursing Facility		Yes				35%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				35%	After Deductible		Note 2	
Outpatient Surgery Physician/Surgical Services		Yes				35%	After Deductible			
Urgent Care		No	$ 65	Before and After Deductible	No					
Emergency Transportation		Yes				35%	After Deductible			
Other EHB Categories										
Virtual Visits		No	$ -	Before and After Deductible					Note 3	
Non-EHB Benefits										
Allergy Testing		Yes				35%	After Deductible			
Fertility Preservation		Yes				35%	After Deductible			
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Preferred Generic Drugs (Tier 1)		No	$ -	Before and After Deductible					Note 4	
Generic Drugs (Tier 2)		No	$ 25	Before and After Deductible	No				Note 4	
Brand Drugs (Tier 3)		No	$ 70	Before and After Deductible	No					
Non-Preferred Drugs (Tier 4)	$200	Yes				50%	After Deductible			
Preferred Specialty Drugs (Tier 5)	$300	Yes				50%	After Deductible			
Specialty Drugs (Tier 6)		Yes				50%	After Deductible			

Notes

Note 1 Laboratory Outpatient and Professional Services have different cost shares. Laboratory Outpatient is 20% coinsurance prior to deductible and Professional Services are 20% after deductible.

Note 2 Outpatient facility fee is 25% in an ambulatory surgery center, 35% in all other facilities.

Note 3 Providence ExpressCare Virtual is zero cost share, other virtual visits same costshare as a PCP or Specialist visit as applicable.

Note 4 Tier 1 contains our preferred generic medications, which are those found to be most cost-effective for chronic disease management. Tier 2 generics are other generic medications that are low cost and typically first-line agents for many different diseases.

Benefit Components

Worksheet Controls

Company: Providence Health Plan **Market:** Individual **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	45834WA0490003	Line 1.3	**Metal Level**	Expanded Bronze	Line 1.5	**Exchange Status**	Off Exchange
Line 1.2	**Plan Name**	Providence Columbia 9200 Bronze	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	No
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	No
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	N/A
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Choice
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: Medical Home

	Medical	Drug	Combined	Errors/Warnings
Deductible			$9,200	
Default Coinsurance			0%	
MOOP			$9,200	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services		Yes				0%	After Deductible			
Inpatient Hospital Services (e.g., Hospital Stay)		Yes				0%	After Deductible			
Primary Care Visit to Treat an Injury or Illness		No	$ 70	Before and After Deductible	No					
Specialist Visit		No	$ 100	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 70	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		Yes				0%	After Deductible			
Imaging (CT/PET Scans, MRIs)		Yes				0%	After Deductible			
Rehabilitative Speech Therapy		Yes				0%	After Deductible			
Rehabilitative Occupational and Rehabilitative Physical Therapy		Yes				0%	After Deductible			
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		Yes				0%	Before and After Deductible			
X-rays and Diagnostic Imaging		Yes				0%	Before and After Deductible			
Skilled Nursing Facility		Yes				0%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes				0%	After Deductible			
Outpatient Surgery Physician/Surgical Services		Yes				0%	After Deductible			
Urgent Care		No	$ 100	Before and After Deductible	No					
Emergency Transportation		Yes				0%	After Deductible			
Other EHB Categories										
Virtual Visits		No	$ -	Before and After Deductible					Note 1	
Non-EHB Benefits										
Allergy Testing		Yes				0%	After Deductible			
Fertility Preservation		Yes				0%	After Deductible			
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Preferred Generic Drugs (Tier 1)		No	$ -	Before and After Deductible					Note 2	
Generic Drugs (Tier 2)		No	$ 35	Before and After Deductible	No				Note 2	
Brand Drugs (Tier 3)		Yes				0%	After Deductible			
Non-Preferred Drugs (Tier 4)		Yes				0%	After Deductible			
Preferred Specialty Drugs (Tier 5)		Yes				0%	After Deductible			
Specialty Drugs (Tier 6)		Yes				0%	After Deductible			

Notes

Note 1 Providence ExpressCare Virtual is zero cost share, other virtual visits same costshare as a PCP or Specialist visit as applicable.

Note 2 Tier 1 contains our preferred generic medications, which are those found to be most cost-effective for chronic disease management. Tier 2 generics are other generic medications that are low cost and typically first-line agents for many different diseases.

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

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

Last Updated: 3/21/2025

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:	Providence Health Plan
HIOS Issuer ID:	45834
Market:	Individual
Plan Year:	2026
State Filing Tracking Number:	PROV-134500631

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
45834WA0490001	Providence Columbia 1500 Gold	Pass	
45834WA0490002	Providence Columbia 5000 Silver	Pass	
45834WA0490003	Providence Columbia 9200 Bronze	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.
	Allowed claims were estimated using the Wakely proprietary national ACA-compliant individual database. This was the same database used for calculating pricing AVs.
2	Identify the period (i.e., date range) represented in the data.
	Calendar Year 2022, trended to 2026 estimated costs
3	Address the credibility of the data used in your MHSUD financial requirement parity testing.
	The dataset is highly credible and consists of over 40 million member months. Thus, it is credible at the benefit line level required for mental health parity testing and pricing AV modeling.
4	Identify whether the data is consistent with the data in your URRT. If not, explain why the data is not consistent, why the data is appropriate, and summarize material adjustments made to the data.
	The Wakely proprietary data is not consistent with the underlying data used for rate development. The data used for rate development used a manual source (2023 URRT data) specific to the Washington individual ACA market. We do not have granular data from the 2023 URRT data for pricing AV modeling. The Wakely proprietary national ACA database was used for MHSUD testing because Providence experience is not credible and it includes detailed claim line level information. We calibrated the utilization and unit cost assumptions in the model to the plan's prospective allowed costs, adjusted for induced demand by metal tier.
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?
	The data source is Wakely's proprietary national ACA database. It is appropriate for MHSUD parity testing because it is credible at the benefit line level.

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		
Virtual Visits	Outpatient - Office Visits		
Skilled Nursing Facility	Inpatient		
Primary Care Visit to Treat an Injury or Illness	Outpatient - Office Visits		
Specialist Visit	Outpatient - Office Visits		
Preventive Care/Screening/Immunization	Outpatient - Office Visits		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient - All Other		
Urgent Care	Outpatient - All Other		
Laboratory Outpatient and Professional Services	Outpatient - All Other		
Allergy Testing	Outpatient - All Other		
Fertility Preservation	Outpatient - All Other		
Outpatient Surgery Physician/Surgical Services	Outpatient - All Other		
X-rays and Diagnostic Imaging	Outpatient - All Other		
Emergency Transportation	Emergency Care		
Emergency Room Services	Emergency Care		
Imaging (CT/PET Scans, MRIs)	Outpatient - All Other		
Rehabilitative Speech Therapy	Outpatient - All Other		
Rehabilitative Occupational and Rehabilitative Physical Therapy	Outpatient - All Other		
Generic Drugs (Tier 1)	Prescription Drugs		
Generic Drugs (Tier 2)	Prescription Drugs		
Brand Drugs (Tier 3)	Prescription Drugs		
non-Preferred Brand Drugs (Tier 4)	Prescription Drugs		
Preferred Speciality Drugs (Tier 5)	Prescription Drugs		
non-Preferred Specialty Drugs (Tier 6)	Prescription Drugs		

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

Issuer / Market: Providence Health Plan
Market: Individual
State Filing Tracking Number: PROV-134500631

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

PLAN INFORMATION

Plan Name: Providence Columbia 1500 Gold <<<<This will auto populate from summary sheet macro
Plan ID: 45834WA0490001 <<<<This will auto populate from summary sheet macro
CSR Variant Description: <<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: Pass

Links only work for sections that are not already hidden>>>>>>

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>

Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	Office Visits Separate

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier: D1. In-Network	D. By Network Tier: D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services C							
Outpatient - Office Visits Separate							
Outpatient	No	Yes			Pass		Pass
Outpatient	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

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 (3a) Outpatient - Office Visits, In-Network (OP-OV INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification: Outpatient - Office Vis | Network (In/Out): In-Network | Classification Code: 3a | Table Name: IM_OPOVINN_P1 | OP-OV | INN | OP-OV INN | Number of Rows: 4

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 visits	$30 copay	$338.32	N/A	$30.00	N/A	$8,200.00	
Office Visit - Specialist	$50 copay	$511.14	N/A	$50.00	N/A	$8,200.00	
Preventative Visits	No cost share	$181.83	N/A	N/A	N/A	$8,200.00	x
Providence ExpressCare Virtual Visits	No cost share	$0.00	N/A	N/A	N/A	$8,200.00	x
Total Row		$1,032.35					

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 | Network (In/Out): In-Network | Classification Code: 3b | Table Name: IM_OPAOINN_P1 | OP-AO | INN | OP-AO INN | 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")
Outpatient Services at an Ambulatory surgery Center	Coinsurance After Deductible	$128.50	$1,500.00	N/A	10%	$8,200.00	
All Other Outpatient Services	Coinsurance After Deductible	$2,248.01	$1,500.00	N/A	20%	$8,200.00	
Urgent Care	$50 copay	$34.11	N/A	$50.00	N/A	$8,200.00	
Xray, DP Lab, Testing	Coinsurance No Deductible	$386.31	N/A	N/A	20%	$8,200.00	
Prof Lab	Coinsurance After Deductible	$0.34	$1,500.00	N/A	20%	$8,200.00	
PT/OT/ST	Coinsurance After Deductible	$32.08	$1,500.00	N/A	20%	$8,200.00	
Total Row		$2,829.97					

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	$30.00	$50.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,200.00	$8,200.00	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	$849.45	82.28%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$1,032.35	100.00%	OP-OV INN OOPM
Total Projected	$1,032.35		

Step 2 Predominant Level

Deductible — (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0

Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

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 &	Error Checking
$30.00	$338.32	39.83%	$30.00	
$50.00	$511.14	60.17%	$50.00	
	$0.00			
	$0.00			
Total	$849.45	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
$8,200.00	$1,032.35	100.00%	$8,200.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,032.35	100.00%		

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	$1,500.00	$1,500.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	20%	20%	Pass
OOPM	$8,200.00	$8,200.00	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	$2,408.95	85.12%	OP-AO INN Deductible
Copayment	$34.11	1.21%	Fail
Coinsurance	$2,795.86	98.79%	OP-AO INN Coinsurance
OOPM	$2,829.97	100.00%	OP-AO INN OOPM
Total Projected	$2,829.97		

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
$1,500.00	$2,408.95	100.00%	$1,500.00	
	$0.00			
Total	$2,408.95	100.00%		

Copayment — (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0

Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

Coinsurance — (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
10%	$128.50	4.60%	10%	
20%	$2,667.36	95.40%	20%	
	$0.00			
	$0.00			
Total	$2,795.86	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
$8,200.00	$2,829.97	100.00%	$8,200.00	
	$0.00			
	$0.00			
	$0.00			
Total	$2,829.97	100.00%		

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

Issuer / Market: Providence Health Plan
Market: Individual
State Filing Tracking Number: PROV-134500631

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

PLAN INFORMATION

Plan Name: Providence Columbia 5000 Silver <<<<This will auto populate from summary sheet macro
Plan ID: 45834WA0490002 <<<<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 C							
Outpatient - Office Visits Separate							
Outpatient	No	Yes			Pass		Pass
Outpatient	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 Vis	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		IM_OPOVINN_P1

Number of Rows: 4

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 visits	$45 copay	$311.67	N/A	$45.00	N/A	$8,900.00	
Office Visit - Specialist	$65 copay	$470.87	N/A	$65.00	N/A	$8,900.00	
Preventative Visits	No cost share	$166.75	N/A	N/A	N/A	$8,900.00	x
Providence ExpressCare Virtual Vi	No cost share	$1.39	N/A	N/A	N/A	$8,900.00	x
Total Row		$951.69					

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	$45.00	$65.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,900.00	$8,900.00	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	$782.54	82.28%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$951.69	100.00%	OP-OV INN OOPM
Total Projected	$951.69		

Step 2 Predominant Level

Deductible — (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

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 &	Error Checking
$45.00	$311.67	39.83%	$45.00	
$65.00	$470.87	60.17%	$65.00	
	$0.00			
	$0.00			
Total	$782.54	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
$8,900.00	$951.69	100.00%	$8,900.00	
	$0.00			
	$0.00			
	$0.00			
Total	$951.69	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		IM_OPAOINN_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")
Outpatient Services at an Ambulatory surgery Center	Coinsurance After Deductible	$118.38	$5,000.00	N/A	25%	$8,900.00	
All Other Outpatient Services	Coinsurance After Deductible	$2,070.95	$5,000.00	N/A	35%	$8,900.00	
Urgent Care	$65 copay	$31.42	N/A	$65.00	N/A	$8,900.00	
Xray, DP Lab, Testing	Coinsurance No Deductible	$356.43	N/A	N/A	35%	$8,900.00	
Prof Lab	Coinsurance After Deductible	$0.31	$5,000.00	N/A	35%	$8,900.00	
PT/OT/ST	Coinsurance After Deductible	$29.56	$5,000.00	N/A	35%	$8,900.00	
Total Row		$2,607.05					

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

Financial Parity for (3b) Outpatient - All Other, In-Network (OP-AO INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$5,000.00	$5,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	35%	35%	Pass
OOPM	$8,900.00	$8,900.00	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	$2,219.20	85.12%	OP-AO INN Deductible
Copayment	$31.42	1.21%	Fail
Coinsurance	$2,575.63	98.79%	OP-AO INN Coinsurance
OOPM	$2,607.05	100.00%	OP-AO INN OOPM
Total Projected	$2,607.05		

Step 2 Predominant Level

Deductible — (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$5,000.00	$2,219.20	100.00%	$5,000.00	
	$0.00			
Total	$2,219.20	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
25%	$118.38	4.60%	25%	
35%	$2,457.25	95.40%	35%	
	$0.00			
	$0.00			
Total	$2,575.63	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
$8,900.00	$2,607.05	100.00%	$8,900.00	
	$0.00			
	$0.00			
	$0.00			
Total	$2,607.05	100.00%		

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

Issuer / Market: Providence Health Plan
Market: Individual
State Filing Tracking Number: PROV-134500631

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

PLAN INFORMATION

Plan Name: Providence Columbia 9200 Bronze <<<<This will auto populate from summary sheet macro
Plan ID: 45834WA0490003 <<<<This will auto populate from summary sheet macro
CSR Variant Description: <<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: Pass

Links only work for sections that are not already hidden>>>>>

<<<<Click the links in the cells below to scroll directly to the stated section>>>>>				
Move to IP INN	Move to IP OON	Move to OP INN	Move to OP-OV INN	Move to OP-AO INN
Move to OP OON	Move to OP-OV OON	Move to OP-AO OON	Move to ER	Move to RX

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	Office Visits Separate

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier: D1. In-Network	D. By Network Tier: D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All Services Co							
Outpatient - Office Visits Separate							
Outpatient	No	Yes			Pass		Pass
Outpatient	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 Vis | OP-OV
Network (In/Out): In-Network | INN
Classification Code: 3a | OP-OV INN
Table Name: IM_OPOVINN_P1
Number of Rows: 4

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 visits	$70 copay	$289.87	N/A	$70.00	N/A	$9,200.00	
Office Visit - Specialist	$100 copay	$437.94	N/A	$100.00	N/A	$9,200.00	
Preventative Visits	No cost share	$155.09	N/A	N/A	N/A	$9,200.00	x
Providence ExpressCare Virtual Visits	No cost share	$1.82	N/A	N/A	N/A	$9,200.00	x
Total Row		$884.51					

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	$70.00	$100.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$9,200.00	$9,200.00	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	$727.80	82.28%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$884.51	100.00%	OP-OV INN OOPM
Total Projected	$884.51		

Step 2 Predominant Level

Deductible — (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

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 &	Error Checking
$70.00	$289.87	39.83%	$70.00	
$100.00	$437.94	60.17%	$100.00	
	$0.00			
	$0.00			
Total	$727.80	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
$9,200.00	$884.51	100.00%	$9,200.00	
	$0.00			
	$0.00			
	$0.00			
Total	$884.51	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: IM_OPAOINN_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")
Outpatient Services at an Ambulatory surgery Center	Deductible	$110.10	$9,200.00	N/A	N/A	$9,200.00	
All Other Outpatient Services	Coinsurance After Deductible	$1,935.09	$9,200.00	N/A	N/A	$9,200.00	
Urgent Care	$100 copay	$29.22	$9,200.00	$100.00	N/A	$9,200.00	
Xray, OP Lab, Testing	Coinsurance After Deductible	$331.30	$9,200.00	N/A	N/A	$9,200.00	
Prof Lab	Coinsurance After Deductible	$0.39	$9,200.00	N/A	N/A	$9,200.00	
PT/OT/ST	Coinsurance After Deductible	$27.49	$9,200.00	N/A	N/A	$9,200.00	
Total Row		$2,424.69					

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	$9,200.00	$9,200.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$9,200.00	$9,200.00	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	$2,424.69	100.00%	OP-AO INN Deductible
Copayment	$29.22	1.21%	Fail
Coinsurance	$0.00	0.00%	Fail
OOPM	$2,424.69	100.00%	OP-AO INN OOPM
Total Projected	$2,424.69		

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
$9,200.00	$2,424.69	100.00%	$9,200.00	
	$0.00			
Total	$2,424.69	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
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
$9,200.00	$2,424.69	100.00%	$9,200.00	
	$0.00			
	$0.00			
	$0.00			
Total	$2,424.69	100.00%		

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:	Providence Health Plan
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:

MHSUD Parity Calculations_Duplicate.xlsm MHSUD Parity Calculations.pdf

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

We, Michelle Anderson, FSA, MAAA and Lisa Winters, ASA, MAAA, certify the following:
☐ I am an employee of <<insert company name>> or
☒ I am a consultant associated with the firm of Wakely Consulting Group LLC, an HMA Company;

☒ 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 (MHSUD Parity Calculations_Duplicate.xlsm) 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:	Michelle Anderson, FSA, MAAA	Lisa Winters, ASA, MAAA
Signature:		
Title:	Director & Senior Consulting Actuary	Consulting Actuary
Contact Information:	michelle.anderson@wakely.com; 720-506-1022	
	lisa.winters@wakely.com; 720-226-9805	
Date of Attestation:	5/14/2025	

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	Providence Health Plan
Address	4400 NE Halsey St.
	Portland, OR 97213
Carrier Identification Number	95005

Rate Renewal Period:	From	1/1/2026	To	12/31/2026
Date Submitted:		5/14/2025		

Proposed Rate Summary

Current community rate:	$752.08	per month
Proposed community rate:	$831.73	per month
Percentage change:	10.59%	%
Portion of carrier's total enrollment affected:	0.13	%
Portion of carrier's total premium revenue affected:	1.42	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims	$698.50	83.98%
b) Expenses	$104.12	12.52%
c) Contribution to surplus contingency charges, or risk charges	$29.11	3.50%
d) Investment earnings	$0.00	0.00%
e) Total (a + b + c - d)	$831.73	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	2899	2685	2536
Earned Premium	$1,878,222.98	$1,570,193.68	$1,391,466.34
Paid Claims	$1,865,462.36	$2,206,744.53	$1,983,063.16
Beginning Claim Reserve	$23,114.10	$21,803.44	$77,847.59
Ending Claim Reserve	$21,377.17	$23,114.10	$21,803.44
Incurred Claims	$1,886,839.53	$2,229,858.63	$2,004,866.59
Expenses	$669,670.58	$773,265.37	$692,010.41
Gain/Loss	-$678,287.13	-$1,432,930.32	-$1,305,410.66
Loss Ratio Percentage	100.46%	142.01%	144.08%

General Information

1. Trend Factor Summary

Types of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	10.95%	39.65%
Professional	10.95%	39.65%
Prescription Drugs	14.03%	39.65%
Dental	N/A	39.65%
Other	10.95%	39.65%

2. List the effective date and the rate increase for all rate changes in the past three periods.

		Date	%
1)		1/1/2025	9.35%
2)		1/1/2024	4.69%
3)		1/1/2023	9.64%

3. Since the previous filing, have any changes been made to the factors or methodology for adjusting base rates?

Geographic Area			Yes	x	No
Family Size			Yes	x	No
Age			Yes	x	No
Wellness Activities			Yes	x	No
Other (specify)	Plan Factors	x	Yes		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

6. Preparer's Information

Name:	Michelle Anderson
Title:	Director and Senior Consulting Actuary, Wakely Consulting Group
Telephone Number:	720-506-1022

PROVIDENCE
Health Plan

Individual and Family Commission Schedule – Attachment C Washington

Effective January 1, 2026

Producer Compensation Plan for Individual and Family Business

Providence Health Plan's producer compensation program focuses on long-term relationships with successful producers who are committed to a health plan focus.

PHP Individual and Family Plan new appointment

Before PHP will issue quotes for individual and family plan business, you must be an appointed producer. To receive an appointment, complete and return our appointment application. Please provide all information requested, including references. The application will be reviewed with consideration for professional association affiliation, individual and family plan health insurance focus, and congruence with Providence values.

- The appointment application includes:
  - A completed Agency and Commission Agreement, signed by Agency Principal
  - A copy of your current Errors and Omissions Insurance Policy, stating the policyholder name, policy limits ($1 million minimum aggregate coverage) and policy effective dates
  - A copy of your current Washington producer/agency license(s)
  - A completed W-9 form for accounting purposes

Maintaining an existing appointment

PROVIDENCE
Health Plan

Insurance producers who are currently appointed with Providence Health Plan are required to meet the following ongoing appointment standards:

- Maintain a current Washington producer/agency license
- Maintain and provide proof of $1 million in errors and omissions coverage
- Comply with all provisions of the Providence Health Plan Agency and Commission Agreement

Schedule of Commissions

Individual and Family

Medical	
All plans sold off Exchange	$20.00 PMPM

- Commissions are paid monthly based on actual membership for each billing month
- Commissions for the contract year will be paid at the PMPM rate in effect at the beginning of the contract year

The Company may modify the above commission schedule with written notice. The Agent shall be deemed to have accepted the modified commission schedule unless the Agent provides written notice of termination as required under the Agency and Commission Agreement.

Visit **ProvidenceHealthPlan.com** or call **503-574-6300** (Portland Metro Area) or **877-245-4077** (all other areas) for more information.

PROVIDENCE
Health Plan

I am certifying this attachment includes all proposed commission schedules for Washington Individual and Family block of business for the 2025 plan year.

Signature: 

Name: Shannon Drotning

Title: Market President, Individual

Date: 5/2/2025

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:	Providence Health Plan
HIOS Issuer ID:	45834
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
45834WA0490001	Providence Columbia 1500 Gold	Providence Columbia 1500 Gold	Renewal	106
45834WA0490002	Providence Columbia 5000 Silver	Providence Columbia 5000 Silver	Renewal	58
45834WA0490003	Providence Columbia 8900 Bronze	Providence Columbia 9200 Bronze	Renewal	90
Total				**254**

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:

Yes	Products offered by same health insurer, Providence.
Yes	Products offered as same network type, EPO.
Yes	Products cover same service area.
For plan 45834WA0490003, the deductible was increased from $8,900 to $9,200 and maximum out of pocket cost was increased from $8,900 to $9,200.	Plans have same cost sharing structure.
The following new Essential Health Benefits (EHBs) have been added to all plans: Hearing Aids – includes an annual hearing exam and one hearing aid per ear with hearing loss every three years Donor Human Milk – includes medically necessary donor human milk in an inpatient setting for an infant who is medically or physically unable to receive maternal human milk Artificial Insemination – includes artificial insemination in vivo, covering placement of sperm into the cervix or uterus to achieve a pregnancy	Products provides same covered benefits.

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)**
45834WA0490001	Providence Columbia 1500 Gold	N/A-Same as 2025	PROV-134500631	None	None		
45834WA0490002	Providence Columbia 5000 Silver	N/A-Same as 2025	PROV-134500631	None	None		
45834WA0490003	Providence Columbia 8900 Bronze	Providence Columbia 9200 Bronze	PROV-134500631	None	Deductible	8900	9200
45834WA0490003					MOOP	8900	9200

Question 4b:

For each terminated plan (i.e., a plan offered in 2025 but not in 2026), please provide the following:

1. State the HIOS Plan ID of the terminated plan in 2025. State the applicable HIOS Plan ID on every row in the table as illustrated below.
2. State the 2025 Plan Name of the terminated plan. State the plan name only once per plan as shown below.
3. State the 2026 HIOS Plan ID of the plan that the terminated plan is mapped to in 2026. State the applicable HIOS Plan ID on every row in the table as illustrated below.
4. State the 2026 Plan Name of the plan that the terminated plan is mapped to in 2026. State the plan name only once per plan as shown below.
5. State the SERFF Tracking Number of the corresponding 2026 form filing (state only once per plan as illustrated below).
6. Provide a detailed description of each benefit change from the terminated plan to the mapped 2026 plan, including changes required by Federal and State law (while the cursor is active in a cell in Excel, press [Alt+Enter] to start a new line of text). If no benefit changes, enter "None."
7. Cost-Share Changes: Provide a detailed description of each cost-share change from terminated plan to the mapped 2026 plan.
   - 7.1 For each cost-share change, enter one description of the change per row in the Cost-Share Description column as illustrated below. If no cost-share changes, enter "None" and go to your next plan.
   - 7.2 Enter the corresponding design for the 2025 plan year. Please include all applicable dollar signs ($), commas (,) and percent signs (%) for each value.
   - 7.3 Enter the corresponding design for the 2026 plan year. Please include all applicable dollar signs ($), commas (,) and percent signs (%) for each value.

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then, complete the table as described above.

Response:

						Cost-Share Changes		
2025 Terminated HIOS Plan ID	**2025 Terminated Plan Plan Name**	**2026 Mapped Plan HIOS Plan ID**	**2026 Mapped Plan Plan Name**	**2026 Mapped Plan Form Filing SERFF Tracking Number**	**Benefit Changes (2025 Terminated to 2026 Mapped Plan)**	**Cost-Share Description**	**From (2025)**	**To (2026)**

Question 5:

Using the following table, provide the calculations of the proposed average rate change for this line of business and break out the average rate change by benefit, cost-share, and experience. For the 2025 plans that will discontinue in 2026, please apply appropriate mapping of membership for purposes of calculating the average rate increase.

1. In column 5(a), list all 2025 Plan IDs (one 2025 Plan ID per row; insert rows in the table as needed).
2. In column 5(b), list the corresponding 2025 Plan Names.
3. In column 5(c), state whether the 2025 plan is a "Renewal" plan (a plan offered in 2025 and 2026) or "Terminated" plan (a plan offered in 2025 but not 2026).
4. In column 5(d), provide the enrollment by plan as of March 31, 2025 in all renewing counties. Note: the total enrollment should match the enrollment provided in Question #1, unless the carrier is exiting counties in 2026 which are currently being covered.
5. In column 5(e), if the plan is a "Terminated" plan, provide the corresponding 2026 Plan ID that the 2025 Plan is mapped to. If the plan is a "Renewal" plan, state "N/A."
6. In column 5(f), if the plan is a "Terminated" plan, provide the corresponding 2026 Plan Name that the 2025 Plan is mapped to. If the plan is a "Renewal" plan, state "N/A."
7. In column 5(g), state the experience rate change for the plan. For "Terminated" plans, state the experience rate change by plan mapped from the 2025 Plan to the 2026 Plan.
8. In column 5(h), state the benefit rate change for the plan. For "Terminated" plans, base the rate change on mapping from the 2025 plan to the 2026 plan.
9. In column 5(i), state the cost-share rate change for the plan. For "Terminated" plans, base the rate change on mapping from the 2025 plan to the 2026 plan.
10. In column 5(j), the Overall Average Rate Change by plan is calculated automatically [calculated as (1+Experience Rate Change)*(1+Benefit Rate Change)*(1+Cost-Share Rate Change)-1]. Note that the percentage of overall average rate change by plan for renewal plans should be the same as the rate change indicated in the URRT.
11. In cell 5(k), the total enrollment as of March 31, 2025 is calculated automatically [calculated as the sum of column 5(d)].
12. In cell 5(l), the overall average rate change (weighted by March 2025 enrollment) for this line of business is calculated automatically [calculated as the sum-product of columns 5(d) and 5(j), divided by 5(k)].

Note: Illustrative information has been provided in the table below. Please remove the illustrative information; then, complete the table as described above.

Response:

Total Enrollment 5(k):	254
Overall Average Rate Change (weighted by 03/31/2025 enrollment) 5(l):	10.59%

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
45834WA0490001	Providence Columbia 1500 Gold	Renewal	106	N/A	N/A	12.94%	0.14%	0.00%	13.11%
45834WA0490002	Providence Columbia 5000 Silver	Renewal	58	N/A	N/A	10.74%	0.14%	0.00%	10.89%
45834WA0490003	Providence Columbia 9200 Bronze	Renewal	90	N/A	N/A	6.75%	0.13%	0.50%	7.43%

Unique Plan Design—Supporting Documentation and Justification

Issuers must fill in the following information.

Health Insurance Oversight System (HIOS) Issuer ID:

45834

HIOS Product IDs:

45834WA049

Applicable HIOS Plan IDs (Standard Component):

45834WA0490001, 45834WA0490002, 45834WA0490003

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:

The AV Calculator did not provide for as much specificity as the plan's benefits; thus, it was necessary to make adjustments to account for the plan benefits accurately. The following adjustments were made:

-Pharmacy: We developed an effective coinsurance rate for the two-tier specialty drugs and generic drugs. Generic drugs were also blended for the percentage of preventive drugs.

-Emergency Room: An effective coinsurance rate was developed for services that had a copay followed by coinsurance.

-Effective copays and coinsurance values for situations where there were varying cost sharing amounts and/or structures within the service categories and/or they varied based on when the deductible applied.

-Virtual Visits: An effective copay was developed for virtual visits. ExpressCare virtual visits are provided at zero cost share.

Acceptable alternate method used per *Code of Federal Regulations* (CFR) 156.135(b)(2) or 156.135(b)(3):

156.135(b)(2)

Confirmation that only in-network cost sharing, including multitier networks, was considered:

I confirm that only in-network cost sharing, including multi-tier networks, was considered in determining actuarial value.

Description of the standardized plan population data used:

Company experience was used for drug tier utilization, free virtual visit utilization blending, and facility fee coinsurance blending. Other adjustments utilized data underlying continuance tables in the Federal AVC. These continuance tables were not adjusted.

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:

Please refer to the description in the "reasons" box above. The blended copays and effective coinsurance rates were input into the Federal AVC to fit the structure of the model.

If the method described in CFR 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

N/A

Certification Language:

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.

Michelle Anderson
Senior Consulting Actuary
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Lisa Winters
Consulting Actuary
Associate, Society of Actuaries
Member, American Academy of Actuaries

Date: 5/14/2025

Rate Review Detail

i. Number of current covered lives affected, as of March 2025 – 254
ii. Requested Rate Change Information
    a. Change period – Annual
    b. Member months in 2024 experience period – 2,899
    c. Min Rate Change per UPMJ – 7.43%, Plan 45834WA0490003
    d. Max Rate Change per UPMJ – 13.11%, Plan 45834WA0490001
    e. Weighted Average Rate Change per UPMJ – 10.59%
    f. Written Premium Change for this Program – $242,562
        i. Calculated as the Product of the following:
            1. 2025 Current Premium PMPM per URRT WS2 – $751.51
            2. 2025 Current Enrollment per URRT WS2 – 254
            3. Average Rate Change per UPMJ – 10.59%
            4. Annualization Factor – 12
iii. Prior Rate
    a. Projected earned premiums for 2025 – $2,193,562; incurred claims for 2025 – $2,758,459
    b. Premium Min – $281.98
    c. Premium Max – $1,687.59
    d. Average – $745.86 PMPM
iv. Requested Rate
    a. Projected earned premiums for 2026 – $2,595,817 per URRT Worksheet 2, Section 4.8; incurred claims for 2026 – $3,070,052 per URRT Worksheet 2, Section 4.6
    b. Premium Min – (Base Rate) * (Plan Factor 45834WA0490003) * (Age Factor 14) * (Area Factor 4) = ($655.41) * (0.6826) * (0.765) * (0.8852) = $302.93
    c. Premium Max – (Base Rate) * (Plan Factor 45834WA0490001) * (Age Factor 64+) * (Area Factor 3) * (Tobacco Factor) = ($655.41) * (0.8825) * (3.000) * (1.000) * (1.1) = $1,908.78
    d. Average – $831.73 PMPM per URRT Worksheet 2, Section 4.17

Types of Service	**Annual Trend Assumed**
Hospital	10.9%
Professional	10.9%
Prescription Drugs	14.0%
Dental	N/A
Total	11.6%

GOLD

HIOS Plan ID: 45834WA049001-00

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 ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$8,200.00			
MOOP if Separate ($)						

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	☑	☑	73.71%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$29.58	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☑	76.14%	$30.29	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100.00%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☑		$21.75	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☑		$22.43	☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	81.80%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☐ All			☐ All	☐ All
Generics	☐	☐		$5.72	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$50.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	50.00%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	83.36%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Plan Description:

Name: Providence Columbia 1500 Gold
Plan HIOS ID: 45835WA490001
Issuer HIOS ID: 45834
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.38%
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

Revised Final 2026 AV Calculator

SILVER

HIOS Plan ID: 45834WA049002-00

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:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			65.00%			
MOOP ($)			$8,900.00			
MOOP if Separate ($)						

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	☑	☑	60.45%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$44.38	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☑	65.12%	$45.71	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100.00%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☑		$27.33	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☑		$57.95	☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	66.80%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☐ All			☐ All	☐ All
Generics	☐	☐		$14.29	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$70.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	50.00%		☑	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	83.36%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Plan Description:

Name: Providence Columbia 5000 Silver
Plan HIOS ID: 45835WA490002
Issuer HIOS ID: 45834
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.70%
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:	0.0859 seconds

Revised Final 2026 AV Calculator

BRONZE

HIOS Plan ID: 45834WA049003-00

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$9,200.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$9,200.00			
MOOP if Separate ($)						

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)	☐	☐		$69.03	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☑		$70.83	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100.00%	$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	☐	☐		$20.00	☑	☑			☐	☐
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):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Providence Columbia 9200 Bronze
Plan HIOS ID: 45835WA490003
Issuer HIOS ID: 45834
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	64.95%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.168 seconds

Revised Final 2026 AV Calculator

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: Providence Health Plan

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

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."		
45834WA0490001	Providence Columbia 1500 Gold	Yes	See Section 12. AV Metal Levels of Part III Rate Filing Documentation and Actuarial Memorandum	No	Allergy Testing, Fertility Preservation
45834WA0490002	Providence Columbia 5000 Silver	Yes	See Section 12. AV Metal Levels of Part III Rate Filing Documentation and Actuarial Memorandum	No	Allergy Testing, Fertility Preservation
45834WA0490003	Providence Columbia 9200 Bronze	Yes	See Section 12. AV Metal Levels of Part III Rate Filing Documentation and Actuarial Memorandum	No	Allergy Testing, Fertility Preservation

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
45834WA0490003	Providence Columbia 9200 Bronze	No	Yes	Office visits to Primary Care Provider, Office visits to Specialist, Generic Drugs

[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
Choice	EPO	Single	1/1/2026

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.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Section II – Experience Data and Projections

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

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

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
EXPERIENCE PERIOD DATA			
1	**Complete Experience:** Include the complete experience for all 2024 individual non-grandfathered plans which includes subsidized populations defined under the Cost Sharing Reduction (CSR) programs. • Per CCIIO, include experience data for the American Indian/Alaska Native (AIAN) population (see https://www.healthcare.gov/american-indians-alaska-natives/coverage/). • Include experience for membership covered by plans with benefits and subsidy levels (73%, 87%, and 94% AV levels, as well as any zero cost-share subsidies for the AIAN population) sold in the market. Note: per CCIIO, the AIAN population is not restricted to silver level plans, however, eligible individuals must select a metal level plan (i.e., they are not eligible for AIAN-related subsidies with a catastrophic plan). • Net of Rx rebates: Any prescription drug claims should be net of rebates received from drug manufacturers; please document in the Part III Actuarial Memorandum where and how this is addressed. • Note: if financial data paid through March 2025 is not directly used as the foundation for this rate filing, discuss why the March 2025 data was not available. Discuss what data was used instead and how it was or was not adjusted to mimic data paid through March 2025.		
a	Financial data consistency: Demonstrate that the financial data, including the member months, in (i) URRT Worksheet 1, Section I General Product and Plan Information, (ii) URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, (iii) the WAC 284-43-6660 summary, and (iv) the actuarial memorandum exhibits are consistent as of March 2025. If not consistent, explain why the discrepancy is appropriate.	**WA State Exhibits**	**Exhibit 37**

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
	b	Support for URRT Worksheet 1, Section I experience period data for 2024: Provide separately for medical and prescription drugs (Rx), as appropriate: • By incurred month and paid month, for claims paid through March 2025: allowed claims and incurred claims (Note that any embedded pediatric dental claims experience should also be included and will be considered part of EHB experience; see URR Instructions' section 1.4 for additional information.) • Any annual estimated payable and/or receivable amounts (e.g., reserves, reinsurance, overpayments, rebates, and other) as of March 2025, including justification of such amounts • Any annual risk adjustment transfer amounts, including justification of such amounts • Monthly premium amounts • Monthly membership	**WA State Exhibits** **Risk adjustment is from WNRAR reports, using data paid and incurred through December 31, 2024, not completed.**	**Exhibit 30a-30d and 31** **Exhibit 43**
	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. (iv) Additionally, provide related monthly information in WA Exhibit 1.	**WA State Exhibits** **(iv) EHB allowed claims were obtained from claims records.** **WA Standard State Exhibits**	**Exhibit 33** **Exhibit 1**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	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 State Exhibits** **WA Standard State Exhibits**	**Exhibits 38, 40, 41** **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**	**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.	**Part III Rate Filing Documentation and Actuarial Memorandum**	**Section 5.1, Page 6**
	b	Manual EHB allowed claims PMPM: • Show the detailed calculation of the Manual EHB Allowed Claims PMPM entered in URRT Worksheet 1, Section II.	**Part III Rate Filing Documentation and Actuarial Memorandum**	**Section 5, Pages 6-10**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		• 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.	**WA State Exhibits**	**Exhibit 7**
	c	Credibility of experience data: Describe the credibility methodology and assumptions used, per Actuarial Standard of Practice (ASOP) No. 25. • Identify the actuarially sound and appropriate credibility procedure used to develop your credibility estimate. • At what level is experience determined to be more than 0% credible? • How is partial credibility determined? • At what level is experience determined to be 100% credible?	**Part III Rate Filing Documentation and Actuarial Memorandum**	**Section 4.3, Pages 5-6**
	d	Show how you estimated credibility of the 2024 allowed claims and member months used in rate development. Use your credibility procedure.	**Part III Rate Filing Documentation and Actuarial Memorandum**	**Section 4.3, Pages 5-6**
3		**Experience in WAC 284-43-6660 Summary, and Summary of Pooled Experience with Adjustments:**		
	a	WAC 284-43-6660 summary, experience: Complete the WAC 284-43-6660 summary for Individual and Small Group Contract filings. • Provide data to support WAC 284-43-6660 without adjustments for Risk Adjustment and High-Cost Risk Pool (HCRP) receipts and assessments. • Data should be based on the incurred years 2024, 2023, and 2022.	**WAC-284-43-6660**	

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	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. • Note: Since the federal Reinsurance and Risk Corridor programs ended in 2016, they should not be included in the summary.	**WA State Exhibits**	**Exhibit 16**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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.	**WA State Exhibits**	**Exhibit 16**
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.	**WA State Exhibits**	**Exhibits 33, 35, 43** **Claims were not allocated but based on actual experience. There are no differences between WS1 and WSII.**
TREND FACTORS			
5	**Allowed Claims Trends:** Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more categories of non-EHBs, as applicable. Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data. As indicated in URR Instructions, describe the trend development in the Part III actuarial memorandum.		
a	Allowed claims EHB trend analysis: • In WA Exhibit 3, provide annual EHB trends by benefit category. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • In WA Exhibit 4, provide your retrospective analysis of normalized EHB allowed claim trends. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • In WA Exhibit 5, provide aggregate actual experience (A) EHB trends, projected (i.e., expected; E) EHB trends, and actual-to-expected (a.k.a. A:E) EHB trend analysis. See instructions in the exhibit	**WA Standard State Exhibits**	**Exhibit 3** **Exhibit 4** **Exhibit 5**

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

	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 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
			WA State Exhibits
			
			Part III Rate Filing Documentation and Actuarial Memorandum
			
			WA Standard State Exhibits
				Exhibit 24
				
				Section 5.3.3, Page 7
				
				Exhibit 3

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		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).	**WA State Exhibits** **Part III Rate Filing Documentation and Actuarial Memorandum**	**Exhibit 24** **Section 5.3.3, Page 7**
6		**Incurred Claims Trends:** • Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more separate non-EHB categories, as applicable. They should also be available for each type of service in the WAC 284-43-6660 trend factor summary. • Incurred claims trends differ from allowed claims trends in that they reflect leveraging of fixed cost-shares. • Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data. • Describe the trend development in the Part III actuarial memorandum.		
	a	Incurred claims projected trend (EHB & non-EHB): (see also #32.c of this checklist) • Include an exhibit that develops the incurred claims trend percentages entered in the WAC 284-43-6660 summary. Justify the projected incurred claims trend percentages. • Show how to calculate the Portion of Claim Dollars for trends in the WAC 284-43-6660 summary. Note: the percentages should be based on the 2024 incurred claims dollars by trend category. The total incurred claims used in the calculation should be consistent with the incurred claims PMPM in URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.17. • Demonstrate that the overall incurred claims annual trend (EHB and non-EHB) matches (1) the annualized trend from URRT Worksheet 1, Section I General Product and Plan Information to URRT	**N/A – manual trends**	

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	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.	**Because the 2024 experience is 0.00% credible, the trend, morbidity, demographic, plan design, and other factors in URRT Worksheet 1, Section II are listed as 1.000.** **WA Standard State Exhibits**	 **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 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	**AV Screenshots**	

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	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: o Use one of the two methods, 45 CFR §156.135(b)(2) **<u>or</u>** 45 CFR §156.135(b)(3), to certify the Metal Value and provide the exact AV Metal Value for the plan. o You must also provide detailed support for your unique plan design AVs. • Please provide supporting unique AV calculations in your rate filing memorandum and exhibits.		

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

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		○ *Plans that include "Services not Subject to Deductible and with a copay":* Copays paid during the deductible range do not accumulate toward the deductible, regardless of whether the benefit is subject to deductible. ○ *Plans that partition benefit categories into subcategories with different cost-share designs:* If the plan has different cost-sharing for subcategories of benefits included in the AVC but the AVC only accepts one cost-sharing structure, you must (1) enter the cost-share variations in the 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.	**WA State Exhibits** **A PDF of the screen shots has been included in the filing.**	**Exhibit 18**
	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.	**N/A**	**N/A**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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.	**Unique Plan Design Justification**	
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.	**Unique Plan Design Justification**	
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 Standard State Exhibits**	**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.	

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

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

	a	**AV Pricing Value (a.k.a. EHB paid-to-allowed factors) by plan:**
		• Provide the factor for each plan that shows the impact of benefit differences for EHB-only cost sharing.
		• See WAC 284-43-6800(3) for the definition of AV pricing value and WAC 284-43-6800(1) for the definition of AV metal value.
		• Per WAC 284-43-6810(3):
		  o Rate development exhibits should demonstrate compliance with the following:
		  ▪ "The AV pricing value must be within ±2% of a plan's designated AV metal value."
		  ▪ "The allowable range of AV pricing value may be increased or decreased by 1% and must not result in a total adjustment exceeding ±3%, if the plan has significant features that are not considered in the AV metal value calculation. Applicable plan features may include, but are not limited to, an embedded pediatric dental benefit, aggregate family deductible, or significant out-of-network utilization."
		  ▪ If you are requesting the expanded AV Pricing Value range of ±3%, identify this in WA Exhibit 9 and provide supporting documentation for the request. Documentation for this request must show significant plan features impact EHBs, those plan features are excluded from consideration in the federal AV calculator and AV metal value, and those plan features have a material pricing impact supported by actuarial analysis.
			WA State Exhibits	**Exhibit 25**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		▪ Note that AV pricing value must be actuarially sound, and the ranges referenced above should not be used as an adjustment (i.e., ceiling or floor) to AV pricing values. ▪ AV pricing values should be normalized for impacts of all other allowable plan-level rating adjustments (including subcomponents of the "AV and Cost Sharing Design of Plan") and for use in the calculations of the "AV and Cost Sharing Design of Plan" factors. o The Part III actuarial memorandum in the rate filing must include the following information related to AV metal value and AV pricing value: ▪ Each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values. ▪ The methodology that was used to develop the AV pricing value including that it is based on a standardized population. The carrier must identify all material changes in the AV pricing value development and their impacts. ▪ Note that if you have a commercial or other (e.g., internal) reinsurance/pooling agreement, consider projected recoverable amounts in the overall AV Pricing Value.		
	b	**Induced demand factors (IDFs) by plan:** • Each plan's IDF can vary by plan design but must be consistent with the federal risk adjustment transfer formula per WAC 284-43-6810(2). Therefore, plan IDFs should be determined by the formula (AV pricing value)^2 – (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 State Exhibits** **Part III Rate Filing Documentation and Actuarial Memorandum (for how IDFs were developed)**	**Exhibit 25** **Section 11, Page 13**

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.	**N/A - Providence is only offering off-exchange plans for the 2026 benefit year. Therefore, no CSR load is included.**	**N/A**
d	**Exchange plan adjustment for cost of covering certain abortion services:** (see also #13 & #27 of this checklist) For Exchange plans only, include an adjustment factor to remove the impact of coverage of abortion services for which public funding is prohibited. Per 45 CFR §156.280(e)(4)(iii), you may not estimate such a cost at less than one dollar per enrollee, per month (i.e., $1.00 premium PMPM, see https://www.cms.gov/files/document/qhp-abortion-faq.pdf Q3). • Note that you must include abortion services in URRT Worksheet 1, Section II because Washington considers abortion services to be EHBs. • The impact of coverage of abortion services for which public funding is prohibited should be addressed in URRT Worksheet 2, Section II Experience Period and Current Plan Level Information. In other words, related costs should flow through with other claim experience. • For Exchange plans: o Include the impact as part of URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5 Benefits in Addition to EHB. o Remove the impact from URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3 AV and Cost Sharing Design of Plan. The abortion adjustment applied to Field 3.3 is the reciprocal of the abortion adjustment applied to Field 3.5. (URR Instructions Section 2.2.3). This load should be explicitly listed as a separate column in your development exhibit for the AV and Cost Sharing Design of Plan factors. o Explain in the Part III actuarial memorandum that per URR instructions, coverage of abortion services for which public funding is prohibited are included in the URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5 as a non-EHB.	**N/A - Providence is only offering off-exchange plans for the 2026 benefit year.**	**N/A**

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).	**WA State Exhibits**	**Exhibit 25**
	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 State Exhibits** **Part III Rate Filing Documentation and Actuarial Memorandum (for explanation of the variance)** **WA Standard State Exhibits**	**Exhibit 25 and Exhibit 4** **Section 13, Page 16** **Exhibit 6 and 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)	**WA State Exhibits**	**Exhibit 10**
	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.	**WA State Exhibits**	**Exhibit 26**

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
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: 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).	**N/A**	**N/A**
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.	**WA State Exhibits** **WA Standard State Exhibits**	**Exhibit 9** **Exhibit 7**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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** **WA Standard State Exhibits**	**N/A** **Exhibit 7**
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.	**WA State Exhibits**	**Exhibit 19**
b	Age calibration factors, projected versus prior: Compare the 2026 age calibration factor to the 2023, 2024, and 2025 factors.	**WA State Exhibits**	**Exhibit 19**
c	Average age: Show the average age and provide actuarial justification for the methodology employed to calculate the average age.	**Part III Rate Filing Documentation and Actuarial Memorandum**	**Calibration, Page 14**
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.	**Part III Rate Filing Documentation**	**Geographic Factors, Pages 14-15**

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

		Document and justify the 2026 factors with details including, but not limited to, the following:
		• Certify that the following items were not used to establish any geographic rating area factor:
		  o Health status of enrollees or the population in an area.
		  o Medical condition of enrollees or the population in an area including physical, mental, and behavioral health illnesses.
		  o Claims experience.
		  o Health services utilization in the area.
		  o Medical history of enrollees or the population in an area.
		  o Genetic information of enrollees or the population in an area.
		  o Disability status of enrollees or the population in an area.
		  o 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.
			and Actuarial Memorandum
			
			WA State Exhibits
				
				Exhibit 2

	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.	**WA State Exhibits**	**Exhibit 2**
	c	Area factors, projected versus prior: Compare the 2026 area factors and calibration factor to the 2023, 2024, and 2025 factors. If the 2026 factors did not change from those in the prior filing, indicate why the factors did not change; indicate when the factors were last evaluated and what data was used in that evaluation. Note: Our opinion is that the geographic area factors should be regularly evaluated.	**WA State Exhibits**	**Exhibit 23**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	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.	**WA State Exhibits**	**Exhibit 2**
	e	Load area factors into URRT: Provide the geographic rating areas and rating factors in URRT Worksheet 3.	**WA State Exhibits**	**Exhibit 2**
17		**Tobacco Use Factor and Tobacco Calibration Factor:**		
	a	Tobacco use factor development: Document and justify the 2026 Tobacco Use factor. • The maximum factor is 1.500 (see 45 CFR §147.102(a)(1)(iv)). • If the factor did not change from the prior filing, indicate when the factor was last evaluated and what data was used in that evaluation. Note: Our opinion is that the factor should be re-evaluated periodically.	**WA State Exhibits**	**Exhibit 17**
	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.	**WA State Exhibits**	**Exhibit 17**
	c	Tobacco factors, projected versus prior: Compare the 2026 tobacco use factor and calibration factor to amounts for 2023, 2024, and 2025.	**WA State Exhibits**	**Exhibit 17**
RISK ADJUSTMENT AND HIGH-COST RISK POOL (HCRP)				
18		**Experience Period Risk Adjustment & HCRP:**		
	a	Experience period risk adjustment formula details:	**WA State Exhibits**	**Exhibit 43**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		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. 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.	**WA Standard State Exhibits**	**Exhibit 10**
	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 State Exhibits**	**Exhibit 43**
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 State Exhibits** **WA Standard State Exhibits**	**Exhibit 14, Exhibit 8** **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**	**Section 5.4, Pages 9-10**

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.	**WA State Exhibits**	**Exhibit 8**
	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.	**N/A – No adjustment for RADV was made.**	**N/A**
	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.	**WA State Exhibits** **Part III Rate Filing Documentation and Actuarial Memorandum**	**Exhibit 29** **Section 5.4, Pages 9-10**
	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 State Exhibits**	**Exhibit 14**

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).	**WA State Exhibits – Exhibits 5a, 5b, and 15**	

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).	**WA State Exhibits – Exhibits 5a and 5b**	

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.	**WA State Exhibits – Exhibit 41**	
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.	**Rate Review Detail**	
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)	**Rate Review Detail**	

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.	**WA State Exhibits** **Current enrollment is consistent.**	**Exhibit 36**
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.	**WA State Exhibits** **Projected enrollment is consistent.**	**Exhibit 36**
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).*		
	(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.	**WA State Exhibits**	**Exhibit 20**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(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.	**WA State Exhibits**	**Exhibit 20**
	(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.	**WA State Exhibits**	**Exhibit 20**
	(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.	**WA State Exhibits**	**Exhibit 20**
	(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.	**WA State Exhibits**	**Exhibit 20**
	(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.	**WA State Exhibits**	**Exhibit 20**
	(vii) The impact of *changes in* reserve needs. Include a discussion of any change in reserve needs.	**WA State Exhibits**	**Exhibit 20**
	(viii) The impact of *changes in* administrative costs related to programs that improve health care quality. Include a discussion of any such changes.	**N/A**	**N/A**
	(ix) The impact of *changes in* other administrative costs. Include a discussion of any such changes.	**WA State Exhibits**	**Exhibit 20**
	(x) The impact of *changes in* applicable taxes, licensing, or regulatory fees. Include a discussion of any such changes.	**WA State Exhibits**	**Exhibit 20**
	(xi) Medical loss ratio (MLR). Include a projected federal MLR calculation [45 CFR §158.221; see also CMS MLR Filing Instructions].	**WA State Exhibits**	**Exhibit 6**

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

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	– Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR filing instructions] • If CBE are included, provide justification that includes the following details: o How total CBE are allocated to lines of business (e.g., individual, small group, and large group) o For federal tax-exempt issuers: ▪ CBE are limited to the highest of either: • Three percent of earned premium; or • The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market. ▪ Please address the impact, if any, of capping CBE for MLR purposes. ▪ MLR reporting instructions say federal tax-exempt issuers may report a value for both state premium taxes and CBE if reported CBE do not exceed the allowable capped amount (as outlined above). If you are a federal tax-exempt issuer, please confirm this requirement has been met. o For non-federal tax-exempt issuers: ▪ CBE are limited to: The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market. ▪ Please address the impact, if any, of capping CBE for MLR purposes. ▪ MLR reporting instructions say non-federal tax-exempt issuers may report a value for state premium taxes or CBE but not both. Issuers may not report zero ($0) CBE in lieu of negative State premium taxes and may not enter CBE more than the allowable capped amount. If you are a non-federal tax-exempt issuer, please confirm this requirement has been met. • Credibility adjustment, if any [45 CFR §158.232]		

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	• 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] o 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). o MLR rebate prepayment and safe harbor [45 CFR §158.240(g)]:		

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	Allowance to prepay a portion or 100% of an estimated MLR rebate for a given MLR reporting year, and establishing a safe harbor allowing such issuers, under certain conditions, to defer the payment of rebates remaining after prepayment until the following MLR reporting year (e.g., see 2022 NBPP). ○ Replacement formula for qualifying issuers (e.g., see 45 CFR §158.103 for definition of qualifying issuer), written with variables: If (ra / p) > or = 50%, then: Adjusted MLR = [(i + q – s + nc – rc) / {(p + s – nc + rc) – t – f – (s – nc + rc) – na + ra}] + c where i = incurred claims q = expenditures on quality improving activities p = earned premiums t = Federal and State taxes f = licensing and regulatory fees including $0 for transitional reinsurance contributions s = issuer's transitional reinsurance receipts (=$0) na = issuer's risk adjustment related payments nc = issuer's risk corridors related payments (=$0) ra = issuer's risk adjustment related receipts rc = issuer's risk corridors related receipts (= $0) c = credibility adjustment, if any		
	(xii) The health insurance issuer's capital and surplus (i.e., if and how rate development considered your issuer's current capital and surplus levels). For example, are changes required to your issuer's premium to surplus ratio? Include a discussion in the Part III actuarial memorandum. Note: This is one of only two 45 CFR §154.301(a)(4) items not written in terms of the impact of changes; the other is (xi) for MLR.	**Part III Rate Filing Documentation and Actuarial Memorandum**	**Section 9, Pages 11-12**
	(xiii) The impacts of geographic factors and variations.	**WA State Exhibits**	**Exhibit 23**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(xiv) The impact of *changes within* a single risk pool to all products or plans within the risk pool.	**WA State Exhibits**	**Exhibit 7**
	(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.	**WA State Exhibits** **Part III Rate Filing Documentation and Actuarial Memorandum**	**Exhibit 7** **Section 8, Page 11**
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.	**PHP will not be implementing this option.**	
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.	**WA INDV 2024 ADS Tie Out.pdf**	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	• 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.		
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.	**WA State Exhibits**	**Exhibit 42**
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.	**PHP is not offering these services.**	

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
SEPARATE DOCUMENTS Address the following items together with other relevant items covered elsewhere in this checklist.				
28		**Part I Unified Rate Review Template (URRT):** Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the Exchange User Fee input for URRT Worksheet 1 Section II, please use and reference the applicable amount(s) calculated in the URRT. Please do not disable the macros in the Excel version of the URRT; please submit a macro-enabled URRT workbook. The URRT worksheets allow up to 16 characters including decimal places. Only apply rounding to amounts directly loaded into the URRT and only to the extent necessary to meet the 16-character limitation. Do not round any intermediate amounts.		
	a	URRT Exchange User Fees: (URRT Worksheet 1, Section II Projections) If the issuer is only outside the exchange, please respond "N/A." The Exchange user fee for 2026 is $5.11 PMPM. • For issuers marketing both inside and outside the Exchange, confirm that the Exchange user fees, or Exchange assessment fees, are spread across the entire pool. • 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.	**N/A**	**N/A**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
b	URRT factor to toggle between worksheet 1 and worksheet 2 amounts for risk adjustment transfers and Exchange user fees: Justify the factor used to develop Risk Adjustment Payment/Charge and Exchange User Fees for URRT Worksheet 1, Section II. The adjustment should be the aggregate impact of the four plan factors from URRT Worksheet 2, Section III Plan Adjustment Factors (i.e., Fields 3.3, 3.4, 3.5, and 3.9). Later URRT steps apply the plan factors through multiplication; to neutralize the overall impact, URRT Worksheet 1 needs to divide by their aggregate impact.	**WA State Exhibits**	**Exhibit 25**
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.	**WA State Exhibits**	**Exhibit 21**
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.	**N/A - There are no terminated plans for the 2026 plan year**	
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**	**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.	**WA State Exhibits** **WA Standard State Exhibits**	**Exhibit 35** **Exhibit 12**
	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** **WA State Exhibits**	**Section 14, Page 16** **Exhibit 13**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	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.	**WA State Exhibits**	**Exhibit 27**
	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**	**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, 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.	**Part II Written Description Justifying the Rate Increase**	**Page 1**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	• 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**	**Section 20, Pages 17-18**
b	Controlled group renewal clarification for Part III: Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #28.i and #31.c of this checklist). If not applicable, indicate "N/A." In both the current and new issuers' Part III actuarial memorandums, add a crosswalk detailing the current and renewing plan information. Include: • The name of the current and new issuers offering the plan.	**N/A**	**N/A**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		• 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**	**Section 2, Page 4**
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)." • 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.	**Confirmed**	
	b	UPMJ Q5: (i) Column 5(d): • Only include enrollment from renewing counties.	**Confirmed** **WA State Exhibits**	 **Exhibit 34**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		• 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 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).	**N/A**	**N/A**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		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.		
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).	**Confirmed**	
	b	Components of proposed community rate: • Component (a) Claims should match (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.15 Incurred Claims PMPM) minus (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.16 Risk Adjustment Transfer Amount PMPM). • Component (b) Expenses combined with component (d) Investment Earnings must be consistent with the combined values of (Exchange User Fees in URRT Worksheet 1, Section II) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6 Administrative Expense) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7 Taxes and Fees). • Component (c) Contribution to Surplus Contingency Charges, or Risk Charges must be consistent with (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8 Profit & Risk Load). • Total row (e) must match the Proposed Community Rate from #32.a above (i.e., Proposed rate summary) in the WAC 284-43-6660 summary.	**Confirmed**	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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.	**Variation is not expected**	
d	General Information section #4: Respond with "See Rate Schedule."	**See Rate Schedule**	
33	**Benefit Components:** Provide a completed Benefit Components Speed-to-Market Tool. • The file "Format - Rates - 2026 Med Benefit Components" is provided on the Washington State OIC website. • The cost-shares for all embedded benefits, including pediatric dental, must have every different cost-share visible such as for different kinds of pediatric dental care (e.g., cleaning versus extensive surgeries, or as preventive, basic, major services), if applicable. • Note: the information you provide in this file should be consistent with the other documents in your binder, rate, and form filings (e.g., PBT, AVC Screenshots, MH/SUD Certification). • Include the benefit components for the Exchange silver plan CSR variations. • The plans should indicate integrated or separate medical and drug deductibles consistent with the AVC screenshots (see also #9 of this checklist).	**Benefit Components 2026**	

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
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.	**Mental Health and Substance Use Disorder Financial Requirement Parity Certification**	
	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. • 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.	**MHSUD Parity Calculations**	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	• The cost-shares for all embedded benefits, including dental and vision, must have every different cost-share visible, such as for different kinds of pediatric dental care, in the list of medical/surgical benefits. • Include the parity calculations for the Exchange silver plan CSR variations. • As noted in WAC 284-43-7020(5)(a), a plan or issuer must treat the least restrictive level of the financial requirement limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification. In the case of multiple cost shares across provider tiers, we recommend demonstrating parity by comparing each tier's MH/SUD cost shares versus the least restrictive level of medical/surgical benefit cost shares across all provider tiers in the classification.		
35	**Commission Certification:** (see also #20.a of this checklist) Provide detailed proposed commission schedules, even if no commissions are expected to be paid for this block of business for plan year 2026. They should be signed and dated by an officer or a senior manager of your company who oversees commission schedule implementation. The officer or senior 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.	**2026 WA Producer Compensation Attachment C.pdf**	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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**	
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.	**Sample Consumer Adjusted Premium Rate Table (Exhibit 11).pdf**	
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)	**Mitigating Inequity Certification**	

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
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**	**N/A**
40	**1332 waiver checklist:** Complete and submit the file "Checklist – Rates – 2026 Individual Supplemental Checklist for 1332 Waiver Reporting."	**Supplemental Checklist 2026 WA INDV**	

WAC 284-43-6590 Actuarial Certification

Background

As a requirement under WAC 284-43-6590:

> ***Requirements for mitigating inequity in the health insurance market.***
>
> *For the purposes of mitigating inequity in the health insurance market, unless waived by the commissioner pursuant to RCW 48.43.725 and subsection (3) of this section, the commissioner must assess a fee on any health carrier offering a health plan or student health plan that excludes, under state or federal law, any benefit mandated or required by Title 48 RCW or rules adopted by the commissioner.*

Data and Analysis

To develop the cost of excluded services, we combined Providence Health Plan internal data, national studies, and provider specific reimbursement rates.

The table below shows the development of the projected cost for termination of pregnancy services. These costs reflect the actuarial equivalent expected cost for providers performing these services in the WA market based on reimbursement information collected from providers. Additionally, we have added administrative costs associated with developing a network and paying claims. We do not have information regarding the cost structure of the program and have assumed an administrative load that is consistent with Providence's internal administrative costs relative to benefit expense.

Component	Value	Formula	Source
Terminations per 1,000 Women Aged 15-44	11.3	A	CDC 2018 Surveillance Report[1]
Cost Per Termination	$3,058.83	B	Cost per service from direct provider contract
% Projected Enrollment, Women Aged 15-44	23%	C	2026 Projected Enrollment
Annual Cost Per 1,000	$8,031.10	D = A x B x C	Calculation
Service Cost PMPM	$0.67	E = D / 1,000 / 12	Calculation
Additional Administrative %	10.33%	F	2026 Administration as a % of Revenue
Total Cost PMPM	$0.75	G = E / (1 - F)	Calculation
Estimated Member Months	3,121	H	Rate Filing
Total Cost	$2,329.47	I = G x H	Calculation
Total Service Cost	$2,088.75	J = E x H	Calculation
Administrative Cost	$240.72	K = I - J	Calculation

[1] Kortsmit K, Jatlaoui TC, Mandel MG, et al. Abortion Surveillance — United States, 2018. MMWR Surveill Summ 2020;69(No. SS-7):1–29. DOI: http://dx.doi.org/10.15585/mmwr.ss6907a1external icon

Result

After accounting for administrative costs and the expected payment rates from the Washington Department of Health Family Planning Program, we estimate the cost of $0.75 PMPM.

Certification

Reliance: I relied upon utilization data from the Center for Disease Control and Prevention (CDC) and internal data from Providence Health Plan.

Qualification: We, Michelle Anderson and Lisa Winters, meet the qualification requirements for making this certification. Michelle is a Fellow of the Society of Actuaries (FSA) and Lisa is an Associate of the Society of Actuaries (ASA). We are both members of the American Academy of Actuaries (MAAA).

Opinion: $0.75 PMPM is the actuarial equivalent of costs for the provision and administration of the excluded benefit per Section 1(2)(a) of WAC 284-43-6590.

Michelle Anderson
Senior Consulting Actuary
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Lisa Winters
Consulting Actuary
Associate, Society of Actuaries
Member, American Academy of Actuaries

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:	Providence Health Plan
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.

    N/A

    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.

    N/A

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**.

Average Annual Members by Rating Area	
Rating Area 1	0
Rating Area 2	0
Rating Area 3	123
Rating Area 4	90
Rating Area 5	10
Rating Area 6	21
Rating Area 7	0
Rating Area 8	0
Rating Area 9	16
Total	260

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.

Average Annual Members by Rating Area	
Rating Area 1	0
Rating Area 2	0
Rating Area 3	123
Rating Area 4	90
Rating Area 5	10
Rating Area 6	21
Rating Area 7	0
Rating Area 8	0

Average Annual Members by Rating Area	
Rating Area 9	16
Total	260

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.

Average Annual Members by Plan	
45834WA0490001	121
45834WA0490002	55
45834WA0490003	84
Total	260

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.

Total Premium by Rating Area	
Rating Area 1	$0
Rating Area 2	$0
Rating Area 3	$1,225,217
Rating Area 4	$883,800
Rating Area 5	$104,504
Rating Area 6	$211,484

Total Premium by Rating Area	
Rating Area 7	$0
Rating Area 8	$0
Rating Area 9	$170,812
Total	$2,595,817

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.

Total Premium by Rating Area	
Rating Area 1	$0
Rating Area 2	$0
Rating Area 3	$1,225,217
Rating Area 4	$883,800
Rating Area 5	$104,504
Rating Area 6	$211,484
Rating Area 7	$0
Rating Area 8	$0
Rating Area 9	$170,812
Total	$2,595,817

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.

Because PHP only offers plans off-exchange, the impact of the waiver is expected to be negligible. Additionally, given the lack of information available and certainty regarding potential take-up of waiver enrollees, relative morbidity of the undocumented newly insured, and any induced utilization offsets from pent up demand, we feel it is reasonable to maintain the same premium rates with or without the waiver.

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.

    N/A

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.

Total Allowed Claims by Rating Area	
Rating Area 1	$0
Rating Area 2	$0
Rating Area 3	$1,918,925
Rating Area 4	$1,364,382
Rating Area 5	$170,955
Rating Area 6	$330,552

Total Allowed Claims by Rating Area	
Rating Area 7	$0
Rating Area 8	$0
Rating Area 9	$282,356
Total	$4,067,169

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.

Total Allowed Claims by Rating Area	
Rating Area 1	$0
Rating Area 2	$0
Rating Area 3	$1,918,925
Rating Area 4	$1,364,382
Rating Area 5	$170,955
Rating Area 6	$330,552
Rating Area 7	$0
Rating Area 8	$0
Rating Area 9	$282,356
Total	$4,067,169

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.

    Because PHP only offers plans off-exchange, the impact of the waiver is expected to be negligible. Additionally, given the lack of information available and certainty regarding potential take-up of waiver enrollees, relative morbidity of the undocumented newly insured, and any induced utilization offsets from pent up demand, we feel it is reasonable to maintain the same claims with or without the 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.

    Given the lack of information available and certainty regarding potential take-up of waiver enrollees and relative morbidity of the undocumented newly insured, we feel it is reasonable to maintain the same risk adjustment projection with or without the waiver. Additionally, with the lack of credibility and fluctuation of risk adjustment year over year, applying an adjustment to an already unpredictable number did not seem warranted.

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.

    Because PHP only offers plans off-exchange, the impact of the waiver is expected to be negligible.

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.

Providence Health Plan
RATE SCHEDULE

Plan Information

Plan Name: Providence Columbia 1500 Gold
HIOS Plan ID: 45834WA0490001
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the exchange
Metal Level: Gold
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	No	
2	No	
3	Yes	Clark
4	Yes	Spokane
5	Yes	Thurston
6	Yes	Benton, Franklin
7	No	
8	No	
9	Yes	Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14			438.30	387.97	429.39	418.19			408.28			438.30	387.97	429.39	418.19			408.28
15			477.26	422.45	467.56	455.36			444.57			477.26	422.45	467.56	455.36			444.57
16			492.16	435.64	482.15	469.57			458.44			492.16	435.64	482.15	469.57			458.44
17			507.06	448.82	496.74	483.79			472.32			507.06	448.82	496.74	483.79			472.32
18			523.10	463.02	512.46	499.09			487.26			523.10	463.02	512.46	499.09			487.26
19			539.14	477.22	528.18	514.40			502.21			539.14	477.22	528.18	514.40			502.21
20			555.76	491.93	544.45	530.25			517.68			555.76	491.93	544.45	530.25			517.68
21			572.95	507.14	561.29	546.65			533.70			630.25	557.85	617.42	601.32			587.07
22			572.95	507.14	561.29	546.65			533.70			630.25	557.85	617.42	601.32			587.07
23			572.95	507.14	561.29	546.65			533.70			630.25	557.85	617.42	601.32			587.07
24			572.95	507.14	561.29	546.65			533.70			630.25	557.85	617.42	601.32			587.07
25			575.24	509.17	563.54	548.84			535.83			632.76	560.09	619.89	603.72			589.41
26			586.70	519.32	574.76	559.77			546.50			645.37	571.25	632.24	615.75			601.15
27			600.45	531.49	588.24	572.89			559.31			660.50	584.64	647.06	630.18			615.24
28			622.79	551.27	610.13	594.21			580.13			685.07	606.40	671.14	653.63			638.14
29			641.13	567.49	628.09	611.70			597.21			705.24	624.24	690.90	672.87			656.93
30			650.29	575.61	637.07	620.45			605.74			715.32	633.17	700.78	682.50			666.31
31			664.04	587.78	650.54	633.57			618.55			730.44	646.56	715.59	696.93			680.41
32			677.79	599.95	664.01	646.69			631.36			745.57	659.95	730.41	711.36			694.50
33			686.39	607.56	672.43	654.89			639.37			755.03	668.32	739.67	720.38			703.31
34			695.56	615.67	681.41	663.63			647.91			765.12	677.24	749.55	729.99			712.70
35			700.14	619.73	685.90	668.01			652.18			770.15	681.70	754.49	734.81			717.40
36			704.72	623.79	690.39	672.38			656.45			775.19	686.17	759.43	739.62			722.10
37			709.31	627.84	694.88	676.75			660.72			780.24	690.62	764.37	744.43			726.79
38			713.89	631.90	699.37	681.13			664.98			785.28	695.09	769.31	749.24			731.48
39			723.06	640.02	708.35	689.87			673.52			795.37	704.02	779.19	758.86			740.87
40			732.22	648.13	717.33	698.62			682.06			805.44	712.94	789.06	768.48			750.27
41			745.98	660.30	730.80	711.74			694.87			820.58	726.33	803.88	782.91			764.36
42			759.15	671.97	743.71	724.31			707.15			835.07	739.17	818.08	796.74			777.87
43			777.49	688.19	761.67	741.80			724.23			855.24	757.01	837.84	815.98			796.65
44			800.41	708.48	784.13	763.67			745.57			880.45	779.33	862.54	840.04			820.13
45			827.33	732.32	810.51	789.36			770.66			910.06	805.55	891.56	868.30			847.73
46			859.42	760.72	841.94	819.97			800.54			945.36	836.79	926.13	901.97			880.59
47			895.51	792.67	877.30	854.41			834.17			985.06	871.94	965.03	939.85			917.59
48			936.77	829.18	917.71	893.77			872.59			1030.45	912.10	1009.48	983.15			959.85
49			977.45	865.19	957.57	932.58			910.48			1075.20	951.71	1053.33	1025.84			1001.53
50			1023.28	905.76	1002.47	976.32			953.18			1125.61	996.34	1102.72	1073.95			1048.50
51			1068.54	945.82	1046.81	1019.50			995.34			1175.39	1040.40	1151.49	1121.45			1094.87
52			1118.39	989.94	1095.64	1067.06			1041.77			1230.23	1088.93	1205.20	1173.77			1145.95
53			1168.81	1034.57	1145.04	1115.17			1088.74			1285.69	1138.03	1259.54	1226.69			1197.61
54			1223.24	1082.75	1198.36	1167.10			1139.44			1345.56	1191.03	1318.20	1283.81			1253.38
55			1277.67	1130.93	1251.68	1219.03			1190.14			1405.44	1244.02	1376.85	1340.93			1309.15
56			1336.68	1183.17	1309.50	1275.33			1245.11			1470.35	1301.49	1440.45	1402.86			1369.62
57			1396.27	1235.91	1367.87	1332.19			1300.62			1535.90	1359.50	1504.66	1465.41			1430.68
58			1459.87	1292.20	1430.17	1392.86			1359.86			1605.86	1421.42	1573.19	1532.15			1495.85
59			1491.38	1320.10	1461.05	1422.93			1389.21			1640.52	1452.11	1607.16	1565.22			1528.13
60			1554.97	1376.39	1523.35	1483.61			1448.45			1710.47	1514.03	1675.69	1631.97			1593.30
61			1609.98	1425.07	1577.23	1536.09			1499.69			1770.98	1567.58	1734.95	1689.70			1649.66
62			1646.07	1457.02	1612.60	1570.53			1533.31			1810.68	1602.72	1773.86	1727.58			1686.64
63			1691.34	1497.09	1656.94	1613.71			1575.47			1860.47	1646.80	1822.63	1775.08			1733.02
64 and over			1718.84	1521.42	1683.87	1639.95			1601.09			1890.72	1673.55	1852.26	1803.95			1761.20

Providence Health Plan
RATE SCHEDULE

Plan Information

Plan Name: Providence Columbia 5000 Silver
HIOS Plan ID: 45834WA0490002
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the exchange
Metal Level: Silver
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	No	
2	No	
3	Yes	Clark
4	Yes	Spokane
5	Yes	Thurston
6	Yes	Benton, Franklin
7	No	
8	No	
9	Yes	Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14			381.65	337.82	373.89	364.14			355.51			381.65	337.82	373.89	364.14			355.51
15			415.58	367.85	407.13	396.50			387.11			415.58	367.85	407.13	396.50			387.11
16			428.55	379.33	419.83	408.88			399.19			428.55	379.33	419.83	408.88			399.19
17			441.52	390.81	432.54	421.26			411.27			441.52	390.81	432.54	421.26			411.27
18			455.49	403.18	446.23	434.58			424.29			455.49	403.18	446.23	434.58			424.29
19			469.46	415.54	459.91	447.91			437.30			469.46	415.54	459.91	447.91			437.30
20			483.93	428.35	474.08	461.72			450.77			483.93	428.35	474.08	461.72			450.77
21			498.89	441.60	488.75	476.00			464.72			548.78	485.76	537.63	523.60			511.19
22			498.89	441.60	488.75	476.00			464.72			548.78	485.76	537.63	523.60			511.19
23			498.89	441.60	488.75	476.00			464.72			548.78	485.76	537.63	523.60			511.19
24			498.89	441.60	488.75	476.00			464.72			548.78	485.76	537.63	523.60			511.19
25			500.89	443.36	490.70	477.90			466.58			550.98	487.70	539.77	525.69			513.24
26			510.87	452.19	500.48	487.42			475.87			561.96	497.41	550.53	536.16			523.46
27			522.84	462.79	512.21	498.84			487.02			575.12	509.07	563.43	548.72			535.72
28			542.30	480.02	531.27	517.41			505.15			596.53	528.02	584.40	569.15			555.67
29			558.26	494.15	546.91	532.64			520.02			614.09	543.57	601.60	585.90			572.02
30			566.24	501.21	554.73	540.26			527.45			622.86	551.33	610.20	594.29			580.20
31			578.22	511.81	566.46	551.68			538.61			636.04	562.99	623.11	606.85			592.47
32			590.19	522.41	578.19	563.10			549.76			649.21	574.65	636.01	619.41			604.74
33			597.67	529.03	585.52	570.24			556.73			657.44	581.93	644.07	627.26			612.40
34			605.66	536.10	593.34	577.86			564.17			666.23	589.71	652.67	635.65			620.59
35			609.65	539.63	597.25	581.67			567.88			670.62	593.59	656.98	639.84			624.67
36			613.64	543.16	601.16	585.48			571.60			675.00	597.48	661.28	644.03			628.76
37			617.63	546.70	605.07	589.28			575.32			679.39	601.37	665.58	648.21			632.85
38			621.62	550.23	608.98	593.09			579.04			683.78	605.25	669.88	652.40			636.94
39			629.60	557.29	616.80	600.71			586.47			692.56	613.02	678.48	660.78			645.12
40			637.59	564.36	624.62	608.32			593.91			701.35	620.80	687.08	669.15			653.30
41			649.56	574.96	636.35	619.75			605.06			714.52	632.46	699.99	681.73			665.57
42			661.03	585.12	647.59	630.70			615.75			727.13	643.63	712.35	693.77			677.33
43			677.00	599.25	663.23	645.93			630.62			744.70	659.18	729.55	710.52			693.68
44			696.95	616.91	682.78	664.97			649.21			766.65	678.60	751.06	731.47			714.13
45			720.40	637.67	705.75	687.34			671.05			792.44	701.44	776.33	756.07			738.16
46			748.34	662.39	733.12	713.99			697.07			823.17	728.63	806.43	785.39			766.78
47			779.77	690.22	763.91	743.98			726.35			857.75	759.24	840.30	818.38			798.99
48			815.69	722.01	799.10	778.25			759.81			897.26	794.21	879.01	856.08			835.79
49			851.11	753.36	833.80	812.05			792.81			936.22	828.70	917.18	893.26			872.09
50			891.02	788.69	872.90	850.13			829.98			980.12	867.56	960.19	935.14			912.98
51			930.44	823.58	911.51	887.73			866.70			1023.48	905.94	1002.66	976.50			953.37
52			973.84	862.00	954.03	929.14			907.13			1071.22	948.20	1049.43	1022.05			997.84
53			1017.74	900.86	997.04	971.03			948.02			1119.51	990.95	1096.74	1068.13			1042.82
54			1065.14	942.81	1043.47	1016.25			992.17			1171.65	1037.09	1147.82	1117.88			1091.39
55			1112.53	984.76	1089.91	1061.47			1036.32			1223.78	1083.24	1198.90	1167.62			1139.95
56			1163.92	1030.24	1140.25	1110.50			1084.18			1280.31	1133.26	1254.28	1221.55			1192.60
57			1215.80	1076.17	1191.08	1160.00			1132.51			1337.38	1183.79	1310.19	1276.00			1245.76
58			1271.18	1125.19	1245.33	1212.84			1184.10			1398.30	1237.71	1369.86	1334.12			1302.51
59			1298.62	1149.48	1272.21	1239.02			1209.66			1428.48	1264.43	1399.43	1362.92			1330.63
60			1354.00	1198.49	1326.46	1291.85			1261.24			1489.40	1318.34	1459.11	1421.04			1387.36
61			1401.89	1240.89	1373.38	1337.55			1305.85			1542.08	1364.98	1510.72	1471.31			1436.44
62			1433.32	1268.71	1404.17	1367.54			1335.13			1576.65	1395.58	1544.59	1504.29			1468.64
63			1472.73	1303.59	1442.78	1405.14			1371.84			1620.00	1433.95	1587.06	1545.65			1509.02
64 and over			1496.67	1324.79	1466.24	1427.99			1394.15			1646.34	1457.27	1612.86	1570.79			1533.57

Providence Health Plan
RATE SCHEDULE

Plan Information

Plan Name: Providence Columbia 9200 Bronze
HIOS Plan ID: 45834WA0490003
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Outside the exchange
Metal Level: Bronze
Plan Type: Non-Standardized Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	No	
2	No	
3	Yes	Clark
4	Yes	Spokane
5	Yes	Thurston
6	Yes	Benton, Franklin
7	No	
8	No	
9	Yes	Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14			339.10	300.15	332.20	323.53			315.87			339.10	300.15	332.20	323.53			315.87
15			369.24	326.83	361.73	352.29			343.94			369.24	326.83	361.73	352.29			343.94
16			380.76	337.03	373.02	363.29			354.68			380.76	337.03	373.02	363.29			354.68
17			392.29	347.23	384.31	374.28			365.41			392.29	347.23	384.31	374.28			365.41
18			404.70	358.22	396.47	386.13			376.98			404.70	358.22	396.47	386.13			376.98
19			417.11	369.21	408.63	397.97			388.54			417.11	369.21	408.63	397.97			388.54
20			429.97	380.58	421.22	410.23			400.51			429.97	380.58	421.22	410.23			400.51
21			443.26	392.36	434.25	422.92			412.90			487.59	431.60	477.68	465.21			454.19
22			443.26	392.36	434.25	422.92			412.90			487.59	431.60	477.68	465.21			454.19
23			443.26	392.36	434.25	422.92			412.90			487.59	431.60	477.68	465.21			454.19
24			443.26	392.36	434.25	422.92			412.90			487.59	431.60	477.68	465.21			454.19
25			445.04	393.92	435.99	424.61			414.55			489.54	433.31	479.59	467.07			456.01
26			453.90	401.77	444.67	433.07			422.81			499.29	441.95	489.14	476.38			465.09
27			464.54	411.19	455.09	443.22			432.72			510.99	452.31	500.60	487.54			475.99
28			481.83	426.49	472.03	459.71			448.82			530.01	469.14	519.23	505.68			493.70
29			496.01	439.05	485.92	473.25			462.03			545.61	482.96	534.51	520.58			508.23
30			503.10	445.32	492.87	480.01			468.64			553.41	489.85	542.16	528.01			515.50
31			513.74	454.74	503.29	490.16			478.55			565.11	500.21	553.62	539.18			526.41
32			524.38	464.16	513.72	500.31			488.46			576.82	510.58	565.09	550.34			537.31
33			531.03	470.04	520.23	506.66			494.65			584.13	517.04	572.25	557.33			544.12
34			538.12	476.32	527.18	513.42			501.26			591.93	523.95	579.90	564.76			551.39
35			541.67	479.46	530.65	516.81			504.56			595.84	527.41	583.72	568.49			555.02
36			545.21	482.60	534.13	520.19			507.86			599.73	530.86	587.54	572.21			558.65
37			548.76	485.74	537.60	523.57			511.17			603.64	534.31	591.36	575.93			562.29
38			552.31	488.87	541.07	526.96			514.47			607.54	537.76	595.18	579.66			565.92
39			559.40	495.15	548.02	533.72			521.08			615.34	544.67	602.82	587.09			573.19
40			566.49	501.43	554.97	540.49			527.68			623.14	551.57	610.47	594.54			580.45
41			577.13	510.85	565.39	550.64			537.59			634.84	561.94	621.93	605.70			591.35
42			587.32	519.87	575.38	560.37			547.09			646.05	571.86	632.92	616.41			601.80
43			601.51	532.43	589.27	573.90			560.30			661.66	585.67	648.20	631.29			616.33
44			619.24	548.12	606.64	590.82			576.82			681.16	602.93	667.30	649.90			634.50
45			640.07	566.56	627.05	610.70			596.22			704.08	623.22	689.76	671.77			655.84
46			664.90	588.53	651.37	634.38			619.35			731.39	647.38	716.51	697.82			681.29
47			692.82	613.25	678.73	661.02			645.36			762.10	674.58	746.60	727.12			709.90
48			724.74	641.50	710.00	691.47			675.09			797.21	705.65	781.00	760.62			742.60
49			756.21	669.36	740.83	721.50			704.40			831.83	736.30	814.91	793.65			774.84
50			791.67	700.75	775.57	755.33			737.43			870.84	770.83	853.13	830.86			811.17
51			826.69	731.74	809.87	788.74			770.05			909.36	804.91	890.86	867.61			847.06
52			865.25	765.88	847.65	825.54			805.98			951.78	842.47	932.42	908.09			886.58
53			904.26	800.41	885.87	862.76			842.31			994.69	880.45	974.46	949.04			926.54
54			946.37	837.68	927.12	902.93			881.54			1041.01	921.45	1019.83	993.22			969.69
55			988.48	874.95	968.37	943.11			920.76			1087.33	962.45	1065.21	1037.42			1012.84
56			1034.13	915.37	1013.10	986.67			963.29			1137.54	1006.91	1114.41	1085.34			1059.62
57			1080.23	956.17	1058.26	1030.65			1006.23			1188.25	1051.79	1164.09	1133.72			1106.85
58			1129.44	999.72	1106.46	1077.60			1052.06			1242.38	1099.69	1217.11	1185.36			1157.27
59			1153.81	1021.30	1130.35	1100.86			1074.77			1269.19	1123.43	1243.39	1210.95			1182.25
60			1203.02	1064.85	1178.55	1147.80			1120.60			1323.32	1171.34	1296.41	1262.58			1232.66
61			1245.57	1102.52	1220.24	1188.40			1160.24			1370.13	1212.77	1342.26	1307.24			1276.26
62			1273.50	1127.24	1247.60	1215.05			1186.25			1400.85	1239.96	1372.36	1336.56			1304.88
63			1308.51	1158.23	1281.90	1248.46			1218.87			1439.36	1274.05	1410.09	1373.31			1340.76
64 and over			1329.78	1177.07	1302.74	1268.76			1238.69			1462.76	1294.78	1433.01	1395.63			1362.56

Unified Rate Review v6.0

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:	Providence Health Plan
HIOS Issuer ID:	45834
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	$2,500,626.45	$862.58
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$1,886,839.53	$650.86
Risk Adjustment	$1,237,092.01	$426.73
Experience Period Premium	$1,878,222.98	$647.89
Experience Period Member Months	2,899	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend Cost	Year 1 Trend Utilization	Year 2 Trend Cost	Year 2 Trend Utilization	Trended EHB Allowed Claims PMPM
Inpatient Hospital	$114.86	1.000	1.000	1.000	1.000	$114.86
Outpatient Hospital	$168.70	1.000	1.000	1.000	1.000	$168.70
Professional	$265.04	1.000	1.000	1.000	1.000	$265.04
Other Medical	$20.60	1.000	1.000	1.000	1.000	$20.60
Capitation	$0.86	1.000	1.000	1.000	1.000	$0.86
Prescription Drug	$289.36	1.000	1.000	1.000	1.000	$289.36
Total	$859.41					**$859.41**

Morbidity Adjustment	1.000
Demographic Shift	1.000
Plan Design Changes	1.000
Other	1.000
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$859.41**

Manual EHB Allowed Claims PMPM	$1,302.60
Applied Credibility %	0.00%

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$1,302.60**	$4,065,414.60
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	$387.53	$1,209,490.44
Exchange User Fees	0.00%	$0.00
Market Adjusted Index Rate	**$915.07**	**$2,855,924.16**

Projected Member Months	**3,121**

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: **Providence Health Plan**
HIOS Issuer ID: **45834** 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		Columbia Individual		
1.2	Product ID		45834WA049		
1.3	Plan Name		Providence	Providence	Providence
1.4	Plan ID (Standard Component ID)		45834WA0490001	45834WA0490002	45834WA0490003
1.5	Metal		Gold	Silver	Bronze
1.6	AV Metal Value		0.804	0.717	0.650
1.7	Plan Category		Renewing	Renewing	Renewing
1.8	Plan Type		EPO	EPO	EPO
1.9	Exchange Plan?		No	No	No
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		12.04%	9.86%	6.45%
1.12	Product Rate Increase %		9.59%		
1.13	Submission Level Rate Increase %		9.59%		

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information				
	2.1	Plan ID (Standard Component ID)	Total	45834WA0490001	45834WA0490002	45834WA0490003
$2,500,626	2.2	Allowed Claims	$2,500,626	$1,213,560	$415,237	$871,829
$0	2.3	Reinsurance	$0	$0	$0	$0
	2.4	Member Cost Sharing	$613,787	$262,544	$149,864	$201,379
	2.5	Cost Sharing Reduction	$0	$0	$0	$0
$1,886,840	2.6	Incurred Claims	$1,886,840	$951,016	$265,373	$670,451
$1,237,092	2.7	Risk Adjustment Transfer Amount	$1,237,092	$676,099	$168,936	$392,057
$1,878,223	2.8	Premium	$1,878,223	$867,061	$473,439	$537,723
2,899	2.9	Experience Period Member Months	2,899	1,270	729	900
	2.10	Current Enrollment	254	106	58	90
	2.11	Current Premium PMPM	$751.51	$779.18	$701.18	$751.35
	2.12	Loss Ratio	60.57%	61.63%	41.31%	72.11%
		Per Member Per Month				
	2.13	Allowed Claims	$862.58	$955.56	$569.60	$968.70
	2.14	Reinsurance	$0.00	$0.00	$0.00	$0.00
	2.15	Member Cost Sharing	$211.72	$206.73	$205.58	$223.75
	2.16	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00
	2.17	Incurred Claims	$650.86	$748.83	$364.02	$744.95
	2.18	Risk Adjustment Transfer Amount	$426.73	$532.36	$231.74	$435.62
	2.19	Premium	$647.89	$682.72	$649.44	$597.47

	Section III: Plan Adjustment Factors				
3.1	Plan ID (Standard Component ID)		45834WA0490001	45834WA0490002	45834WA0490003
3.2	Market Adjusted Index Rate		$915.07		
3.3	AV and Cost Sharing Design of Plan		0.8497	0.7277	0.6360
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB		1.0005	1.0006	1.0007
	Administrative Costs				
3.6	Administrative Expense		9.39%	10.79%	12.14%
3.7	Taxes and Fees		2.18%	2.18%	2.18%
3.8	Profit & Risk Load		3.50%	3.50%	3.50%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**		$915.98	$797.59	$708.66
3.11	Age Calibration Factor	0.5959	0.5959		
3.12	Geographic Calibration Factor	1.0509	1.0509		
3.13	Tobacco Calibration Factor	0.9987	0.9987		
3.14	**Calibrated Plan Adjusted Index Rate**		$572.95	$498.89	$443.26

	Section IV: Projected Plan Level Information				
4.1	Plan ID (Standard Component ID)	Total	45834WA0490001	45834WA0490002	45834WA0490003
4.2	Allowed Claims	$4,067,169	$2,318,302	$855,400	$893,468
4.3	Reinsurance	$0	$0	$0	$0
4.4	Member Cost Sharing	$997,117	$458,534	$236,748	$301,835
4.5	Cost Sharing Reduction	$0	$0	$0	$0
4.6	Incurred Claims	$3,070,052	$1,859,768	$618,651	$591,633
4.7	Risk Adjustment Transfer Amount	$912,972	$730,169	$178,233	$4,571
4.8	Premium	$2,571,545	$1,330,009	$527,210	$714,327
4.9	Projected Member Months	3,121	1,452	661	1,008
4.10	Loss Ratio	88.11%	90.27%	87.70%	82.30%
	Per Member Per Month				
4.11	Allowed Claims	$1,303.16	$1,596.63	$1,294.10	$886.38
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$319.49	$315.79	$358.17	$299.44
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$983.68	$1,280.83	$935.93	$586.94
4.16	Risk Adjustment Transfer Amount	$292.53	$502.87	$269.64	$4.53
4.17	Premium	$823.95	$915.98	$797.59	$708.66

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 3	1.0000
Rating Area 4	0.8852
Rating Area 5	0.9797
Rating Area 6	0.9541
Rating Area 9	0.9315