Filing at a Glance

Company:	Community Health Plan of Washington
Product Name:	2026 Non-Grandfathered Individual
State:	Washington
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Rate
Date Submitted:	05/13/2025
SERFF Tr Num:	CHPW-134525946
SERFF Status:	Pending Industry Response
State Tr Num:	484514
State Status:	Active Suspense
Co Tr Num:	CHPW-202
Effective Date Requested:	01/01/2026
Author(s):	Kat Myers, Goetz Jan
Reviewer(s):	Jeff Oberle (primary), Ben Driver
Disposition Date:	
Disposition Status:	
Effective Date:	
Destruction Date:	

State Filing Description:

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
Project Name/Number: */*

General Information

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

Deemer Date:
Submitted By: Kat Myers

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/21/2025
State Status Changed: 05/21/2025
Created By: Kat Myers
Corresponding Filing Tracking Number: CHPW-134525928

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions:

Exchange Only

Filing Description:

Filings were prepared with the intention of following the STM – Rates – Health – Individual and Small Group guide.

Company and Contact

Filing Contact Information

Kat Myers, Product Manager
1111 3rd Ave
Suite 400
Seattle, WA 98101

kat.myers@chpw.org
206-595-6856 [Phone]

Filing Company Information

Community Health Plan of Washington
1111 3rd Avenue
Suite 400
Seattle, WA 98101
(206) 521-8833 ext. [Phone]

CoCode: 47049
Group Code:
Group Name:
FEIN Number: 91-1729710

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

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
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 #:	*CHPW-134525946*	***State Tracking #:***	*484514*	***Company Tracking #:***	*CHPW-202*

State:	*Washington*	***Filing Company:***	*Community Health Plan of Washington*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Non-Grandfathered Individual*		
Project Name/Number:	*/*		

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Active Suspense	Jeff Oberle	05/21/2025	05/21/2025

Response Letters

Responded By	Created On	Date Submitted

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Notice for Second Set of Rates Review Process	Note To Filer	Jeff Oberle	05/19/2025	05/19/2025
RE: Correction Needed	Note To Reviewer	Kat Myers	05/13/2025	05/13/2025
Correction Needed	Note To Filer	Kim Bauer	05/13/2025	05/13/2025
Rate Request Summary	Reviewer Note	Kelli Armfield	05/27/2025	

State: Washington **Filing Company:** Community Health Plan of Washington
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 Non-Grandfathered Individual
Project Name/Number: /

Objection Letter

Objection Letter Status	Active Suspense
Objection Letter Date	05/21/2025
Submitted Date	05/21/2025
Respond By Date	05/30/2025

Dear Kat Myers,

Introduction:

Thank you for your filing submission. To allow our continued review of this filing, please reply on or before the Respond By Date.

The filing is being placed in an Active Suspense status, pending your response. Please note review of this rate filing is ongoing. Response letters not submitted with complete responses to the objections and in a timely manner [WAC 284-44A-090 (HCSC), WAC 284-46A-090 (HMO)] will be subject to disapproval. Additional objections may be forthcoming.

The following are based on a preliminary review.

Objection 1

- Uniform Product Modification Justification (Supporting Document)
Comments: Please revise UPMJ Q4a for the following.

a.List the HIOS Plan ID on every line as indicated in item 1 of the instruction.
b.Add the 2026 Form Filing SERFF Tracking Numbers.

Objection 2

- Rate Schedule, [Community Health Plan of Washington Cascade Select Gold Silver Bronze (2026)] (Rate)
- Illustrative Rate Calculation, [Community Health Plan of Washington Cascade Select Gold Silver Bronze (2026)] (Rate)
- Unified Rate Review Template (URRT)
- Actuarial Memorandum (URRT)
- Actuarial Memorandum - Redacted (URRT)
- Consumer Justification Narrative (URRT)
- Other Supporting Documents (URRT)
- Written Description Justifying the Rate Increase (Supporting Document)
- Actuarial Memorandum Tables (Supporting Document)
- WAC 284-43-6660 (Supporting Document)
- Uniform Product Modification Justification (Supporting Document)
- View Rate Review Detail (Supporting Document)
- Benefit Components (Supporting Document)
- MHSUD Financial Requirements Certification (Supporting Document)
- MHSUD Parity Calculations (Supporting Document)
- Wakely AV Certification (Supporting Document)
- Justification for Profit and Risk Load (Supporting Document)
- Commissions Certification (Supporting Document)
- Financial Statement Analysis (Supporting Document)
- Additional Data Statement 12 31 2024 (Supporting Document)
- Experience Reconciliation (Checklist 1-3) (Supporting Document)
- Plan Statutory pg 34-5 (Supporting Document)

State: Washington **Filing Company:** Community Health Plan of Washington
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 Non-Grandfathered Individual
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- Checklist - Rates - 1332 Waiver Reporting (Supporting Document)
- Checklist - Rates - 2026 Individual Nongrandfathered Health Plans (Supporting Document)
- WA_Exhibits_CHPW_2026 (Supporting Document)
- Rating Documents for Extended ARPA Subsidies (Supporting Document)

Comments: Upon preliminary review, we found that the plan-mapping assumptions in your rate filing do not appear to align with the Washington Health Benefit Exchange (WAHBE) mapping procedures established for plan year 2026.

WAHBE mapping rules will automatically map certain 2025 Exchange silver-plan enrollees to the issuers standardized Cascade Vital Gold plan for 2026 if:
the renewing member does not qualify for cost-sharing reductions (CSR), or
the member qualifies for the 73% CSR silver variant.

For these members, the Vital Gold Plan is expected to offer lower premiums and richer benefits than 2026 silver plans that include CSR silver loaded premiums. Although these members may choose to shop for another plan, rather than accept automatic mapping to the Vital Gold plan, we believe they are unlikely to remain in the Exchange silver plan in 2026. Note that all other members are expected to renew in the same 2025 plan (if still offered in 2026) or follow standard plan-mapping rules.

In response to this objection, please do the following:
i.If you expect members to reject the automatic mapping rules to the gold plan, provide justification for this assumption, including detailed qualitative reasoning and quantitative actuarial support. Ensure that you update your actuarial memo to identify this assumption.

ii.If you agree that the members mapped to the Vital Gold plan will accept that mapping, update the rate filing to reflect the Exchange mapping assumptions:
--a.Update the actuarial memorandum to clearly state the mapping logic and its impact on rate development, projection factors, and morbidity adjustments.
--b.Update the projected membership distribution and downstream components of the rate development to account for this assumption.
--c.Revise the Uniform Product Modification Justification document (Sheet UPMJ Q5) to reflect the mapping procedures by splitting the exchange silver plan membership listed in UPMJ Q1 into two separate rows in UPMJ Q5 (one row for membership renewed in the silver plan and one for exchange silver plan membership mapping to the Cascade Vital Gold plan).
--d.Do not submit a post-submission update to revise the Company Rate Information and the Rate Review Details on the Rate/Rule Schedule tab in SERFF.

Conclusion:

Sincerely,
Jeff Oberle

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
Project Name/Number: */*

Note To Filer

Created By:

Jeff Oberle on 05/19/2025 06:15 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:17 PM

Subject:

Notice for Second Set of Rates Review Process

Comments:

We are sending this note to clarify when you should update the second set of rate documents included in your rate filing.

Do NOT update the second set of rate documents submitted under the Supporting Documentation tab in SERFF during the normal objection-and-response process, unless an objection specifically instructs you to do so.

Do NOT update the Company Rate Information or Rate Review Detail sections in SERFF unless an objection explicitly requests it.

If a material change in federal or state law occurs during the review process, the OIC will send an objection with instructions on how to make the necessary updates to your filing.

Please note that only one set of rates may remain active when the OIC takes a positive final action on a rate filing. At the appropriate time, we will send an objection instructing you on how to finalize the rate filing and deactivate the unused set of rates.

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
Project Name/Number: */*

Note To Reviewer

Created By:

Kat Myers on 05/13/2025 04:28 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:17 PM

Subject:

RE: Correction Needed

Comments:

Overall Rate Impact field was not populated on General Information tab as this was not listed in the Rate Filing General Instructions and was not required for the previous year's submitted Rate filing.

Thank you.

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
Project Name/Number: */*

Note To Filer

Created By:

Kim Bauer on 05/13/2025 03:54 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:17 PM

Subject:

Correction Needed

Comments:

Our initial review of your filing has revealed an error on the General Information tab. The Overall Rate Impact field is not populated. Please submit a Post Submission Update adding the Overall Rate Impact.

If you have any questions please contact the Rates, Forms & Provider Networks helpdesk at 360-725-7111.

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
Project Name/Number: */*

Reviewer Note

Created By:

Kelli Armfield on 05/27/2025 12:15 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:17 PM

Subject:

Rate Request Summary

Comments:

See attached

Community Health Plan of Washington – 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:	27.57% *average**
Requested effective date:	Jan. 1, 2026
Plans impacted:	Community Health Plan of Washington's Individual plans
People impacted:	34,463
Counties:	Adams, Asotin, Benton, Chelan, Clallam, Columbia, Douglas, Ferry, Franklin, Grant, Jefferson, King, Kitsap, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pierce, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whitman and Yakima

Key information used to develop the rate request

(Jan. 2024 - Dec. 2024)

Premiums	$153,416,318
Claims	$112,945,234
Administrative expenses	$13,139,651
Risk adjustment	-$44,291,653
Company lost	**-$16,960,220**

The company expects its annual medical costs to increase 4.9%.

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:

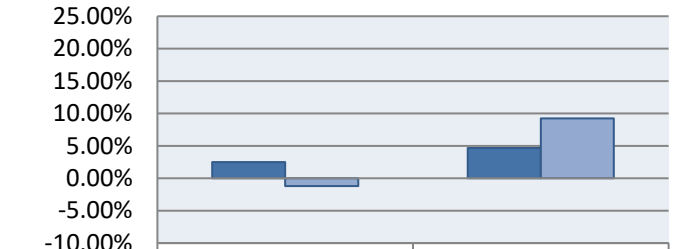
Claims:	87.07**%**
Administration:	10.93**%**
Profit:	2.00**%**

Are there any benefit changes?

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

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

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



	2024	2025
Requested	2.50%	4.68%
Accepted	-1.21%	9.25%

Need Help?

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

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SERFF Tracking #:	*CHPW-134525946*	***State Tracking #:***	*484514*	***Company Tracking #:***	*CHPW-202*

State:	*Washington*	***Filing Company:***	*Community Health Plan of Washington*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Non-Grandfathered Individual*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	Review and Approve
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	4.680%
Effective Date of Last Rate Revision:	01/01/2025
Filing Method of Last Filing:	Prior Approval
SERFF Tracking Number of Last Filing:	CHPW-134100436

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):
Community Health Plan of Washington	Increase	27.570%	27.570%	$57,501,430	34,463	$208,565,216	35.680%	5.710%

State: *Washington* ***Filing Company:*** *Community Health Plan of Washington*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Non-Grandfathered Individual*
Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name: Community Health Plan of Washington
HHS Issuer Id: 18581

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Cascade Select Gold Silver Bronze	18581WA014		34463

Trend Factors: Average annual claims trend 4.90%, including Wtd avg 2026 WAC 284-43-6660 summary Hospital (3.53%); Professional (-1.33%); Pharmacy (12.75%); Other (-1.06%)

FORMS:

New Policy Forms: Community Health Plan of Washington Cascade Select Gold Silver Bronze (2026)
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 335,501
Benefit Change: Increase
Percent Change Requested: Min: 5.71 Max: 35.68 Avg: 27.57

PRIOR RATE:

Total Earned Premium: 149,382,286.00
Total Incurred Claims: 103,969,118.00
Annual $: Min: 178.36 Max: 1,412.93 Avg: 493.84

REQUESTED RATE:

Projected Earned Premium: 117,306,587.00
Projected Incurred Claims: 75,586,508.00
Annual $: Min: 195.77 Max: 1,495.41 Avg: 630.01

SERFF Tracking #:	*CHPW-134525946*	***State Tracking #:***	*484514*	***Company Tracking #:***	*CHPW-202*

State:	*Washington*	***Filing Company:***	*Community Health Plan of Washington*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Non-Grandfathered Individual*		
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	Community Health Plan of Washington Cascade Select Gold Silver Bronze (2026)	Revised	Previous State Filing Number: CHPW-134100436 Percent Rate Change Request: 4.68	Rate Schedule.pdf, Rate Schedule DUPLICATE.xlsm,
2		Illustrative Rate Calculation	Community Health Plan of Washington Cascade Select Gold Silver Bronze (2026)	Revised	Previous State Filing Number: CHPW-134100436 Percent Rate Change Request: 4.68	Illustrative Rate Calculation.pdf,

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Complete Gold
HIOS Plan ID: 18581WA0140001
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	296.99	319.21		293.49	277.58	287.20	305.74	298.88	288.12	296.99	319.21		293.49	277.58	287.20	305.74	298.88	288.12
15	323.39	347.59		319.58	302.25	312.73	332.91	325.45	313.73	323.39	347.59		319.58	302.25	312.73	332.91	325.45	313.73
16	333.49	358.44		329.55	311.68	322.49	343.30	335.61	323.52	333.49	358.44		329.55	311.68	322.49	343.30	335.61	323.52
17	343.58	369.29		339.53	321.12	332.25	353.70	345.76	333.31	343.58	369.29		339.53	321.12	332.25	353.70	345.76	333.31
18	354.45	380.97		350.27	331.28	342.77	364.89	356.70	343.86	354.45	380.97		350.27	331.28	342.77	364.89	356.70	343.86
19	365.32	392.65		361.01	341.44	353.28	376.08	367.64	354.40	365.32	392.65		361.01	341.44	353.28	376.08	367.64	354.40
20	376.58	404.75		372.13	351.96	364.16	387.67	378.97	365.32	376.58	404.75		372.13	351.96	364.16	387.67	378.97	365.32
21	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62
22	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62
23	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62
24	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62	388.23	417.27		383.64	362.85	375.43	399.66	390.69	376.62
25	389.78	418.94		385.18	364.30	376.93	401.25	392.26	378.13	389.78	418.94		385.18	364.30	376.93	401.25	392.26	378.13
26	397.54	427.29		392.85	371.55	384.44	409.25	400.07	385.66	397.54	427.29		392.85	371.55	384.44	409.25	400.07	385.66
27	406.86	437.30		402.06	380.26	393.45	418.84	409.45	394.70	406.86	437.30		402.06	380.26	393.45	418.84	409.45	394.70
28	422.00	453.57		417.02	394.41	408.09	434.43	424.68	409.39	422.00	453.57		417.02	394.41	408.09	434.43	424.68	409.39
29	434.43	466.93		429.30	406.02	420.10	447.21	437.19	421.44	434.43	466.93		429.30	406.02	420.10	447.21	437.19	421.44
30	440.64	473.60		435.44	411.83	426.11	453.61	443.44	427.47	440.64	473.60		435.44	411.83	426.11	453.61	443.44	427.47
31	449.96	483.62		444.64	420.54	435.12	463.20	452.81	436.51	449.96	483.62		444.64	420.54	435.12	463.20	452.81	436.51
32	459.27	493.63		453.85	429.25	444.13	472.79	462.19	445.55	459.27	493.63		453.85	429.25	444.13	472.79	462.19	445.55
33	465.10	499.89		459.61	434.69	449.76	478.79	468.05	451.19	465.10	499.89		459.61	434.69	449.76	478.79	468.05	451.19
34	471.31	506.57		465.74	440.49	455.77	485.18	474.30	457.22	471.31	506.57		465.74	440.49	455.77	485.18	474.30	457.22
35	474.41	509.91		468.81	443.40	458.77	488.38	477.43	460.23	474.41	509.91		468.81	443.40	458.77	488.38	477.43	460.23
36	477.52	513.24		471.88	446.30	461.78	491.58	480.55	463.25	477.52	513.24		471.88	446.30	461.78	491.58	480.55	463.25
37	480.63	516.58		474.95	449.20	464.78	494.77	483.68	466.26	480.63	516.58		474.95	449.20	464.78	494.77	483.68	466.26
38	483.73	519.92		478.02	452.11	467.78	497.97	486.80	469.27	483.73	519.92		478.02	452.11	467.78	497.97	486.80	469.27
39	489.94	526.60		484.16	457.91	473.79	504.37	493.06	475.30	489.94	526.60		484.16	457.91	473.79	504.37	493.06	475.30
40	496.15	533.27		490.30	463.72	479.80	510.76	499.31	481.32	496.15	533.27		490.30	463.72	479.80	510.76	499.31	481.32
41	505.47	543.29		499.50	472.42	488.81	520.35	508.68	490.36	505.47	543.29		499.50	472.42	488.81	520.35	508.68	490.36
42	514.40	552.89		508.33	480.77	497.44	529.54	517.67	499.03	514.40	552.89		508.33	480.77	497.44	529.54	517.67	499.03
43	526.82	566.24		520.61	492.38	509.46	542.33	530.17	511.08	526.82	566.24		520.61	492.38	509.46	542.33	530.17	511.08
44	542.35	582.93		535.95	506.89	524.47	558.32	545.80	526.14	542.35	582.93		535.95	506.89	524.47	558.32	545.80	526.14
45	560.60	602.54		553.98	523.95	542.12	577.10	564.16	543.84	560.60	602.54		553.98	523.95	542.12	577.10	564.16	543.84
46	582.34	625.91		575.47	544.27	563.14	599.48	586.04	564.93	582.34	625.91		575.47	544.27	563.14	599.48	586.04	564.93
47	606.80	652.20		599.64	567.13	586.79	624.66	610.65	588.66	606.80	652.20		599.64	567.13	586.79	624.66	610.65	588.66
48	634.75	682.24		627.26	593.25	613.82	653.44	638.78	615.78	634.75	682.24		627.26	593.25	613.82	653.44	638.78	615.78
49	662.32	711.87		654.50	619.01	640.48	681.81	666.52	642.52	662.32	711.87		654.50	619.01	640.48	681.81	666.52	642.52
50	693.37	745.25		685.19	648.04	670.51	713.78	697.78	672.65	693.37	745.25		685.19	648.04	670.51	713.78	697.78	672.65
51	724.04	778.21		715.50	676.71	700.17	745.36	728.64	702.40	724.04	778.21		715.50	676.71	700.17	745.36	728.64	702.40
52	757.82	814.51		748.87	708.27	732.83	780.13	762.63	735.17	757.82	814.51		748.87	708.27	732.83	780.13	762.63	735.17
53	791.98	851.23		782.63	740.20	765.87	815.30	797.01	768.31	791.98	851.23		782.63	740.20	765.87	815.30	797.01	768.31
54	828.86	890.88		819.08	774.67	801.54	853.26	834.13	804.09	828.86	890.88		819.08	774.67	801.54	853.26	834.13	804.09
55	865.75	930.52		855.53	809.14	837.20	891.23	871.25	839.87	865.75	930.52		855.53	809.14	837.20	891.23	871.25	839.87
56	905.73	973.50		895.04	846.52	875.87	932.40	911.49	878.66	905.73	973.50		895.04	846.52	875.87	932.40	911.49	878.66
57	946.11	1016.89		934.94	884.25	914.92	973.96	952.12	917.83	946.11	1016.89		934.94	884.25	914.92	973.96	952.12	917.83
58	989.20	1063.21		977.53	924.53	956.59	1018.32	995.49	959.64	989.20	1063.21		977.53	924.53	956.59	1018.32	995.49	959.64
59	1010.55	1086.16		998.63	944.49	977.24	1040.30	1016.98	980.35	1010.55	1086.16		998.63	944.49	977.24	1040.30	1016.98	980.35
60	1053.65	1132.48		1041.21	984.76	1018.91	1084.66	1060.34	1022.16	1053.65	1132.48		1041.21	984.76	1018.91	1084.66	1060.34	1022.16
61	1090.92	1172.53		1078.04	1019.59	1054.95	1123.03	1097.85	1058.31	1090.92	1172.53		1078.04	1019.59	1054.95	1123.03	1097.85	1058.31
62	1115.38	1198.82		1102.21	1042.45	1078.60	1148.21	1122.46	1082.04	1115.38	1198.82		1102.21	1042.45	1078.60	1148.21	1122.46	1082.04
63	1146.05	1231.79		1132.52	1071.12	1108.26	1179.78	1153.33	1111.79	1146.05	1231.79		1132.52	1071.12	1108.26	1179.78	1153.33	1111.79
64 and over	1164.68	1251.81		1150.92	1088.54	1126.28	1198.97	1172.07	1129.86	1164.68	1251.81		1150.92	1088.54	1126.28	1198.97	1172.07	1129.86

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Vital Gold
HIOS Plan ID: 18581WA0140004
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	278.41	299.24		275.13	260.21	269.23	286.61	280.18	270.09	278.41	299.24		275.13	260.21	269.23	286.61	280.18	270.09
15	303.16	325.84		299.58	283.34	293.16	312.08	305.09	294.10	303.16	325.84		299.58	283.34	293.16	312.08	305.09	294.10
16	312.62	336.01		308.93	292.18	302.32	321.82	314.61	303.28	312.62	336.01		308.93	292.18	302.32	321.82	314.61	303.28
17	322.08	346.18		318.28	301.03	311.47	331.57	324.13	312.46	322.08	346.18		318.28	301.03	311.47	331.57	324.13	312.46
18	332.27	357.13		328.35	310.55	321.32	342.06	334.39	322.34	332.27	357.13		328.35	310.55	321.32	342.06	334.39	322.34
19	342.46	368.09		338.42	320.07	331.17	352.55	344.64	332.23	342.46	368.09		338.42	320.07	331.17	352.55	344.64	332.23
20	353.02	379.43		348.85	329.94	341.38	363.41	355.26	342.47	353.02	379.43		348.85	329.94	341.38	363.41	355.26	342.47
21	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06
22	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06
23	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06
24	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06	363.94	391.16		359.64	340.14	351.94	374.65	366.25	353.06
25	365.39	392.73		361.08	341.50	353.35	376.15	367.71	354.47	365.39	392.73		361.08	341.50	353.35	376.15	367.71	354.47
26	372.67	400.55		368.27	348.31	360.38	383.64	375.04	361.53	372.67	400.55		368.27	348.31	360.38	383.64	375.04	361.53
27	381.41	409.94		376.90	356.47	368.83	392.63	383.83	370.01	381.41	409.94		376.90	356.47	368.83	392.63	383.83	370.01
28	395.60	425.20		390.93	369.74	382.56	407.25	398.11	383.78	395.60	425.20		390.93	369.74	382.56	407.25	398.11	383.78
29	407.25	437.71		402.44	380.62	393.82	419.23	409.83	395.07	407.25	437.71		402.44	380.62	393.82	419.23	409.83	395.07
30	413.07	443.97		408.19	386.06	399.45	425.23	415.69	400.72	413.07	443.97		408.19	386.06	399.45	425.23	415.69	400.72
31	421.80	453.36		416.82	394.23	407.90	434.22	424.48	409.20	421.80	453.36		416.82	394.23	407.90	434.22	424.48	409.20
32	430.54	462.75		425.46	402.39	416.34	443.21	433.27	417.67	430.54	462.75		425.46	402.39	416.34	443.21	433.27	417.67
33	436.00	468.62		430.85	407.49	421.62	448.83	438.77	422.97	436.00	468.62		430.85	407.49	421.62	448.83	438.77	422.97
34	441.82	474.87		436.60	412.93	427.25	454.83	444.63	428.61	441.82	474.87		436.60	412.93	427.25	454.83	444.63	428.61
35	444.73	478.00		439.48	415.66	430.07	457.82	447.56	431.44	444.73	478.00		439.48	415.66	430.07	457.82	447.56	431.44
36	447.64	481.13		442.36	418.38	432.88	460.82	450.49	434.26	447.64	481.13		442.36	418.38	432.88	460.82	450.49	434.26
37	450.55	484.26		445.24	421.10	435.70	463.82	453.42	437.09	450.55	484.26		445.24	421.10	435.70	463.82	453.42	437.09
38	453.47	487.39		448.11	423.82	438.52	466.81	456.35	439.91	453.47	487.39		448.11	423.82	438.52	466.81	456.35	439.91
39	459.29	493.65		453.87	429.26	444.15	472.81	462.21	445.56	459.29	493.65		453.87	429.26	444.15	472.81	462.21	445.56
40	465.11	499.91		459.62	434.70	449.78	478.80	468.07	451.21	465.11	499.91		459.62	434.70	449.78	478.80	468.07	451.21
41	473.85	509.30		468.25	442.87	458.22	487.80	476.86	459.68	473.85	509.30		468.25	442.87	458.22	487.80	476.86	459.68
42	482.22	518.29		476.52	450.69	466.32	496.41	485.28	467.80	482.22	518.29		476.52	450.69	466.32	496.41	485.28	467.80
43	493.86	530.81		488.03	461.57	477.58	508.40	497.00	479.10	493.86	530.81		488.03	461.57	477.58	508.40	497.00	479.10
44	508.42	546.46		502.42	475.18	491.66	523.39	511.65	493.22	508.42	546.46		502.42	475.18	491.66	523.39	511.65	493.22
45	525.53	564.84		519.32	491.17	508.20	541.00	528.86	509.82	525.53	564.84		519.32	491.17	508.20	541.00	528.86	509.82
46	545.91	586.75		539.46	510.22	527.91	561.98	549.37	529.59	545.91	586.75		539.46	510.22	527.91	561.98	549.37	529.59
47	568.83	611.39		562.12	531.64	550.08	585.58	572.45	551.83	568.83	611.39		562.12	531.64	550.08	585.58	572.45	551.83
48	595.04	639.55		588.01	556.13	575.42	612.55	598.82	577.25	595.04	639.55		588.01	556.13	575.42	612.55	598.82	577.25
49	620.88	667.33		613.55	580.28	600.41	639.15	624.82	602.32	620.88	667.33		613.55	580.28	600.41	639.15	624.82	602.32
50	649.99	698.62		642.32	607.50	628.56	669.13	654.12	630.56	649.99	698.62		642.32	607.50	628.56	669.13	654.12	630.56
51	678.74	729.52		670.73	634.37	656.37	698.72	683.06	658.46	678.74	729.52		670.73	634.37	656.37	698.72	683.06	658.46
52	710.41	763.55		702.02	663.96	686.98	731.32	714.92	689.17	710.41	763.55		702.02	663.96	686.98	731.32	714.92	689.17
53	742.43	797.98		733.67	693.89	717.95	764.29	747.15	720.24	742.43	797.98		733.67	693.89	717.95	764.29	747.15	720.24
54	777.01	835.14		767.83	726.21	751.39	799.88	781.94	753.78	777.01	835.14		767.83	726.21	751.39	799.88	781.94	753.78
55	811.58	872.30		802.00	758.52	784.82	835.47	816.74	787.32	811.58	872.30		802.00	758.52	784.82	835.47	816.74	787.32
56	849.07	912.59		839.04	793.55	821.07	874.06	854.46	823.69	849.07	912.59		839.04	793.55	821.07	874.06	854.46	823.69
57	886.91	953.27		876.45	828.93	857.67	913.02	892.55	860.41	886.91	953.27		876.45	828.93	857.67	913.02	892.55	860.41
58	927.31	996.69		916.37	866.69	896.74	954.61	933.20	899.60	927.31	996.69		916.37	866.69	896.74	954.61	933.20	899.60
59	947.33	1018.20		936.15	885.39	916.10	975.22	953.35	919.01	947.33	1018.20		936.15	885.39	916.10	975.22	953.35	919.01
60	987.73	1061.62		976.07	923.15	955.16	1016.80	994.00	958.20	987.73	1061.62		976.07	923.15	955.16	1016.80	994.00	958.20
61	1022.66	1099.17		1010.59	955.80	988.95	1052.77	1029.16	992.10	1022.66	1099.17		1010.59	955.80	988.95	1052.77	1029.16	992.10
62	1045.59	1123.82		1033.25	977.23	1011.12	1076.37	1052.23	1014.34	1045.59	1123.82		1033.25	977.23	1011.12	1076.37	1052.23	1014.34
63	1074.34	1154.72		1061.66	1004.10	1038.92	1105.97	1081.17	1042.23	1074.34	1154.72		1061.66	1004.10	1038.92	1105.97	1081.17	1042.23
64 and over	1091.81	1173.48		1078.92	1020.42	1055.82	1123.95	1098.75	1059.18	1091.81	1173.48		1078.92	1020.42	1055.82	1123.95	1098.75	1059.18

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Silver
HIOS Plan ID: 18581WA0140002
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Silver
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	354.79	381.33		350.60	331.59	343.09	365.23	357.04	344.18	354.79	381.33		350.60	331.59	343.09	365.23	357.04	344.18
15	386.32	415.22		381.76	361.07	373.59	397.69	388.78	374.78	386.32	415.22		381.76	361.07	373.59	397.69	388.78	374.78
16	398.38	428.18		393.68	372.33	385.25	410.11	400.91	386.47	398.38	428.18		393.68	372.33	385.25	410.11	400.91	386.47
17	410.44	441.15		405.59	383.60	396.91	422.52	413.05	398.17	410.44	441.15		405.59	383.60	396.91	422.52	413.05	398.17
18	423.42	455.10		418.43	395.74	409.46	435.89	426.11	410.77	423.42	455.10		418.43	395.74	409.46	435.89	426.11	410.77
19	436.41	469.06		431.26	407.88	422.02	449.26	439.18	423.37	436.41	469.06		431.26	407.88	422.02	449.26	439.18	423.37
20	449.86	483.52		444.55	420.45	435.03	463.10	452.72	436.41	449.86	483.52		444.55	420.45	435.03	463.10	452.72	436.41
21	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91
22	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91
23	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91
24	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91	463.77	498.47		458.30	433.45	448.48	477.42	466.72	449.91
25	465.63	500.46		460.13	435.19	450.28	479.33	468.59	451.71	465.63	500.46		460.13	435.19	450.28	479.33	468.59	451.71
26	474.90	510.43		469.30	443.85	459.25	488.88	477.92	460.71	474.90	510.43		469.30	443.85	459.25	488.88	477.92	460.71
27	486.03	522.40		480.30	454.26	470.01	500.34	489.12	471.51	486.03	522.40		480.30	454.26	470.01	500.34	489.12	471.51
28	504.12	541.84		498.17	471.16	487.50	518.96	507.32	489.05	504.12	541.84		498.17	471.16	487.50	518.96	507.32	489.05
29	518.96	557.79		512.84	485.03	501.85	534.24	522.26	503.45	518.96	557.79		512.84	485.03	501.85	534.24	522.26	503.45
30	526.38	565.76		520.17	491.97	509.03	541.88	529.73	510.65	526.38	565.76		520.17	491.97	509.03	541.88	529.73	510.65
31	537.51	577.73		531.17	502.37	519.79	553.34	540.93	521.45	537.51	577.73		531.17	502.37	519.79	553.34	540.93	521.45
32	548.64	589.69		542.17	512.77	530.55	564.79	552.13	532.24	548.64	589.69		542.17	512.77	530.55	564.79	552.13	532.24
33	555.60	597.17		549.04	519.27	537.28	571.95	559.13	538.99	555.60	597.17		549.04	519.27	537.28	571.95	559.13	538.99
34	563.02	605.14		556.37	526.21	544.46	579.59	566.60	546.19	563.02	605.14		556.37	526.21	544.46	579.59	566.60	546.19
35	566.73	609.13		560.04	529.68	548.05	583.41	570.33	549.79	566.73	609.13		560.04	529.68	548.05	583.41	570.33	549.79
36	570.44	613.12		563.71	533.15	551.63	587.23	574.06	553.39	570.44	613.12		563.71	533.15	551.63	587.23	574.06	553.39
37	574.15	617.10		567.37	536.61	555.22	591.05	577.80	556.99	574.15	617.10		567.37	536.61	555.22	591.05	577.80	556.99
38	577.86	621.09		571.04	540.08	558.81	594.87	581.53	560.59	577.86	621.09		571.04	540.08	558.81	594.87	581.53	560.59
39	585.28	629.07		578.37	547.02	565.98	602.51	589.00	567.79	585.28	629.07		578.37	547.02	565.98	602.51	589.00	567.79
40	592.70	637.04		585.70	553.95	573.16	610.15	596.47	574.99	592.70	637.04		585.70	553.95	573.16	610.15	596.47	574.99
41	603.83	649.01		596.70	564.35	583.92	621.61	607.67	585.78	603.83	649.01		596.70	564.35	583.92	621.61	607.67	585.78
42	614.50	660.47		607.24	574.32	594.24	632.59	618.40	596.13	614.50	660.47		607.24	574.32	594.24	632.59	618.40	596.13
43	629.34	676.42		621.91	588.19	608.59	647.87	633.34	610.53	629.34	676.42		621.91	588.19	608.59	647.87	633.34	610.53
44	647.89	696.36		640.24	605.53	626.53	666.96	652.01	628.52	647.89	696.36		640.24	605.53	626.53	666.96	652.01	628.52
45	669.69	719.79		661.78	625.90	647.61	689.40	673.94	649.67	669.69	719.79		661.78	625.90	647.61	689.40	673.94	649.67
46	695.66	747.70		687.45	650.18	672.72	716.14	700.08	674.87	695.66	747.70		687.45	650.18	672.72	716.14	700.08	674.87
47	724.88	779.11		716.32	677.48	700.98	746.21	729.48	703.21	724.88	779.11		716.32	677.48	700.98	746.21	729.48	703.21
48	758.27	815.00		749.32	708.69	733.27	780.59	763.09	735.60	758.27	815.00		749.32	708.69	733.27	780.59	763.09	735.60
49	791.20	850.39		781.86	739.47	765.11	814.49	796.22	767.55	791.20	850.39		781.86	739.47	765.11	814.49	796.22	767.55
50	828.30	890.27		818.52	774.14	800.99	852.68	833.56	803.54	828.30	890.27		818.52	774.14	800.99	852.68	833.56	803.54
51	864.94	929.64		854.73	808.39	836.42	890.40	870.43	839.08	864.94	929.64		854.73	808.39	836.42	890.40	870.43	839.08
52	905.28	973.01		894.60	846.10	875.44	931.93	911.04	878.23	905.28	973.01		894.60	846.10	875.44	931.93	911.04	878.23
53	946.10	1016.88		934.93	884.24	914.90	973.95	952.11	917.82	946.10	1016.88		934.93	884.24	914.90	973.95	952.11	917.82
54	990.15	1064.23		978.47	925.42	957.51	1019.30	996.44	960.56	990.15	1064.23		978.47	925.42	957.51	1019.30	996.44	960.56
55	1034.21	1111.59		1022.00	966.60	1000.12	1064.66	1040.78	1003.30	1034.21	1111.59		1022.00	966.60	1000.12	1064.66	1040.78	1003.30
56	1081.98	1162.93		1069.21	1011.24	1046.31	1113.83	1088.86	1049.64	1081.98	1162.93		1069.21	1011.24	1046.31	1113.83	1088.86	1049.64
57	1130.21	1214.77		1116.87	1056.32	1092.95	1163.48	1137.39	1096.43	1130.21	1214.77		1116.87	1056.32	1092.95	1163.48	1137.39	1096.43
58	1181.69	1270.10		1167.74	1104.43	1142.73	1216.48	1189.20	1146.37	1181.69	1270.10		1167.74	1104.43	1142.73	1216.48	1189.20	1146.37
59	1207.20	1297.52		1192.95	1128.27	1167.40	1242.74	1214.87	1171.12	1207.20	1297.52		1192.95	1128.27	1167.40	1242.74	1214.87	1171.12
60	1258.68	1352.85		1243.82	1176.39	1217.18	1295.73	1266.68	1221.06	1258.68	1352.85		1243.82	1176.39	1217.18	1295.73	1266.68	1221.06
61	1303.20	1400.70		1287.82	1218.00	1260.23	1341.56	1311.48	1264.25	1303.20	1400.70		1287.82	1218.00	1260.23	1341.56	1311.48	1264.25
62	1332.42	1432.10		1316.69	1245.31	1288.49	1371.64	1340.88	1292.59	1332.42	1432.10		1316.69	1245.31	1288.49	1371.64	1340.88	1292.59
63	1369.06	1471.48		1352.89	1279.55	1323.92	1409.36	1377.75	1328.14	1369.06	1471.48		1352.89	1279.55	1323.92	1409.36	1377.75	1328.14
64 and over	1391.31	1495.41		1374.89	1300.35	1345.44	1432.26	1400.16	1349.73	1391.31	1495.41		1374.89	1300.35	1345.44	1432.26	1400.16	1349.73

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Bronze
HIOS Plan ID: 18581WA0140003
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Bronze
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	209.47	225.14		206.99	195.77	202.56	215.63	210.80	203.20	209.47	225.14		206.99	195.77	202.56	215.63	210.80	203.20
15	228.08	245.15		225.39	213.17	220.56	234.80	229.53	221.27	228.08	245.15		225.39	213.17	220.56	234.80	229.53	221.27
16	235.20	252.80		232.43	219.83	227.45	242.13	236.70	228.17	235.20	252.80		232.43	219.83	227.45	242.13	236.70	228.17
17	242.32	260.45		239.46	226.48	234.33	249.46	243.86	235.08	242.32	260.45		239.46	226.48	234.33	249.46	243.86	235.08
18	249.99	268.69		247.04	233.65	241.75	257.35	251.58	242.52	249.99	268.69		247.04	233.65	241.75	257.35	251.58	242.52
19	257.66	276.93		254.61	240.81	249.16	265.24	259.29	249.96	257.66	276.93		254.61	240.81	249.16	265.24	259.29	249.96
20	265.60	285.47		262.46	248.23	256.84	273.42	267.28	257.66	265.60	285.47		262.46	248.23	256.84	273.42	267.28	257.66
21	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63
22	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63
23	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63
24	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63	273.81	294.30		270.58	255.91	264.78	281.87	275.55	265.63
25	274.91	295.47		271.66	256.93	265.84	283.00	276.65	266.69	274.91	295.47		271.66	256.93	265.84	283.00	276.65	266.69
26	280.38	301.36		277.07	262.05	271.14	288.64	282.16	272.00	280.38	301.36		277.07	262.05	271.14	288.64	282.16	272.00
27	286.95	308.42		283.57	268.19	277.49	295.40	288.78	278.38	286.95	308.42		283.57	268.19	277.49	295.40	288.78	278.38
28	297.63	319.90		294.12	278.17	287.82	306.39	299.52	288.74	297.63	319.90		294.12	278.17	287.82	306.39	299.52	288.74
29	306.39	329.32		302.78	286.36	296.29	315.41	308.34	297.24	306.39	329.32		302.78	286.36	296.29	315.41	308.34	297.24
30	310.78	334.03		307.11	290.46	300.53	319.92	312.75	301.49	310.78	334.03		307.11	290.46	300.53	319.92	312.75	301.49
31	317.35	341.09		313.60	296.60	306.88	326.69	319.36	307.86	317.35	341.09		313.60	296.60	306.88	326.69	319.36	307.86
32	323.92	348.15		320.09	302.74	313.24	333.45	325.98	314.24	323.92	348.15		320.09	302.74	313.24	333.45	325.98	314.24
33	328.03	352.57		324.15	306.58	317.21	337.68	330.11	318.22	328.03	352.57		324.15	306.58	317.21	337.68	330.11	318.22
34	332.41	357.28		328.48	310.67	321.45	342.19	334.52	322.47	332.41	357.28		328.48	310.67	321.45	342.19	334.52	322.47
35	334.60	359.63		330.65	312.72	323.57	344.45	336.72	324.60	334.60	359.63		330.65	312.72	323.57	344.45	336.72	324.60
36	336.79	361.98		332.81	314.77	325.68	346.70	338.93	326.72	336.79	361.98		332.81	314.77	325.68	346.70	338.93	326.72
37	338.98	364.34		334.98	316.82	327.80	348.96	341.13	328.85	338.98	364.34		334.98	316.82	327.80	348.96	341.13	328.85
38	341.17	366.69		337.14	318.86	329.92	351.21	343.34	330.97	341.17	366.69		337.14	318.86	329.92	351.21	343.34	330.97
39	345.55	371.40		341.47	322.96	334.16	355.72	347.74	335.22	345.55	371.40		341.47	322.96	334.16	355.72	347.74	335.22
40	349.93	376.11		345.80	327.05	338.39	360.23	352.15	339.47	349.93	376.11		345.80	327.05	338.39	360.23	352.15	339.47
41	356.50	383.17		352.29	333.19	344.75	367.00	358.77	345.85	356.50	383.17		352.29	333.19	344.75	367.00	358.77	345.85
42	362.80	389.94		358.52	339.08	350.84	373.48	365.10	351.96	362.80	389.94		358.52	339.08	350.84	373.48	365.10	351.96
43	371.56	399.36		367.18	347.27	359.31	382.50	373.92	360.46	371.56	399.36		367.18	347.27	359.31	382.50	373.92	360.46
44	382.51	411.13		378.00	357.51	369.90	393.77	384.94	371.08	382.51	411.13		378.00	357.51	369.90	393.77	384.94	371.08
45	395.38	424.96		390.72	369.53	382.35	407.02	397.90	383.57	395.38	424.96		390.72	369.53	382.35	407.02	397.90	383.57
46	410.72	441.44		405.87	383.86	397.18	422.81	413.33	398.44	410.72	441.44		405.87	383.86	397.18	422.81	413.33	398.44
47	427.97	459.98		422.91	399.99	413.86	440.56	430.69	415.18	427.97	459.98		422.91	399.99	413.86	440.56	430.69	415.18
48	447.68	481.17		442.40	418.41	432.92	460.86	450.53	434.30	447.68	481.17		442.40	418.41	432.92	460.86	450.53	434.30
49	467.12	502.07		461.61	436.58	451.72	480.87	470.09	453.16	467.12	502.07		461.61	436.58	451.72	480.87	470.09	453.16
50	489.03	525.61		483.25	457.05	472.90	503.42	492.13	474.41	489.03	525.61		483.25	457.05	472.90	503.42	492.13	474.41
51	510.66	548.86		504.63	477.27	493.82	525.69	513.90	495.39	510.66	548.86		504.63	477.27	493.82	525.69	513.90	495.39
52	534.48	574.47		528.17	499.54	516.86	550.21	537.87	518.50	534.48	574.47		528.17	499.54	516.86	550.21	537.87	518.50
53	558.57	600.36		551.98	522.06	540.16	575.02	562.12	541.88	558.57	600.36		551.98	522.06	540.16	575.02	562.12	541.88
54	584.59	628.32		577.69	546.37	565.31	601.80	588.30	567.11	584.59	628.32		577.69	546.37	565.31	601.80	588.30	567.11
55	610.60	656.28		603.39	570.68	590.47	628.57	614.48	592.35	610.60	656.28		603.39	570.68	590.47	628.57	614.48	592.35
56	638.80	686.59		631.26	597.04	617.74	657.61	642.86	619.71	638.80	686.59		631.26	597.04	617.74	657.61	642.86	619.71
57	667.28	717.20		659.40	623.65	645.28	686.92	671.52	647.33	667.28	717.20		659.40	623.65	645.28	686.92	671.52	647.33
58	697.67	749.87		689.43	652.06	674.67	718.21	702.10	676.82	697.67	749.87		689.43	652.06	674.67	718.21	702.10	676.82
59	712.73	766.05		704.32	666.13	689.23	733.71	717.26	691.43	712.73	766.05		704.32	666.13	689.23	733.71	717.26	691.43
60	743.12	798.72		734.35	694.54	718.62	765.00	747.84	720.91	743.12	798.72		734.35	694.54	718.62	765.00	747.84	720.91
61	769.41	826.97		760.33	719.11	744.04	792.06	774.30	746.41	769.41	826.97		760.33	719.11	744.04	792.06	774.30	746.41
62	786.66	845.51		777.37	735.23	760.72	809.82	791.66	763.15	786.66	845.51		777.37	735.23	760.72	809.82	791.66	763.15
63	808.29	868.76		798.75	755.45	781.64	832.08	813.43	784.13	808.29	868.76		798.75	755.45	781.64	832.08	813.43	784.13
64 and over	821.43	882.89		811.74	767.73	794.34	845.61	826.65	796.88	821.43	882.89		811.74	767.73	794.34	845.61	826.65	796.88

Community Health Plan of Washington
Rating Example
Checklist Item 37

Family Rating Example

Plan Design:	Community Health Plan of Washington Cascade Select Complete Gold
Product:	18581WA014
HIOS:	18581WA0140001

Member	Age	Smoking Status	Rating Area	Final Premium
Subscriber	40	*n/a*	Rating Area 2	$533.27
Spouse	38	*n/a*	Rating Area 2	$519.92
Child 1	18	*n/a*	Rating Area 2	$380.97
Child 2	16	*n/a*	Rating Area 2	$358.44
Child 3	14	*n/a*	Rating Area 2	$319.21
Child 4	11	*n/a*	Rating Area 2	$0.00
Total				**$2,111.81**

(1) The Rate Schedule includes a table outlining premiums by age, smoking status and rating area for each plan. 'Final Premium' is taken directly from the Rate Schedule for the appropriate plan, age, and rating area combination.
(2) Rates are charged to no more than the three oldest covered children under 21 for family coverage.
(3) Tobacco rating is prohibited beginning with the 2026 plan year.

SERFF Tracking #:	*CHPW-134525946*	***State Tracking #:***	*484514*	***Company Tracking #:***	*CHPW-202*

State:	*Washington*	***Filing Company:***	*Community Health Plan of Washington*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Non-Grandfathered Individual*		
Project Name/Number:	*/*		

URRT

State Determination

Review Status:	Incomplete

SERFF Tracking #:	*CHPW-134525946*	***State Tracking #:***	*484514*	***Company Tracking #:***	*CHPW-202*

State:	*Washington*	***Filing Company:***	*Community Health Plan of Washington*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Non-Grandfathered Individual*		
Project Name/Number:	*/*		

URRT Items

Item Name	Attachment(s)
Unified Rate Review Template	*Part_I_Unified_Rate_Review_Template.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*

Part III Actuarial Memorandum

Community Health Plan of Washington
Individual Rate Filing
Effective January 1, 2026

Prepared for:
Community Health Plan of Washington

Prepared by:
Jordan Pettibon, FSA, MAAA
Consulting Actuary
Milliman, Inc.

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Seattle, WA 98101
Tel +1 206 504 5771

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TABLE OF CONTENTS

The following table summarizes the exhibits included in this document. Some exhibits may span multiple pages.

EXHIBIT 1. GENERAL INFORMATION

Document Overview

This document contains the Part III Actuarial Memorandum for Community Health Plan of Washington's (CHPW) individual block of business, effective January 1, 2026. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the State of Washington State Office of the Insurance Commissioner, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of CHPW's individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Milliman under any theory of law.

As prescribed by Washington or as instructed by Community Health Plan of Washington the premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded as is described in current regulations and guidance. Future modifications in legislation, regulation and/or court decisions may affect the extent to which the premium rates are neither excessive nor deficient. Community Health Plan of Washington reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed.

At the time of this rate filing submission, we acknowledge there is uncertainty regarding whether the enhanced premium tax credit subsidies, first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA) in 2022, will or will not be extended beyond 2025. As instructed by the WA OIC, we have prepared this set of rate filing materials assuming that these enhanced premium tax credits will expire at the end of 2025 and will not be applicable in 2026. The expiration versus extension of these subsidies could materially impact the morbidity, enrollment, and other factors related to the Individual market. We have incorporated various premium rate adjustments to reflect the estimated financial impact of these subsidies expiring. These adjustments are derived from a Milliman model that leverages data from CMS reports, proprietary Milliman datasets, and other publicly available information. Our model results will evolve as new information becomes available and new actions are taken by the authorities and other stakeholders. If subsequent information becomes available that would materially affect this rate filing submission, CHPW would pursue opportunities to revise the pricing assumptions and resubmit this rate filing.

This rate filing submission includes adjustments for the emergency rule issued by the WA OIC requiring a uniform CSR silver load adjustment (WAC 284-43-6820), standardized induced demand factors (WAC 284-43-6810(2)), and pricing actuarial value guardrails (WAC 284-43-6810(3)).

Company Identifying Information

Company Legal Name: Community Health Plan of Washington
State: The State of Washington has regulatory authority over these policies.
HIOS Issuer ID: 18581
Market: Individual
Effective Date: January 1, 2026

Company Contact Information

Primary Contact Name: Elaine Corrough
Primary Contact Telephone Number: (206) 521-8833
Primary Contact Email Address: elaine.corrough@chpw.org

EXHIBIT 2. PROPOSED RATE CHANGES

The rate projections for 2026 have been updated from the previous year's projections to reflect the most recent information available.

Table 2.1 below describes and quantifies the primary drivers underlying the proposed rate change for 2026, including but not limited to, the estimated impact of enhanced premium tax credit subsidy expiration. This breakdown is intended only for explanatory purposes and is distinct from the development of rates, as described in the subsequent sections of this memorandum.

Table 2.1
Community Health Plan of Washington
Breakdown of Proposed Rate Change

Description	Value
Estimated Changes in Experience	1.068
Additional Year of Trend (2025 to 2026)	1.053
Impact of eAPTC Subsidy Expiration	1.036
Changes in Net Morbidity and Risk Adjustment (Excluding eAPTC Subsidy Expiration Impact)	1.088
Changes in Benefits	0.987
Changes in Plan Mix and CSR Rate Load	1.034
Changes in Administrative Costs	0.989

Estimated Changes in Experience

The individual single risk pool experience underlying the rate projections has been updated, including marketplace enrollee mix. This impact reflects the difference between the interim 2024 projection of claims from 2025 rate development and the actual 2024 experience, normalized for changes in population morbidity and plan mix.

Additional Year of Medical and Prescription Drug Utilization and Unit Cost Trend

This impact reflects one additional year of medical and prescription drug utilization and unit cost trend from 2025 to 2026. Please refer to Table 5.1 for a breakdown of these trend assumptions by major service category as reported on Worksheet 1, Section II of the URRT.

Impact of eAPTC Subsidy Expiration

We modeled adjustments to CHPW's projected claims and risk adjustment transfer position to account for the anticipated impact of enhanced premium tax credit subsidy expiration. This impact reflects some assumed level of deterioration in the single risk pool due to anticipated disenrollment in 2026.

Changes in Net Morbidity and Risk Adjustment (Excluding eAPTC Subsidy Expiration Impact)

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. Risk adjustment transfer experience for calendar year 2024 was projected forward to 2026, including consideration of changes to the statewide average premium, risk adjustment program, and CHPW enrollee population morbidity relative to the Washington single risk pool. This excludes the impact of pricing assumptions explicitly related to the expiration of enhanced premium tax credit subsidies, which is quantified separately in the line item above.

Changes in Plan Benefits

We updated the plan designs to align with the standardized plan designs issued by WAHBE for the 2026 plan year. This impact reflects changes in the standardized plan designs from 2025 to 2026 as measured by changes in projected plan level AV pricing values and induced utilization, holding plan mix constant.

EXHIBIT 2. PROPOSED RATE CHANGES

Changes in Plan Mix and CSR Rate Load

We modeled changes in CHPW's projected plan mix between 2025 and 2026 due to the anticipated expiration of enhanced premium tax credit subsidies and the WA OIC's emergency rule requiring issuers to implement a standardized silver CSR rate load. This reflects the residual impact of plan mix changes, normalized for changes in the composite plan rating factor between 2025 and 2026, and the impact of changes in the silver CSR rate load on the rate change.

New Taxes, Fees and Administrative Expenses

Administrative costs decreased modestly due to restatement in administrative expenses and the impact of fixed administrative costs as a percentage of the higher aggregate premium in 2026. The administrative cost assumptions also reflect the impact of CHPW's smaller membership basis in 2026 increasing the impact of fixed costs. There was no change to the Exchange User Fee ($5.11 PMPM) between 2025 and 2026.

See Exhibit 10 for further details on projected non-benefit expenses.

The variance in the rate changes across plans does not reflect the incorporation of plan-specific morbidity. When projecting plan rating factors, we have assumed the same demographic and risk characteristics for each plan priced. This pricing method excludes expected differences in the morbidity of members assumed to select the plan.

Single Risk Pool

The 2026 rate development is based on the single risk pool set by the State of Washington, which was established according to the requirements in *45 CFR Part 156.80* . The single risk pool is defined as the non-grandfathered individual business in Washington.

Neither the single risk pool for the experience period nor the projection period include members who are eligible to remain enrolled in transitional plans.

Additional Rate Change Information

The following section addresses the requirements contained in item 24 of the Individual Non-Grandfathered Health Plan Checklist.

45 CFR 154.301(a)(4)(i) The impact of medical trend changes by major service categories:
See above and Exhibit 5 for discussion of medical trend changes.

45 CFR 154.301(a)(4)(ii) The impact of utilization changes by major service categories:
See above and Exhibit 5 for discussion of utilization changes.

45 CFR 154.301(a)(4)(iii) The impact of cost-sharing changes by major service categories, including actuarial values:
See Exhibit 10 for discussion of cost-sharing changes.

45 CFR 154.301(a)(4)(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits:
See Exhibit 5 for discussion of the impact of benefit changes.

45 CFR 154.301(a)(4)(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:
See Exhibit 5 and Exhibit 10 for a discussion of the impact of changes in enrollee risk profile and pricing and Exhibit 11 for discussion of the rating limitations for age and tobacco use.

EXHIBIT 2. PROPOSED RATE CHANGES

45 CFR 154.301(a)(4)(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase:
This consideration is not directly applicable to CHPW's 2026 rate development. CHPW's 2026 rate projections were informed by its 2024 claims experience and expectations regarding trend and other drivers of rate change from 2024 to 2026.
CHPW makes no explicit adjustment for overestimation or underestimation of medical trend.

45 CFR 154.301(a)(4)(vii) The impact of changes in reserve needs:
This consideration is not directly applicable to CHPW's 2026 rate development. CHPW makes no explicit adjustment due to changes in reserve needs.

45 CFR 154.301(a)(4)(viii) The impact of changes in administrative costs related to programs that improve health care quality:
See Exhibit 10 for a discussion of administrative costs related to programs that improve health care quality.

45 CFR 154.301(a)(4)(ix) The impact of changes in other administrative costs:
See above and Exhibit 10 for a discussion of other administrative costs.

45 CFR 154.301(a)(4)(x) The impact of changes in applicable taxes, licensing or regulatory fees:
See above and Exhibit 10 for a discussion of applicable taxes, licensing, and regulatory fees.

45 CFR 154.301(a)(4)(xi) Medical loss ratio:
CHPW's 2026 rate projections were informed by the claims experience and quality improvement activities underlying its estimated 2024 MLR. However, its 2026 projected MLR includes independent projections for each component of the MLR formula (including premium), as opposed to a projection directly built off of its 2024 MLR. The claims used in the MLR calculation have been adjusted for quality improvement expenses and provider incentive payments. The pharmacy claims used in the MLR calculation are net of prescription drug rebates. In 2024, prescription drug rebates are $3,105,866 based on CHPW's most recent accrual information.

45 CFR 154.301(a)(4)(xii) The health insurance issuer's capital and surplus:
Contribution to surplus, contingency charges, or risk charges have not changed between 2025 and 2026.

45 CFR 154.301(a)(4)(xiii) The impacts of geographic factors and variations:
See Exhibit 12 for a discussion of the geographic factors.

45 CFR 154.301(a)(4)(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool:
See Exhibit 5 for a discussion of the impact of changes within a single risk pool to all plans within the risk pool.

45 CFR 154.301(a)(4)(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act:
See Exhibit 9 for a discussion of the impact of reinsurance and risk adjustment payments and charges.

EXHIBIT 3. EXPERIENCE AND CURRENT PERIOD PREMIUM, CLAIMS, AND ENROLLMENT

The experience reported on Worksheet 1, Section I of the URRT shows CHPW's earned premium, incurred and paid claims, and enrollment for the period of 1/1/2024 through 12/31/2024, with claims paid through 3/31/2025. Current enrollment and current premium on Worksheet 2, Section II are reported as of 4/1/2025.

Premiums in Experience Period

The premiums earned during the experience and as reported on Worksheet 1, Section I of the URRT are from CHPW's audited financial statements for CY2024. The premiums are not adjusted for MLR rebates.

Method for Determining Allowed Claims

All allowed claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported allowed claims was added to the processed amount to arrive at a final estimate of total allowed claims. No estimate of incurred but not reported claims was added to the prescription drug claims under the assumption that these claims are complete.

Method for Determining Paid Claims

All paid claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported claims was added to the processed amount to arrive at a final estimate of total paid claims. No estimate of incurred but not reported claims was added to the prescription drug claims under the assumption that these claims are complete.

Method for Determining Incurred But Not Reported Paid Claims

Incurred claims were calculated by applying a completion factor to the paid claims from the experience period. The completion factors were developed using the lag development method. The completion factors applied to paid and allowed claims are the same.

Method for Determining Paid Cost Sharing

Paid member cost sharing was determined by subtracting paid claims from allowed claims.

Claims Lags and Experience by Benefit Category (Checklist items 1b and 1c)

Tables 3.1a-d include allowed and incurred claims lags separately for medical and pharmacy for claims incurred in calendar year 2024 and paid through March 2025. Table 3.2 includes allowed and incurred claims by benefit category and month, premiums by month, monthly membership, changes in reserves during the period, and paid-to-allowed ratios.

Documentation and Justification for URRT Worksheet 2, Section II: Experience Period and Current Plan Level Information

The following supports item 4 of the Individual Non-Grandfathered Health Plan Checklist.

"Section II: Experience Period and Current Plan Level Information" from Worksheet 2 of the URRT is based on information as of March 2025 from the following sources:

- Line 2.2, Allowed Claims: Plan-level experience period data, with runout through March 2025. Allowed claims include an estimate for incurred but not paid amounts.
- Line 2.3, Reinsurance: There is no state reinsurance, so this field has been populated with zero for all plans.
- Line 2.4, Member Cost Sharing: Plan-level experience period data, with runout through March 2025.
- Line 2.5, Cost Sharing Reduction: Plan-level experience period data, with runout through March 2025.
- Line 2.6, Incurred Claims: This line is calculated by the URRT. It includes all incurred claims that are the issuer's responsibility.
- Line 2.7, Risk Adjustment Transfer Amount: Based on the CMS "Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025. The Risk Adjustment User Fee is not included in this line, as it is included in the Taxes & Fees line (3.7) of the URRT.
- Line 2.8, Premium: Plan-level experience period data, reported as of March 2025.
- Line 2.9, Experience Period Member Months: Plan-level experience period data, reported as of March 2025.
- Line 2.10, Current Enrollment: Current enrollment by plan as of April 2025.
- Line 2.11, Current Premium PMPM: April 2025 premium by plan divided by enrollment for April 2025.

EXHIBIT 4. BENEFIT CATEGORIES

We assigned the experience data utilization and cost information to benefit categories as shown in Worksheet 1, Section II of the Part 1 URRT based on place and type of service using a detailed claims mapping algorithm summarized as follows:

Inpatient Hospital

The inpatient hospital category 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

The outpatient hospital category 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

The professional category includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based physicians whose payments are included in facility fees.

Other Medical

The other medical category includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation

The capitation category includes all services provided under one or more capitated arrangements.

Prescription Drug

The prescription drug category includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

EXHIBIT 5. PROJECTION FACTORS

This section includes a description of trend factors used to project the experience period Index Rate to the projection period, and supporting information related to the development of those factors. For a demonstration of the trends, please see Table 5.1 below. This section also includes a description of adjustment factors (other than trend) that are applied to the experience period Index Rate in order to develop the projected Index Rate, and supporting information related to the development of those factors.

Trend Factors (Cost/Utilization)

This development of the CY2026 rates reflects an annual trend rate in Year 1 of 4.4% and an annual trend rate in Year 2 of 5.3%, which were developed using the following data source and methodology:

The trend factors reflect CHPW's expectations regarding increases in in-network contractual reimbursement and the impact of trends in both projected in-network and out-of-network costs. The prescription drug trends reflect changes in the drug formulary, expiration of drug patents and introduction of new drugs. Table 5.1 below documents CHPW's projected trends by category and year. The factors only reflect trend applicable to the single risk pool; they have been normalized and/or adjusted when appropriate to account for other changes such as changes in age, benefit changes, seasonality patterns, and non-recurring events.

Table 5.1
Community Health Plan of Washington
Annual Unit Cost and Utilization Trend Assumptions

	Year 1			Year 2		
Service Type	**Cost**	**Util**	**Total**	**Cost**	**Util**	**Total**
Inpatient Hospital	3.1%	-0.5%	2.6%	3.1%	-0.5%	2.5%
Outpatient	3.1%	1.0%	4.1%	3.0%	1.0%	4.0%
Professional	-2.8%	0.0%	-2.8%	0.1%	0.0%	0.1%
Other Medical	-2.5%	0.0%	-2.5%	0.4%	0.0%	0.4%
Capitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prescription Drug	10.0%	2.5%	12.8%	10.0%	2.5%	12.8%
Total			**4.4%**			**5.3%**

Months of Trend Year 1	12.0
Months of Trend Year 2	12.0

The cost trend factors reflect the following:

- Changes in contractual reimbursement between the experience and projection periods for a fixed basket of services. This is based on actual 2024 contracts and ongoing contracting efforts for 2026, controlling for changes in service mix, the geographic distribution of enrollees, and pharmacy rebates.
  - For Plan Year 2026, CHPW has retained and expanded upon the CHPW Cascade Care Affiliates Network. As of the date of submission of this actuarial memorandum, final contract negotiations with physicians and hospitals are largely complete. At this time, CHPW has executed agreements with approximately 92% of the targeted hospitals and over 2,600 provider groups. CHPW has successfully updated all contracts with Community Health Centers (CHCs) to provide primary care services wherever available throughout the network. CHPW is in continued discussions with the remaining targeted providers, with the projected completion of all required contracts by January 1, 2026.
- Average charge trend between the experience and projection periods normalized for demographics, morbidity, and benefit design.
  - Medical charge trends are set equal to anticipated Medicare fee schedule changes, as CHPW contracts on a percentage of FFS Medicare basis.
  - Pharmacy charge trends are informed by the Milliman *Health Cost Guidelines* and a review of CHPW's PBM contracts and reporting.

EXHIBIT 5. PROJECTION FACTORS

The utilization trend factors reflect the following:

- Assumed changes in the mix or intensity of services provided for a fixed level of illness burden.
- Secular utilization trend (the expected force of utilization trend over time for a static population with a fixed set of benefits), normalized for demographics, morbidity, and benefit design, informed by consideration of typical industry trend assumptions and the Milliman *Health Cost Guidelines* .
- Utilization trend is independent from the morbidity adjustments described below. As the utilization trends are on a secular basis and do not include any impact related to population morbidity shifts, there is no overlap between these estimates.

Table 5.2 includes a breakout of utilization and unit cost for the benefit categories shown on URRT Worksheet 1. Table 5.2 shows the development of the claims trends entered in the WAC 284-43-6660 summary.

Morbidity Adjustment

We used the following data source(s) and methodology in order to estimate the changes between the morbidity of the experience population and the projected population, as shown in the Morbidity Adjustment row of Worksheet 1, Section II of the URRT:

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. The adjustment was based on a review of CHPW's estimated 2024 morbidity levels, with particular consideration given to the large cohort of new members in 2024.

Assuming the enhanced premium subsidies first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA) expire at the end of 2025, we anticipate a reduction in the overall market size in 2026. This will lead to increasing average statewide morbidity in 2026 relative to the 2024 experience period as consumers either lose access to subsidies (for those at or above 400% of the Federal Poverty Level) or face higher net premiums due to less generous subsidies. We anticipate the remaining risk pool in 2026 to have higher healthcare needs, on average, as healthier consumers are more likely to lapse coverage. Given these considerations, we applied a morbidity adjustment to reflect anticipated changes in statewide average morbidity in 2026 relative to 2024.

Consistent with the URR instructions, the morbidity adjustment reflects the component of the change in average allowed claims PMPM holding constant the experience period population's demographics (i.e., age, gender, and region), product mix, and all provider network contracts and time parameters.

The morbidity assumption used for projecting claims reflects CHPW's expectations regarding the morbidity of its 2026 membership and is consistent with the relative morbidity assumption used to estimate CHPW's risk transfer payment.

Demographic Shift

We used the following data source(s) and methodology in order to estimate the changes in the demographic and geographic mix of the population, as shown in the Demographic Shift row of Worksheet 1, Section II:

Our rate projection is based on CY2024 experience, and reflects the average demographics and geographic mix of the CY2024 enrollees. Our development of the CY2026 Index Rate reflects the anticipated differences in the demographic and geographic mix of the population, as compared to the CY2024 experience period.

We used the Milliman *Health Cost Guidelines* age/sex factors, utilization area factors, and unit cost area factors applied to both the 2024 and 2026 population to develop the demographic adjustment.

Plan Design Changes

We made the following adjustments to reflect the expected differences in benefits between the experience period and projection period, as shown in the Plan Design Changes row of Worksheet 1, Section II of the URRT:

EXHIBIT 5. PROJECTION FACTORS

Experience period claims were adjusted for changes in plan mix and plan design. This adjustment factor reflects anticipated changes in the demand for services due to differences in product mix and cost-sharing from the experience period to the projection period. Population demographics and morbidity were held constant across plan designs for this adjustment to avoid confounding with demographics and morbidity shifts.

We used Milliman's Health Cost Guidelines (HCGs), in conjunction with the historical experience of CHPW's individual block of business, in order to estimate the benefit changes for each of the items listed above.

The WA OIC introduced new EHBs to the state benchmark plan for CY2026:

- human donor milk,
- hearing aids and hearing exams, and
- artificial insemination

We modeled adjustments to projected claims to reflect the anticipated impact of these new essential health benefits.

Other Adjustments

The Other row of Worksheet 1, Section II contains additional adjustments from those described above. These adjustments have been made to recognize the additional anticipated changes in claims experience between the base period and the projection period. We used the following data sources and methodology in order to estimate these changes:

- The above components are applied at an aggregate level in the claims projection. We measured their mix/interaction impact across service categories and applied the resulting factor as an other adjustment.
- The pricing AV guardrails imposed by WAC 284-43-6800(3) reduced CHPW's aggregate projected AV in such a way that normalization could not restore the aggregate 2026 paid claims to the projected level. We included an offsetting adjustment to projected allowed claims such that projected paid claims are restored to the pre-AV adjustment level.
- Changes in anticipated pediatric vision costs: CHPW is self-insured through VSP for this benefit, and we rely on VSP's estimates of projected claims. The difference between actual experience and VSP's projections are reflected in this factor.

EXHIBIT 6. MANUAL RATE ADJUSTMENTS

Not applicable. CHPW's 2024 experience is fully credible for the purposes of the rate projection.

EXHIBIT 7. CREDIBILITY OF EXPERIENCE

Description of the Credibility Method Used

Credibility is calculated using the following formula:

If Member Months < 66,000: (Member Months / 66,000)^(1/2)
If Member Months ≥ 66,000: 100%

This credibility threshold is based on research into the minimum number of member months required such that the projected allowed PMPM of a group based on historical experience is within 10% of the actual allowed PMPM 95% of the time.

Resulting Credibility Level Assigned to the Base Period Experience

As CHPW had 335,501 member months in the base period, the credibility assigned to the base period experience is 100%.

EXHIBIT 8. ESTABLISHING THE INDEX RATE

The Index Rate for the experience period is a measurement of the average allowed claims PMPM for EHB benefits. The experience period Index Rate reflects the actual mixture of smoker/non-smoker population, area factors, catastrophic/non-catastrophic enrollment, and the actual mixture of risk morbidity that CHPW received in the Single Risk Pool during the experience period. Note that there were additional benefits offered beyond the EHB benefits. The experience period Index Rate has not been adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange User Fees.

The experience period Index Rate is equal to the experience period total allowed claims PMPM minus the total non-EHB allowed claims PMPM.

Per item 11d of the Individual Non-Grandfathered Health Plan Checklist, abortion services are included in the index rate projected in URRT Worksheet 1, Section II as Washington considers these services to be EHBs.

The Index Rate for the projection period is a measurement of the average allowed claims PMPM for EHB benefits. The Projection Period Index Rate reflects the projected CY2026 mixture of area factors, and the projected mixture of risk morbidity that CHPW expects to receive in the Single Risk Pool. Note that there were additional benefits offered beyond the EHB benefits. The Projection Period Index Rate has not been adjusted for payments and charges projected under the risk adjustment program nor for Exchange User Fees.

The Projection Period Index Rate is equal to the projected total allowed claims PMPM minus the total non-EHB allowed claims PMPM.

The following table summarizes the factors applied to the Experience Period Index Rate to determine the Projection Period Index Rate. Please see Exhibit 5 for a description and development of these factors.

Table 8.1
Community Health Plan of Washington
Projection Period Index Rate Development

Description	Experience
2024 Total Allowed Claims PMPM	$392.63
2024 Non-EHB Allowed Claims PMPM	$0.00
2024 EHB Allowed Claims PMPM	$392.63
Trend	1.099
2026 EHB Allowed Claims PMPM	$431.52
Morbidity Adjustment	**1.050**
Risk Pool Deterioration	1.050
Demographic Shift	**1.025**
Demographics	1.021
Geography	1.004
Plan Design Changes	**0.986**
Induced Utilization	0.985
New Essential Health Benefits	1.001
Other	**1.017**
Mix/Interaction	0.977
Aggregate Paid Restoration	1.040
VSP Pediatric Vision Change	1.000
Projected EHB Allowed Claims PMPM	$465.65
Credibility	100%
Projection Period Index Rate PMPM	**$465.65**

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

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

Table 9.1 Community Health Plan of Washington Market-Wide Adjusted Index Rate Development	
2026 Index Rate PMPM	$465.65
Market-Wide Adjustments (paid basis)	
Risk Adjustment Transfer Amount	$142.59
Exchange User Fees	$5.11
Paid-to-Allowed Ratio	0.872
Market-Wide Adjustments (allowed basis)	
Risk Adjustment Transfer Amount	$163.56
Exchange User Fees	$5.86
Market-Wide Adjusted Index Rate PMPM	**$635.08**

The Market-Wide Adjusted Index Rate is not calibrated. This means that this rate reflects the average demographic characteristics of the single risk pool.

Each of the above modifiers were developed as follows:

- Risk Adjustment Transfer Amount
  This factor includes the impact of the estimated risk adjustment transfer payment as addressed in a subsequent section of this Exhibit.

- Exchange User Fee Adjustment
  The Exchange User Fee adjustment was determined as the average of no fee and the WAHBE Exchange User Fee ($5.11 PMPM), weighted using the expected distribution of issuer enrollment sold through versus outside the Exchange.

Experience Period Risk Adjustments PMPM

The following methodology was used to estimate final risk adjustment transfers for CY2024:

The experience period risk adjustment transfer amount was calculated using the HHS risk adjuster formula, as shown below. Factors calculated for CHPW and the State are based on Wakely's Risk Adjustment Reporting based on EDGE data submissions through December 2024. The projected CY2024 risk adjustment transfer reflects anticipated PLRS completion assumptions for both CHPW and the market. The projected CY2024 risk adjustment transfer is a charge of -$132.02 PMPM from CHPW into the risk pool, net of the HCRP receivable and assessment.

"WA Exhibit 10: Summarized Risk Adjustment" includes the calculation of the expected risk adjustment transfer payment amount (gross of risk adjustment fees), using the HHS risk adjuster formula.

Risk Adjustment Payment/Charge

Worksheet 1, Section II of the URRT shows how the anticipated risk adjustment transfer revenue is applied to the Index Rate in the development of the Market-Wide Adjusted Index Rate. The Projected Risk Adjustment Transfer PMPM (-$163.56) is shown on Worksheet 1, Section II on an allowed basis. This amount does not include the 2026 Risk Adjustment User Fee of $0.20 PMPM. The Risk Adjustment User Fee is included with Taxes and Fees on Worksheet 2, line 3.7. "WA Exhibit 10: Summarized Risk Adjustment" includes quantitative support for CHPW's projected 2026 risk adjustment liability.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The state transfer calculation portion of the total risk adjustment transfer is based on the risk adjustment transfer formula, as provided in the Federal Register.

We project each factor in the risk adjustment transfer formula at the metal level using the state's actual historical risk adjustment factors adjusted to the projected population.

For the purpose of our modeling, each of these factors was approximated as follows:

- Statewide Average Premium: The state average premium was assumed to be approximately $603.45 PMPM (net of the 14% administrative cost carve out).

- Plan Liability Risk Score (PLRS): The statewide average risk score (1.331) is projected based on the average PLRS of the single risk pool in 2024, as reported by the U.S. Department of Health and Human Services (HHS) as of March 14, 2025, adjusted for projected changes in the demographics, morbidity, and plan mix of the single risk pool from 2024 to 2026. This includes the projected change in statewide morbidity from 2025 to 2026 driven by the assumed expiration of enhanced APTC subsidies at the end of 2025.
  - The average risk score for CHPW's membership (0.897) is projected based on the completed 2024 CHPW PLRS adjusted for changes in the composition of CHPW's population between 2024 and 2026, including the impact of disenrollment due to expiration of the enhanced APTC subsidies as well as the impact to CHPW's relative risk score due to underlying changes in the HHS-HCC risk model.

- Induced Demand Factor (IDF) (1.035 Single Risk Pool; 1.037 CHPW): The statewide average IDF is projected based on the average IDF of the single risk pool in 2024, as reported by HHS as of March 14, 2025.
  - The average IDF for CHPW is projected by applying the induced demand factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11 to CHPW's projected population. Similarly, the projected market IDF is calculated using the same metal level induced demand factors applied to the projected market metal mix. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.
  - The projected average IDF for CHPW and the market reflect the anticipated changes in metal mix driven by the 43.5% mandated silver CSR load. Consistent with the assumptions underlying the OIC's development of the mandated CSR rate load, we assume that all Silver 70% members will migrate to the new low AV Vital Gold plan and that all Silver 73% members will disenroll entirely due to the silver plan premium cost increase.

- Actuarial Value (AV) (0.695 Single Risk Pool; 0.708 CHPW): The statewide average AV is projected based on the average metal level AV of the single risk pool in 2024, as reported by HHS as of March 14, 2025.
  - The average AV for CHPW is projected by applying the metal level AV factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 9 to CHPW's projected population. Similarly, the projected market AV is calculated using the same metal level AV factors applied to the projected market metal mix. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold 0.80, and Platinum 0.90.
  - The projected average AV for CHPW and the market reflect the anticipated changes in metal mix driven by the 43.5% mandated silver CSR load in PY 2026 as described in the development of the projected average IDF assumptions above.

- Allowable Rating Factor (ARF) (1.715 Single Risk Pool; 1.550 CHPW): As stated in the March 11, 2013 Federal Register, page 15433, the ARF adjustment accounts only for age rating.
  - The statewide average ARF is projected based on the average ARF of the single risk pool in 2024, as reported by HHS as of March 14, 2025, adjusted for projected changes in the demographics of the single risk pool from 2024 to 2026.
  - The average ARF for CHPW is projected by applying the 2026 HHS age rating factors to CHPW's projected population.
  - The projected average ARF assumptions for CHPW and the market reflect changes in the assumed demographic profile of the market in 2026 due to the anticipated expiration of enhanced APTC subsidies.

- Geographic Cost Factor (GCF): The average GCF for CHPW relative to the statewide average was modeled based on historical GCFs by rating areas reported by HHS as of March 14, 2025 and CHPW's projected enrollment by rating area.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The total transfer is calculated as the sum of the state transfer calculation described above and a net transfer for 2026 attributable to the high cost risk pooling (HCRP) program (-$1.05). The projected HCRP receivable (-$1.25) is based on the on the attachment point and coinsurance from the 2026 Notice of Benefit and Payment Parameters (NBPP), and the projected HCRP assessment (-$2.30) is modeled as approximately 0.36% of premium.

The projected transfer amount assumes no impact under the Risk Adjustment Data Validation (RADV) process.

The risk adjustment transfer amount (-$163.56) reported on Worksheet 1 of the URRT is the actual PMPM amount expected in the projection period on an allowed basis. The risk adjustment transfer amount applied to the Index Rate in the development of the Market-Wide Adjusted Index Rate is on an allowed claims basis, as the Index Rate is on an allowed claims basis.

The assumptions used in developing the risk adjustment transfer amount are current as of the date of this filing. The demographic, plan mix, and morbidity assumptions supporting the risk transfer projection are consistent with the demographic, plan mix, and morbidity assumptions used to project claims costs.

Risk Adjustment Data by Metal Level and Risk Model Changes

"WA Exhibit 10: Summarized Risk Adjustment" includes support for the Individual Non-Grandfathered Health Plan Checklist items 18, 19a, 19b, and 19f. WA Exhibit 10 summarizes the 2024 risk adjustment data used to develop CHPW’s projected 2026 risk adjustment transfer liability, including the projected 2026 statewide average premium. In WA Exhibit 10, projected membership and all components of the risk adjustment transfer formula are reported separately by metal level.

We adjusted CHPW's projected relative PLRS to account for changes in the underlying HHS-HCC risk model between 2024 and 2026. We leveraged prevalence exhibits in Wakely's Risk Adjustment Reports to evaluate the impact of risk model changes on CHPW's PLRS relative to the market in 2026. The prevalence exhibits include simulated issuer (CHPW) and market PLRS using both the final 2024 and 2026 HHS-HCC risk models. To isolate the impact of model changes independent of changes in the demographic profile of the single risk pool, the simulated risk scores are calculated using a static 2024 population.

High Cost Risk Pool Receipt/(Assessment)

The HCRP reinsurance program reimburses issuers at 60% of annualized enrollee claims costs in excess of the $1M attachment point. We used an all service category claim probability distribution (CPD) from the Milliman Health Cost Guidelines (HCGs), scaled to the CHPW’s projected annual allowed claims for each benefit plan, to model estimated risk adjustment reinsurance receivables. Changes in CHPW’s contractual reimbursement, demographic composition, and risk profile, among others, will contribute to changes in CHPW’s anticipated HCRP receivables between 2024 and 2026.

The High-Cost Risk Pool (HCRP) reinsurance program assessment fee is based on an assumed 0.36% of premium, consistent with the assessment reported in the final BY 2023 risk adjustment report.

The following table includes the actual (2022-2024) and filed (2022-2026) HCRP receipts and assessments. In 2026, we are projecting a net HCRP payment for CHPW based on historical experience and the anticipated morbidity profile of CHPW's 2026 population.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

Table 9.2
Community Health Plan of Washington
Actual and Projected HCRP Receipt/Assessment PMPM

	2023	2024	2025	2026
High-Cost Risk Pool Receipt				
Actual	$0.00	$6.73	*n/a*	*n/a*
Filed	$1.14	$1.70	$0.91	$1.25
High-Cost Risk Pool Assessment				
Actual	($1.32)	($1.83)	*n/a*	*n/a*
Filed	($1.14)	($1.70)	($1.75)	($2.30)
Net High-Cost Risk Pool Receipt/(Assessment)				
Actual	($1.32)	$4.90	*n/a*	*n/a*
Filed	$0.00	$0.00	($0.84)	($1.05)

The green highlighted cells reconcile to the estimated 2024 and projected 2026 HCRP receipts and assessments in WA Exhibit 10. Negative value implies a net payment and a positive value implied a net receipt, consistent with the sign of the risk adjustment transfers in WA Exhibit 10.

Impact due to Risk Adjustment Data Validation (RADV)

CHPW's 2026 projected risk adjustment transfer does not reflect any assumed impact for RADV.

Paid to Allowed Ratios

The following table provides support for the average projected paid-to-allowed ratio. The average projected allowed and incurred PMPM reflects the member month weighted average from Worksheet 2, Section IV of the URRT.

The following table provides support for the average paid-to-allowed ratio by plan metal level:

Table 9.3
Community Health Plan of Washington
Average Paid to Allowed Factor Support

Metal Level	Member Months	Paid Claims PMPM	Allowed Claims PMPM	Paid-to-Allowed Ratio	AV Metal Value
Gold	43,848	$371.81	$451.85	0.823	80.6%
Silver	113,770	$453.78	$483.16	0.939	71.8%
Bronze	28,579	$267.91	$417.11	0.642	65.0%
Total	**186,197**	**$405.95**	**$465.65**	**0.872**	**72.9%**

The projected paid and allowed claims reflect the member month weighted average by metal level from Worksheet 2, Section IV of the URRT. The average AV metal value is based on AVs calculated using the federal AV calculator, weighted on projected allowable cost by metal level.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

The Market-Wide Adjusted Index Rate is adjusted to compute the Plan Adjusted Index Rate using the following allowable adjustments:

- Actuarial value and cost sharing adjustment
    - Since CHPW only offers standardized plans through the public option, we are relying on AV Calculator AVs from Wakely Consulting Group's Unique Plan Design Certification for the metal AV of Washington standardized benefit designs.
    - The AV and cost sharing pricing adjustment was developed utilizing the HCGs. Relativities between plans were based on the differences in cost and utilization for varying levels of cost sharing, holding morbidity and population constant for all plans.
    - AV pricing values were adjusted to be no more than +/- 2% of the AV metal value, in accordance with WAC 284-43-6810(3).
    - Induced demand factors were calculated based on the federal risk adjustment formula, in accordance with WAC 284-43-6810(2).
    - The AV and cost sharing pricing adjustment reflects full plan liability for CSR subsidies. CSR costs are reflected as a uniform percentage load (43.5%) applied to each Silver ACA-compliant plan (those sold through the Exchange).
    - In accordance with item 11d from the Individual Non-Grandfathered Health Plan Checklist, we removed the impact of coverage of abortion services from the AV and cost sharing factors. This impact is the reciprocal of the abortion adjustment applied to the benefits in addition to the EHBs factor described below.
    - Development of the AV and cost sharing adjustment can be found in Table 10.1.

- Provider network, delivery system and utilization management adjustment
    - There are no expected differences in the provider network and/or utilization management between plans.

- Adjustment for benefits in addition to the EHBs
    - All plans include coverage for elective abortion. In accordance with the URR instructions and checklist item 13, the $1.00 premium adjustment for elective abortion is included in the Benefits in Addition to EHB line of the URRT. Please see Table 10.3 for further details.

- Adjustment for distribution and administrative costs
    - Non-benefit expenses are discussed in detail below.

- There are no catastrophic plans being offered, so there is no eligibility adjustment made for catastrophic plan enrollment.

The following table demonstrates the Plan Adjusted Index Rate development for each plan in the projection period:

Table 10.2
Community Health Plan of Washington
Projection Period Plan Adjusted Index Rate Development

Plan Name	HIOS ID	Market-Wide Adjusted Index Rate	AV & Cost Sharing	Provider Network Adjustment	Benefits In Addition to EHBs	Admin Cost Fee	Catastrophic Eligibility	Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$635.08	0.814	1.000	1.002	1.138	1.000	$589.53
CHPW Vital Gold	18581WA0140004	$635.08	0.763	1.000	1.002	1.138	1.000	$552.65
CHPW Silver	18581WA0140002	$635.08	0.972	1.000	1.002	1.138	1.000	$704.25
CHPW Bronze	18581WA0140003	$635.08	0.574	1.000	1.002	1.138	1.000	$415.79

The Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool and therefore are not calibrated.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

Silver CSR Loading and Subsidized Membership

CHPW received no member cost sharing subsidy payments from HHS in 2024. To reflect the expectation that CHPW will continue to not be reimbursed for cost sharing on Silver CSR plans, CSR costs are included as a percentage load applied to each Silver ACA-compliant plan sold through the Exchange. Per WAC 284-43-6820, the CSR rate load is set to 1.435 for PY2026. As this is higher than our projected impact of CSRs, the revenue-neutral application of this mandated CSR load puts downward pressure on the non-Silver plan premiums.

No explicit projection assumptions are made for the AIAN population due to CHPW's limited membership and claims experience for AIAN enrollees.

Non-Benefit Expenses, Profit, and Risk

The administrative expense load was provided by CHPW. Development of the load shown on URRT Worksheet 2 is shown in WA Exhibit 11. This expense load is based on projected enrollment and is estimated to appropriately cover expenses for overhead, operations, and sales and marketing expenses. The administrative expenses are allocated proportionally by plan on a percentage of premium basis.

Commission expenses have been eliminated from the administrative expense projection for 2026. CHPW is eliminating broker commissions, as noted in the Commissions Certification accompanying this filing.

The taxes and fees which may be subtracted from premiums for purposes of calculating the MLR are listed in WA Exhibit 11. The taxes and fees shown on URRT Worksheet 2 do not include the Exchange User Fee, and are applied on a percentage of premium basis. The development of this amount is shown in WA Exhibit 11.

The Patient Centered Outcomes Research Fee (PCORI) amount of $0.31 shown in WA Exhibit 11 is calculated as follows: $3.47 / 12 * ($16,387 / $15,074) = $0.31 PMPM. The $3.47 annual fee per member for plan years ending October 1, 2024 through September 30, 2025 is first divided by 12 to transfer the fee to a PMPM basis. It is then trended by the projected NHE change from 2024 to 2026 to project the payment for plan years ending 12/31/2026.

The regulatory surchage fee, WSHIP assessment, WAPAL assessment, and insurance fraud surchage fee are also included in WA Exhibit 11.

For 2024, the Risk Adjustment User Fee is included as part of Taxes and Fees on line 3.7 of Worksheet 2 of the URRT.

The profit and risk load was applied proportionally to all products. Development of the load shown on URRT Worksheet 2 is included in WA Exhibit 11. This target profit percentage was provided by CHPW and relied upon in this filing.

EXHIBIT 11. CALIBRATION

A single calibration factor is applied to the Plan Adjusted Index Rates from Exhibit 10 to calibrate rates for the expected age, geographic, and tobacco use distribution expected to enroll in the plan. The single calibration factor is applied uniformly across all plans.

Age Curve Calibration

The approximate weighted average age, rounded to a whole number, for the single risk pool is 47. The weighted average age curve calibration factor is 1.545.

In order to determine the calibration factor for age, the projected distribution of members by age was determined. The weighted average of the factors in the age curve was then calculated using this distribution. The average age was then determined by finding the age of a member that would have the closest factor to the weighted average age curve calibration factor. Prior to applying the allowed rating factors for age, geography, and tobacco, the plan adjusted Index Rates need to be divided by the age curve calibration factor. A development of the age curve calibration factor is shown in Table 11.2.

Additional information regarding the age curve can be found on Exhibit 12.

Geographic Factor Calibration

In order to determine the calibration factor for geography, the projected distribution of members by area was determined. The weighted average of the area factors was then determined using this distribution. The area factors used are reflective of differences in delivery costs (including unit cost and provider practice pattern differences) only, and do not reflect any differences in the the following health-status related factors listed in line 16b of the Individual Non-Grandfathered Health Plan Checklist:

(a) Health status of enrollees or the population in an area
(b) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health illnesses
(c) Claims experience
(d) Health services utilization in the area
(e) Medical history of enrollees or the population in an area
(f) Genetic information of enrollees or the population in an area
(g) Disability status of enrollees or the population in an area
(h) Other evidence of insurability applicable in the area.

Prior to applying the allowed rating factors for age, geography, and tobacco, the plan adjusted Index Rates need to be divided by the geography calibration factor. A development of the geographic calibration factor is shown in Table 11.2.

Additional information regarding the area rating factors can be found on Exhibit 12.

Tobacco Factor Calibration

CHPW will not charge a tobacco surcharge for smokers.

The following tables demonstrate the calibration performed for each plan.

Table 11.1
Community Health Plan of Washington
Calibrated Plan Adjusted Index Rate Development

Plan	HIOS ID	Plan Adjusted Index Rate	Age Calibration Factor	Geographic Calibration Factor	Tobacco Calibration Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$589.53	1.545	0.983	1.000	1.519	$388.23
CHPW Vital Gold	18581WA0140004	$552.65	1.545	0.983	1.000	1.519	$363.94
CHPW Silver	18581WA0140002	$704.25	1.545	0.983	1.000	1.519	$463.77
CHPW Bronze	18581WA0140003	$415.79	1.545	0.983	1.000	1.519	$273.81

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual or family utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. It is the product of the Plan Adjusted Index Rate, the geographic rating factor, the age rating factor and the tobacco status rating factor. All rating factors are described and shown below.

CHPW's CY2026 age and tobacco rating factors are shown below. The age rating factors used by CHPW are identical to those prescribed by CMS. Tobacco factors are uniformly 1.0 as CHPW does not intend to rate for tobacco in PY2026.

Table 12.1
Community Health Plan of Washington
Age and Tobacco Factors

Age Band	Age Rating Factor	Tobacco Factor		Age Band	Age Rating Factor	Tobacco Factor
0-14	0.765	1.000		40	1.278	1.000
15	0.833	1.000		41	1.302	1.000
16	0.859	1.000		42	1.325	1.000
17	0.885	1.000		43	1.357	1.000
18	0.913	1.000		44	1.397	1.000
19	0.941	1.000		45	1.444	1.000
20	0.970	1.000		46	1.500	1.000
21	1.000	1.000		47	1.563	1.000
22	1.000	1.000		48	1.635	1.000
23	1.000	1.000		49	1.706	1.000
24	1.000	1.000		50	1.786	1.000
25	1.004	1.000		51	1.865	1.000
26	1.024	1.000		52	1.952	1.000
27	1.048	1.000		53	2.040	1.000
28	1.087	1.000		54	2.135	1.000
29	1.119	1.000		55	2.230	1.000
30	1.135	1.000		56	2.333	1.000
31	1.159	1.000		57	2.437	1.000
32	1.183	1.000		58	2.548	1.000
33	1.198	1.000		59	2.603	1.000
34	1.214	1.000		60	2.714	1.000
35	1.222	1.000		61	2.810	1.000
36	1.230	1.000		62	2.873	1.000
37	1.238	1.000		63	2.952	1.000
38	1.246	1.000		64+	3.000	1.000
39	1.262	1.000				

CHPW's CY2026 geographic rating factors and their development are shown in Table 12.2. These area factors reflect differences in unit cost by region. They were developed using Milliman's Health Cost Guidelines™ and CHPW's anticipated provider reimbursement by region and have been normalized to remove the impact of differences in population demographics and health status on claim costs.

The geographic area factors do not include the impact of any of the following:

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

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The premium for family coverage is determined by summing the consumer adjusted premium rates for each individual family member, provided at most three child dependents under age 21 are taken into account.

The following table demonstrates the premium rate development for the Consumer Adjusted Premium Rate beginning with the Calibrated Plan Adjusted Index Rate and applying the appropriate age, area, and tobacco factors.

Table 12.3 Community Health Plan of Washington Sample Consumer Adjusted Premium Rate Development	
Community Health Plan of Washington Cascade Select Complete Gold - 18581WA0140001	
Calibrated Plan Adjusted Index Rate	$388.23
Age: 33	1.198
Area: 6	0.967
Tobacco Status: Non-Tobacco User	1.000
Consumer Adjusted Premium Rate	**$449.76**

EXHIBIT 13. PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) is 89.8%. This loss ratio is calculated based on the MLR methodology as prescribed by 45 CFR 158.

The following table summarizes the calculation for the projected federal medical loss ratio:

Table 13.1
Community Health Plan of Washington
Projected Federal Medical Loss Ratio

Member Months	186,197
MLR Numerator Calculations	
Paid Claims PMPM	$405.95
Claim-Related Retention (QI/Health IT) PMPM	$0.00
Prior Rebate	$0.00
Other Claim-Related Adjustments	$0.00
Risk Adjustment Paid (Received) PMPM	$142.59
Market Reinsurance Recoveries (Received) PMPM	$0.00
MLR Numerator Calculations	**$548.54**
MLR Denominator Calculations	
Premium PMPM	$630.01
Other Premium-Related Adjustments	$0.00
Premium-Related Retention (Taxes & Fees) PMPM	$19.15
MLR Denominator	**$610.87**
Medical Loss Ratio	**89.8%**

No additional state-specific projected loss ratio demonstration is required in the State of Washington.

EXHIBIT 14. AV METAL VALUES

The AV Metal Values included in URRT Worksheet 2 were calculated by Wakely Consulting, which provided a Unique Plan Design Certification for the Washington standardized benefit designs. This filing has relied upon that certification, and it is included in the rate filing material for reference. The following reason was provided for the unique plan designs:

- For the Expanded Bronze Standard Option, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature.

EXHIBIT 15. MEMBERSHIP PROJECTIONS

Enrollment projections were developed by county and metal level through a combination of inputs from CHPW leadership, review of CHPW's current enrollment distribution for Cascade Select, and Milliman modeling of eAPTC expiration. Specifically:

- We developed enrollment projections by county based on the following factors:
  - Current (2025) CHPW Cascade Select membership
  - Anticipated 2026 retention (i.e., current enrollees renewing in CHPW plans)
  - Overall Exchange market decline (as modeled by Milliman and compared against WAHBE/Wakely reporting)

- Enrollment by metal level and CSR status reflects current CHPW enrollment patterns adjusted for both eAPTC expiration and the mandated uniform CSR load.

- As rates were developed, anticipated rate competitiveness in each market was reviewed for potential impact to projected enrollment.

- These inputs were then combined to develop the projected enrollment by county and metal level, which was then rolled up to the rating area and metal level.

As a result, 2026 enrollment is projected at 186,197 member months.

These projections are consistent with company expectations for the product line in 2026. Each plan in this filing has nonzero projected enrollment with the exception of the Silver 70% and 73% variants. Consistent with the assumptions underlying the OIC's development of the mandated CSR rate load, we assume that all Silver 70% members will migrate to the new low AV Vital Gold plan and that all Silver 73% members will disenroll entirely due to the silver plan premium cost increase.

Projected cost sharing reduction (CSR) eligibles are shown in Table 15.1:

Table 15.1
Community Health Plan of Washington
Projected Enrollment (Member Months) by Benefit Level (Silver Plans)

Plan Name	HIOS ID	70%	73%	87%	94%	Total
CHPW Cascade Select Silver	18581WA0140002	0	0	73,162	40,608	113,770

EXHIBIT 16. TERMINATED PRODUCTS

No products will be terminated prior to the effective date.

EXHIBIT 17. PLAN TYPE

There are no differences between the plans of CHPW and the plan type selected in the drop-down box in Worksheet 2, Section I of the URRT.

EXHIBIT 18. EFFECTIVE RATE REVIEW INFORMATION

URRT Worksheet 2, Section IV Projected Allowed Claims, Incurred Claims & Premiums (Checklist item 28f)

Please see Table 18.1 for a calculation of the projected dollar amounts by plan for URRT Worksheet 2, Section IV.

URRT Projected PAIR and Premium PMPM (Checklist item 28h)

The weighted-average Plan Adjusted Index Rates in Field 3.10 of URRT Worksheet 2 matches the aggregate premium PMPM in Field 4.17.

Mental Health and Substance Use Disorder Parity (Checklist item 33)

The Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity Certification has been completed by Elaine Corrough, FSA, MAAA, Senior Director of Actuarial Services, Community Health Plan of Washington. I am relying on Elaine's work and note the following:

- Projected plan and benefit classification/sub-classification dollar amounts are consistent with the actuarial cost model developed for 2026 rate projection, as described earlier in this Actuarial Memorandum;
- The underlying data sources and adjustments are as described earlier in this Actuarial Memorandum;
- There are no differences between the data used to project PY 2026 claims and premium rates, and the data used for MH/SUD parity testing;
- Projections are required to reflect plan-level assumptions – because all plans' rates have been developed from the same allowed claims basis, the same projected allowed cost has been used for MH/SUD parity testing for all plans;
- Dollar amounts used for testing are based on allowed claims, before any member cost-sharing; and
- A reasonable actuarial method was used for the dollar projections for each plan, in accordance with WAC 284-43-7040(1)(c)(ii) and in compliance with applicable Actuarial Standards of Practice.

The Certification ("MHSUD Financial Requirements Certification") and supporting Excel workbook ("MHSUD Parity Calculations Duplicate.xlsm" / "MHSUD Parity Calculations.pdf") have been submitted separately in this rate filing.

Parity calculations reflect the entirety of projected allowed claims for each service category tested. Under 45 CFR 144.103, parity analyses should reflect data at the plan level, rather than the product level. However, per CMS/CCIIO , an issuer "can use data at the product level to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method based on the best available data)." Premium rates for all of CHPW's plans have been developed from the same projection of allowed costs, the development of which is described elsewhere in this memorandum. Projected allowed costs are distributed amongst benefit categories based on the actual distribution reflected in base period experience across all plans. This represents our best estimate of the expected distribution of allowed costs by service category for each plan.

The 2026 standard ("Cascade") plan designs set by WAHBE include reduced copays ($1) for the first two MH/SUD visits, followed by higher standard copays for remaining visits ($30 for Cascade Silver and $50 for Cascade Bronze). Testing in the supporting Excel workbook ("MHSUD Parity Calculations Duplicate.xlsm" / "MHSUD Parity Calculations.pdf") has been completed to reflect these higher copays paid for all visits, even though the first two visits are at a lower copay. This effectively creates a "safe harbor" for the test – if parity is achieved using only the higher copays for all visits, then the actual plans, with reduced copays for the first two visits, should also pass the parity test. This is noted in the Excel workbook.

Differences in the UPMJ and URRT Aggregate Rate Change (Checklist item 30c)

The URRT Worksheet 2 fields 1.12 and 1.13 premium-weight the overall rate change while the Aggregate Rate Change in the UPMJ Q5 weights by current enrollment.

EXHIBIT 19. RELIANCE

In performing this analysis, I relied on data and other information provided by CHPW. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

As permitted by the OIC, we have relied on the Actuarial Value Certification for WAHBE 2026 Standard Medical Plan designs performed by Wakely Consulting Group. We have relied on the certification by Wakely Consulting Group since we do not have access to the underlying data used in their assessment of the Actuarial Value for these plans which the OIC has indicated must be matched. Documentation of the analysis performed by Wakely Consulting Group is included in Exhibit 14.

Table 19.1
Community Health Plan of Washington
Reliance

Data / Assumption	Source
2024 individual QHP claims and membership experience	Elaine Corrough, CHPW
2024 interim risk adjustment transfer receivable/payment	"Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025, CMS; "HHS public and carrier-specific interim 2024 risk adjustment reports", provided by Elaine Corrough, CHPW "Wakely National Risk Adjustment Reporting", provided by Elaine Corrough, CHPW
Other 2024 individual QHP marketplace revenue and expenditures	Elaine Corrough, CHPW
2024 IBNP estimate	Elaine Corrough, CHPW
2024 Plan Liability Risk Score associated with Individual QHP claims and membership experience	Elaine Corrough, CHPW
2025 emerging individual QHP membership	Elaine Corrough, CHPW
Utilization trends	Milliman (*Health Cost Guidelines*)
Unit cost trends	CMS; Milliman (*Health Cost Guidelines*)
Administrative costs, taxes, and fees	Elaine Corrough, CHPW
Broker fees and commissions	Elaine Corrough, CHPW
County Rating Areas	Elaine Corrough, CHPW
Community Health Plan of Washington service areas	Elaine Corrough, CHPW
Expected reimbursement by Rating Area	Elaine Corrough, CHPW
3:1 age band Factors	HHS
2026 pediatric vision administrative fees and claims cost	VSP
Prescription drug AWP discounts, dispensing fees, rebates, and retail/mail utilization assumptions	Elaine Corrough, CHPW
2026 Exchange user fee	Washington Health Benefits Exchange
WSHIP assessment	Elaine Corrough, CHPW
WAPAL assessment	Elaine Corrough, CHPW
Contribution to surplus % of premium	Elaine Corrough, CHPW
SHB 1979 impacts	Elaine Corrough, CHPW

EXHIBIT 20. ACTUARIAL CERTIFICATION

I am a Consulting Actuary with the firm of Milliman, Inc. Community Health Plan of Washington engaged me to provide the opinion herein.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I certify to the best of my knowledge and judgment:

1. The projected Index Rate is
   - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102)
   - Developed in compliance with the applicable Actuarial Standards of Practice
   - Reasonable in relation to the benefits provided and the population anticipated to be covered
   - Neither excessive nor deficient based on my best estimates of the 2026 individual market.

2. 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.

3. The geographic rating factors shown in Worksheet 3 of the URRT reflect only differences in the cost of delivery, and do not include differences for population morbidity by geographic area.

4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans.

The URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The 2026 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2026 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendments, court decisions, or decisions by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. At the time of this rate filing submission, we acknowledge there is uncertainty regarding the expiration of the enhanced premium subsidies first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA). Consistent with WA OIC instructions, we have assumed that these subsidies will expire at the end of 2025 and adjusted our assumptions for the 2026 premium rates accordingly. However, I have made no prediction or estimate of the likelihood of these events. Due to the substantial uncertainty regarding the impact of removing these subsidies, some of the related assumptions may exhibit a greater divergence from expectations.

Signed: 

Name: Jordan Pettibon, FSA, MAAA

Title: Consulting Actuary

Date: May 12, 2025

Part III Actuarial Memorandum

Community Health Plan of Washington
Individual Rate Filing
Effective January 1, 2026

Prepared for:
Community Health Plan of Washington

Prepared by:
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TABLE OF CONTENTS

The following table summarizes the exhibits included in this document. Some exhibits may span multiple pages.

EXHIBIT 1. GENERAL INFORMATION

Document Overview

This document contains the Part III Actuarial Memorandum for Community Health Plan of Washington's (CHPW) individual block of business, effective January 1, 2026. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the State of Washington State Office of the Insurance Commissioner, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of CHPW's individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Milliman under any theory of law.

As prescribed by Washington or as instructed by Community Health Plan of Washington the premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded as is described in current regulations and guidance. Future modifications in legislation, regulation and/or court decisions may affect the extent to which the premium rates are neither excessive nor deficient. Community Health Plan of Washington reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed.

At the time of this rate filing submission, we acknowledge there is uncertainty regarding whether the enhanced premium tax credit subsidies, first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA) in 2022, will or will not be extended beyond 2025. As instructed by the WA OIC, we have prepared this set of rate filing materials assuming that these enhanced premium tax credits will expire at the end of 2025 and will not be applicable in 2026. The expiration versus extension of these subsidies could materially impact the morbidity, enrollment, and other factors related to the Individual market. We have incorporated various premium rate adjustments to reflect the estimated financial impact of these subsidies expiring. These adjustments are derived from a Milliman model that leverages data from CMS reports, proprietary Milliman datasets, and other publicly available information. Our model results will evolve as new information becomes available and new actions are taken by the authorities and other stakeholders. If subsequent information becomes available that would materially affect this rate filing submission, CHPW would pursue opportunities to revise the pricing assumptions and resubmit this rate filing.

This rate filing submission includes adjustments for the emergency rule issued by the WA OIC requiring a uniform CSR silver load adjustment (WAC 284-43-6820), standardized induced demand factors (WAC 284-43-6810(2)), and pricing actuarial value guardrails (WAC 284-43-6810(3)).

Company Identifying Information

Company Legal Name: Community Health Plan of Washington
State: The State of Washington has regulatory authority over these policies.
HIOS Issuer ID: 18581
Market: Individual
Effective Date: January 1, 2026

Company Contact Information

Primary Contact Name: Elaine Corrough
Primary Contact Telephone Number: (206) 521-8833
Primary Contact Email Address: elaine.corrough@chpw.org

EXHIBIT 2. PROPOSED RATE CHANGES

The rate projections for 2026 have been updated from the previous year's projections to reflect the most recent information available.

Table 2.1 below describes and quantifies the primary drivers underlying the proposed rate change for 2026, including but not limited to, the estimated impact of enhanced premium tax credit subsidy expiration. This breakdown is intended only for explanatory purposes and is distinct from the development of rates, as described in the subsequent sections of this memorandum.

Table 2.1
Community Health Plan of Washington
Breakdown of Proposed Rate Change

Description	Value
Estimated Changes in Experience	1.068
Additional Year of Trend (2025 to 2026)	1.053
Impact of eAPTC Subsidy Expiration	1.036
Changes in Net Morbidity and Risk Adjustment (Excluding eAPTC Subsidy Expiration Impact)	1.088
Changes in Benefits	0.987
Changes in Plan Mix and CSR Rate Load	1.034
Changes in Administrative Costs	0.989

Estimated Changes in Experience

The individual single risk pool experience underlying the rate projections has been updated, including marketplace enrollee mix. This impact reflects the difference between the interim 2024 projection of claims from 2025 rate development and the actual 2024 experience, normalized for changes in population morbidity and plan mix.

Additional Year of Medical and Prescription Drug Utilization and Unit Cost Trend

This impact reflects one additional year of medical and prescription drug utilization and unit cost trend from 2025 to 2026. Please refer to Table 5.1 for a breakdown of these trend assumptions by major service category as reported on Worksheet 1, Section II of the URRT.

Impact of eAPTC Subsidy Expiration

We modeled adjustments to CHPW's projected claims and risk adjustment transfer position to account for the anticipated impact of enhanced premium tax credit subsidy expiration. This impact reflects some assumed level of deterioration in the single risk pool due to anticipated disenrollment in 2026.

Changes in Net Morbidity and Risk Adjustment (Excluding eAPTC Subsidy Expiration Impact)

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. Risk adjustment transfer experience for calendar year 2024 was projected forward to 2026, including consideration of changes to the statewide average premium, risk adjustment program, and CHPW enrollee population morbidity relative to the Washington single risk pool. This excludes the impact of pricing assumptions explicitly related to the expiration of enhanced premium tax credit subsidies, which is quantified separately in the line item above.

Changes in Plan Benefits

We updated the plan designs to align with the standardized plan designs issued by WAHBE for the 2026 plan year. This impact reflects changes in the standardized plan designs from 2025 to 2026 as measured by changes in projected plan level AV pricing values and induced utilization, holding plan mix constant.

EXHIBIT 2. PROPOSED RATE CHANGES

Changes in Plan Mix and CSR Rate Load

We modeled changes in CHPW's projected plan mix between 2025 and 2026 due to the anticipated expiration of enhanced premium tax credit subsidies and the WA OIC's emergency rule requiring issuers to implement a standardized silver CSR rate load. This reflects the residual impact of plan mix changes, normalized for changes in the composite plan rating factor between 2025 and 2026, and the impact of changes in the silver CSR rate load on the rate change.

New Taxes, Fees and Administrative Expenses

Administrative costs decreased modestly due to restatement in administrative expenses and the impact of fixed administrative costs as a percentage of the higher aggregate premium in 2026. The administrative cost assumptions also reflect the impact of CHPW's smaller membership basis in 2026 increasing the impact of fixed costs. There was no change to the Exchange User Fee ($5.11 PMPM) between 2025 and 2026.

See Exhibit 10 for further details on projected non-benefit expenses.

The variance in the rate changes across plans does not reflect the incorporation of plan-specific morbidity. When projecting plan rating factors, we have assumed the same demographic and risk characteristics for each plan priced. This pricing method excludes expected differences in the morbidity of members assumed to select the plan.

Single Risk Pool

The 2026 rate development is based on the single risk pool set by the State of Washington, which was established according to the requirements in *45 CFR Part 156.80* . The single risk pool is defined as the non-grandfathered individual business in Washington.

Neither the single risk pool for the experience period nor the projection period include members who are eligible to remain enrolled in transitional plans.

Additional Rate Change Information

The following section addresses the requirements contained in item 24 of the Individual Non-Grandfathered Health Plan Checklist.

45 CFR 154.301(a)(4)(i) The impact of medical trend changes by major service categories:
See above and Exhibit 5 for discussion of medical trend changes.

45 CFR 154.301(a)(4)(ii) The impact of utilization changes by major service categories:
See above and Exhibit 5 for discussion of utilization changes.

45 CFR 154.301(a)(4)(iii) The impact of cost-sharing changes by major service categories, including actuarial values:
See Exhibit 10 for discussion of cost-sharing changes.

45 CFR 154.301(a)(4)(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits:
See Exhibit 5 for discussion of the impact of benefit changes.

45 CFR 154.301(a)(4)(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:
See Exhibit 5 and Exhibit 10 for a discussion of the impact of changes in enrollee risk profile and pricing and Exhibit 11 for discussion of the rating limitations for age and tobacco use.

EXHIBIT 2. PROPOSED RATE CHANGES

45 CFR 154.301(a)(4)(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase:
This consideration is not directly applicable to CHPW's 2026 rate development. CHPW's 2026 rate projections were informed by its 2024 claims experience and expectations regarding trend and other drivers of rate change from 2024 to 2026.
CHPW makes no explicit adjustment for overestimation or underestimation of medical trend.

45 CFR 154.301(a)(4)(vii) The impact of changes in reserve needs:
This consideration is not directly applicable to CHPW's 2026 rate development. CHPW makes no explicit adjustment due to changes in reserve needs.

45 CFR 154.301(a)(4)(viii) The impact of changes in administrative costs related to programs that improve health care quality:
See Exhibit 10 for a discussion of administrative costs related to programs that improve health care quality.

45 CFR 154.301(a)(4)(ix) The impact of changes in other administrative costs:
See above and Exhibit 10 for a discussion of other administrative costs.

45 CFR 154.301(a)(4)(x) The impact of changes in applicable taxes, licensing or regulatory fees:
See above and Exhibit 10 for a discussion of applicable taxes, licensing, and regulatory fees.

45 CFR 154.301(a)(4)(xi) Medical loss ratio:
CHPW's 2026 rate projections were informed by the claims experience and quality improvement activities underlying its estimated 2024 MLR. However, its 2026 projected MLR includes independent projections for each component of the MLR formula (including premium), as opposed to a projection directly built off of its 2024 MLR. The claims used in the MLR calculation have been adjusted for quality improvement expenses and provider incentive payments. The pharmacy claims used in the MLR calculation are net of prescription drug rebates. In 2024, prescription drug rebates are $3,105,866 based on CHPW's most recent accrual information.

45 CFR 154.301(a)(4)(xii) The health insurance issuer's capital and surplus:
Contribution to surplus, contingency charges, or risk charges have not changed between 2025 and 2026.

45 CFR 154.301(a)(4)(xiii) The impacts of geographic factors and variations:
See Exhibit 12 for a discussion of the geographic factors.

45 CFR 154.301(a)(4)(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool:
See Exhibit 5 for a discussion of the impact of changes within a single risk pool to all plans within the risk pool.

45 CFR 154.301(a)(4)(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act:
See Exhibit 9 for a discussion of the impact of reinsurance and risk adjustment payments and charges.

EXHIBIT 3. EXPERIENCE AND CURRENT PERIOD PREMIUM, CLAIMS, AND ENROLLMENT

The experience reported on Worksheet 1, Section I of the URRT shows CHPW's earned premium, incurred and paid claims, and enrollment for the period of 1/1/2024 through 12/31/2024, with claims paid through 3/31/2025. Current enrollment and current premium on Worksheet 2, Section II are reported as of 4/1/2025.

Premiums in Experience Period

The premiums earned during the experience and as reported on Worksheet 1, Section I of the URRT are from CHPW's audited financial statements for CY2024. The premiums are not adjusted for MLR rebates.

Method for Determining Allowed Claims

All allowed claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported allowed claims was added to the processed amount to arrive at a final estimate of total allowed claims. No estimate of incurred but not reported claims was added to the prescription drug claims under the assumption that these claims are complete.

Method for Determining Paid Claims

All paid claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported claims was added to the processed amount to arrive at a final estimate of total paid claims. No estimate of incurred but not reported claims was added to the prescription drug claims under the assumption that these claims are complete.

Method for Determining Incurred But Not Reported Paid Claims

Incurred claims were calculated by applying a completion factor to the paid claims from the experience period. The completion factors were developed using the lag development method. The completion factors applied to paid and allowed claims are the same.

Method for Determining Paid Cost Sharing

Paid member cost sharing was determined by subtracting paid claims from allowed claims.

Claims Lags and Experience by Benefit Category (Checklist items 1b and 1c)

Tables 3.1a-d include allowed and incurred claims lags separately for medical and pharmacy for claims incurred in calendar year 2024 and paid through March 2025. Table 3.2 includes allowed and incurred claims by benefit category and month, premiums by month, monthly membership, changes in reserves during the period, and paid-to-allowed ratios.

Documentation and Justification for URRT Worksheet 2, Section II: Experience Period and Current Plan Level Information

The following supports item 4 of the Individual Non-Grandfathered Health Plan Checklist.

"Section II: Experience Period and Current Plan Level Information" from Worksheet 2 of the URRT is based on information as of March 2025 from the following sources:

- Line 2.2, Allowed Claims: Plan-level experience period data, with runout through March 2025. Allowed claims include an estimate for incurred but not paid amounts.
- Line 2.3, Reinsurance: There is no state reinsurance, so this field has been populated with zero for all plans.
- Line 2.4, Member Cost Sharing: Plan-level experience period data, with runout through March 2025.
- Line 2.5, Cost Sharing Reduction: Plan-level experience period data, with runout through March 2025.
- Line 2.6, Incurred Claims: This line is calculated by the URRT. It includes all incurred claims that are the issuer's responsibility.
- Line 2.7, Risk Adjustment Transfer Amount: Based on the CMS "Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025. The Risk Adjustment User Fee is not included in this line, as it is included in the Taxes & Fees line (3.7) of the URRT.
- Line 2.8, Premium: Plan-level experience period data, reported as of March 2025.
- Line 2.9, Experience Period Member Months: Plan-level experience period data, reported as of March 2025.
- Line 2.10, Current Enrollment: Current enrollment by plan as of April 2025.
- Line 2.11, Current Premium PMPM: April 2025 premium by plan divided by enrollment for April 2025.

EXHIBIT 4. BENEFIT CATEGORIES

We assigned the experience data utilization and cost information to benefit categories as shown in Worksheet 1, Section II of the Part 1 URRT based on place and type of service using a detailed claims mapping algorithm summarized as follows:

Inpatient Hospital

The inpatient hospital category 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

The outpatient hospital category 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

The professional category includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based physicians whose payments are included in facility fees.

Other Medical

The other medical category includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation

The capitation category includes all services provided under one or more capitated arrangements.

Prescription Drug

The prescription drug category includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

EXHIBIT 5. PROJECTION FACTORS

This section includes a description of trend factors used to project the experience period Index Rate to the projection period, and supporting information related to the development of those factors. For a demonstration of the trends, please see Table 5.1 below. This section also includes a description of adjustment factors (other than trend) that are applied to the experience period Index Rate in order to develop the projected Index Rate, and supporting information related to the development of those factors.

Trend Factors (Cost/Utilization)

This development of the CY2026 rates reflects an annual trend rate in Year 1 of 4.4% and an annual trend rate in Year 2 of 5.3%, which were developed using the following data source and methodology:

The trend factors reflect CHPW's expectations regarding increases in in-network contractual reimbursement and the impact of trends in both projected in-network and out-of-network costs. The prescription drug trends reflect changes in the drug formulary, expiration of drug patents and introduction of new drugs. Table 5.1 below documents CHPW's projected trends by category and year. The factors only reflect trend applicable to the single risk pool; they have been normalized and/or adjusted when appropriate to account for other changes such as changes in age, benefit changes, seasonality patterns, and non-recurring events.

Table 5.1
Community Health Plan of Washington
Annual Unit Cost and Utilization Trend Assumptions

	Year 1			Year 2		
Service Type	**Cost**	**Util**	**Total**	**Cost**	**Util**	**Total**
Inpatient Hospital	3.1%	-0.5%	2.6%	3.1%	-0.5%	2.5%
Outpatient	3.1%	1.0%	4.1%	3.0%	1.0%	4.0%
Professional	-2.8%	0.0%	-2.8%	0.1%	0.0%	0.1%
Other Medical	-2.5%	0.0%	-2.5%	0.4%	0.0%	0.4%
Capitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prescription Drug	10.0%	2.5%	12.8%	10.0%	2.5%	12.8%
Total			**4.4%**			**5.3%**

Months of Trend Year 1	12.0
Months of Trend Year 2	12.0

The cost trend factors reflect the following:

- Changes in contractual reimbursement between the experience and projection periods for a fixed basket of services. This is based on actual 2024 contracts and ongoing contracting efforts for 2026, controlling for changes in service mix, the geographic distribution of enrollees, and pharmacy rebates.
  - For Plan Year 2026, CHPW has retained and expanded upon the CHPW Cascade Care Affiliates Network. As of the date of submission of this actuarial memorandum, final contract negotiations with physicians and hospitals are largely complete. At this time, CHPW has executed agreements with approximately 92% of the targeted hospitals and over 2,600 provider groups. CHPW has successfully updated all contracts with Community Health Centers (CHCs) to provide primary care services wherever available throughout the network. CHPW is in continued discussions with the remaining targeted providers, with the projected completion of all required contracts by January 1, 2026.
- Average charge trend between the experience and projection periods normalized for demographics, morbidity, and benefit design.
  - Medical charge trends are set equal to anticipated Medicare fee schedule changes, as CHPW contracts on a percentage of FFS Medicare basis.
  - Pharmacy charge trends are informed by the Milliman *Health Cost Guidelines* and a review of CHPW's PBM contracts and reporting.

EXHIBIT 5. PROJECTION FACTORS

The utilization trend factors reflect the following:

- Assumed changes in the mix or intensity of services provided for a fixed level of illness burden.
- Secular utilization trend (the expected force of utilization trend over time for a static population with a fixed set of benefits), normalized for demographics, morbidity, and benefit design, informed by consideration of typical industry trend assumptions and the Milliman *Health Cost Guidelines* .
- Utilization trend is independent from the morbidity adjustments described below. As the utilization trends are on a secular basis and do not include any impact related to population morbidity shifts, there is no overlap between these estimates.

Table 5.2 includes a breakout of utilization and unit cost for the benefit categories shown on URRT Worksheet 1. Table 5.2 shows the development of the claims trends entered in the WAC 284-43-6660 summary.

Morbidity Adjustment

We used the following data source(s) and methodology in order to estimate the changes between the morbidity of the experience population and the projected population, as shown in the Morbidity Adjustment row of Worksheet 1, Section II of the URRT:

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. The adjustment was based on a review of CHPW's estimated 2024 morbidity levels, with particular consideration given to the large cohort of new members in 2024.

Assuming the enhanced premium subsidies first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA) expire at the end of 2025, we anticipate a reduction in the overall market size in 2026. This will lead to increasing average statewide morbidity in 2026 relative to the 2024 experience period as consumers either lose access to subsidies (for those at or above 400% of the Federal Poverty Level) or face higher net premiums due to less generous subsidies. We anticipate the remaining risk pool in 2026 to have higher healthcare needs, on average, as healthier consumers are more likely to lapse coverage. Given these considerations, we applied a morbidity adjustment to reflect anticipated changes in statewide average morbidity in 2026 relative to 2024.

Consistent with the URR instructions, the morbidity adjustment reflects the component of the change in average allowed claims PMPM holding constant the experience period population's demographics (i.e., age, gender, and region), product mix, and all provider network contracts and time parameters.

The morbidity assumption used for projecting claims reflects CHPW's expectations regarding the morbidity of its 2026 membership and is consistent with the relative morbidity assumption used to estimate CHPW's risk transfer payment.

Demographic Shift

We used the following data source(s) and methodology in order to estimate the changes in the demographic and geographic mix of the population, as shown in the Demographic Shift row of Worksheet 1, Section II:

Our rate projection is based on CY2024 experience, and reflects the average demographics and geographic mix of the CY2024 enrollees. Our development of the CY2026 Index Rate reflects the anticipated differences in the demographic and geographic mix of the population, as compared to the CY2024 experience period.

We used the Milliman *Health Cost Guidelines* age/sex factors, utilization area factors, and unit cost area factors applied to both the 2024 and 2026 population to develop the demographic adjustment.

Plan Design Changes

We made the following adjustments to reflect the expected differences in benefits between the experience period and projection period, as shown in the Plan Design Changes row of Worksheet 1, Section II of the URRT:

EXHIBIT 5. PROJECTION FACTORS

Experience period claims were adjusted for changes in plan mix and plan design. This adjustment factor reflects anticipated changes in the demand for services due to differences in product mix and cost-sharing from the experience period to the projection period. Population demographics and morbidity were held constant across plan designs for this adjustment to avoid confounding with demographics and morbidity shifts.

We used Milliman's Health Cost Guidelines (HCGs), in conjunction with the historical experience of CHPW's individual block of business, in order to estimate the benefit changes for each of the items listed above.

The WA OIC introduced new EHBs to the state benchmark plan for CY2026:

- human donor milk,
- hearing aids and hearing exams, and
- artificial insemination

We modeled adjustments to projected claims to reflect the anticipated impact of these new essential health benefits.

Other Adjustments

The Other row of Worksheet 1, Section II contains additional adjustments from those described above. These adjustments have been made to recognize the additional anticipated changes in claims experience between the base period and the projection period. We used the following data sources and methodology in order to estimate these changes:

- The above components are applied at an aggregate level in the claims projection. We measured their mix/interaction impact across service categories and applied the resulting factor as an other adjustment.
- The pricing AV guardrails imposed by WAC 284-43-6800(3) reduced CHPW's aggregate projected AV in such a way that normalization could not restore the aggregate 2026 paid claims to the projected level. We included an offsetting adjustment to projected allowed claims such that projected paid claims are restored to the pre-AV adjustment level.
- Changes in anticipated pediatric vision costs: CHPW is self-insured through VSP for this benefit, and we rely on VSP's estimates of projected claims. The difference between actual experience and VSP's projections are reflected in this factor.

EXHIBIT 6. MANUAL RATE ADJUSTMENTS

Not applicable. CHPW's 2024 experience is fully credible for the purposes of the rate projection.

EXHIBIT 7. CREDIBILITY OF EXPERIENCE

Description of the Credibility Method Used

Credibility is calculated using the following formula:

If Member Months < 66,000: (Member Months / 66,000)^(1/2)
If Member Months ≥ 66,000: 100%

This credibility threshold is based on research into the minimum number of member months required such that the projected allowed PMPM of a group based on historical experience is within 10% of the actual allowed PMPM 95% of the time.

Resulting Credibility Level Assigned to the Base Period Experience

As CHPW had 335,501 member months in the base period, the credibility assigned to the base period experience is 100%.

EXHIBIT 8. ESTABLISHING THE INDEX RATE

The Index Rate for the experience period is a measurement of the average allowed claims PMPM for EHB benefits. The experience period Index Rate reflects the actual mixture of smoker/non-smoker population, area factors, catastrophic/non-catastrophic enrollment, and the actual mixture of risk morbidity that CHPW received in the Single Risk Pool during the experience period. Note that there were additional benefits offered beyond the EHB benefits. The experience period Index Rate has not been adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange User Fees.

The experience period Index Rate is equal to the experience period total allowed claims PMPM minus the total non-EHB allowed claims PMPM.

Per item 11d of the Individual Non-Grandfathered Health Plan Checklist, abortion services are included in the index rate projected in URRT Worksheet 1, Section II as Washington considers these services to be EHBs.

The Index Rate for the projection period is a measurement of the average allowed claims PMPM for EHB benefits. The Projection Period Index Rate reflects the projected CY2026 mixture of area factors, and the projected mixture of risk morbidity that CHPW expects to receive in the Single Risk Pool. Note that there were additional benefits offered beyond the EHB benefits. The Projection Period Index Rate has not been adjusted for payments and charges projected under the risk adjustment program nor for Exchange User Fees.

The Projection Period Index Rate is equal to the projected total allowed claims PMPM minus the total non-EHB allowed claims PMPM.

The following table summarizes the factors applied to the Experience Period Index Rate to determine the Projection Period Index Rate. Please see Exhibit 5 for a description and development of these factors.

Table 8.1
Community Health Plan of Washington
Projection Period Index Rate Development

Description	Experience
2024 Total Allowed Claims PMPM	$392.63
2024 Non-EHB Allowed Claims PMPM	$0.00
2024 EHB Allowed Claims PMPM	$392.63
Trend	1.099
2026 EHB Allowed Claims PMPM	$431.52
Morbidity Adjustment	**1.050**
Risk Pool Deterioration	1.050
Demographic Shift	**1.025**
Demographics	1.021
Geography	1.004
Plan Design Changes	**0.986**
Induced Utilization	0.985
New Essential Health Benefits	1.001
Other	**1.017**
Mix/Interaction	0.977
Aggregate Paid Restoration	1.040
VSP Pediatric Vision Change	1.000
Projected EHB Allowed Claims PMPM	$465.65
Credibility	100%
Projection Period Index Rate PMPM	**$465.65**

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

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

Table 9.1 Community Health Plan of Washington Market-Wide Adjusted Index Rate Development	
2026 Index Rate PMPM	$465.65
Market-Wide Adjustments (paid basis)	
Risk Adjustment Transfer Amount	$142.59
Exchange User Fees	$5.11
Paid-to-Allowed Ratio	0.872
Market-Wide Adjustments (allowed basis)	
Risk Adjustment Transfer Amount	$163.56
Exchange User Fees	$5.86
Market-Wide Adjusted Index Rate PMPM	**$635.08**

The Market-Wide Adjusted Index Rate is not calibrated. This means that this rate reflects the average demographic characteristics of the single risk pool.

Each of the above modifiers were developed as follows:

- Risk Adjustment Transfer Amount
  This factor includes the impact of the estimated risk adjustment transfer payment as addressed in a subsequent section of this Exhibit.

- Exchange User Fee Adjustment
  The Exchange User Fee adjustment was determined as the average of no fee and the WAHBE Exchange User Fee ($5.11 PMPM), weighted using the expected distribution of issuer enrollment sold through versus outside the Exchange.

Experience Period Risk Adjustments PMPM

The following methodology was used to estimate final risk adjustment transfers for CY2024:

The experience period risk adjustment transfer amount was calculated using the HHS risk adjuster formula, as shown below. Factors calculated for CHPW and the State are based on Wakely's Risk Adjustment Reporting based on EDGE data submissions through December 2024. The projected CY2024 risk adjustment transfer reflects anticipated PLRS completion assumptions for both CHPW and the market. The projected CY2024 risk adjustment transfer is a charge of -$132.02 PMPM from CHPW into the risk pool, net of the HCRP receivable and assessment.

"WA Exhibit 10: Summarized Risk Adjustment" includes the calculation of the expected risk adjustment transfer payment amount (gross of risk adjustment fees), using the HHS risk adjuster formula.

Risk Adjustment Payment/Charge

Worksheet 1, Section II of the URRT shows how the anticipated risk adjustment transfer revenue is applied to the Index Rate in the development of the Market-Wide Adjusted Index Rate. The Projected Risk Adjustment Transfer PMPM (-$163.56) is shown on Worksheet 1, Section II on an allowed basis. This amount does not include the 2026 Risk Adjustment User Fee of $0.20 PMPM. The Risk Adjustment User Fee is included with Taxes and Fees on Worksheet 2, line 3.7. "WA Exhibit 10: Summarized Risk Adjustment" includes quantitative support for CHPW's projected 2026 risk adjustment liability.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The state transfer calculation portion of the total risk adjustment transfer is based on the risk adjustment transfer formula, as provided in the Federal Register.

We project each factor in the risk adjustment transfer formula at the metal level using the state's actual historical risk adjustment factors adjusted to the projected population.

For the purpose of our modeling, each of these factors was approximated as follows:

- Statewide Average Premium: The state average premium was assumed to be approximately $603.45 PMPM (net of the 14% administrative cost carve out).

- Plan Liability Risk Score (PLRS): The statewide average risk score (1.331) is projected based on the average PLRS of the single risk pool in 2024, as reported by the U.S. Department of Health and Human Services (HHS) as of March 14, 2025, adjusted for projected changes in the demographics, morbidity, and plan mix of the single risk pool from 2024 to 2026. This includes the projected change in statewide morbidity from 2025 to 2026 driven by the assumed expiration of enhanced APTC subsidies at the end of 2025.
  - The average risk score for CHPW's membership (0.897) is projected based on the completed 2024 CHPW PLRS adjusted for changes in the composition of CHPW's population between 2024 and 2026, including the impact of disenrollment due to expiration of the enhanced APTC subsidies as well as the impact to CHPW's relative risk score due to underlying changes in the HHS-HCC risk model.

- Induced Demand Factor (IDF) (1.035 Single Risk Pool; 1.037 CHPW): The statewide average IDF is projected based on the average IDF of the single risk pool in 2024, as reported by HHS as of March 14, 2025.
  - The average IDF for CHPW is projected by applying the induced demand factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11 to CHPW's projected population. Similarly, the projected market IDF is calculated using the same metal level induced demand factors applied to the projected market metal mix. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.
  - The projected average IDF for CHPW and the market reflect the anticipated changes in metal mix driven by the 43.5% mandated silver CSR load. Consistent with the assumptions underlying the OIC's development of the mandated CSR rate load, we assume that all Silver 70% members will migrate to the new low AV Vital Gold plan and that all Silver 73% members will disenroll entirely due to the silver plan premium cost increase.

- Actuarial Value (AV) (0.695 Single Risk Pool; 0.708 CHPW): The statewide average AV is projected based on the average metal level AV of the single risk pool in 2024, as reported by HHS as of March 14, 2025.
  - The average AV for CHPW is projected by applying the metal level AV factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 9 to CHPW's projected population. Similarly, the projected market AV is calculated using the same metal level AV factors applied to the projected market metal mix. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold 0.80, and Platinum 0.90.
  - The projected average AV for CHPW and the market reflect the anticipated changes in metal mix driven by the 43.5% mandated silver CSR load in PY 2026 as described in the development of the projected average IDF assumptions above.

- Allowable Rating Factor (ARF) (1.715 Single Risk Pool; 1.550 CHPW): As stated in the March 11, 2013 Federal Register, page 15433, the ARF adjustment accounts only for age rating.
  - The statewide average ARF is projected based on the average ARF of the single risk pool in 2024, as reported by HHS as of March 14, 2025, adjusted for projected changes in the demographics of the single risk pool from 2024 to 2026.
  - The average ARF for CHPW is projected by applying the 2026 HHS age rating factors to CHPW's projected population.
  - The projected average ARF assumptions for CHPW and the market reflect changes in the assumed demographic profile of the market in 2026 due to the anticipated expiration of enhanced APTC subsidies.

- Geographic Cost Factor (GCF): The average GCF for CHPW relative to the statewide average was modeled based on historical GCFs by rating areas reported by HHS as of March 14, 2025 and CHPW's projected enrollment by rating area.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The total transfer is calculated as the sum of the state transfer calculation described above and a net transfer for 2026 attributable to the high cost risk pooling (HCRP) program (-$1.05). The projected HCRP receivable (-$1.25) is based on the on the attachment point and coinsurance from the 2026 Notice of Benefit and Payment Parameters (NBPP), and the projected HCRP assessment (-$2.30) is modeled as approximately 0.36% of premium.

The projected transfer amount assumes no impact under the Risk Adjustment Data Validation (RADV) process.

The risk adjustment transfer amount (-$163.56) reported on Worksheet 1 of the URRT is the actual PMPM amount expected in the projection period on an allowed basis. The risk adjustment transfer amount applied to the Index Rate in the development of the Market-Wide Adjusted Index Rate is on an allowed claims basis, as the Index Rate is on an allowed claims basis.

The assumptions used in developing the risk adjustment transfer amount are current as of the date of this filing. The demographic, plan mix, and morbidity assumptions supporting the risk transfer projection are consistent with the demographic, plan mix, and morbidity assumptions used to project claims costs.

Risk Adjustment Data by Metal Level and Risk Model Changes

"WA Exhibit 10: Summarized Risk Adjustment" includes support for the Individual Non-Grandfathered Health Plan Checklist items 18, 19a, 19b, and 19f. WA Exhibit 10 summarizes the 2024 risk adjustment data used to develop CHPW’s projected 2026 risk adjustment transfer liability, including the projected 2026 statewide average premium. In WA Exhibit 10, projected membership and all components of the risk adjustment transfer formula are reported separately by metal level.

We adjusted CHPW's projected relative PLRS to account for changes in the underlying HHS-HCC risk model between 2024 and 2026. We leveraged prevalence exhibits in Wakely's Risk Adjustment Reports to evaluate the impact of risk model changes on CHPW's PLRS relative to the market in 2026. The prevalence exhibits include simulated issuer (CHPW) and market PLRS using both the final 2024 and 2026 HHS-HCC risk models. To isolate the impact of model changes independent of changes in the demographic profile of the single risk pool, the simulated risk scores are calculated using a static 2024 population.

High Cost Risk Pool Receipt/(Assessment)

The HCRP reinsurance program reimburses issuers at 60% of annualized enrollee claims costs in excess of the $1M attachment point. We used an all service category claim probability distribution (CPD) from the Milliman Health Cost Guidelines (HCGs), scaled to the CHPW’s projected annual allowed claims for each benefit plan, to model estimated risk adjustment reinsurance receivables. Changes in CHPW’s contractual reimbursement, demographic composition, and risk profile, among others, will contribute to changes in CHPW’s anticipated HCRP receivables between 2024 and 2026.

The High-Cost Risk Pool (HCRP) reinsurance program assessment fee is based on an assumed 0.36% of premium, consistent with the assessment reported in the final BY 2023 risk adjustment report.

The following table includes the actual (2022-2024) and filed (2022-2026) HCRP receipts and assessments. In 2026, we are projecting a net HCRP payment for CHPW based on historical experience and the anticipated morbidity profile of CHPW's 2026 population.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

Table 9.2
Community Health Plan of Washington
Actual and Projected HCRP Receipt/Assessment PMPM

	2023	2024	2025	2026
High-Cost Risk Pool Receipt				
Actual	$0.00	$6.73	*n/a*	*n/a*
Filed	$1.14	$1.70	$0.91	$1.25
High-Cost Risk Pool Assessment				
Actual	($1.32)	($1.83)	*n/a*	*n/a*
Filed	($1.14)	($1.70)	($1.75)	($2.30)
Net High-Cost Risk Pool Receipt/(Assessment)				
Actual	($1.32)	$4.90	*n/a*	*n/a*
Filed	$0.00	$0.00	($0.84)	($1.05)

The green highlighted cells reconcile to the estimated 2024 and projected 2026 HCRP receipts and assessments in WA Exhibit 10. Negative value implies a net payment and a positive value implied a net receipt, consistent with the sign of the risk adjustment transfers in WA Exhibit 10.

Impact due to Risk Adjustment Data Validation (RADV)

CHPW's 2026 projected risk adjustment transfer does not reflect any assumed impact for RADV.

Paid to Allowed Ratios

The following table provides support for the average projected paid-to-allowed ratio. The average projected allowed and incurred PMPM reflects the member month weighted average from Worksheet 2, Section IV of the URRT.

The following table provides support for the average paid-to-allowed ratio by plan metal level:

Table 9.3
Community Health Plan of Washington
Average Paid to Allowed Factor Support

Metal Level	Member Months	Paid Claims PMPM	Allowed Claims PMPM	Paid-to-Allowed Ratio	AV Metal Value
Gold	43,848	$371.81	$451.85	0.823	80.6%
Silver	113,770	$453.78	$483.16	0.939	71.8%
Bronze	28,579	$267.91	$417.11	0.642	65.0%
Total	**186,197**	**$405.95**	**$465.65**	**0.872**	**72.9%**

The projected paid and allowed claims reflect the member month weighted average by metal level from Worksheet 2, Section IV of the URRT. The average AV metal value is based on AVs calculated using the federal AV calculator, weighted on projected allowable cost by metal level.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

The Market-Wide Adjusted Index Rate is adjusted to compute the Plan Adjusted Index Rate using the following allowable adjustments:

- Actuarial value and cost sharing adjustment
    - Since CHPW only offers standardized plans through the public option, we are relying on AV Calculator AVs from Wakely Consulting Group's Unique Plan Design Certification for the metal AV of Washington standardized benefit designs.
    - The AV and cost sharing pricing adjustment was developed utilizing the HCGs. Relativities between plans were based on the differences in cost and utilization for varying levels of cost sharing, holding morbidity and population constant for all plans.
    - AV pricing values were adjusted to be no more than +/- 2% of the AV metal value, in accordance with WAC 284-43-6810(3).
    - Induced demand factors were calculated based on the federal risk adjustment formula, in accordance with WAC 284-43-6810(2).
    - The AV and cost sharing pricing adjustment reflects full plan liability for CSR subsidies. CSR costs are reflected as a uniform percentage load (43.5%) applied to each Silver ACA-compliant plan (those sold through the Exchange).
    - In accordance with item 11d from the Individual Non-Grandfathered Health Plan Checklist, we removed the impact of coverage of abortion services from the AV and cost sharing factors. This impact is the reciprocal of the abortion adjustment applied to the benefits in addition to the EHBs factor described below.
    - Development of the AV and cost sharing adjustment can be found in Table 10.1.

- Provider network, delivery system and utilization management adjustment
    - There are no expected differences in the provider network and/or utilization management between plans.

- Adjustment for benefits in addition to the EHBs
    - All plans include coverage for elective abortion. In accordance with the URR instructions and checklist item 13, the $1.00 premium adjustment for elective abortion is included in the Benefits in Addition to EHB line of the URRT. Please see Table 10.3 for further details.

- Adjustment for distribution and administrative costs
    - Non-benefit expenses are discussed in detail below.

- There are no catastrophic plans being offered, so there is no eligibility adjustment made for catastrophic plan enrollment.

The following table demonstrates the Plan Adjusted Index Rate development for each plan in the projection period:

Table 10.2
Community Health Plan of Washington
Projection Period Plan Adjusted Index Rate Development

Plan Name	HIOS ID	Market-Wide Adjusted Index Rate	AV & Cost Sharing	Provider Network Adjustment	Benefits In Addition to EHBs	Admin Cost Fee	Catastrophic Eligibility	Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$635.08	0.814	1.000	1.002	1.138	1.000	$589.53
CHPW Vital Gold	18581WA0140004	$635.08	0.763	1.000	1.002	1.138	1.000	$552.65
CHPW Silver	18581WA0140002	$635.08	0.972	1.000	1.002	1.138	1.000	$704.25
CHPW Bronze	18581WA0140003	$635.08	0.574	1.000	1.002	1.138	1.000	$415.79

The Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool and therefore are not calibrated.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

Silver CSR Loading and Subsidized Membership

CHPW received no member cost sharing subsidy payments from HHS in 2024. To reflect the expectation that CHPW will continue to not be reimbursed for cost sharing on Silver CSR plans, CSR costs are included as a percentage load applied to each Silver ACA-compliant plan sold through the Exchange. Per WAC 284-43-6820, the CSR rate load is set to 1.435 for PY2026. As this is higher than our projected impact of CSRs, the revenue-neutral application of this mandated CSR load puts downward pressure on the non-Silver plan premiums.

No explicit projection assumptions are made for the AIAN population due to CHPW's limited membership and claims experience for AIAN enrollees.

Non-Benefit Expenses, Profit, and Risk

The administrative expense load was provided by CHPW. Development of the load shown on URRT Worksheet 2 is shown in WA Exhibit 11. This expense load is based on projected enrollment and is estimated to appropriately cover expenses for overhead, operations, and sales and marketing expenses. The administrative expenses are allocated proportionally by plan on a percentage of premium basis.

Commission expenses have been eliminated from the administrative expense projection for 2026. CHPW is eliminating broker commissions, as noted in the Commissions Certification accompanying this filing.

The taxes and fees which may be subtracted from premiums for purposes of calculating the MLR are listed in WA Exhibit 11. The taxes and fees shown on URRT Worksheet 2 do not include the Exchange User Fee, and are applied on a percentage of premium basis. The development of this amount is shown in WA Exhibit 11.

The Patient Centered Outcomes Research Fee (PCORI) amount of $0.31 shown in WA Exhibit 11 is calculated as follows: $3.47 / 12 * ($16,387 / $15,074) = $0.31 PMPM. The $3.47 annual fee per member for plan years ending October 1, 2024 through September 30, 2025 is first divided by 12 to transfer the fee to a PMPM basis. It is then trended by the projected NHE change from 2024 to 2026 to project the payment for plan years ending 12/31/2026.

The regulatory surchage fee, WSHIP assessment, WAPAL assessment, and insurance fraud surchage fee are also included in WA Exhibit 11.

For 2024, the Risk Adjustment User Fee is included as part of Taxes and Fees on line 3.7 of Worksheet 2 of the URRT.

The profit and risk load was applied proportionally to all products. Development of the load shown on URRT Worksheet 2 is included in WA Exhibit 11. This target profit percentage was provided by CHPW and relied upon in this filing.

EXHIBIT 11. CALIBRATION

A single calibration factor is applied to the Plan Adjusted Index Rates from Exhibit 10 to calibrate rates for the expected age, geographic, and tobacco use distribution expected to enroll in the plan. The single calibration factor is applied uniformly across all plans.

Age Curve Calibration

The approximate weighted average age, rounded to a whole number, for the single risk pool is 47. The weighted average age curve calibration factor is 1.545.

In order to determine the calibration factor for age, the projected distribution of members by age was determined. The weighted average of the factors in the age curve was then calculated using this distribution. The average age was then determined by finding the age of a member that would have the closest factor to the weighted average age curve calibration factor. Prior to applying the allowed rating factors for age, geography, and tobacco, the plan adjusted Index Rates need to be divided by the age curve calibration factor. A development of the age curve calibration factor is shown in Table 11.2.

Additional information regarding the age curve can be found on Exhibit 12.

Geographic Factor Calibration

In order to determine the calibration factor for geography, the projected distribution of members by area was determined. The weighted average of the area factors was then determined using this distribution. The area factors used are reflective of differences in delivery costs (including unit cost and provider practice pattern differences) only, and do not reflect any differences in the the following health-status related factors listed in line 16b of the Individual Non-Grandfathered Health Plan Checklist:

(a) Health status of enrollees or the population in an area
(b) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health illnesses
(c) Claims experience
(d) Health services utilization in the area
(e) Medical history of enrollees or the population in an area
(f) Genetic information of enrollees or the population in an area
(g) Disability status of enrollees or the population in an area
(h) Other evidence of insurability applicable in the area.

Prior to applying the allowed rating factors for age, geography, and tobacco, the plan adjusted Index Rates need to be divided by the geography calibration factor. A development of the geographic calibration factor is shown in Table 11.2.

Additional information regarding the area rating factors can be found on Exhibit 12.

Tobacco Factor Calibration

CHPW will not charge a tobacco surcharge for smokers.

The following tables demonstrate the calibration performed for each plan.

Table 11.1
Community Health Plan of Washington
Calibrated Plan Adjusted Index Rate Development

Plan	HIOS ID	Plan Adjusted Index Rate	Age Calibration Factor	Geographic Calibration Factor	Tobacco Calibration Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$589.53	1.545	0.983	1.000	1.519	$388.23
CHPW Vital Gold	18581WA0140004	$552.65	1.545	0.983	1.000	1.519	$363.94
CHPW Silver	18581WA0140002	$704.25	1.545	0.983	1.000	1.519	$463.77
CHPW Bronze	18581WA0140003	$415.79	1.545	0.983	1.000	1.519	$273.81

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual or family utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. It is the product of the Plan Adjusted Index Rate, the geographic rating factor, the age rating factor and the tobacco status rating factor. All rating factors are described and shown below.

CHPW's CY2026 age and tobacco rating factors are shown below. The age rating factors used by CHPW are identical to those prescribed by CMS. Tobacco factors are uniformly 1.0 as CHPW does not intend to rate for tobacco in PY2026.

Table 12.1
Community Health Plan of Washington
Age and Tobacco Factors

Age Band	Age Rating Factor	Tobacco Factor		Age Band	Age Rating Factor	Tobacco Factor
0-14	0.765	1.000		40	1.278	1.000
15	0.833	1.000		41	1.302	1.000
16	0.859	1.000		42	1.325	1.000
17	0.885	1.000		43	1.357	1.000
18	0.913	1.000		44	1.397	1.000
19	0.941	1.000		45	1.444	1.000
20	0.970	1.000		46	1.500	1.000
21	1.000	1.000		47	1.563	1.000
22	1.000	1.000		48	1.635	1.000
23	1.000	1.000		49	1.706	1.000
24	1.000	1.000		50	1.786	1.000
25	1.004	1.000		51	1.865	1.000
26	1.024	1.000		52	1.952	1.000
27	1.048	1.000		53	2.040	1.000
28	1.087	1.000		54	2.135	1.000
29	1.119	1.000		55	2.230	1.000
30	1.135	1.000		56	2.333	1.000
31	1.159	1.000		57	2.437	1.000
32	1.183	1.000		58	2.548	1.000
33	1.198	1.000		59	2.603	1.000
34	1.214	1.000		60	2.714	1.000
35	1.222	1.000		61	2.810	1.000
36	1.230	1.000		62	2.873	1.000
37	1.238	1.000		63	2.952	1.000
38	1.246	1.000		64+	3.000	1.000
39	1.262	1.000				

CHPW's CY2026 geographic rating factors and their development are shown in Table 12.2. These area factors reflect differences in unit cost by region. They were developed using Milliman's Health Cost Guidelines™ and CHPW's anticipated provider reimbursement by region and have been normalized to remove the impact of differences in population demographics and health status on claim costs.

The geographic area factors do not include the impact of any of the following:

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

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The premium for family coverage is determined by summing the consumer adjusted premium rates for each individual family member, provided at most three child dependents under age 21 are taken into account.

The following table demonstrates the premium rate development for the Consumer Adjusted Premium Rate beginning with the Calibrated Plan Adjusted Index Rate and applying the appropriate age, area, and tobacco factors.

Table 12.3 Community Health Plan of Washington Sample Consumer Adjusted Premium Rate Development	
Community Health Plan of Washington Cascade Select Complete Gold - 18581WA0140001	
Calibrated Plan Adjusted Index Rate	$388.23
Age: 33	1.198
Area: 6	0.967
Tobacco Status: Non-Tobacco User	1.000
Consumer Adjusted Premium Rate	**$449.76**

EXHIBIT 13. PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) is 89.8%. This loss ratio is calculated based on the MLR methodology as prescribed by 45 CFR 158.

The following table summarizes the calculation for the projected federal medical loss ratio:

Table 13.1
Community Health Plan of Washington
Projected Federal Medical Loss Ratio

Member Months	186,197
MLR Numerator Calculations	
Paid Claims PMPM	$405.95
Claim-Related Retention (QI/Health IT) PMPM	$0.00
Prior Rebate	$0.00
Other Claim-Related Adjustments	$0.00
Risk Adjustment Paid (Received) PMPM	$142.59
Market Reinsurance Recoveries (Received) PMPM	$0.00
MLR Numerator Calculations	**$548.54**
MLR Denominator Calculations	
Premium PMPM	$630.01
Other Premium-Related Adjustments	$0.00
Premium-Related Retention (Taxes & Fees) PMPM	$19.15
MLR Denominator	**$610.87**
Medical Loss Ratio	**89.8%**

No additional state-specific projected loss ratio demonstration is required in the State of Washington.

EXHIBIT 14. AV METAL VALUES

The AV Metal Values included in URRT Worksheet 2 were calculated by Wakely Consulting, which provided a Unique Plan Design Certification for the Washington standardized benefit designs. This filing has relied upon that certification, and it is included in the rate filing material for reference. The following reason was provided for the unique plan designs:

- For the Expanded Bronze Standard Option, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature.

EXHIBIT 15. MEMBERSHIP PROJECTIONS

Enrollment projections were developed by county and metal level through a combination of inputs from CHPW leadership, review of CHPW's current enrollment distribution for Cascade Select, and Milliman modeling of eAPTC expiration. Specifically:

- We developed enrollment projections by county based on the following factors:
  - Current (2025) CHPW Cascade Select membership
  - Anticipated 2026 retention (i.e., current enrollees renewing in CHPW plans)
  - Overall Exchange market decline (as modeled by Milliman and compared against WAHBE/Wakely reporting)

- Enrollment by metal level and CSR status reflects current CHPW enrollment patterns adjusted for both eAPTC expiration and the mandated uniform CSR load.

- As rates were developed, anticipated rate competitiveness in each market was reviewed for potential impact to projected enrollment.

- These inputs were then combined to develop the projected enrollment by county and metal level, which was then rolled up to the rating area and metal level.

As a result, 2026 enrollment is projected at 186,197 member months.

These projections are consistent with company expectations for the product line in 2026. Each plan in this filing has nonzero projected enrollment with the exception of the Silver 70% and 73% variants. Consistent with the assumptions underlying the OIC's development of the mandated CSR rate load, we assume that all Silver 70% members will migrate to the new low AV Vital Gold plan and that all Silver 73% members will disenroll entirely due to the silver plan premium cost increase.

Projected cost sharing reduction (CSR) eligibles are shown in Table 15.1:

Table 15.1
Community Health Plan of Washington
Projected Enrollment (Member Months) by Benefit Level (Silver Plans)

Plan Name	HIOS ID	70%	73%	87%	94%	Total
CHPW Cascade Select Silver	18581WA0140002	0	0	73,162	40,608	113,770

EXHIBIT 16. TERMINATED PRODUCTS

No products will be terminated prior to the effective date.

EXHIBIT 17. PLAN TYPE

There are no differences between the plans of CHPW and the plan type selected in the drop-down box in Worksheet 2, Section I of the URRT.

EXHIBIT 18. EFFECTIVE RATE REVIEW INFORMATION

URRT Worksheet 2, Section IV Projected Allowed Claims, Incurred Claims & Premiums (Checklist item 28f)

Please see Table 18.1 for a calculation of the projected dollar amounts by plan for URRT Worksheet 2, Section IV.

URRT Projected PAIR and Premium PMPM (Checklist item 28h)

The weighted-average Plan Adjusted Index Rates in Field 3.10 of URRT Worksheet 2 matches the aggregate premium PMPM in Field 4.17.

Mental Health and Substance Use Disorder Parity (Checklist item 33)

The Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity Certification has been completed by Elaine Corrough, FSA, MAAA, Senior Director of Actuarial Services, Community Health Plan of Washington. I am relying on Elaine's work and note the following:

- Projected plan and benefit classification/sub-classification dollar amounts are consistent with the actuarial cost model developed for 2026 rate projection, as described earlier in this Actuarial Memorandum;
- The underlying data sources and adjustments are as described earlier in this Actuarial Memorandum;
- There are no differences between the data used to project PY 2026 claims and premium rates, and the data used for MH/SUD parity testing;
- Projections are required to reflect plan-level assumptions – because all plans' rates have been developed from the same allowed claims basis, the same projected allowed cost has been used for MH/SUD parity testing for all plans;
- Dollar amounts used for testing are based on allowed claims, before any member cost-sharing; and
- A reasonable actuarial method was used for the dollar projections for each plan, in accordance with WAC 284-43-7040(1)(c)(ii) and in compliance with applicable Actuarial Standards of Practice.

The Certification ("MHSUD Financial Requirements Certification") and supporting Excel workbook ("MHSUD Parity Calculations Duplicate.xlsm" / "MHSUD Parity Calculations.pdf") have been submitted separately in this rate filing.

Parity calculations reflect the entirety of projected allowed claims for each service category tested. Under 45 CFR 144.103, parity analyses should reflect data at the plan level, rather than the product level. However, per CMS/CCIIO , an issuer "can use data at the product level to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method based on the best available data)." Premium rates for all of CHPW's plans have been developed from the same projection of allowed costs, the development of which is described elsewhere in this memorandum. Projected allowed costs are distributed amongst benefit categories based on the actual distribution reflected in base period experience across all plans. This represents our best estimate of the expected distribution of allowed costs by service category for each plan.

The 2026 standard ("Cascade") plan designs set by WAHBE include reduced copays ($1) for the first two MH/SUD visits, followed by higher standard copays for remaining visits ($30 for Cascade Silver and $50 for Cascade Bronze). Testing in the supporting Excel workbook ("MHSUD Parity Calculations Duplicate.xlsm" / "MHSUD Parity Calculations.pdf") has been completed to reflect these higher copays paid for all visits, even though the first two visits are at a lower copay. This effectively creates a "safe harbor" for the test – if parity is achieved using only the higher copays for all visits, then the actual plans, with reduced copays for the first two visits, should also pass the parity test. This is noted in the Excel workbook.

Differences in the UPMJ and URRT Aggregate Rate Change (Checklist item 30c)

The URRT Worksheet 2 fields 1.12 and 1.13 premium-weight the overall rate change while the Aggregate Rate Change in the UPMJ Q5 weights by current enrollment.

EXHIBIT 19. RELIANCE

In performing this analysis, I relied on data and other information provided by CHPW. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

As permitted by the OIC, we have relied on the Actuarial Value Certification for WAHBE 2026 Standard Medical Plan designs performed by Wakely Consulting Group. We have relied on the certification by Wakely Consulting Group since we do not have access to the underlying data used in their assessment of the Actuarial Value for these plans which the OIC has indicated must be matched. Documentation of the analysis performed by Wakely Consulting Group is included in Exhibit 14.

Table 19.1
Community Health Plan of Washington
Reliance

Data / Assumption	Source
2024 individual QHP claims and membership experience	Elaine Corrough, CHPW
2024 interim risk adjustment transfer receivable/payment	"Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025, CMS; "HHS public and carrier-specific interim 2024 risk adjustment reports", provided by Elaine Corrough, CHPW "Wakely National Risk Adjustment Reporting", provided by Elaine Corrough, CHPW
Other 2024 individual QHP marketplace revenue and expenditures	Elaine Corrough, CHPW
2024 IBNP estimate	Elaine Corrough, CHPW
2024 Plan Liability Risk Score associated with Individual QHP claims and membership experience	Elaine Corrough, CHPW
2025 emerging individual QHP membership	Elaine Corrough, CHPW
Utilization trends	Milliman (*Health Cost Guidelines*)
Unit cost trends	CMS; Milliman (*Health Cost Guidelines*)
Administrative costs, taxes, and fees	Elaine Corrough, CHPW
Broker fees and commissions	Elaine Corrough, CHPW
County Rating Areas	Elaine Corrough, CHPW
Community Health Plan of Washington service areas	Elaine Corrough, CHPW
Expected reimbursement by Rating Area	Elaine Corrough, CHPW
3:1 age band Factors	HHS
2026 pediatric vision administrative fees and claims cost	VSP
Prescription drug AWP discounts, dispensing fees, rebates, and retail/mail utilization assumptions	Elaine Corrough, CHPW
2026 Exchange user fee	Washington Health Benefits Exchange
WSHIP assessment	Elaine Corrough, CHPW
WAPAL assessment	Elaine Corrough, CHPW
Contribution to surplus % of premium	Elaine Corrough, CHPW
SHB 1979 impacts	Elaine Corrough, CHPW

EXHIBIT 20. ACTUARIAL CERTIFICATION

I am a Consulting Actuary with the firm of Milliman, Inc. Community Health Plan of Washington engaged me to provide the opinion herein.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I certify to the best of my knowledge and judgment:

1. The projected Index Rate is
   - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102)
   - Developed in compliance with the applicable Actuarial Standards of Practice
   - Reasonable in relation to the benefits provided and the population anticipated to be covered
   - Neither excessive nor deficient based on my best estimates of the 2026 individual market.

2. 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.

3. The geographic rating factors shown in Worksheet 3 of the URRT reflect only differences in the cost of delivery, and do not include differences for population morbidity by geographic area.

4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans.

The URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The 2026 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2026 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendments, court decisions, or decisions by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. At the time of this rate filing submission, we acknowledge there is uncertainty regarding the expiration of the enhanced premium subsidies first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA). Consistent with WA OIC instructions, we have assumed that these subsidies will expire at the end of 2025 and adjusted our assumptions for the 2026 premium rates accordingly. However, I have made no prediction or estimate of the likelihood of these events. Due to the substantial uncertainty regarding the impact of removing these subsidies, some of the related assumptions may exhibit a greater divergence from expectations.

Signed: 

Name: Jordan Pettibon, FSA, MAAA

Title: Consulting Actuary

Date: May 12, 2025

Part II: Written Justification of Rate Increase

Community Health Plan of Washington

Individual Exchange Product / Plans

Effective January 1, 2026

Product ID: 18581WA014

Community Health Plan of Washington Cascade Select Complete Gold

Community Health Plan of Washington Cascade Select Vital Gold

Community Health Plan of Washington Cascade Select Silver

Community Health Plan of Washington Cascade Select Bronze

GEOGRAPHIC AREA

Community Health Plan of Washington (CHPW) offered Gold, Silver, and Bronze Cascade Select Public Option plans effective 1/1/2025 in 26 counties. For plan year 2026, CHPW is renewing its plans in the same 26 counties. CHPW's plans are marketed only on the Washington Health Benefit Exchange.

Geographic Area WAC 284-43-6701	Counties Where Community Health Plan of Washington Will Offer This Product
1	King
2	Clallam, Jefferson, Kitsap, Lewis
4	Ferry, Lincoln, Spokane, Stevens
5	Mason, Pierce, Thurston
6	Benton, Franklin, Kittitas, Yakima
7	Adams, Chelan, Douglas, Grant, Okanogan
8	Snohomish
9	Asotin, Columbia, Walla Walla, Whitman

SCOPE AND RANGE OF THE RATE INCREASE

The overall proposed rate change for 2026 across all plans is 28.02%. There are approximately 34,463 members[1] who would receive a rate change to their premiums ranging from -11.6% to 37.2% (for the same age), with rate changes varying by plan and rating area. CHPW is renewing its Complete Gold, Silver, and Bronze Cascade Select Public Option plans and will be adding the Vital Gold Cascade Select Public Option plan in 2026.

COMPONENTS OF THE 2026 PREMIUM VS. 2025 PREMIUM

Below is the projected breakdown of the average 2026 premium across all plans, as compared with the 2025 filed rates:

Premium Component	2025 % of Premium	2026 % of Premium
Claims expense	85.6%	87.1%
Administrative expenses	9.1%	7.9%
Taxes and fees	3.3%	3.0%
Contribution to surplus	2.0%	2.0%
Total	100%	100%

FINANCIAL EXPERIENCE OF THE PRODUCT

Net Morbidity and Risk Adjustment Transfer Estimate

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. Risk adjustment transfer experience for calendar year 2024 was projected forward to 2026, including consideration of changes to the statewide average premium, risk adjustment program, and CHPW enrollee population morbidity relative to the Washington single risk pool.

Experience and Mix

The individual single risk pool experience underlying the rate projections has been updated, including marketplace enrollee mix. The table below shows a summary of the pooled experience with adjustments.

[1] Enrollment as of March 31, 2025

Experience Period Summary From 1/1/2024 to 12/31/2024	
Member months	335,501
Earned premium	$153,416,318.04
Paid claims	$103,996,811.49
Beginning claim reserve	$5,222,914.00
Ending claim reserve	$14,111,009.61
Incurred claims	$112,945,234.01
Expenses	$13,139,650.98
Gain/loss	$27,331,433.05
Loss ratio percentage	73.62%
RA transfer amount	-$45,934,766.89
HCRP transfer amount	$2,256,779.00
HCRP assessment	-$613,665.27
HHS-RADV adjustments	$0.00
Adjusted gain/loss	-$16,960,220.11
MLR rebates	$0.00

CHANGES IN MEDICAL SERVICE COSTS

Changes in medical service costs were driven by expectations for medical inflation (cost per service and utilization of medical and pharmacy services), provider contracting, and care management. Average annual medical/pharmacy inflation of 5.3% is reflected in these rates.

CHANGES IN BENEFITS

CHPW will continue to offer the Cascade Select Complete Gold, Silver, and Bronze plans in plan year 2026. Benefits and member cost-sharing for these plans are set forth by the Washington Health Benefit Exchange. Changes for 2026 include the following.

	Deductible		OOP Max	
2026 Plan Name	2025	2026	2025	2026
Cascade Select Complete Gold	$600	$1,000	$7,000	$7,000
Cascade Select Silver	$2,500	$2,500	$9,200	$9,750
Cascade Select Silver - 73% CSR	$2,500	$2,500	$7,250	$7,950
Cascade Select Silver - 87% CSR	$750	$750	$2,500	$2,850
Cascade Select Silver - 94% CSR	$0	$0	$1,900	$2,400
Cascade Select Bronze	$6,000	$6,000	$9,200	$10,150

	Service Category			
	Primary Care Visit to Treat an Injury or Illness		Mental Health & Substance Use Disorder All Other OP Services	
2026 Plan Name	2025	2026	2025	2026
Cascade Select Complete Gold	$15	$15	$15	$15
Cascade Select Silver	$30	$20	$30	$20
Cascade Select Silver - 73% CSR	$30	$20	$30	$20
Cascade Select Silver - 87% CSR	$10	$5	$10	$5
Cascade Select Silver - 94% CSR	$5	$1	$5	$1
Cascade Select Bronze	$50	$40	$50	$40

All other standard plan benefits are the same from 2025 to 2026.

ADMINISTRATIVE COSTS AND ANTICIPATED SURPLUS

The assumptions for administrative expenses, taxes, and fees were updated for the 2026 rate development based on a review of CHPW's historical expenses and projected direct costs for the Cascade Select line of business. On a per-member basis, administrative costs have increased as CHPW's projected population has decreased. As a result, admin expenses are estimated to increase from $45.77 PMPM in 2025, to $49.72 PMPM in 2026. Taxes and Fees

decreased from 3.3% to 3.0% driven by an increase in premiums while the exchange fee remained constant. The target contribution to surplus (2.0%) did not change from 2025 to 2026.

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:	Community Health Plan of Washington		
HIOS Issuer ID:	18581	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	$131,726,287.66	$392.63
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$112,945,234.01	$336.65
Risk Adjustment	-$44,291,653.16	-$132.02
Experience Period Premium	$153,416,318.04	$457.28
Experience Period Member Months	335,501	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$73.33	1.031	0.995	1.031	0.995	$77.11
Outpatient Hospital	$126.54	1.031	1.010	1.030	1.010	$137.10
Professional	$85.91	0.972	1.000	1.001	1.000	$83.63
Other Medical	$7.40	0.975	1.000	1.004	1.000	$7.24
Capitation	$0.00	1.000	1.000	1.000	1.000	$0.00
Prescription Drug	$99.45	1.100	1.025	1.100	1.025	$126.43
Total	$392.63					**$431.52**

Morbidity Adjustment	1.050
Demographic Shift	1.025
Plan Design Changes	0.986
Other	1.017
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$465.65**

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

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$465.65**	$86,702,633.05
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	-$163.56	-$30,455,033.89
Exchange User Fees	0.92%	$1,091,394.29
Market Adjusted Index Rate	**$635.08**	**$118,249,061.23**

Projected Member Months	**186,197**

Product-Plan Data Collection

Company Legal Name: **Community Health Plan of Washington**
HIOS Issuer ID: **18581** 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		Community Health Plan of Washington Cascade Select			
1.2	Product ID		18581WA014			
1.3	Plan Name		Community Health	Community Health	Community Health	Community
1.4	Plan ID (Standard Component ID)		18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
1.5	Metal		Gold	Gold	Silver	Bronze
1.6	AV Metal Value		0.818	0.781	0.718	0.650
1.7	Plan Category		Renewing	New	Renewing	Renewing
1.8	Plan Type		EPO	EPO	EPO	EPO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		5.71%	0.00%	35.68%	8.73%
1.12	Product Rate Increase %		28.02%			
1.13	Submission Level Rate Increase %		28.02%			

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information				
	2.1 Plan ID (Standard Component ID)	Total	18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
$131,726,288	2.2 Allowed Claims	$131,726,288	$34,798,111	$0	$89,775,619	$7,152,557
$0	2.3 Reinsurance	$0	$0	$0	$0	$0
	2.4 Member Cost Sharing	$18,781,054	$4,108,044	$0	$12,500,942	$2,172,068
	2.5 Cost Sharing Reduction	$0	$0	$0	$0	$0
$112,945,234	2.6 Incurred Claims	$112,945,234	$30,690,067	$0	$77,274,677	$4,980,490
-$44,291,653	2.7 Risk Adjustment Transfer Amount	-$44,291,653	$3,240,040	$0	-$39,816,023	-$7,715,670
$153,416,318	2.8 Premium	$153,416,318	$20,522,607	$0	$120,759,154	$12,134,558
335,501	2.9 Experience Period Member Months	335,501	44,136	0	260,686	30,679
	2.10 Current Enrollment	34,463	4,924	0	24,649	4,890
	2.11 Current Premium PMPM	$504.32	$538.63	$0.00	$516.80	$406.87
	2.12 Loss Ratio	103.50%	129.15%	#DIV/0!	95.47%	112.71%
	Per Member Per Month					
	2.13 Allowed Claims	$392.63	$788.43	#DIV/0!	$344.38	$233.14
	2.14 Reinsurance	$0.00	$0.00	#DIV/0!	$0.00	$0.00
	2.15 Member Cost Sharing	$55.98	$93.08	#DIV/0!	$47.95	$70.80
	2.16 Cost Sharing Reduction	$0.00	$0.00	#DIV/0!	$0.00	$0.00
	2.17 Incurred Claims	$336.65	$695.35	#DIV/0!	$296.43	$162.34
	2.18 Risk Adjustment Transfer Amount	-$132.02	$73.41	#DIV/0!	-$152.74	-$251.50
	2.19 Premium	$457.28	$464.99	#DIV/0!	$463.24	$395.53

	Section III: Plan Adjustment Factors				
3.1	Plan ID (Standard Component ID)	18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
3.2	Market Adjusted Index Rate	$635.08			
3.3	AV and Cost Sharing Design of Plan	0.8138	0.7628	0.9721	0.5739
3.4	Provider Network Adjustment	1.0000	1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB	1.0025	1.0025	1.0025	1.0025
	Administrative Costs				
3.6	Administrative Expense	7.89%	7.89%	7.89%	7.89%
3.7	Taxes and Fees	2.23%	2.23%	2.23%	2.23%
3.8	Profit & Risk Load	2.00%	2.00%	2.00%	2.00%
3.9	Catastrophic Adjustment	1.0000	1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**	$589.53	$552.65	$704.25	$415.79
3.11	Age Calibration Factor	0.6472	0.6472		
3.12	Geographic Calibration Factor	1.0175	1.0175		
3.13	Tobacco Calibration Factor	1.0000	1.0000		
3.14	**Calibrated Plan Adjusted Index Rate**	$388.23	$363.94	$463.77	$273.81

	Section IV: Projected Plan Level Information					
4.1	Plan ID (Standard Component ID)	Total	18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
4.2	Allowed Claims	$86,702,702	$13,188,966	$6,623,869	$54,969,421	$11,920,446
4.3	Reinsurance	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$11,116,194	$2,178,604	$1,331,192	$3,342,632	$4,263,766
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0
4.6	Incurred Claims	$75,586,508	$11,010,361	$5,292,677	$51,626,789	$7,656,680
4.7	Risk Adjustment Transfer Amount	-$26,550,380	$671,288	$344,225	-$19,352,073	-$8,213,819
4.8	Premium	$117,306,587	$17,087,546	$8,213,978	$80,122,268	$11,882,795
4.9	Projected Member Months	186,197	28,985	14,863	113,770	28,579
4.10	Loss Ratio	83.29%	62.00%	61.84%	84.95%	208.69%
	Per Member Per Month					
4.11	Allowed Claims	$465.65	$455.03	$445.66	$483.16	$417.11
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$59.70	$75.16	$89.56	$29.38	$149.19
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$405.95	$379.86	$356.10	$453.78	$267.91
4.16	Risk Adjustment Transfer Amount	-$142.59	$23.16	$23.16	-$170.10	-$287.41
4.17	Premium	$630.01	$589.53	$552.65	$704.25	$415.79

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.0748
Rating Area 4	0.9882
Rating Area 5	0.9346
Rating Area 6	0.9670
Rating Area 7	1.0294
Rating Area 8	1.0064
Rating Area 9	0.9701

State: Washington **Filing Company:** Community Health Plan of Washington
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 Non-Grandfathered Individual
Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Written Description Justifying the Rate Increase
Comments:	The Part II Written Description Justifying the Rate Increase file is loaded on the URRT tab per filing instructions for non-grandfathered plans.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum Tables
Comments:	
Attachment(s):	Actuarial_Memorandum_Tables.pdf Actuarial_Memorandum_Tables_Duplicate.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	WAC 284-43-6660
Comments:	
Attachment(s):	WAC 284-43-6660.pdf WAC 284-43-6660 DUPLICATE.xlsx
Item Status:	
Status Date:	

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

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

Satisfied - Item:	Benefit Components
Comments:	

State: Washington **Filing Company:** Community Health Plan of Washington
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 Non-Grandfathered Individual
Project Name/Number: /

Attachment(s):	Benefit Components.pdf Benefit Components DUPLICATE.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	MHSUD Financial Requirements Certification
Comments:	
Attachment(s):	MHSUD Financial Requirements Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	MHSUD Parity Calculations
Comments:	
Attachment(s):	MHSUD Parity Calculations.pdf MHSUD Parity Calculations DUPLICATE.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Wakely AV Certification
Comments:	
Attachment(s):	Wakely - WAHBE 2026 Medical AV Certification 78% Gold 202500415.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Justification for Profit and Risk Load
Comments:	
Attachment(s):	Justification for Profit and Risk Load.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Commissions Certification
Comments:	
Attachment(s):	Commissions Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Financial Statement Analysis
Comments:	

State: Washington **Filing Company:** Community Health Plan of Washington
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: 2026 Non-Grandfathered Individual
Project Name/Number: /

Attachment(s):	Financial Statement Analysis.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Additional Data Statement 12 31 2024
Comments:	
Attachment(s):	Additional Data Statement 12 31 2024.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Experience Reconciliation (Checklist 1-3)
Comments:	
Attachment(s):	Experience Reconciliation (Checklist 1-3).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Plan Statutory pg 34-5
Comments:	
Attachment(s):	Plan Statutory 2024 Pg 34-5.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Checklist - Rates - 1332 Waiver Reporting
Comments:	
Attachment(s):	Checklist - Rates - 1332 Waiver Reporting.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Checklist - Rates - 2026 Individual Nongrandfathered Health Plans
Comments:	
Attachment(s):	Checklist - Rates - 2026 Individual Nongrandfathered Health Plans.pdf
Item Status:	
Status Date:	

Satisfied - Item:	WA_Exhibits_CHPW_2026
Comments:	
Attachment(s):	WA_Exhibits_CHPW_2026.xlsx

SERFF Tracking #:	*CHPW-134525946*	***State Tracking #:***	*484514*	***Company Tracking #:***	*CHPW-202*

State:	*Washington*	***Filing Company:***	*Community Health Plan of Washington*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*2026 Non-Grandfathered Individual*		
Project Name/Number:	*/*		

Item Status:	
Status Date:	

Satisfied - Item:	Rating Documents for Extended ARPA Subsidies
Comments:	
Attachment(s):	Rate Schedule with ARPA Extension.pdf Rate Schedule with ARPA Extension DUPLICATE.xlsm Part I Unified Rate Review Template with ARPA Extension.pdf Part I Unified Rate Review Template with ARPA Extension DUPLICATE.xlsm UnifiedRateReviewSubmission_18581 20250512 with ARPA Extension_20250512155231.xml Part_III_Rate_Filing_Documentation_and_Actuarial_Memorandum_with_ARPA_Extension.pdf Actuarial_Memorandum_Tables with ARPA Extension.pdf Actuarial_Memorandum_Tables with ARPA Extension_Duplicate.xlsx
Item Status:	
Status Date:	

Table 2.1
Community Health Plan of Washington
Breakdown of Proposed Rate Change

Description	Value
Estimated Changes in Experience	1.068
Additional Year of Trend (2025 to 2026)	1.053
Impact of eAPTC Subsidy Expiration	1.036
Changes in Net Morbidity and Risk Adjustment (Excluding eAPTC Subsidy Expiration Impact)	1.088
Changes in Benefits	0.987
Changes in Plan Mix and CSR Rate Load	1.034
Changes in Administrative Costs	0.989

Table 3.1a
Community Health Plan of Washington
Allowed Claims - Medical
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$693,132	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$693,132
202402	$2,475,876	$1,003,004	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,478,879
202403	$403,882	$2,645,588	$971,241	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,020,710
202404	$175,299	$1,089,088	$3,789,813	$1,385,779	$0	$0	$0	$0	$0	$0	$0	$0	$6,439,979
202405	$98,281	$188,854	$807,784	$4,189,584	$1,243,421	$0	$0	$0	$0	$0	$0	$0	$6,527,924
202406	$81,727	$92,255	$338,419	$1,409,505	$3,756,689	$1,119,462	$0	$0	$0	$0	$0	$0	$6,798,057
202407	$22,582	$119,330	$119,044	$366,142	$2,011,312	$4,770,791	$1,968,365	$0	$0	$0	$0	$0	$9,377,565
202408	$66,975	$61,467	$147,407	$184,397	$213,385	$779,792	$4,230,311	$1,285,792	$0	$0	$0	$0	$6,969,526
202409	$10,119	$55,455	$54,736	$177,524	$157,562	$225,789	$1,347,014	$4,797,572	$1,156,518	$0	$0	$0	$7,982,289
202410	$8,690	-$7,852	$4,767,700	$60,381	$56,873	$160,489	$232,935	$1,773,358	$4,905,291	$2,019,055	$0	$0	$13,976,919
202411	$12,324	$11,166	$144,499	$74,854	$79,017	$85,403	$133,250	$244,991	$728,771	$4,921,708	$1,661,892	$0	$8,097,874
202412	$10,059	$22,739	$40,778	$104,314	$49,000	$69,417	$99,967	$307,144	$216,895	$2,179,422	$5,721,310	$2,544,215	$11,365,261
202501	$4,037	-$98,823	$2,125	$34,053	$33,625	-$10,432	$26,366	-$15,696	$208,015	$181,872	$1,067,632	$4,526,329	$5,959,105
202502	-$8,514	$63,985	$40,755	$36,367	-$10,316	$29,262	$99,960	$126,209	$140,395	$395,851	$500,440	$1,409,301	$2,823,695
202503	$703	$3,171	$26,172	-$9,377	$27,468	$11,200	$38,975	$30,376	$37,080	$128,858	$249,891	$250,893	$795,410
Total	$4,055,170	$5,249,428	$11,250,472	$8,013,522	$7,618,037	$7,241,173	$8,177,144	$8,549,746	$7,392,965	$9,826,767	$9,201,165	$8,730,738	$95,306,326

IBNP Adjustment	$3,045,900
Other EHB Incurred Claims (VSP Experience)	$8,025
Member Months	335,501
Experience Period Index Rate PMPM (Medical Only Subtotal)	$293.17

Table 3.1b
Community Health Plan of Washington
Allowed Claims - Rx
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$1,440,352	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,440,352
202402	$307,227	$1,516,090	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,823,317
202403	$4,218	$364,050	$2,236,545	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,604,813
202404	$35	$4,274	-$2,639	$2,354,616	$0	$0	$0	$0	$0	$0	$0	$0	$2,356,286
202405	$0	$2,505	-$367	$176,681	$2,537,623	$0	$0	$0	$0	$0	$0	$0	$2,716,442
202406	$0	$0	$1,099	-$1,189	$264,039	$2,955,589	$0	$0	$0	$0	$0	$0	$3,219,538
202407	$0	$0	$963	$166	$1,380	-$211,969	$3,000,410	$0	$0	$0	$0	$0	$2,790,950
202408	$0	$0	$9	$81	$321	-$720	$315,352	$3,596,349	$0	$0	$0	$0	$3,911,393
202409	$388	$0	$220	$54	$3,050	$1,242	$4,728	-$174,185	$3,728,909	$0	$0	$0	$3,564,406
202410	$1,219	$0	$430	$2,824	$1,007	$1,692	$3,138	-$1,270	$150,556	$3,267,734	$0	$0	$3,427,331
202411	$0	$0	$0	$0	$0	$683	$761	$3,233	$1,251	$630,726	$3,921,574	$0	$4,558,229
202412	$0	$0	$0	$0	$0	$0	$0	$0	$11,128	$1,033	-$162,167	$3,822,277	$3,672,271
202501	$0	$2,287	$860	$0	$0	$0	$52	$777	-$316	-$4,046	$3,337	$380,750	$383,702
202502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,358	$1,131	$2,490
202503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35	$36	$315	$386
Total	$1,753,438	$1,889,208	$2,237,120	$2,533,235	$2,807,420	$2,746,516	$3,324,441	$3,424,904	$3,891,528	$3,895,483	$3,764,138	$4,204,473	$36,471,903

Rx Rebates	$3,105,866
Member Months	335,501
Experience Period Index Rate PMPM (Prescription Drug Only)	$99.45

Table 3.1c
Community Health Plan of Washington
Paid Claims - Medical
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$449,211	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$449,211
202402	$1,954,603	$698,632	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,653,235
202403	$326,976	$2,122,458	$688,502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,137,936
202404	$120,333	$894,812	$3,108,705	$982,847	$0	$0	$0	$0	$0	$0	$0	$0	$5,106,696
202405	$90,403	$150,684	$671,761	$3,554,028	$897,648	$0	$0	$0	$0	$0	$0	$0	$5,364,524
202406	$75,602	$74,387	$253,786	$1,284,700	$3,114,776	$818,991	$0	$0	$0	$0	$0	$0	$5,622,242
202407	$5,724	$111,905	$102,962	$306,873	$1,831,544	$3,960,859	$1,512,756	$0	$0	$0	$0	$0	$7,832,621
202408	$71,170	$56,769	$127,534	$178,514	$154,904	$665,165	$3,529,233	$970,727	$0	$0	$0	$0	$5,754,017
202409	$9,692	$51,047	$46,540	$86,840	$138,954	$167,483	$1,068,308	$4,016,552	$858,650	$0	$0	$0	$6,444,065
202410	$21,772	$42,511	$4,798,472	$88,089	$67,762	$121,032	$188,486	$1,588,224	$4,103,330	$1,533,923	$0	$0	$12,553,601
202411	$10,240	$8,844	$143,923	$67,651	$74,534	$67,056	$106,446	$168,284	$627,544	$4,280,586	$1,287,858	$0	$6,842,966
202412	$6,649	$9,907	$18,354	$93,733	$45,049	$61,993	$78,910	$212,584	$183,120	$1,808,174	$4,880,917	$2,012,622	$9,412,011
202501	$149,293	$11,650	$89,714	$130,217	$95,025	$69,027	$122,980	$51,576	$229,960	$146,748	$943,888	$3,911,422	$5,951,499
202502	$9,377	$64,940	$39,867	$39,931	-$3,770	$30,504	$86,173	$118,840	$123,138	$348,409	$422,763	$1,242,690	$2,522,861
202503	$490	$3,490	$26,247	-$5,415	$23,631	$9,849	$30,462	$21,474	$24,306	$116,713	$213,416	$179,597	$644,260
Total	$3,301,535	$4,302,034	$10,116,365	$6,808,008	$6,440,055	$5,971,959	$6,723,753	$7,148,261	$6,150,047	$8,234,553	$7,748,842	$7,346,332	$80,291,744

Table 3.1d
Community Health Plan of Washington
Paid Claims - Rx
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$1,274,542	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,274,542
202402	$295,340	$1,322,140	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,617,480
202403	$3,671	$334,273	$1,979,407	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,317,351
202404	$9	$4,076	$2,656	$2,130,718	$0	$0	$0	$0	$0	$0	$0	$0	$2,137,458
202405	$0	$2,430	-$485	$162,179	$2,296,160	$0	$0	$0	$0	$0	$0	$0	$2,460,283
202406	$0	$0	$943	-$1,446	$240,377	$2,677,983	$0	$0	$0	$0	$0	$0	$2,917,857
202407	$0	$0	$963	$166	$971	-$184,990	$2,726,618	$0	$0	$0	$0	$0	$2,543,727
202408	$0	$0	$3	$66	$182	-$682	$296,332	$3,274,577	$0	$0	$0	$0	$3,570,478
202409	$388	$0	$37	$18	$2,566	$993	$3,423	-$154,110	$3,412,287	$0	$0	$0	$3,265,602
202410	$1,942	$0	$408	$2,711	$970	$1,637	$3,097	-$1,262	$145,329	$2,991,666	$0	$0	$3,146,497
202411	$0	$0	$0	$0	$0	$623	$584	$3,090	$1,011	$584,446	$3,598,913	$0	$4,188,667
202412	$0	$0	$0	$0	$0	$0	$0	$0	$10,962	$636	-$152,638	$3,524,785	$3,383,745
202501	$0	$2,031	$566	$0	$0	$0	$23	$593	-$211	-$3,846	$2,768	$357,180	$359,103
202502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,267	$978	$2,245
202503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14	$3	$231	$248
Total	$1,575,891	$1,664,950	$1,984,497	$2,294,412	$2,541,225	$2,495,563	$3,030,076	$3,122,888	$3,569,379	$3,572,917	$3,450,312	$3,883,173	$33,185,283

Table 3.2
Community Health Plan of Washington
Experience by Benefit Category
Checklist Items 1b, 1c & 11h

Allowed Claims by Benefit Category and Month

Benefit Category	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
Inpatient Hospital	$733,427	$1,043,240	$6,272,042	$2,188,203	$1,666,461	$1,411,777	$1,386,753	$1,496,781	$1,145,445	$2,542,926	$2,121,556	$1,830,615
Outpatient Hospital	$1,918,786	$2,436,590	$2,889,401	$3,423,870	$3,354,558	$3,372,661	$4,028,642	$4,245,457	$3,531,526	$4,074,997	$4,080,522	$4,011,630
Professional	$1,298,260	$1,665,676	$1,927,893	$2,219,290	$2,404,294	$2,265,770	$2,554,377	$2,646,460	$2,558,057	$2,964,037	$2,740,707	$2,684,546
Other Medical	$104,697	$103,922	$161,135	$182,160	$192,725	$190,965	$207,373	$161,049	$157,936	$244,806	$258,379	$203,947
Capitation												
Prescription Drug	$1,753,438	$1,889,208	$2,237,120	$2,533,235	$2,807,420	$2,746,516	$3,324,441	$3,424,904	$3,891,528	$3,895,483	$3,764,138	$4,204,473

Paid Claims by Benefit Category and Month

Benefit Category	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
Inpatient Hospital	$701,220	$979,622	$6,153,671	$2,030,616	$1,559,790	$1,331,742	$1,239,443	$1,334,968	$1,078,650	$2,240,734	$2,039,626	$1,703,475
Outpatient Hospital	$1,488,226	$1,898,221	$2,263,621	$2,820,877	$2,760,684	$2,654,340	$3,251,821	$3,507,596	$2,860,233	$3,338,885	$3,257,633	$3,254,283
Professional	$1,027,816	$1,347,987	$1,574,970	$1,808,694	$1,960,730	$1,829,820	$2,066,419	$2,175,610	$2,080,143	$2,445,387	$2,228,349	$2,224,517
Other Medical	$84,273	$76,204	$124,103	$147,821	$158,852	$156,056	$166,070	$130,088	$131,021	$209,548	$223,235	$164,056
Capitation												
Prescription Drug	$1,575,891	$1,664,950	$1,984,497	$2,294,412	$2,541,225	$2,495,563	$3,030,076	$3,122,888	$3,569,379	$3,572,917	$3,450,312	$3,883,173

Member Months[1]	16,913	21,085	23,156	25,117	26,809	28,379	29,515	30,956	32,276	33,188	33,948	33,982
Total Premium	$7,713,959	$9,735,535	$10,690,878	$11,541,847	$12,276,142	$12,940,329	$13,597,935	$14,088,103	$14,696,448	$15,126,412	$15,493,490	$15,515,240

Benefit Category	Experience Member Months	Paid Claims[2]	Incurred Claims[3]	Beginning Claim Reserve	Ending Claim Reserve	Paid to Allowed Factor	Allowed Claims	Paid PMPM	Incurred PMPM	Allowed PMPM
Inpatient Hospital	335,324	$19,589,367	$22,393,557	$1,354,973	$3,791,174	0.939	$23,839,227	$58.42	$66.78	$71.09
Outpatient Hospital	335,324	$29,412,363	$33,356,419	$2,018,306	$5,647,159	0.806	$41,368,640	$87.71	$99.48	$123.37
Professional	335,324	$20,699,462	$22,770,440	$1,377,777	$3,854,979	0.815	$27,929,366	$61.73	$67.91	$83.29
Other Medical	335,324	$1,471,933	$1,771,327	$107,178	$299,881	0.817	$2,169,092	$4.39	$5.28	$6.47
Capitation	335,324	$0	$0	$0	$0		$0	$0.00	$0.00	$0.00
Prescription Drug	335,324	$32,823,687	$33,185,283	$364,679	$517,817	0.910	$36,471,903	$97.89	$98.96	$108.77

(1) Member months differ from the URRT and other filing items due to timing of when the data was pulled and retroactive eligibility changes being applied..
(2) Paid claims include claims incurred through 12/31/2024, paid in calendar year 2024. All other amounts are incurred 1/1/2024 through 12/31/2024, paid through 3/31/2025.
(3) Incurred and allowed claims recorded are not adjusted for pharmacy rebates or estimated claims IBNP.

Table 5.1
Community Health Plan of Washington
Annual Unit Cost and Utilization Trend Assumptions
Checklist Item 5b

	Year 1			Year 2		
Service Type	**Cost**	**Utilization**	**Total**	**Cost**	**Utilization**	**Total**
Inpatient Hospital	3.1%	-0.5%	2.6%	3.1%	-0.5%	2.5%
Outpatient Hospital	3.1%	1.0%	4.1%	3.0%	1.0%	4.0%
Professional	-2.8%	0.0%	-2.8%	0.1%	0.0%	0.1%
Other Medical	-2.5%	0.0%	-2.5%	0.4%	0.0%	0.4%
Capitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prescription Drug	10.0%	2.5%	12.8%	10.0%	2.5%	12.8%
Total			**4.4%**			**5.3%**

Months of Trend Year 1	12.0
Months of Trend Year 2	12.0

Table 5.2
Community Health Plan of Washington
Incurred Claims Projected Trend for WAC 284-43-6660 Summary
Checklist Item 6a

WAC Trend Category	Experience Incurred PMPM	Incurred Cost Trend	Incurred Util Trend	WAC Percentages	
				Annual Trend Assumed	Portion of Claim Dollars
Hospital	$171.48	1.031	1.005	3.53%	49.50%
Professional	$70.04	0.987	1.000	-1.33%	18.36%
Prescription Drugs	$89.66	1.100	1.025	12.75%	30.70%
Dental	n/a	n/a	n/a	n/a	n/a
Other	$5.47	0.989	1.000	-1.06%	1.44%
Total	$336.65	1.039	1.009	4.90%	100.00%

URRT WS1 Section I, Experience Incurred PMPM:	$336.65
URRT WS2 Section IV, Field 4.15, Projected Incurred PMPM:	$405.95
Annual Incurred Claims Projected Trend[(1)]:	9.81%

Notes:

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

Table 8.1 Community Health Plan of Washington Projection Period Index Rate Development	
Description	**Experience**
2024 Total Allowed Claims PMPM	$392.63
2024 Non-EHB Allowed Claims PMPM	$0.00
2024 EHB Allowed Claims PMPM	$392.63
Trend	1.099
2026 EHB Allowed Claims PMPM	$431.52
Morbidity Adjustment	**1.050**
Risk Pool Deterioration	1.050
Demographic Shift	**1.025**
Demographics	1.021
Geography	1.004
Plan Design Changes	**0.986**
Induced Utilization	0.985
New Essential Health Benefits	1.001
Other	**1.017**
Mix/Interaction	0.977
Aggregate Paid Restoration	1.040
VSP Pediatric Vision Change	1.000
Projected EHB Allowed Claims PMPM	$465.65
Credibility	100%
Projection Period Index Rate PMPM	**$465.65**

Table 9.1 Community Health Plan of Washington Market-Wide Adjusted Index Rate Development Checklist Item 28a	
2025 Index Rate PMPM	$465.65
<u>Market-Wide Adjustments (paid basis)</u>	
Risk Adjustment Transfer Amount	$142.59
Exchange User Fees	$5.11
Paid-to-Allowed Ratio	0.872
<u>Market-Wide Adjustments (allowed basis)</u>	
Risk Adjustment Transfer Amount	$163.56
Exchange User Fees	$5.86
Market-Wide Adjusted Index Rate PMPM	**$635.08**

Table 9.2
Community Health Plan of Washington
Actual and Projected HCRP Receipt/Assessment PMPM
Checklist Item 19c & 19e

High-Cost Risk Pool Receipt

	2023	2024	2025	2026
Actual	$0.00	$6.73	*n/a*	*n/a*
Filed	$1.14	$1.70	$0.91	$1.25

High-Cost Risk Pool Assessment

	2023	2024	2025	2026
Actual	($1.32)	($1.83)	*n/a*	*n/a*
Filed	($1.14)	($1.70)	($1.75)	($2.30)

Net High-Cost Risk Pool Receipt/(Assessment)

	2023	2024	2025	2026
Actual	($1.32)	$4.90	*n/a*	*n/a*
Filed	$0.00	$0.00	($0.84)	($1.05)

Notes:

(1) Green highlighted cells tie to actual 2024 risk adjustment transfer and projected 2026 risk adjustment transfer in WA Exhibit 10.

(2) Negative value implies a net payment and a positive value implied a net receipt, consistent with the sign of the risk adjustment transfers in WA Exhibit 10.

Table 9.3
Community Health Plan of Washington
Average Paid to Allowed Factor Support
Checklist Item 28b

Metal Level	Member Months	Paid Claims PMPM	Allowed Claims	Paid-to-Allowed Ratio	AV Metal Value
Gold	43,848	$371.81	$451.85	0.823	80.6%
Silver	113,770	$453.78	$483.16	0.939	71.8%
Bronze	28,579	$267.91	$417.11	0.642	65.0%
Total	**186,197**	**$405.95**	**$465.65**	**0.872**	**72.9%**

Table 10.1
Community Health Plan of Washington
Development of AV & Cost Sharing Relativities
Checklist Items 11a-11e

Plan ID Plan Name	18581WA0140001 Community Health Plan of Washington Cascade Select Complete Gold	18581WA0140004 Community Health Plan of Washington Cascade Select Vital Gold	18581WA0140002 Community Health Plan of Washington Cascade Select Silver	18581WA0140003 Community Health Plan of Washington Cascade Select Bronze	Total
Projected Member Months	28,985	14,863	113,770	28,579	186,197
AV Pricing Value	0.835	0.799	0.733	0.642	0.740
Induced Demand Factors (IDFs)	1.102	1.079	1.044	1.010	1.051
Normalized IDFs	1.049	1.027	0.994	0.961	1.000
Removal of Abortion Services	0.998	0.998	0.998	0.998	0.998
CSR Non-funding Rate Load	1.000	1.000	1.435	1.000	1.266
Unnormalized AV and Cost Sharing Factor	0.873	0.819	1.043	0.616	0.933
Aggregate Paid-to-Allowed					0.870
AV and Cost Sharing Factor	0.814	0.763	0.972	0.574	0.870

(1) Induced utilization is removed from the AV and cost sharing factor to compare directly to the AV metal values.
(2) The pricing methodology values the pricing AVs differently than the AV Calculator due to known limitations of the federal AV Calculator.

Table 10.2 Community Health Plan of Washington Projection Period Plan Adjusted Index Rate Development								
Plan Name	HIOS ID	Market-Wide Adjusted Index Rate	AV & Cost Sharing	Provider Network Adjustment	Benefits In Addition to EHBs	Admin Cost Fee	Catastrophic Eligibility	Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$635.08	0.814	1.000	1.002	1.138	1.000	$589.53
CHPW Vital Gold	18581WA0140004	$635.08	0.763	1.000	1.002	1.138	1.000	$552.65
CHPW Silver	18581WA0140002	$635.08	0.972	1.000	1.002	1.138	1.000	$704.25
CHPW Bronze	18581WA0140003	$635.08	0.574	1.000	1.002	1.138	1.000	$415.79

Table 10.3
Community Health Plan of Washington
Development of Benefits in Addition to EHB Factor & Non-EHB Claims PMPM
Checklist Items 13 & 27

		(a)	(b)	(c) = (a)*((b)-1)	(d)	(e) = (c)*(d)/(a)
Plan ID	**Plan Name**	**Market-Wide Adjusted Index Rate**	**Benefits in Addition to EHB**	**Non-EHB Component of MAIR**	**Projected Incurred PMPM (All Plans)**	**Non-EHB Incurred Claims**
18581WA0140001	Community Health Plan of Washington Cascade Select Complete Gold	$635.08	1.0025	$1.57	$405.95	$1.00
18581WA0140004	Community Health Plan of Washington Cascade Select Vital Gold	$635.08	1.0025	$1.57	$405.95	$1.00
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	$635.08	1.0025	$1.57	$405.95	$1.00
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	$635.08	1.0025	$1.57	$405.95	$1.00

Table 11.1 Community Health Plan of Washington Calibrated Plan Adjusted Index Rate Development							
Plan	HIOS ID	Plan Adjusted Index Rate	Age Calibration Factor	Geographic Calibration Factor	Tobacco Calibration Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$589.53	1.545	0.983	1.000	1.519	$388.23
CHPW Vital Gold	18581WA0140004	$552.65	1.545	0.983	1.000	1.519	$363.94
CHPW Silver	18581WA0140002	$704.25	1.545	0.983	1.000	1.519	$463.77
CHPW Bronze	18581WA0140003	$415.79	1.545	0.983	1.000	1.519	$273.81

Table 11.2
Community Health Plan of Washington
Development of Composite & Calibrated Rating Factors
Checklist Items 15, 16 & 17

Composite Factors

	2023	2024	2025	2026
Composite Age Factor	1.6798	1.6126	1.5319	1.5452
Composite Area Factor	0.9803	0.9864	0.9806	0.9828
Tobacco Factor	1.2000	1.2000	1.2000	1.0000
Composite Tobacco Use Factor	1.0070	1.0050	1.0078	1.0000

Calibration Factors

	2023	2024	2025	2026
Calibration Age Factor	0.5953	0.6201	0.6528	0.6472
Calibration Area Factor	1.0201	1.0138	1.0198	1.0175
Calibration Tobacco Use Factor	0.9930	0.9950	0.9923	1.0000

Rating Area Factors

Region	2023	2024	2025	2026
Rating Area 1	1.0000	1.0000	1.0000	1.0000
Rating Area 2	1.0695	1.0755	1.0719	1.0748
Rating Area 4	0.9552	0.9617	0.9855	0.9882
Rating Area 5	0.9797	0.9584	0.9321	0.9346
Rating Area 6	0.9552	0.9625	0.9636	0.9670
Rating Area 7	1.0398	1.0526	1.0292	1.0294
Rating Area 8	0.9564	0.9617	1.0059	1.0064
Rating Area 9	0.9300	0.9783	0.9654	0.9701
Total	**0.9803**	**0.9864**	**0.9806**	**0.9828**

2026 Rating Area Factors

Counties	Region	Actual MMs	Percent Distribution	Area Factor[1][2]
King	Rating Area 1	45,312	24.3%	1.0000
Challam, Jefferson, Kitsap, Lewis	Rating Area 2	8,757	4.7%	1.0748
Ferry, Lincoln, Spokane, Stevens	Rating Area 4	15,316	8.2%	0.9882
Mason, Pierce, Thurston	Rating Area 5	50,896	27.3%	0.9346
Benton, Franklin, Kittitas, Yakima	Rating Area 6	28,119	15.1%	0.9670
Adams, Chelan, Douglas, Grant, Okanogan	Rating Area 7	18,602	10.0%	1.0294
Snohomish	Rating Area 8	16,438	8.8%	1.0064
Asotin, Columbia, Walla Walla, Whitman	Rating Area 9	2,757	1.5%	0.9701
Total		**186,197**	**100%**	**0.9828**

Max / Min[4]	1.1500

2026 Age and Tobacco Factors

Age Band	Distribution	Age Factor[3]	Non-Tobacco	Tobacco	Tobacco Factor[5]
0-1	0.32%	0.765	0.32%	0.00%	1.000
2-6	0.59%	0.765	0.59%	0.00%	1.000
7-18	2.15%	0.801	2.15%	0.00%	1.000
19-20	4.38%	0.956	4.38%	0.00%	1.000
21-24	8.78%	1.000	8.78%	0.00%	1.000
25-29	13.22%	1.056	13.22%	0.00%	1.000
30-34	13.05%	1.178	13.05%	0.00%	1.000
35-39	11.11%	1.240	11.11%	0.00%	1.000
40-44	9.96%	1.332	9.96%	0.00%	1.000
45-49	8.52%	1.570	8.52%	0.00%	1.000
50-54	7.97%	1.956	7.97%	0.00%	1.000
55-59	8.36%	2.430	8.36%	0.00%	1.000
60-63	7.86%	2.837	7.86%	0.00%	1.000
64+	3.72%	3.000	3.72%	0.00%	1.000
Total	**100.00%**	**1.545**	**100.00%**	**0.00%**	**1.000**

Notes:
(1) Factors comply with limit of 1.15 ratio between highest cost area factor and lowest cost area factor (WAC 284-43-6681).
(2) Area factors weighted so that King County (Washington Rating Area 1) is equal to 1.00 (WAC 284-43-6681).
(3) The nearest whole age corresponding to the composite factor is 47. The age rating curve is shown on Table 12.1.
(4) Rating Area factors satisfy the 1.15 maximum to minimum threshold.
(5) CHPW is not rating based on tobacco use in 2026. There is assumed to be zero tobacco membership and all tobacco factors are set to 1.0.

Table 11.3
Community Health Plan of Washington
Rating Area Relativities
Checklist Item 16b

		Relativities (Versus Area 1)							
	Statewide	**Area 1**	**Area 2**	**Area 4**	**Area 5**	**Area 6**	**Area 7**	**Area 8**	**Area 9**
Util / 1,000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Unit Cost	1.0000	1.0000	1.1326	0.9797	0.8899	0.9438	1.0513	1.0110	0.9490
Raw Area Factors	1.0000	1.0000	1.1326	0.9797	0.8899	0.9438	1.0513	1.0110	0.9490
Final Area Factors[(1)]	1.0000	1.0000	1.0748	0.9882	0.9346	0.9670	1.0294	1.0064	0.9701

Max / Min	1.1500

Notes:
(1) Rating Area factors are compressed to satisfy the 1.15 maximum to minimum threshold.

Table 12.1 Community Health Plan of Washington Age and Tobacco Factors						
Age Band	**Age Rating Factor**	**Tobacco Factor**		**Age Band**	**Age Rating Factor**	**Tobacco Factor**
0-14	0.765	1.000		40	1.278	1.000
15	0.833	1.000		41	1.302	1.000
16	0.859	1.000		42	1.325	1.000
17	0.885	1.000		43	1.357	1.000
18	0.913	1.000		44	1.397	1.000
19	0.941	1.000		45	1.444	1.000
20	0.970	1.000		46	1.500	1.000
21	1.000	1.000		47	1.563	1.000
22	1.000	1.000		48	1.635	1.000
23	1.000	1.000		49	1.706	1.000
24	1.000	1.000		50	1.786	1.000
25	1.004	1.000		51	1.865	1.000
26	1.024	1.000		52	1.952	1.000
27	1.048	1.000		53	2.040	1.000
28	1.087	1.000		54	2.135	1.000
29	1.119	1.000		55	2.230	1.000
30	1.135	1.000		56	2.333	1.000
31	1.159	1.000		57	2.437	1.000
32	1.183	1.000		58	2.548	1.000
33	1.198	1.000		59	2.603	1.000
34	1.214	1.000		60	2.714	1.000
35	1.222	1.000		61	2.810	1.000
36	1.230	1.000		62	2.873	1.000
37	1.238	1.000		63	2.952	1.000
38	1.246	1.000		64+	3.000	1.000
39	1.262	1.000				

Table 12.2 Community Health Plan of Washington Geographic Rating Factors Checklist Item 16a	
Area	**Area Rating Factor**
Rating Area 1	1.000
Rating Area 2	1.075
Rating Area 4	0.988
Rating Area 5	0.935
Rating Area 6	0.967
Rating Area 7	1.029
Rating Area 8	1.006
Rating Area 9	0.970

Table 12.3 Community Health Plan of Washington Sample Consumer Adjusted Premium Rate Development	
Community Health Plan of Washington Cascade Select Complete Gold - 18581WA0140001	
Calibrated Plan Adjusted Index Rate	$388.23
Age: 33	1.198
Area: 6	0.967
Tobacco Status: Non-Tobacco User	1.000
Consumer Adjusted Premium Rate	**$449.76**

Table 13.1 Community Health Plan of Washington Projected Federal Medical Loss Ratio	
Member Months	186,197
MLR Numerator Calculations	
Paid Claims PMPM	$405.95
Claim-Related Retention (QI/Health IT) PMPM	$0.00
Prior Rebate	$0.00
Other Claim-Related Adjustments	$0.00
Risk Adjustment Paid (Received) PMPM	$142.59
Market Reinsurance Recoveries (Received) PMPM	$0.00
MLR Numerator Calculations	**$548.54**
MLR Denominator Calculations	
Premium PMPM	$630.01
Other Premium-Related Adjustments	$0.00
Premium-Related Retention (Taxes & Fees) PMPM	$19.15
MLR Denominator	**$610.87**
Medical Loss Ratio	**89.8%**

Table 15.1
Community Health Plan of Washington
Projected Enrollment (Member Months) by Benefit Level (Silver Plans)

Plan Name	HIOS ID	70%	73%	87%	94%	Total
CHPW Cascade Select Silver	18581WA0140002	0	0	73,162	40,608	113,770

Table 18.1
Community Health Plan of Washington
Development of URRT Worksheet 2, Section IV Values
Checklist Item 28f

Plan ID			18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003	
Component	URRT Reference		Community Health Plan of Washington Cascade Select Complete Gold	Community Health Plan of Washington Cascade Select Vital Gold	Community Health Plan of Washington Cascade Select Silver	Community Health Plan of Washington Cascade Select Bronze	Total
Projected Member Months	WS2, Field 4.9	(a)	28,985	14,863	113,770	28,579	186,197
Plan Adjusted Index Rate	WS2, Field 3.10	(b)	$589.53	$552.65	$704.25	$415.79	$630.01
Allowed Claims PMPM	WS2, Field 4.11	(c)	$455.03	$445.66	$483.16	$417.11	$465.65
Reinsurance PMPM	WS2, Field 4.12	(d)	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Sharing PMPM	WS2, Field 4.13	(e)	$75.16	$89.56	$29.38	$149.19	$59.70
Cost Sharing Reduction PMPM	WS2, Field 4.14	(f)	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	WS2, Field 4.15	(g)	$379.86	$356.10	$453.78	$267.91	$405.95
Risk Adjustment Transfer Amount PMPM	WS2, Field 4.16	(h)	$23.16	$23.16	($170.10)	($287.41)	($142.59)
Premium PMPM	WS2, Field 4.17	(i)	$589.53	$552.65	$704.25	$415.79	$630.01
Retention PMPM	n/a	(j) + … + (m)	$76.24	$71.47	$91.07	$53.77	$81.47
Administrative Expense	n/a	(j)	$46.53	$43.62	$55.58	$32.82	$49.72
Taxes and Fees	n/a	(k)	$13.13	$12.31	$15.69	$9.26	$14.04
Profit & Risk Load	n/a	(l)	$11.79	$11.05	$14.08	$8.32	$12.60
Exchange User Fee	n/a	(m)	$4.78	$4.48	$5.71	$3.37	$5.11
Total Allowed Claims	WS2, Field 4.2	(a) x (c)	$13,188,966	$6,623,869	$54,969,421	$11,920,446	$86,702,702
Total Reinsurance	WS2, Field 4.3	(a) x (d)	$0	$0	$0	$0	$0
Total Member Cost Sharing	WS2, Field 4.4	(a) x (e)	$2,178,604	$1,331,192	$3,342,632	$4,263,766	$11,116,194
Total Cost Sharing Reduction	WS2, Field 4.5	(a) x (f)	$0	$0	$0	$0	$0
Total Incurred Claims	WS2, Field 4.6	(a) x (g)	$11,010,361	$5,292,677	$51,626,789	$7,656,680	$75,586,508
Total Risk Adjustment Transfer Amount	WS2, Field 4.7	(a) x (h)	$671,288	$344,225	($19,352,073)	($8,213,819)	($26,550,380)
Total Premium	WS2, Field 4.8	(a) x (i)	$17,087,546	$8,213,978	$80,122,268	$11,882,795	$117,306,587
Actual Incurred Claims PMPM	WS2, Field 4.15	(g)	$379.86	$356.10	$453.78	$267.91	$405.95
Calculated Incurred Claims PMPM	n/a	(n)	$536.45	$504.34	$443.08	$74.61	$405.95
Difference PMPM[1]	n/a	(g) - (n)	($156.59)	($148.24)	$10.70	$193.30	($0.00)

Notes:
(1) Differences at the plan level are driven by the use of plan-level risk adjustment transfers in CHPW's rate development as opposed to the aggregate PMPM risk transfer allocated to the plan level using a percent of premium allocation approach.

Table 19.1 Community Health Plan of Washington Reliance	
Data / Assumption	**Source**
2024 individual QHP claims and membership experience	Elaine Corrough, CHPW
2024 interim risk adjustment transfer receivable/payment	"Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025, CMS; "HHS public and carrier-specific interim 2024 risk adjustment reports", provided by Elaine Corrough, CHPW "Wakely National Risk Adjustment Reporting", provided by Elaine Corrough, CHPW
Other 2024 individual QHP marketplace revenue and expenditures	Elaine Corrough, CHPW
2024 IBNP estimate	Elaine Corrough, CHPW
2024 Plan Liability Risk Score associated with Individual QHP claims and membership experience	Elaine Corrough, CHPW
2025 emerging individual QHP membership	Elaine Corrough, CHPW
Basic tables of utilization, cost, claims probability distributions, pricing adjustment factors, and primary care/specialty care utilization distribution	Milliman (Health Cost Guidelines)
Utilization trends	Milliman (Health Cost Guidelines)
Unit cost trends	CMS; Milliman (Health Cost Guidelines)
Administrative costs, taxes, and fees	Elaine Corrough, CHPW
Broker fees and commissions	Elaine Corrough, CHPW
County Rating Areas	Elaine Corrough, CHPW
Community Health Plan of Washington service areas	Elaine Corrough, CHPW
Expected reimbursement by Rating Area	Elaine Corrough, CHPW
3:1 age band Factors	HHS
2026 pediatric vision administrative fees and claims cost	VSP
Prescription drug AWP discounts, dispensing fees, rebates, and retail/mail utilization assumptions	Elaine Corrough, CHPW
2026 Exchange user fee	Washington Health Benefits Exchange
WSHIP assessment	Elaine Corrough, CHPW
WAPAL assessment	Elaine Corrough, CHPW
Contribution to surplus % of premium	Elaine Corrough, CHPW
SHB 1979 impacts	Elaine Corrough, CHPW

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	Community Health Plan of Washington
Address	1111 3rd Ave #400
	Seattle, WA 98101
Carrier Identification Number	18581

Rate Renewal Period:	From	1/1/2026	To	12/31/2026
Date Submitted:		5/15/2025		

Proposed Rate Summary

Current community rate:	$493.84	per month
Proposed community rate:	$630.01	per month
Percentage change:	27.57%	%
Portion of carrier's total enrollment affected:	8.66	%
Portion of carrier's total premium revenue affected:	6.95	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims	$548.54	87.07%
b) Expenses	$68.87	10.93%
c) Contribution to surplus contingency charges, or risk charges	$12.60	2.00%
d) Investment earnings	$0.00	0.00%
e) Total (a + b + c - d)	$630.01	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 To
Member Months	335501	95487	
Earned Premium	$153,416,318.04	$44,881,022.25	
Paid Claims	$103,996,811.49	$28,396,446.59	
Beginning Claim Reserve	$5,222,914.00	$2,571,371.91	
Ending Claim Reserve	$14,111,009.61	$4,858,234.58	
Incurred Claims	$112,945,234.01	$32,178,759.71	
Expenses	$13,139,650.98	$5,117,649.32	
Gain/Loss	$27,331,433.05	$7,584,613.22	
Loss Ratio Percentage	73.62%	71.70%	

General Information

1. Trend Factor Summary

Types of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	3.53%	49.50%
Professional	-1.33%	18.36%
Prescription Drugs	12.75%	30.70%
Dental	0.00%	0.00%
Other	-1.06%	1.44%

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

	1)	2)	3)
Date	1/1/2025	1/1/2024	
%	4.68%	-1.21%	

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)	Removed tobacco rating	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

In the "Summary of Pooled Experience" section, the "Second Prior Period" information is not applicable since CHPW's Cascade Select product was first offered effective 1/1/2023.

6. Preparer's Information

Name: Jordan Pettibon, FSA, MAAA
Title: Consulting Actuary
Telephone Number: +1 206 504 5771

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:	Community Health Plan of Washington
HIOS Issuer ID:	18581
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
18581WA0140001	Community Health Plan of Washington Cascade Select Gold	Community Health Plan of Washington Cascade Select Complete Gold	Renewal	4,924
18581WA0140004	N/A	Community Health Plan of Washington Cascade Select Vital Gold	New	0
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	Community Health Plan of Washington Cascade Select Silver	Renewal	24,649
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	Community Health Plan of Washington Cascade Select Bronze	Renewal	4,890
Total				**34,463**

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:

The following HIOS Plan IDs are all renewal plans included in 2026:
18581WA0140001 - Community Health Plan of Washington Cascade Select Complete Gold
18581WA0140002 - Community Health Plan of Washington Cascade Select Silver
18581WA0140003 - Community Health Plan of Washington Cascade Select Bronze

With respect to 45 CFR 147.106(e)(3), the following are true:

3)(i) The product is offered by the same health insurance issuer.
(3)(ii) The product is offered as the same product network type (EPO).
(3)(iii) The product continues to cover the entire 2025 service area.
(3)(iv) Within the product, each plan has the same cost-sharing structure as before the modification.
(3)(v) The product provides the same covered benefits. There are no changes that cumulatively impact the plan-adjusted index rate for any plan outside +/-2 percentage points.

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?
18581WA0140004	Community Health Plan of Washington Cascade Select Vital Gold	This plan is in a new standard plan in 2026.

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)**
18581WA0140001	Community Health Plan of Washington Cascade Select Gold	Community Health Plan of Washington Cascade Select Complete Gold	TBD	Added Hearing Aids and Hearing Exams, Artificial Insemination, Human Donor Milk benefits	Deductible	$600	$1,000
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	N/A-Same as 2025	TBD	Added Hearing Aids and Hearing Exams, Artificial Insemination, Human Donor Milk benefits	MOOP	$9,200	$9,750
					PCP Office Visit Copay	$30	$20
					MH/SUD Office Visit Copay	$30	$20
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	N/A-Same as 2025	TBD	Added Hearing Aids and Hearing Exams, Artificial Insemination, Human Donor Milk benefits	MOOP	$9,200	$10,150
					PCP Office Visit Copay	$50	$40
					MH/SUD Office Visit Copay	$50	$40

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):	34,463
Overall Average Rate Change (weighted by 03/31/2025 enrollment) 5(l):	27.57%

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
18581WA0140001	Community Health Plan of Washington Cascade Select Gold	Renewal	4,924	N/A	N/A	7.21%	0.12%	-1.52%	5.71%
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	Renewal	24,649	N/A	N/A	36.07%	0.14%	-0.42%	35.68%
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	Renewal	4,890	N/A	N/A	12.08%	0.16%	-3.14%	8.73%

COMMUNITY HEALTH PLAN OF WASHINGTON
VIEW RATE REVIEW DETAIL - 2026
Product ID: 18581WA014

Company Rate Information		**COMMENTS**
Overall % indicated change/overall % rate impact (Initial UPMJ Q5):	27.57%	Initial UPMJ Q5, 5(l)
Written premium change for this program:	$57,501,430	
Number of policy holders affected for this program (3/2025 subscribers):	34,463	Initial UPMJ Q5, 5(k)
Written premium for this program (2025 projected premium):	$208,565,216	URRT Wksh 2, 2.11 x # policy holders
Maximum % change (initial UPMJ Q5):	35.68%	Initial UPMJ Q5, 5(j) - maximum*
Minimum % change (initial UPMJ Q5):	5.71%	Initial UPMJ Q5, 5(j) - minimum*

Rate Review Detail		
Trend Factors:	Average annual claims trend 4.90%, including Hospital (3.53%); Professional (-1.33%); Pharmacy (12.75%); Other (-1.06%)	Wtd avg 2026 WAC 284-43-6660 summary
Number of covered lives (members) as of March 2025	34,463	
PRODUCTS		
Number of Covered Lives	15,516	Projected 2026 average enrollment
REQUESTED RATE CHANGE INFORMATION:		
Member months for 2024 experience period	335,501	
Minimum rate change (initial UPMJ Q5)	5.71%	Initial UPMJ Q5, 5(j) - minimum*
Maximum rate change (initial UPMJ Q5)	35.68%	Initial UPMJ Q5, 5(j) - maximum*
Weighted average rate change (initial UPMJ Q5)	27.57%	Initial UPMJ Q5, 5(l)
PRIOR RATE:		
Total earned premium (final 2025 URRT)	$149,382,286	2025 Final URRT 4.8
Total incurred claims (final 2025 URRT)	$103,969,118	2025 Final URRT 4.6
Minimum PMPM rate (final 2025 filed rates)	$178.36	2025 Final Rate Schedule
Maximum PMPM rate (final 2025 filed rates)	$1,412.93	2025 Final Rate Schedule
Weighted average PMPM rate	$493.84	2026 WAC 284-43-6660 current comm rate
INITIAL REQUESTED RATE:		
Projected earned premium (initial 2026 URRT)	$117,306,587	Initial 2026 URRT 4.8
Projected incurred claims (initial 2026 URRT)	$75,586,508	Initial 2026 URRT 4.6
Minimum PMPM rate (initial 2026 filed rates)	$195.77	Initial 2026 Rate Schedule
Maximum PMPM rate (initial 2026 filed rates)	$1,495.41	Initial 2026 Rate Schedule
Weighted average PMPM rate (based on projected enrollment)	$630.01	Initial 2026 URRT 4.17

Enrollment Comparison (OIC Rates Checklist 23c and 23d)		
CURRENT ENROLLMENT		
RRD Number of Covered Lives	34,463	
URRT Wksh 2, Field 2.10 Current Enrollment	34,463	
UPMJ Q1 Enrollment as of 3/31/2025	34,463	
Part III supporting exhibits	n/a	
PROJECTED ENROLLMENT		
RRD (Projected Earned Premium)/(Requested Rate Weighted Avg. PMPM)	186,197	Calculated from REQUESTED RATE inputs
URRT Wksh 2, Field 4.9 Projected Member Months	186,197	Initial 2026 URRT 4.9
Part II Written Explanation	n/a	
Part III supporting exhibits	186,197	Act Memo Exhibits

Notes

* Min/max changes are taken from UPMJ, per OIC checklist. Individual rates by area and plan may demonstrate changes outside the range reported in the UPMJ, which aggregates all changes at the plan level.

[May 12, 2025]

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140001	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select Complete Gold	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	No	
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes	
Line 2.3	**Apply Inpatient Copay per Day?**	Yes	
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes	
Line 2.5	**Separate MOOP for Medical & Drug Spending?**		
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5	
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	0	
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A	
Line 2.9	**HSA Plan?**	No	
Line 2.10	**HSA Employer Contribution Amount**		
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes	*<- Provide Explanation in Note 1 (at the bottom of the page).*
Line 2.12	**Pediatric Dental Embedded?**	No	
Line 2.13	**Includes Non-EHBs?**	No	

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW/Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$1,000	
Default Coinsurance			20%	
MOOP			$7,000	

			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	$ 450	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)		No	$ 525	Before and After Deductible	No					
Primary Care Visit to Treat an Injury or Illness		No	$ 15	Before and After Deductible	No					
Specialist Visit		No	$ 40	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 15	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		No	$ 15	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)		Yes	$ 300	After Deductible						
Rehabilitative Speech Therapy		No	$ 25	Before and After Deductible	No					
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 25	Before and After Deductible	No					
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 20	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 30	Before and After Deductible	No					
Skilled Nursing Facility		Yes	$ 350	After Deductible						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	$ 350	After Deductible						
Outpatient Surgery Physician/Surgical Services		Yes	$ 75	After Deductible						
Urgent Care		No	$ 35	Before and After Deductible	No				Note 1	
Emergency Transportation		No	$ 375	Before and After Deductible	No					
Other EHB Categories										
DME		Yes				20%	After Deductible			
Home Health		No	$ 15	Before and After Deductible	No				Note 2	
Hospice		No	$ 15	Before and After Deductible	No				Note 2	
Abortion for Which Public Funding Is Prohibited		No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children		No	$ -	Before and After Deductible						
Other Practitioner Office Visit		No	$ 15	Before and After Deductible	No				Note 3	
Hearing Exams		No	$ 15	Before and After Deductible	No				Note 4	
Hearing Aids		No				20%	Before and After Deductible	No	Note 5	
Artificial Insemination		Yes				20%	After Deductible		Note 6	
Human Donor Milk		No	$ -	Before and After Deductible					Note 7	
All Other EHBs		Yes				20%	After Deductible		Note 8	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 10	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 60	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		No	$ 100	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 100	Before and After Deductible	No					

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Home Health, Hospice: Per-day copay
Note 3 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 4 Hearing Exams: Categorized as Primary Care Visits
Note 5 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 6 Artificial Insemination: Categorized as All Other Benefits
Note 7 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 8 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140004	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select Vital Gold	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	New

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	No
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	0
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW/Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$1,900	
Default Coinsurance			20%	
MOOP			$8,800	

			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	$ 800	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)		No	$ 650	Before and After Deductible	No					
Primary Care Visit to Treat an Injury or Illness		No	$ 15	Before and After Deductible	No					
Specialist Visit		No	$ 40	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 15	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		No	$ 15	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)		Yes	$ 300	After Deductible						
Rehabilitative Speech Therapy		No	$ 30	Before and After Deductible	No					
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 30	Before and After Deductible	No					
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 30	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 30	Before and After Deductible	No					
Skilled Nursing Facility		Yes	$ 350	After Deductible						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	$ 350	After Deductible						
Outpatient Surgery Physician/Surgical Services		Yes	$ 75	After Deductible						
Urgent Care		No	$ 35	Before and After Deductible	No				Note 1	
Emergency Transportation		No	$ 375	Before and After Deductible	No					
Other EHB Categories										
DME		Yes				20%	After Deductible			
Home Health		No	$ 15	Before and After Deductible					Note 2	
Hospice		No	$ 15	Before and After Deductible					Note 2	
Abortion for Which Public Funding Is Prohibited		No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children		No	$ -	Before and After Deductible						
Other Practitioner Office Visit		No	$ 15	Before and After Deductible					Note 3	
Hearing Exams		No	$ 15	Before and After Deductible					Note 4	
Hearing Aids		No				20%	Before and After Deductible	No	Note 5	
Artificial Insemination		Yes				20%	After Deductible		Note 6	
Human Donor Milk		No	$ -	Before and After Deductible					Note 7	
All Other EHBs		Yes				20%	After Deductible		Note 8	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 10	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 75	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		Yes	$ 200	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 200	After Deductible						

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Home Health, Hospice: Per-day copay
Note 3 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 4 Hearing Exams: Categorized as Primary Care Visits
Note 5 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 6 Artificial Insemination: Categorized as All Other Benefits
Note 7 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 8 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140002	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select 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?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$2,500	
Default Coinsurance			30%	
MOOP			$9,750	

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays Amount	Copays Applies	Copays Accrues toward Deductible?	Coinsurance Amount	Coinsurance Applies	Coinsurance Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services	No	Yes	$ 800	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes	$ 800	After Deductible						
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 20	Before and After Deductible	No				Note 2	
Specialist Visit	No	No	$ 65	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 20	Before and After Deductible	No				Note 3	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 30	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	Yes				30%	After Deductible			
Rehabilitative Speech Therapy	No	No	$ 40	Before and After Deductible	No					
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 40	Before and After Deductible	No					
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 40	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 65	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 800	After Deductible						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes	$ 600	After Deductible						
Outpatient Surgery Physician/Surgical Services	No	Yes	$ 200	After Deductible						
Urgent Care	No	No	$ 65	Before and After Deductible	No				Note 1	
Emergency Transportation	No	No	$ 375	Before and After Deductible	No					
Other EHB Categories										
DME	No	Yes				30%	After Deductible			
Home Health	No	No	$ 30	Before and After Deductible	No				Note 4	
Hospice	No	No	$ 30	Before and After Deductible	No				Note 4	
Abortion for Which Public Funding Is Prohibited	No	No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Other Practitioner Office Visit	No	No	$ 20	Before and After Deductible	No				Note 5	
Hearing Exams	Yes	No	$ 20	Before and After Deductible	No				Note 6	
Hearing Aids	No	No				30%	Before and After Deductible	No	Note 7	
Artificial Insemination	No	Yes				30%	After Deductible		Note 8	
Human Donor Milk	No	No	$ -	Before and After Deductible					Note 9	
All Other EHBs	No	Yes				30%	After Deductible		Note 10	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 25	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 75	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		Yes	$ 250	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 250	After Deductible						

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Primary Care Visit: Copay is $1 for first two visits
Note 3 Mental Health & Substance Use Disorder Office Visits: Copay is $1 for first two visits
Note 4 Home Health, Hospice: Per-day copay
Note 5 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 6 Hearing Exams: Categorized as Primary Care Visits; see Note 2
Note 7 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 8 Artificial Insemination: Categorized as All Other Benefits
Note 9 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 10 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140003	Line 1.3	**Metal Level**	Expanded Bronze	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select 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**	2
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$6,000	
Default Coinsurance			40%	
MOOP			$10,150	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services	No	Yes				40%	After Deductible			
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes				40%	After Deductible			
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 40	Before and After Deductible	No				Note 2	
Specialist Visit	No	No	$ 100	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 40	Before and After Deductible	No				Note 3	
Mental Health & Substance Use Disorder All Other OP Services	No	Yes				40%	After Deductible			
Imaging (CT/PET Scans, MRIs)	No	Yes				40%	After Deductible			
Rehabilitative Speech Therapy	No	Yes				40%	After Deductible			
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	Yes				40%	After Deductible			
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	Yes				40%	After Deductible			
X-rays and Diagnostic Imaging	No	Yes				40%	After Deductible			
Skilled Nursing Facility	No	Yes				40%	After Deductible			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes				40%	After Deductible			
Outpatient Surgery Physician/Surgical Services	No	Yes				40%	After Deductible			
Urgent Care	No	No	$ 100	Before and After Deductible	No				Note 1	
Emergency Transportation	No	Yes				40%	After Deductible			
Other EHB Categories										
DME	No	Yes				40%	After Deductible			
Home Health	No	No	$ 50	Before and After Deductible	No				Note 4	
Hospice	No	No	$ 50	Before and After Deductible	No				Note 4	
Abortion for Which Public Funding Is Prohibited	No	No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Other Practitioner Office Visit	No	No	$ 40	Before and After Deductible	No				Note 5	
Hearing Exams	Yes	No	$ 40	Before and After Deductible	No				Note 6	
Hearing Aids	No	No				40%	Before and After Deductible	No	Note 7	
Artificial Insemination	No	Yes				40%	After Deductible		Note 8	
Human Donor Milk	No	No	$ -	Before and After Deductible					Note 9	
All Other EHBs	No	Yes				40%	After Deductible		Note 10	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 32	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		Yes				40%	After Deductible			
Non-Preferred Brand Drugs (Tier 3)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				40%	After Deductible			

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Primary Care Visit: Copay is $1 for first two visits
Note 3 Mental Health & Substance Use Disorder Office Visits: Copay is $1 for first two visits
Note 4 Home Health, Hospice: Per-day copay
Note 5 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 6 Hearing Exams: Categorized as Primary Care Visits; see Note 2
Note 7 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 8 Artificial Insemination: Categorized as All Other Benefits
Note 9 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 10 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140002	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select Silver	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	73% AV Level Silver Plan	Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$2,500	
Default Coinsurance			30%	
MOOP			$7,950	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services	No	Yes	$ 800	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes	$ 800	After Deductible						
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 20	Before and After Deductible	No				Note 2	
Specialist Visit	No	No	$ 65	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 20	Before and After Deductible	No				Note 3	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 30	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	Yes				30%	After Deductible			
Rehabilitative Speech Therapy	No	No	$ 40	Before and After Deductible	No					
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 40	Before and After Deductible	No					
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 40	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 65	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 800	After Deductible						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes	$ 600	After Deductible						
Outpatient Surgery Physician/Surgical Services	No	Yes	$ 200	After Deductible						
Urgent Care	No	No	$ 65	Before and After Deductible	No				Note 1	
Emergency Transportation	No	No	$ 325	Before and After Deductible	No					
Other EHB Categories										
DME	No	Yes				30%	After Deductible			
Home Health	No	No	$ 30	Before and After Deductible	No				Note 4	
Hospice	No	No	$ 30	Before and After Deductible	No				Note 4	
Abortion for Which Public Funding Is Prohibited	No	No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Other Practitioner Office Visit	No	No	$ 20	Before and After Deductible	No				Note 5	
Hearing Exams	Yes	No	$ 20	Before and After Deductible	No				Note 6	
Hearing Aids	No	No				30%	Before and After Deductible	No	Note 7	
Artificial Insemination	No	Yes				30%	After Deductible		Note 8	
Human Donor Milk	No	No	$ -	Before and After Deductible					Note 9	
All Other EHBs	No	Yes				30%	After Deductible		Note 10	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 24	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 75	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		Yes	$ 250	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 250	After Deductible						

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Primary Care Visit: Copay is $1 for first two visits
Note 3 Mental Health & Substance Use Disorder Office Visits: Copay is $1 for first two visits
Note 4 Home Health, Hospice: Per-day copay
Note 5 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 6 Hearing Exams: Categorized as Primary Care Visits; see Note 2
Note 7 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 8 Artificial Insemination: Categorized as All Other Benefits
Note 9 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 10 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140002	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select Silver	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	87% AV Level Silver Plan	Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes
Line 2.3	**Apply Inpatient Copay per Day?**	Yes
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes
Line 2.5	**Separate MOOP for Medical & Drug Spending?**	
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	2
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	No

<- Provide Explanation in Note 1 (at the bottom of the page).

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$750	
Default Coinsurance			20%	
MOOP			$2,850	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services	No	Yes	$ 425	After Deductible						
Inpatient Hospital Services (e.g., Hospital Stay)	No	Yes	$ 425	After Deductible						
Primary Care Visit to Treat an Injury or Illness	Yes	No	$ 5	Before and After Deductible	No				Note 2	
Specialist Visit	No	No	$ 30	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 5	Before and After Deductible	No				Note 3	
Mental Health & Substance Use Disorder All Other OP Services	No	No	$ 10	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)	No	Yes				20%	After Deductible			
Rehabilitative Speech Therapy	No	No	$ 20	Before and After Deductible	No					
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	No	$ 20	Before and After Deductible	No					
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services	No	No	$ 20	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 40	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 425	After Deductible						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No	Yes	$ 325	After Deductible						
Outpatient Surgery Physician/Surgical Services	No	Yes	$ 120	After Deductible						
Urgent Care	No	No	$ 30	Before and After Deductible	No				Note 1	
Emergency Transportation	No	No	$ 175	Before and After Deductible	No					
Other EHB Categories										
DME	No	Yes				20%	After Deductible			
Home Health	No	No	$ 10	Before and After Deductible	No				Note 4	
Hospice	No	No	$ 10	Before and After Deductible	No				Note 4	
Abortion for Which Public Funding Is Prohibited	No	No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Other Practitioner Office Visit	No	No	$ 5	Before and After Deductible	No				Note 5	
Hearing Exams	Yes	No	$ 5	Before and After Deductible	No				Note 6	
Hearing Aids	No	No				20%	Before and After Deductible	No	Note 7	
Artificial Insemination	No	Yes				20%	After Deductible		Note 8	
Human Donor Milk	No	No	$ -	Before and After Deductible					Note 9	
All Other EHBs	No	Yes				20%	After Deductible		Note 10	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 12	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 35	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		No	$ 160	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 160	Before and After Deductible	No					

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Primary Care Visit: Copay is $1 for first two visits
Note 3 Mental Health & Substance Use Disorder Office Visits: Copay is $1 for first two visits
Note 4 Home Health, Hospice: Per-day copay
Note 5 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 6 Hearing Exams: Categorized as Primary Care Visits; see Note 2
Note 7 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 8 Artificial Insemination: Categorized as All Other Benefits
Note 9 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 10 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

Benefit Components

Worksheet Controls

Company: Community Health Plan of Washington | **Market:** Individual | **Plan Year:** 2026

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	18581WA0140002	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	Community Health Plan of Washington Cascade Select Silver	Line 1.4	**Cost-Share Reduction (CSR) Plan?**	94% AV Level Silver Plan	Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	Yes	
Line 2.2	**Use Integrated Medical & Drug Deductible?**	Yes	
Line 2.3	**Apply Inpatient Copay per Day?**	Yes	
Line 2.4	**Apply Skilled Nursing Facility Copay per Day?**	Yes	
Line 2.5	**Separate MOOP for Medical & Drug Spending?**		
Line 2.6	**Maximum Number of Days for Charging an IP Copay**	5	
Line 2.7	**Begin Primary Care Cost-Sharing After a Set Number of Visits**	N/A	
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A	
Line 2.9	**HSA Plan?**	No	
Line 2.10	**HSA Employer Contribution Amount**		
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	Yes	*<- Provide Explanation in Note 1 (at the bottom of the page).*
Line 2.12	**Pediatric Dental Embedded?**	No	
Line 2.13	**Includes Non-EHBs?**	No	

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	CHPW Cascade Care Affiliates Network
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: In-Network

	Medical	Drug	Combined	Errors/Warnings
Deductible			$0	
Default Coinsurance			15%	
MOOP			$2,400	

			Copays			Coinsurance				
Medical Benefits	**Upfront Visits or Copays?**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Emergency Room Services		No	$ 150	Before and After Deductible	No					
Inpatient Hospital Services (e.g., Hospital Stay)		No	$ 100	Before and After Deductible	No					
Primary Care Visit to Treat an Injury or Illness		No	$ 1	Before and After Deductible	No					
Specialist Visit		No	$ 15	Before and After Deductible	No					
Mental Health & Substance Use Disorder Office Visits		No	$ 1	Before and After Deductible	No					
Mental Health & Substance Use Disorder All Other OP Services		No	$ 5	Before and After Deductible	No					
Imaging (CT/PET Scans, MRIs)		No				15%	Before and After Deductible	No		
Rehabilitative Speech Therapy		No	$ 5	Before and After Deductible	No					
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 5	Before and After Deductible	No					
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 5	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 15	Before and After Deductible	No					
Skilled Nursing Facility		No	$ 100	Before and After Deductible	No					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		No	$ 100	Before and After Deductible	No					
Outpatient Surgery Physician/Surgical Services		No	$ 25	Before and After Deductible	No					
Urgent Care		No	$ 15	Before and After Deductible	No				Note 1	
Emergency Transportation		No	$ 75	Before and After Deductible	No					
Other EHB Categories										
DME		No				15%	Before and After Deductible	No		
Home Health		No	$ 5	Before and After Deductible	No				Note 2	
Hospice		No	$ 5	Before and After Deductible	No				Note 2	
Abortion for Which Public Funding Is Prohibited		No	$ -	Before and After Deductible						
Routine Eye Care and Eye Glasses for Children		No	$ -	Before and After Deductible						
Other Practitioner Office Visit		No	$ 1	Before and After Deductible	No				Note 3	
Hearing Exams		No	$ 1	Before and After Deductible	No				Note 4	
Hearing Aids		No				15%	Before and After Deductible	No	Note 5	
Artificial Insemination		No				15%	Before and After Deductible	No	Note 6	
Human Donor Milk		No	$ -	Before and After Deductible					Note 7	
All Other EHBs		No				15%	Before and After Deductible	No	Note 8	
Non-EHB Benefits										
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1)		No	$ 5	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2)		No	$ 12	Before and After Deductible	No					
Non-Preferred Brand Drugs (Tier 3)		No	$ 35	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 35	Before and After Deductible	No					

Notes

Note 1 Virtual Care: Virtual Urgent Care visits offered under CHPW MDLive have $0 copay. Other virtual care (e.g., offered by providers) has same copay as an in-person office visit.
Note 2 Home Health, Hospice: Per-day copay
Note 3 Other Practitioner Office Visit: Includes nurse practitioners, physician assistants, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, applied behavior analysis therapists, registered dieticians and other nutrition advisors
Note 4 Hearing Exams: Categorized as Primary Care Visits
Note 5 Hearing Aids: Subject to DME category coinsurance amount, not subject to deductible
Note 6 Artificial Insemination: Categorized as All Other Benefits
Note 7 Human Donor Milk: Subject to zero cost sharing (no deductible, copay, or coinsurance will apply)
Note 8 All Other EHBs: Includes dialysis, chemotherapy, radiation, prosthetic devices, treatment for TMJ, reconstructive surgery, inherited metabolic disorder-PKU, dental anesthesia

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:	Community Health Plan of Washington
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

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

I, Elaine Corrough, FSA, MAAA, certify the following:
☒ I am an employee of Community Health Plan of Washington or
☐ I am a consultant associated with the firm of <<insert name of consulting firm>>;

☒ I am a qualified actuary as outlined in Chapter 284-05 WAC. I am a member of the American Academy of Actuaries, and I am acting within the scope of my training, experience, and qualifications.

☒ Level of review:
I attest to conducting MHSUD financial requirement parity analysis at the appropriate level, as noted below:
☒ Parity review was done separately by plan, for each type of financial requirement and each benefit classification. Parity analysis does not vary by coverage unit because financial requirements do not vary by coverage unit.

☐ Parity review was done separately by plan and coverage unit, for each type of financial requirement and each benefit classification. Parity analysis varies by coverage unit because financial requirements vary by coverage unit.

☒ Benefit classifications:
I attest that all medical/surgical and MHSUD benefits were assigned to benefit classifications.

I attest that the issuer (1) has criteria documented as to how medical/surgical benefits were assigned to each permitted classification and (2) the same standards apply for both medical/surgical and MHSUD benefits.

Upon request, the documentation can be made available to the Washington OIC within 10 business days.

☒ Cost-share accuracy:
For the 2026 plan year, I certify the accuracy of the cost shares for both medical/surgical and MHSUD benefits that are used to evaluate parity of MHSUD financial requirements as loaded into the calculation workbook (*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:	Elaine Corrough, FSA, MAAA
Signature:	*Elaine Corrough, FSA, MAAA*
Title:	Senior Director, Actuarial Services Community Health Plan of Washington
Contact Information:	elaine.corrough@chpw.org
Date of Attestation:	5/12/2025

MHSUD Financial Requirement Parity Testing -- Summary

Issuer and Filing Information

Issuer Name:	Community Health Plan of Washington
HIOS Issuer ID:	18581
Market:	Individual
Plan Year:	2026

Worksheet Instructions

Step 1) In your Excel application, ensure macros are enabled and calculations are set to automatic.
Step 2) Enter Plans.
- *List HIOS Plan IDs and Plan Names in the first two columns of the table below. Include silver base and CSR plan variants.*
- *When a plan has multiple in-network tiers, load information for each tier. Enter each in-network tier here in this file as a separate "plan" record with the plan ID formatted as "12345WA0010001_INN-T1." This will create a separate worksheet for each in-network tier and allows for parity to be analyzed for each tier.*
- *Confirm all HIOS Plan IDs are included in the table-object and then remove any extra rows in the table.*
- *For ease of review, we request that plans in this file be in the same order as they are in the Benefit Components' file.*

Step 3) Click the button below to start the macro that generates the testing worksheets.

Note: The macro creates a testing template for each Plan ID listed in the table below. It also links the IDs in the table to its worksheet.

Step 4) Populate each testing worksheet with the corresponding plan's information.

This format is used for cells that need user input

Step 5) Prior to submitting this file as part of the rate filing, remove the "Example" sheet from the workbook.
Step 6) After completing all plan testing worksheets, save a copy of the workbook in Excel and PDF formats and include both as part of your rate filing submission.

Testing Summary

HIOS Plan ID	Plan Name	Test Results	Notes
18581WA0140001	Community Health Plan of Washington Cascade Select Complete Gold	Pass	
18581WA0140004	Community Health Plan of Washington Cascade Select Vital Gold	Pass	
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	Pass	
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	Pass	
18581WA0140002_(73%_CSR)	Community Health Plan of Washington Cascade Select Silver (73% CSR)	Pass	
18581WA0140002_(87%_CSR)	Community Health Plan of Washington Cascade Select Silver (87% CSR)	Pass	
18581WA0140002_(94%_CSR)	Community Health Plan of Washington Cascade Select Silver (94% CSR)	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.
	The total allowed claims amount reflects Allowed Claims as reported in Section IV of Part I URRT, Wksh2 and was developed based on CHPW's Cascade Select 2024 claims experience as described in Part III. Amounts by service category have been estimated based on the distribution of costs in the 2024 base period for CHPW's Cascade Select product. Please see the added tab "Benefit Components Values."
2	Identify the period (i.e., date range) represented in the data.
	The base period is January 1, 2024-December 31, 2024.
3	Address the credibility of the data used in your MHSUD financial requirement parity testing.
	The base period data is deemed 100% credible. Please see Part III for further information.
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.
	Other than the exception noted below, the data used for testing is consistent with Part I URRT, Wksh2, Section IV. See the added tab "Benefit Components Values." Exception: For 18581WA0140002 and 18581WA0140002 (73% CSR), projected enrollment throughout the rate filing is zero. For MH parity testing purposes only, enrollment is assumed to be 1 to illustrate test results. This is noted (**) in the Benefit Components Values tab.
5	If data other than State of Washington plan data was used, what is the source, and why is it appropriate for MHSUD financial requirement parity testing purposes?
	N/A

MHSUD Financial Requirement Parity Testing
Mapping Medical/Surgical Services to Benefit Classifications

Instructions

Purpose: Show how medical/surgical services map to benefit classifications used in PART 1 of the testing worksheets.

A. Service Description column:
List all services used to test parity. If additional rows are needed, add rows to the table.
Enter descriptions exactly as they are entered in PART 1 of the testing worksheets.

B. Mapped Benefit Classification for MHSUD Parity Testing column:
Select the parity testing benefit classification assigned to each medical/surgical service:
Inpatient, Outpatient - Office Visits*, Outpatient - All Other*, Emergency Care, or Prescription Drugs.
*Note 1: If **ALL** plans test parity with the combined Outpatient classification,
you may enter "Outpatient" instead of "Outpatient - Office Visits" and "Outpatient - All Other".
*Note 2: If **ANY** plan tests parity using Outpatient subclassifications,
choose either "Outpatient - Office Visits" or "Outpatient - All Other" for each outpatient medical/surgical service.

C. Mapped Benefit in corresponding Benefit Components document (If applicable) column:
Select the benefit from the Benefit Components document that is assigned to each Benefit Classification for MHSUD parity testing.
*Note 1: Click on the "Import Benefit Components Into Column C" button and select the matching benefit components to expand the list of options in column C.
*Note 2: To assign multiple benefits from the Benefit Components document to a single Benefit Classification for MHSUD parity testing, create two separate rows with the same entry in column B, but different entries in column C.

Notes column: Explain any differences by plan.

Mapping Table

A. Service Description	B. Mapped Benefit Classification for MHSUD Parity Testing	C. Mapped Benefit in corresponding Benefit Components document (If applicable)	Notes
Emergency Room Services	Emergency Care	Emergency Room Services	
Inpatient Hospital Services (e.g., Hospital Stay)	Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	
Primary Care Visit to Treat an Injury or Illness	Outpatient - Office Visits	Primary Care Visit to Treat an Injury or Illness	
Specialist Visit	Outpatient - Office Visits	Specialist Visit	
Mental Health & Substance Use Disorder Office Visits	Outpatient - Office Visits	Mental Health & Substance Use Disorder Office Visits	
Mental Health & Substance Use Disorder All Other OP Services	Outpatient - All Other	Mental Health & Substance Use Disorder All Other OP Services	
Imaging (CT/PET Scans, MRIs)	Outpatient - All Other	Imaging (CT/PET Scans, MRIs)	
Rehabilitative Speech Therapy	Outpatient - Office Visits	Rehabilitative Speech Therapy	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Outpatient - Office Visits	Rehabilitative Occupational and Rehabilitative Physical Therapy	
Preventive Care/Screening/Immunization	Outpatient - Office Visits	Preventive Care/Screening/Immunization	
Laboratory Outpatient and Professional Services	Outpatient - All Other	Laboratory Outpatient and Professional Services	
X-rays and Diagnostic Imaging	Outpatient - All Other	X-rays and Diagnostic Imaging	
Skilled Nursing Facility	Inpatient	Skilled Nursing Facility	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient - All Other	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Outpatient Surgery Physician/Surgical Services	Outpatient - All Other	Outpatient Surgery Physician/Surgical Services	
Urgent Care	Outpatient - All Other	Urgent Care	
Emergency Transportation	Emergency Care	Emergency Transportation	
DME	Outpatient - All Other	DME	
Home Health	Outpatient - All Other	Home Health	
Hospice	Inpatient	Hospice	
Abortion for Which Public Funding Is Prohibited	Outpatient - All Other	Abortion for Which Public Funding Is Prohibited	
Routine Eye Care and Eye Glasses for Children	Outpatient - All Other	Routine Eye Care and Eye Glasses for Children	
Other Practitioner Office Visit	Outpatient - Office Visits	Other Practitioner Office Visit	
Hearing Exams	Outpatient - Office Visits	Hearing Exams	
Hearing Aids	Outpatient - All Other	Hearing Aids	
Artificial Insemination	Outpatient - All Other	Artificial Insemination	
Human Donor Milk	Outpatient - All Other	Human Donor Milk	
All Other EHBs - Outpatient	Outpatient - All Other	All Other EHBs	
All Other EHBs - Inpatient	Inpatient	All Other EHBs	
Generic Drugs (Tier 1)	Prescription Drugs	Generic Drugs (Tier 1)	
Preferred Brand Drugs (Tier 2)	Prescription Drugs	Preferred Brand Drugs (Tier 2)	
Non-Preferred Brand Drugs (Tier 3)	Prescription Drugs	Non-Preferred Brand Drugs (Tier 3)	
Specialty Drugs (Tier 4)	Prescription Drugs	Specialty Drugs (Tier 4)	

Community Health Plan of Washington
MHSUD Parity Calculations
Allowed Amounts for Benefit Components for Testing Purposes

Service Description	Allowed PMPM	PROJECTED MEMBER-MONTHS / PLAN PROJECTED ALLOWED AMOUNTS** 18581WA0140001 Complete Gold	18581WA0140004 Vital Gold	18581WA0140002 Silver	18581WA0140003 Bronze	18581WA0140002 (73% CSR) Silver (73% CSR)	18581WA0140002 (87% CSR) Silver (87% CSR)	18581WA0140002 (94% CSR) Silver (94% CSR)
		28,985	14,863	1	28,579	1	73,162	40,608
EHB Categories								
Emergency Room Services	$28.73	$832,613.35	$426,949.53	$28.73	$820,950.73	$28.73	$2,101,626.98	$1,166,491.74
Inpatient Hospital Services (e.g., Hospital Stay)	$83.59	$2,422,814.88	$1,242,377.01	$83.59	$2,388,877.92	$83.59	$6,115,507.42	$3,394,364.91
Primary Care Visit to Treat an Injury or Illness	$20.16	$584,374.18	$299,656.84	$20.16	$576,188.71	$20.16	$1,475,038.25	$818,708.53
Primary Care Visit to Treat an Injury or Illness - Visits 1-2	*$15.12*	*$438,280.63*	*$224,742.63*	*$15.12*	*$432,141.53*	*$15.12*	*$1,106,278.69*	*$614,031.40*
Primary Care Visit to Treat an Injury or Illness - Visits 3+	*$5.04*	*$146,093.54*	*$74,914.21*	*$5.04*	*$144,047.18*	*$5.04*	*$368,759.56*	*$204,677.13*
Specialist Visit	$17.20	$498,454.87	$255,598.92	$17.20	$491,472.89	$17.20	$1,258,166.47	$698,335.53
Mental Health & Substance Use Disorder Office Visits	$6.01	$174,335.33	$89,396.10	$6.01	$171,893.37	$6.01	$440,045.59	$244,243.89
Mental Health & Substance Use Disorder All Other OP Services	$0.39	$11,313.10	$5,801.16	$0.39	$11,154.64	$0.39	$28,555.77	$15,849.66
Imaging (CT/PET Scans, MRIs)	$13.56	$392,897.95	$201,471.18	$13.56	$387,394.54	$13.56	$991,726.76	$550,450.24
Rehabilitative Speech Therapy	$0.44	$12,841.96	$6,585.13	$0.44	$12,662.08	$0.44	$32,414.83	$17,991.60
Rehabilitative Occupational and Rehabilitative Physical Therapy	$3.99	$115,760.27	$59,359.84	$3.99	$114,138.79	$3.99	$292,194.33	$162,180.20
Preventive Care/Screening/Immunization	$14.16	$410,516.58	$210,505.71	$14.16	$404,766.37	$14.16	$1,036,198.52	$575,133.94
Laboratory Outpatient and Professional Services	$18.53	$537,062.33	$275,396.15	$18.53	$529,539.56	$18.53	$1,355,616.84	$752,424.60
X-rays and Diagnostic Imaging	$12.31	$356,721.57	$182,920.57	$12.31	$351,724.88	$12.31	$900,412.75	$499,767.10
Skilled Nursing Facility	$0.42	$12,096.98	$6,203.12	$0.42	$11,927.54	$0.42	$30,534.39	$16,947.88
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$51.31	$1,487,363.08	$762,693.72	$51.31	$1,466,529.22	$51.31	$3,754,302.48	$2,083,796.44
Outpatient Surgery Physician/Surgical Services	$10.73	$311,052.67	$159,502.36	$10.73	$306,695.68	$10.73	$785,138.36	$435,784.95
Urgent Care	$3.22	$93,367.47	$47,877.20	$3.22	$92,059.65	$3.22	$235,671.94	$130,807.88
Emergency Transportation	$1.89	$54,655.52	$28,026.39	$1.89	$53,889.95	$1.89	$137,957.82	$76,572.42
Other EHB Categories								
DME	$3.75	$108,701.77	$55,740.36	$3.75	$107,179.16	$3.75	$274,377.75	$152,291.24
Home Health	$1.42	$41,296.54	$21,176.14	$1.42	$40,718.09	$1.42	$104,237.96	$57,856.47
Hospice	$0.06	$1,844.75	$945.95	$0.06	$1,818.91	$0.06	$4,656.39	$2,584.49
Abortion for which public funding is prohibited	$0.65	$18,806.14	$9,643.46	$0.65	$18,542.72	$0.65	$47,469.20	$26,347.41
Routine eye care and eye glasses for children	$0.19	$5,582.39	$2,862.55	$0.19	$5,504.19	$0.19	$14,090.69	$7,820.93
* Other Practitioner Office Visit	$0.20	$5,770.76	$2,959.14	$0.20	$5,689.92	$0.20	$14,566.16	$8,084.83
Hearing exams	$0.23	$6,729.84	$3,450.94	$0.23	$6,635.57	$0.23	$16,987.01	$9,428.51
Hearing aids	$0.09	$2,691.94	$1,380.38	$0.09	$2,654.23	$0.09	$6,794.81	$3,771.40
Artificial insemination	$0.05	$1,345.97	$690.19	$0.05	$1,327.11	$0.05	$3,397.40	$1,885.70
Human donor milk	$0.09	$2,691.94	$1,380.38	$0.09	$2,654.23	$0.09	$6,794.81	$3,771.40
* All Other EHBs - Outpatient	$20.02	$580,302.56	$297,568.98	$20.02	$572,174.12	$20.02	$1,464,760.93	$813,004.18
* All Other EHBs - Inpatient	$8.15	$236,094.80	$121,065.28	$8.15	$232,787.76	$8.15	$595,934.72	$330,768.94
Drug Benefit Tiers								
Generic Drugs (Tier 1)	$36.53	$1,058,765.84	$542,916.56	$36.53	$1,043,935.44	$36.53	$2,672,465.97	$1,483,331.48
Preferred Brand Drugs (Tier 2)	$28.92	$838,111.53	$429,768.90	$28.92	$826,371.90	$28.92	$2,115,505.12	$1,174,194.69
Non-Preferred Brand Drugs (Tier 3)	$5.44	$157,802.52	$80,918.36	$5.44	$155,592.14	$5.44	$398,314.57	$221,081.41
Specialty Drugs (Tier 4)	$73.21	$2,122,094.61	$1,088,172.92	$73.21	$2,092,369.91	$73.21	$5,356,449.41	$2,973,055.65
Total* **	$465.65	$13,496,875.99	$6,920,961.42	$465.64	$13,307,821.92	$465.64	$34,067,912.40	$18,909,130.24

* See Mapping Information tab, Notes, for services included in this category
** Actual projected enrollment for 18581WA0140002 and 18581WA0140002 (73% CSR) is zero. For purposes of MH parity testing only, enrollment of 1 is shown to illustrate parity
*** Total across plans differs slightly from URRT Wksh2/4.2 due to rounding and illustrative enrollment for 18581WA0140002 and 18581WA0140002 (73% CSR)

TESTING ONLY - Totals by Service Category		18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003	18581WA0140002 (73% CSR)	18581WA0140002 (87% CSR)	18581WA0140002 (94% CSR)
INPATIENT		$2,672,851.41	$1,370,591.36	$92.22	$2,635,412.13	$92.22	$6,746,632.92	$3,744,666.22
OUTPATIENT - OFFICE VISITS		$1,634,448.46	$838,116.52	$56.38	$1,611,554.33	$56.38	$4,125,565.57	$2,289,863.14
OUTPATIENT - OTHER		$3,939,884.32	$2,020,303.62	$135.92	$3,884,697.38	$135.92	$9,944,792.68	$5,519,779.94
OUTPATIENT - TOTAL		$5,574,332.78	$2,858,420.14	$192.30	$5,496,251.71	$192.30	$14,070,358.25	$7,809,643.08

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Complete Gold — *<<<<This will auto populate from summary sheet macro*
Plan ID: 18581WA0140001 — *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: — *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: **Pass**

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

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

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	All Combined

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

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

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>>> Home | Errors found: 0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (1) Inpatient, In-Network (IP INN)

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_P1

Number of Rows: 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")
Inpatient Hospital Services (e.g., Hospital Stay)	Copay per day, max 5 copays per stay, before and after deductible	$2,422,814.88	$0.00	$525.00	N/A	$7,000.00	
Skilled Nursing Facility	Copay per day, after deductible	$12,096.98	$1,000.00	$350.00	N/A	$7,000.00	
Hospice	Copay per day, before and after deductible	$1,844.75	$0.00	$15.00	N/A	$7,000.00	
All Other EHBs - Inpatient	Coinsurance after deductible	$236,094.80	$1,000.00	N/A	20%	$7,000.00	
Total Row		$2,672,851.41					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$525.00	$525.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,000.00	$7,000.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
NA

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

Deductible	$248,191.78	9.29%	Fail
Copayment	$2,436,756.61	91.17%	IP INN Copayment
Coinsurance	$236,094.80	8.83%	Fail
OOPM	$2,672,851.41	100.00%	IP INN OOPM
Total Projected	$2,672,851.41		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$2,424,659.63	100.00%		
Total	$2,424,659.63	100.00%		

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

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$15.00	$1,844.75	0.08%	$15.00	
$350.00	$12,096.98	0.50%	$350.00	
$525.00	$2,422,814.88	99.43%	$525.00	
Total	$2,436,756.61	100.00%		

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

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

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

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

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

OOPM	Allowed Claims	Portion	Predominant &	Error Checking
$7,000.00	$2,672,851.41	100.00%	$7,000.00	
Total	$2,672,851.41	100.00%		

Benefit Classification (3) Outpatient, In-Network (OP INN)

Click>>>>> Home | Errors found: 0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3) Outpatient, In-Network (OP INN)
Notes: *Use this table if you are testing all outpatient services combined.*

Classification	Outpatient	OP
Network (In/Out)	In-Network	INN
Classification Code	3	OP INN
Table Name		tbl_OPINN_P1

Number of Rows: 21

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share (If true, enter "x")
Primary Care Visit to Treat an Injury or Illness	Copay before and after deductible	$584,374.18	$0.00	$15.00	N/A	$7,000.00	
Specialist Visit	Copay before and after deductible	$498,454.87	$0.00	$40.00	N/A	$7,000.00	
Imaging (CT/PET Scans, MRIs)	Copay after deductible	$392,897.95	$1,000.00	$300.00	N/A	$7,000.00	
Rehabilitative Speech Therapy	Copay before and after deductible	$12,841.96	$0.00	$25.00	N/A	$7,000.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay before and after deductible	$115,760.27	$0.00	$25.00	N/A	$7,000.00	
Preventive Care/Screening/Immunization	No cost share	$410,516.58	$0.00	N/A	N/A	$7,000.00	x
Laboratory Outpatient and Professional Services	Copay before and after deductible	$537,062.33	$0.00	$20.00	N/A	$7,000.00	
X-rays and Diagnostic Imaging	Copay before and after deductible	$356,721.57	$0.00	$30.00	N/A	$7,000.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay after deductible	$1,487,363.08	$1,000.00	$350.00	N/A	$7,000.00	
Outpatient Surgery Physician/Surgical Services	Copay after deductible	$311,052.67	$1,000.00	$75.00	N/A	$7,000.00	
Urgent Care	Copay before and after deductible	$93,367.47	$0.00	$35.00	N/A	$7,000.00	
DME	Coinsurance after deductible	$108,701.77	$1,000.00	N/A	20%	$7,000.00	
Home Health	Copay before and after deductible	$41,296.54	$0.00	$15.00	N/A	$7,000.00	
Abortion for Which Public Funding Is Prohibited	No cost share	$18,806.14	$0.00	N/A	N/A	$7,000.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$5,582.39	$0.00	N/A	N/A	$7,000.00	x
Other Practitioner Office Visit	Copay before and after deductible	$5,770.76	$0.00	$15.00	N/A	$7,000.00	
Hearing Exams	Copay before and after deductible	$6,729.84	$0.00	$15.00	N/A	$7,000.00	
Hearing Aids	Coinsurance before and after deductible	$2,691.94	$0.00	N/A	20%	$7,000.00	
Artificial Insemination	Coinsurance after deductible	$1,345.97	$1,000.00	N/A	20%	$7,000.00	
Human Donor Milk	No cost share	$2,691.94	$0.00	N/A	N/A	$7,000.00	x
All Other EHBs - Outpatient	Coinsurance after deductible	$580,302.56	$1,000.00	N/A	20%	$7,000.00	
Total Row		$5,574,332.78					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3) Outpatient, In-Network (OP INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$15.00	$40.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,000.00	$7,000.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$2,881,664.00	51.70%	Fail
Copayment	$4,443,693.49	79.72%	OP INN Copayment
Coinsurance	$693,042.24	12.43%	Fail
OOPM	$5,574,332.78	100.00%	OP INN OOPM
Total Projected	$5,574,332.78		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$2,692,668.78	100.00%		
Total	$2,692,668.78	100.00%		

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

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$15.00	$638,171.32	14.36%	$15.00	
$20.00	$537,062.33	12.09%	$20.00	
$25.00	$128,602.23	2.89%	$25.00	
$30.00	$356,721.57	8.03%	$30.00	
$35.00	$93,367.47	2.10%	$35.00	
$40.00	$498,454.87	11.22%	$40.00	
$75.00	$311,052.67	7.00%		
$300.00	$392,897.95	8.84%		
$350.00	$1,487,363.08	33.47%		
Total	$4,443,693.49	100.00%		

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

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

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

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

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

OOPM	Allowed Claims	Portion	Predominant &	Error Checking
$7,000.00	$5,574,332.78	100.00%	$7,000.00	
Total	$5,574,332.78	100.00%		

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Vital Gold *<<<<This will auto populate from summary sheet macro*
Plan ID: 18581WA0140004 *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: **Pass**

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

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

Testing Options

Option	Selection
Out-of-Network Tier?	No
Outpatient Benefit Testing	All Combined

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

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

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>>> Home | Errors found: 0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (1) Inpatient, In-Network (IP INN)

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_P1

Number of Rows: 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")
Inpatient Hospital Services (e.g., Hospital Stay)	Copay per day, max 5 copays per stay, before and after deductible	$1,242,377.01	$0.00	$650.00	N/A	$8,800.00	
Skilled Nursing Facility	Copay per day, after deductible	$6,203.12	$1,900.00	$350.00	N/A	$8,800.00	
Hospice	Copay per day, before and after deductible	$945.95	$0.00	$15.00	N/A	$8,800.00	
All Other EHBs - Inpatient	Coinsurance after deductible	$121,065.28	$1,900.00	N/A	20%	$8,800.00	
Total Row		$1,370,591.36					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$650.00	$650.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,800.00	$8,800.00	Pass
Overall			Pass

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

*If not applicable, enter "N/A"

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

Deductible	$127,268.40	9.29%	Fail
Copayment	$1,249,526.08	91.17%	IP INN Copayment
Coinsurance	$121,065.28	8.83%	Fail
OOPM	$1,370,591.36	100.00%	IP INN OOPM
Total Projected	$1,370,591.36		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$1,243,322.96	100.00%		
Total	$1,243,322.96	100.00%		

Copayment ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$15.00	$945.95	0.08%	$15.00	
$350.00	$6,203.12	0.50%	$350.00	
$650.00	$1,242,377.01	99.43%	$650.00	
Total	$1,249,526.08	100.00%		

Coinsurance ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

OOPM ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$8,800.00	$1,370,591.36	100.00%	$8,800.00	
Total	$1,370,591.36	100.00%		

Benefit Classification (3) Outpatient, In-Network (OP INN)

Click>>>>> Home | Errors found: 0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3) Outpatient, In-Network (OP INN)
Notes: *Use this table if you are testing all outpatient services combined.*

Classification	Outpatient	OP
Network (In/Out)	In-Network	INN
Classification Code	3	OP INN
Table Name		tbl_OPINN_P1

Number of Rows: 21

For each cost share, if it does not apply, enter "N/A".

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share (If true, enter "x")
Primary Care Visit to Treat an Injury or Illness	Copay before and after deductible	$299,656.84	$0.00	$15.00	N/A	$8,800.00	
Specialist Visit	Copay before and after deductible	$255,598.92	$0.00	$40.00	N/A	$8,800.00	
Imaging (CT/PET Scans, MRIs)	Copay after deductible	$201,471.18	$1,900.00	$300.00	N/A	$8,800.00	
Rehabilitative Speech Therapy	Copay before and after deductible	$6,585.13	$0.00	$30.00	N/A	$8,800.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay before and after deductible	$59,359.84	$0.00	$30.00	N/A	$8,800.00	
Preventive Care/Screening/Immunization	No cost share	$210,505.71	$0.00	N/A	N/A	$8,800.00	x
Laboratory Outpatient and Professional Services	Copay before and after deductible	$275,396.15	$0.00	$30.00	N/A	$8,800.00	
X-rays and Diagnostic Imaging	Copay before and after deductible	$182,920.57	$0.00	$30.00	N/A	$8,800.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay after deductible	$762,693.72	$1,900.00	$350.00	N/A	$8,800.00	
Outpatient Surgery Physician/Surgical Services	Copay after deductible	$159,502.36	$1,900.00	$75.00	N/A	$8,800.00	
Urgent Care	Copay before and after deductible	$47,877.20	$0.00	$35.00	N/A	$8,800.00	
DME	Coinsurance after deductible	$55,740.36	$1,900.00	N/A	20%	$8,800.00	
Home Health	Copay before and after deductible	$21,176.14	$0.00	$15.00	N/A	$8,800.00	
Abortion for Which Public Funding Is Prohibited	No cost share	$9,643.46	$0.00	N/A	N/A	$8,800.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$2,862.55	$0.00	N/A	N/A	$8,800.00	x
Other Practitioner Office Visit	Copay before and after deductible	$2,959.14	$0.00	$15.00	N/A	$8,800.00	
Hearing Exams	Copay before and after deductible	$3,450.94	$0.00	$15.00	N/A	$8,800.00	
Hearing Aids	Coinsurance before and after deductible	$1,380.38	$0.00	N/A	20%	$8,800.00	
Artificial Insemination	Coinsurance after deductible	$690.19	$1,900.00	N/A	20%	$8,800.00	
Human Donor Milk	No cost share	$1,380.38	$0.00	N/A	N/A	$8,800.00	x
All Other EHBs - Outpatient	Coinsurance after deductible	$297,568.98	$1,900.00	N/A	20%	$8,800.00	
Total Row		$2,858,420.14					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3) Outpatient, In-Network (OP INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$15.00	$40.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,800.00	$8,800.00	Pass
Overall			Pass

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

*If not applicable, enter "N/A"

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

Deductible	$1,477,666.79	51.70%	Fail
Copayment	$2,278,648.13	79.72%	OP INN Copayment
Coinsurance	$355,379.91	12.43%	Fail
OOPM	$2,858,420.14	100.00%	OP INN OOPM
Total Projected	$2,858,420.14		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$1,380,753.35	100.00%		
Total	$1,380,753.35	100.00%		

Copayment ---- (3) Outpatient, In-Network (OP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$15.00	$327,243.06	14.36%	$15.00	
$30.00	$524,261.69	23.01%	$30.00	
$35.00	$47,877.20	2.10%	$35.00	
$40.00	$255,598.92	11.22%	$40.00	
$75.00	$159,502.36	7.00%		
$300.00	$201,471.18	8.84%		
$350.00	$762,693.72	33.47%		
Total	$2,278,648.13	100.00%		

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

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

OOPM ---- (3) Outpatient, In-Network (OP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$8,800.00	$2,858,420.14	100.00%	$8,800.00	
Total	$2,858,420.14	100.00%		

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Silver
Plan ID: 18581WA0140002 <<<This will auto populate from summary sheet macro
CSR Variant Description: <<<This will auto populate from summary sheet macro
<<<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

<<<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

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

Testing Options

Option	Selection
Out-of-Network Tier?	Yes
Outpatient Benefit Testing	OP-O Visits Separate

Column Options
Explore Columns
Hide/Unhide All Columns

No Errors Found?
TRUE

Results By Benefit Classification

A. Benefit Classification	B1. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (In-Network)	C1. Test Required? (In-Network)	B2. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification? (Out-of-Network)	C2. Test Required? (Out-of-Network)	D. By Network Tier		
					D1. In-Network	D2. Out-of-Network	D. Test Results
Inpatient	Yes	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combined							
Outpatient - Office Visits Separate							
Outpatient - Office Visits	Yes	Yes			Pass		Pass
Outpatient - All Other	Yes	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>> Display — 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 (1a) Outpatient - Office Visits, In-Network (OP-OV INN)

Click>>>> Display — 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 (1b) Outpatient - All Other, In-Network (OP-AO INN)

Click>>>> Display — Errors Found: 0

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

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

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

Benefit Classification (1) Inpatient, In-Network (IP INN)

Classification	Inpatient
Network (In/Out)	In-Network
Classification Code	IP-INN
Table Name	See Sheets 22

Number of Rows: 4

Accept and close (if data previously exist "N/A")

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share (If True,
Inpatient Hospital Services (e.g., Hospital Stay)	Copay per day, max 5 copays per stay, after deductible	$83.59	$2,500.00	$800.00	N/A	$9,750.00	
Skilled Nursing Facility	Copay per day, after deductible	$0.42	$2,500.00	$800.00	N/A	$9,750.00	
Hospice	Copay per day, before and after deductible	$0.06	$0.00	$30.00	N/A	$9,750.00	
All Other EHBs - Inpatient	Coinsurance after deductible	$8.35	$2,500.00	N/A	30%	$9,750.00	
Total Row		$92.32					

Benefit Classification (1a) 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 Visits
Network (In/Out)	In-Network
Classification Code	OP-OV-INN
Table Name	See Sheets 23

Number of Rows: 6

Accept and close (if data previously exist "N/A")

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum	No Cost-Share (If True,
Primary Care Visit to Treat an Injury or Illness - Visits in-p	Copay before and after deductible	$30.12	$0.00	$5.00	N/A	$9,750.00	
Primary Care Visit to Treat an Injury or Illness - Visits in-	Copay before and after deductible	$5.82	$0.00	$20.00	N/A	$9,750.00	
Specialist Visit	Copay before and after deductible	$17.30	$0.00	$65.00	N/A	$9,750.00	
Rehabilitative Speech Therapy	Copay before and after deductible	$5.82	$0.00	$40.00	N/A	$9,750.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay before and after deductible	$5.82	$0.00	$40.00	N/A	$9,750.00	
Preventive Care/Screening/Immunization	No cost share	$44.36	$0.00	N/A	N/A	$9,750.00	x
Other Practitioner Office Visit	Copay before and after deductible	$5.82	$0.00	$20.00	N/A	$9,750.00	
Hearing Exams	Copay before and after deductible	$5.82	$0.00	$20.00	N/A	$9,750.00	
Total Row		$66.36					

Benefit Classification (1b) 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	OP-AO-INN
Table Name	See Sheets 24

Number of Rows: 10

Accept and close (if data previously exist "N/A")

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum	No Cost-Share (If True,
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$18.56	$0.00	N/A	30%	$9,750.00	
Laboratory Outpatient and Professional Services	Copay before and after deductible	$18.56	$0.00	$40.00	N/A	$9,750.00	
X-rays and Diagnostic Imaging	Copay before and after deductible	$12.35	$0.00	$65.00	N/A	$9,750.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay after deductible	$92.35	$2,500.00	$800.00	N/A	$9,750.00	
Outpatient Surgery Physician/Surgical Services	Copay after deductible	$92.35	$2,500.00	$200.00	N/A	$9,750.00	
Urgent Care	Copay before and after deductible	$9.23	$0.00	$65.00	N/A	$9,750.00	
Walk	Coinsurance after deductible	$9.35	$2,500.00	N/A	30%	$9,750.00	
Nurse Health	Copay before and after deductible	$1.23	$0.00	$30.00	N/A	$9,750.00	
Abortion for Which Public Funding is Prohibited	No cost share	$0.00	$0.00	N/A	N/A	$9,750.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$0.23	$0.00	N/A	N/A	$9,750.00	x
Hearing Aids	Coinsurance before and after deductible	$0.00	$0.00	N/A	30%	$9,750.00	
Artificial Incontinence	Coinsurance after deductible	$0.00	$2,500.00	N/A	30%	$9,750.00	
Nurse Device Visit	No cost share	$0.00	$0.00	N/A	N/A	$9,750.00	x
All Other EHBs - Outpatient	Coinsurance after deductible	$20.23	$2,500.00	N/A	30%	$9,750.00	
Total Row		$135.92					

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

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

Cost-Share Type	MHSUD Cost-Shares in Plan Design*	Predominant Level for Medical/Surgical	MHSUD Financial Parity Result
Deductible	$7,500.00	$4,900.00	Fails
Copayment	$800.00	$800.00	Pass
Coinsurance	N/A	Fail	Fails
OOPM	$9,750.00	$9,750.00	Pass
Overall			Fails

*If not applicable, enter "N/A"

Enter Footnotes (as needed) about MHSUD Cost-Shares: N/A

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

Deductible	$92.38	68.93%	IP-INN Deductible
Copayment	$64.27	91.34%	IP-INN Copayment
Coinsurance	$8.35	8.98%	Fail
OOPM	$92.32	100.00%	IP-INN OOPM
Total Projected	$92.32		

Step 2 Predominant Level

Deductible — (1a) Inpatient, In-Network (IP-INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$4,900.00	$64.27	68.93%	$4,900.00	
Total	$64.27	100.00%		

Copayment — (1a) Inpatient, In-Network (IP-INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$100.00	$0.00	0.00%	$100.00	
$800.00	$64.27	91.34%	$800.00	
Total	$64.27	100.00%		

Coinsurance — (1a) Inpatient, In-Network (IP-INN) — Errors Found: 0

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

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

OOPM — (1a) Inpatient, In-Network (IP-INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$9,750.00	$92.32	100.00%	$9,750.00	
Total	$92.32	100.00%		

Financial Parity for (1a) 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	Fails
Copayment	$30.00	$30.00	Pass
Coinsurance	N/A	Fail	Fails
OOPM	$9,750.00	$9,750.00	Pass
Overall			Fails

*If not applicable, enter "N/A"

Enter Footnotes (as needed) about MHSUD Cost-Shares: Testing has been completed using MHSUD OP-OV supply for visits for, which is higher than $0 supply for visits 3 and thus represents a "safe harbor."

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

Deductible	$0.00	0.00%	Fail
Copayment	$66.36	74.88%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$66.36	100.00%	OP-OV INN OOPM
Total Projected	$66.36		

Step 2 Predominant Level

Deductible — (1a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors Found: 0

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$66.36	100.00%		
Total	$66.36	100.00%		

Copayment — (1a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$5.00	$20.23	30.48%	$5.00	
$20.00	$14.82	22.34%	$20.00	
$65.00	$4.82	7.26%	$65.00	
$30.00	$27.30	41.13%		
Total	$66.36	100.00%		

Coinsurance — (1a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors Found: 0

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

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

OOPM — (1a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$9,750.00	$66.36	100.00%	$9,750.00	
Total	$66.36	100.00%		

Financial Parity for (1b) Outpatient - All Other, In-Network (OP-AO INN)

Cost-Share Type	MHSUD Cost-Shares in Plan Design*	Predominant Level for Medical/Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Fails
Copayment	$65.00	$65.00	Pass
Coinsurance	N/A	Fail	Fails
OOPM	$9,750.00	$9,750.00	Pass
Overall			Fails

*If not applicable, enter "N/A"

Enter Footnotes (as needed) about MHSUD Cost-Shares: N/A

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

Deductible	$80.00	44.47%	Fail
Copayment	$97.51	71.76%	OP-AO INN Copayment
Coinsurance	$14.47	27.87%	Fail
OOPM	$135.92	100.00%	OP-AO INN OOPM
Total Projected	$135.92		

Step 2 Predominant Level

Deductible — (1b) Outpatient - All Other, In-Network (OP-AO INN) — Errors Found: 0

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$80.00	44.47%	$80.00	
Total	$80.00	44.47%	$80.00	

Copayment — (1b) Outpatient - All Other, In-Network (OP-AO INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$30.00	$2.47	1.38%	$30.00	
$65.00	$14.82	8.24%	$65.00	
$40.00	$14.82	8.24%	$65.00	
$200.00	$64.79	36.02%	$200.00	
$800.00	$14.41	8.01%	$800.00	
Total	$97.51	54.21%	$800.00	

Coinsurance — (1b) 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			
Total	$0.00	0.00%		

OOPM — (1b) Outpatient - All Other, In-Network (OP-AO INN) — Errors Found: 0

Applies to substantially all medical/surgical benefits in this classification.
ENTER 4 different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$9,750.00	$135.92	100.00%	$9,750.00	
Total	$135.92	100.00%		

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Bronze *<<<<This will auto populate from summary sheet macro*
Plan ID: 18581WA0140003 *<<<<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 1: D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	No	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combined							
Outpatient - Office Visits Separate							
Outpatient - Office Visits	No	Yes			Pass		Pass
Outpatient - All Other	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>>> Home | Errors Found: 0

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

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

Benefit Classification (1) Inpatient, In-Network (IP INN)

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_P1

Number of Rows: 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,
Inpatient Hospital Services (e.g., Hospital Stay)	Coinsurance after deductible	$2,388,877.92	$6,000.00	N/A	40%	$10,150.00	
Skilled Nursing Facility	Coinsurance after deductible	$11,927.54	$6,000.00	N/A	40%	$10,150.00	
Hospice	Copay before and after deductible	$1,818.91	$0.00	$50.00	N/A	$10,150.00	
All Other EHBs - Inpatient	Coinsurance after deductible	$232,787.76	$6,000.00	N/A	40%	$10,150.00	
Total Row		$2,635,412.13					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$6,000.00	$6,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	40%	40%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$2,633,593.22	99.93%	IP INN Deductible
Copayment	$1,818.91	0.07%	Fail
Coinsurance	$2,633,593.22	99.93%	IP INN Coinsurance
OOPM	$2,635,412.13	100.00%	IP INN OOPM
Total Projected	$2,635,412.13		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$6,000.00	$2,633,593.22	100.00%	$6,000.00	
Total	$2,633,593.22	100.00%		

Copayment ---- (1) Inpatient, In-Network (IP INN) — Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

Coinsurance ---- (1) Inpatient, In-Network (IP INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different coinsurance amounts from smallest to largest.

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
40%	$2,633,593.22	100.00%	40%	
Total	$2,633,593.22	100.00%		

OOPM ---- (1) Inpatient, In-Network (IP INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$2,635,412.13	100.00%	$10,150.00	
Total	$2,635,412.13	100.00%		

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

Click>>>>> Home | Errors Found: 0

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

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

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

Classification	Outpatient - Office Visits	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 8

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	No Cost-Share (If true,
Primary Care Visit to Treat an Injury or Illness - Visits 1-2	Copay before and after deductible	$432,141.53	$0.00	$1.00	N/A	$10,150.00	
Primary Care Visit to Treat an Injury or Illness - Visits 3+	Copay before and after deductible	$144,047.18	$0.00	$40.00	N/A	$10,150.00	
Specialist Visit	Copay before and after deductible	$491,472.89	$0.00	$100.00	N/A	$10,150.00	
Rehabilitative Speech Therapy	Coinsurance after deductible	$12,662.08	$6,000.00	N/A	40%	$10,150.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Coinsurance after deductible	$114,138.79	$6,000.00	N/A	40%	$10,150.00	
Preventive Care/Screening/Immunization	No cost share	$404,766.37	$0.00	N/A	N/A	$10,150.00	x
Other Practitioner Office Visit	Copay before and after deductible	$5,689.92	$0.00	$40.00	N/A	$10,150.00	
Hearing Exams	Copay before and after deductible	$6,635.57	$0.00	$40.00	N/A	$10,150.00	
Total Row		$1,611,554.33					

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

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$40.00	$40.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
Testing has been completed using MH/SUD OV copay for visits 3+, which is higher than the $1 copay for visits 1-2 and thus represents a "safe harbor."

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

Deductible	$126,800.87	7.87%	Fail
Copayment	$1,079,987.09	67.02%	OP-OV INN Copayment
Coinsurance	$126,800.87	7.87%	Fail
OOPM	$1,611,554.33	100.00%	OP-OV INN OOPM
Total Projected	$1,611,554.33		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$1,484,753.46	100.00%		
Total	$1,484,753.46	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$1.00	$432,141.53	40.01%	$1.00	
$40.00	$156,372.67	14.48%	$40.00	
$100.00	$491,472.89	45.51%		
Total	$1,079,987.09	100.00%		

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

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
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 & Smaller	Error Checking
$10,150.00	$1,611,554.33	100.00%	$10,150.00	
Total	$1,611,554.33	100.00%		

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

Click>>>>> Home | Errors Found: 0

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

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

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 14

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	No Cost-Share (If true,
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$387,394.54	$6,000.00	N/A	40%	$10,150.00	
Laboratory Outpatient and Professional Services	Coinsurance after deductible	$529,539.56	$6,000.00	N/A	40%	$10,150.00	
X-rays and Diagnostic Imaging	Coinsurance after deductible	$351,724.88	$6,000.00	N/A	40%	$10,150.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Coinsurance after deductible	$1,466,529.22	$6,000.00	N/A	40%	$10,150.00	
Outpatient Surgery Physician/Surgical Services	Coinsurance after deductible	$306,695.68	$6,000.00	N/A	40%	$10,150.00	
Urgent Care	Copay before and after deductible	$92,059.65	$0.00	$100.00	N/A	$10,150.00	
DME	Coinsurance after deductible	$107,179.16	$6,000.00	N/A	40%	$10,150.00	
Home Health	Copay before and after deductible	$40,718.09	$0.00	$50.00	N/A	$10,150.00	
Abortion for Which Public Funding Is Prohibited	No cost share	$18,542.72	$0.00	N/A	N/A	$10,150.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$5,504.19	$0.00	N/A	N/A	$10,150.00	x
Hearing Aids	Coinsurance before and after deductible	$2,654.23	$0.00	N/A	40%	$10,150.00	
Artificial Insemination	Coinsurance after deductible	$1,327.11	$6,000.00	N/A	40%	$10,150.00	
Human Donor Milk	No cost share	$2,654.23	$0.00	N/A	N/A	$10,150.00	x
All Other EHBs - Outpatient	Coinsurance after deductible	$572,174.12	$6,000.00	N/A	40%	$10,150.00	
Total Row		$3,884,697.38					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$6,000.00	$6,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	40%	40%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$3,722,564.27	95.83%	OP-AO INN Deductible
Copayment	$132,777.74	3.42%	Fail
Coinsurance	$3,725,218.50	95.89%	OP-AO INN Coinsurance
OOPM	$3,884,697.38	100.00%	OP-AO INN OOPM
Total Projected	$3,884,697.38		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$6,000.00	$3,722,564.27	100.00%	$6,000.00	
Total	$3,722,564.27	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			
Total	$0.00	0.00%		

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

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
40%	$3,725,218.50	100.00%	40%	
Total	$3,725,218.50	100.00%		

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$3,884,697.38	100.00%	$10,150.00	
Total	$3,884,697.38	100.00%		

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Silver (73% CSR) *<<<<This will auto populate from summary sheet macro*
Plan ID: 18581WA0140002_(73%_CSR) *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: 73% CSR *<<<<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 1: D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	No	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combined							
Outpatient - Office Visits Separate							
Outpatient - Office Visits	No	Yes			Pass		Pass
Outpatient - All Other	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>>> Home | Errors found: 0

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

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

Benefit Classification: (1) Inpatient, In-Network (IP INN)

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_P1

Number of Rows: 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,*
Inpatient Hospital Services (e.g., Hospital Stay)	Copay per day, max 5 copays per stay, after deductible	$83.59	$2,500.00	$800.00	N/A	$7,950.00	
Skilled Nursing Facility	Copay per day, after deductible	$0.42	$2,500.00	$800.00	N/A	$7,950.00	
Hospice	Copay per day, before and after deductible	$0.06	$0.00	$30.00	N/A	$7,950.00	
All Other EHBs - Inpatient	Coinsurance after deductible	$8.15	$2,500.00	N/A	30%	$7,950.00	
Total Row		$92.22					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$2,500.00	$2,500.00	Pass
Copayment	$800.00	$800.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,950.00	$7,950.00	Pass
Overall			**Pass**

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$92.16	99.93%	IP INN Deductible
Copayment	$84.07	91.16%	IP INN Copayment
Coinsurance	$8.15	8.84%	Fail
OOPM	$92.22	100.00%	IP INN OOPM
Total Projected	$92.22		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP INN) | Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,500.00	$92.16	100.00%	$2,500.00	
Total	$92.16	100.00%		

Copayment ---- (1) Inpatient, In-Network (IP INN) | Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$30.00	$0.06	0.07%	$30.00	
$800.00	$84.01	99.93%	$800.00	
Total	$84.07	100.00%		

Coinsurance ---- (1) Inpatient, In-Network (IP INN) | Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

OOPM ---- (1) Inpatient, In-Network (IP INN) | Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$7,950.00	$92.22	100.00%	$7,950.00	
Total	$92.22	100.00%		

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

Click>>>>> Home | Errors found: 0

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

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

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

Classification	Outpatient - Office Visits	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 8

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	No Cost-Share *(If true,*
Primary Care Visit to Treat an Injury or Illness - Visits 1-2	Copay before and after deductible	$15.12	$0.00	$1.00	N/A	$7,950.00	
Primary Care Visit to Treat an Injury or Illness - Visits 3+	Copay before and after deductible	$5.04	$0.00	$20.00	N/A	$7,950.00	
Specialist Visit	Copay before and after deductible	$17.20	$0.00	$65.00	N/A	$7,950.00	
Rehabilitative Speech Therapy	Copay before and after deductible	$0.44	$0.00	$40.00	N/A	$7,950.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay before and after deductible	$3.99	$0.00	$40.00	N/A	$7,950.00	
Preventive Care/Screening/Immunization	No cost share	$14.16	$0.00	N/A	N/A	$7,950.00	x
Other Practitioner Office Visit	Copay before and after deductible	$0.20	$0.00	$20.00	N/A	$7,950.00	
Hearing Exams	Copay before and after deductible	$0.23	$0.00	$20.00	N/A	$7,950.00	
Total Row		$56.38					

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

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$20.00	$40.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,950.00	$7,950.00	Pass
Overall			**Pass**

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

Enter Footnotes (as needed) about MHSUD Cost Shares
Testing has been completed using MH/SUD OV copay for visits 3+, which is higher than the $1 copay for visits 1-2 and thus represents a "safe harbor."

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

Deductible	$0.00	0.00%	Fail
Copayment	$42.22	74.88%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$56.38	100.00%	OP-OV INN OOPM
Total Projected	$56.38		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$56.38	100.00%		
Total	$56.38	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) | Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$1.00	$15.12	35.81%	$1.00	
$20.00	$5.47	12.96%	$20.00	
$40.00	$4.43	10.49%	$40.00	
$65.00	$17.20	40.74%		
Total	$42.22	100.00%		

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

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
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 & Smaller	Error Checking
$7,950.00	$56.38	100.00%	$7,950.00	
Total	$56.38	100.00%		

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

Click>>>>> Home | Errors found: 0

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

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

Benefit Classification: (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 14

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	No Cost-Share *(If true,*
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$13.56	$2,500.00	N/A	30%	$7,950.00	
Laboratory Outpatient and Professional Services	Copay before and after deductible	$18.53	$0.00	$40.00	N/A	$7,950.00	
X-rays and Diagnostic Imaging	Copay before and after deductible	$12.31	$0.00	$65.00	N/A	$7,950.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay after deductible	$51.31	$2,500.00	$600.00	N/A	$7,950.00	
Outpatient Surgery Physician/Surgical Services	Copay after deductible	$10.73	$2,500.00	$200.00	N/A	$7,950.00	
Urgent Care	Copay before and after deductible	$3.22	$0.00	$65.00	N/A	$7,950.00	
DME	Coinsurance after deductible	$3.75	$2,500.00	N/A	30%	$7,950.00	
Home Health	Copay before and after deductible	$1.42	$0.00	$30.00	N/A	$7,950.00	
Abortion for Which Public Funding Is Prohibited	No cost share	$0.65	$0.00	N/A	N/A	$7,950.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$0.19	$0.00	N/A	N/A	$7,950.00	x
Hearing Aids	Coinsurance before and after deductible	$0.09	$0.00	N/A	30%	$7,950.00	
Artificial Insemination	Coinsurance after deductible	$0.05	$2,500.00	N/A	30%	$7,950.00	
Human Donor Milk	No cost share	$0.09	$0.00	N/A	N/A	$7,950.00	x
All Other EHBs - Outpatient	Coinsurance after deductible	$20.02	$2,500.00	N/A	30%	$7,950.00	
Total Row		$135.92					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	$2,500.00	Pass
Copayment	$30.00	$600.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,950.00	$7,950.00	Pass
Overall			**Pass**

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$99.42	73.15%	OP-AO INN Deductible
Copayment	$97.52	71.75%	OP-AO INN Copayment
Coinsurance	$37.47	27.57%	Fail
OOPM	$135.92	100.00%	OP-AO INN OOPM
Total Projected	$135.92		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,500.00	$99.42	100.00%	$2,500.00	
Total	$99.42	100.00%		

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$30.00	$1.42	1.46%	$30.00	
$40.00	$18.53	19.00%	$40.00	
$65.00	$15.53	15.92%	$65.00	
$200.00	$10.73	11.00%	$200.00	
$600.00	$51.31	52.61%	$600.00	
Total	$97.52	100.00%		

Coinsurance ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) | Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$7,950.00	$135.92	100.00%	$7,950.00	
Total	$135.92	100.00%		

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Silver (87% CSR) *<<<<This will auto populate from summary sheet macro*
Plan ID: 18581WA0140002_(87%_CSR) *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: 87% CSR *<<<<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: D1. In-Network	D. By Network: D2. Out-of-Network	E. Test Results
Inpatient	No	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combined							
Outpatient - Office Visits Separate							
Outpatient - Office Visits	No	Yes			Pass		Pass
Outpatient - All Other	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>>> Home | Errors found: 0

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

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

Benefit Classification: (1) Inpatient, In-Network (IP INN)

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_P1

Number of Rows: 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,*
Inpatient Hospital Services (e.g., Hospital Stay)	Copay per day, max 5 copays per stay, after deductible	$6,115,507.42	$750.00	$425.00	N/A	$2,850.00	
Skilled Nursing Facility	Copay per day, after deductible	$30,534.39	$750.00	$425.00	N/A	$2,850.00	
Hospice	Copay per day, before and after deductible	$4,656.39	$0.00	$10.00	N/A	$2,850.00	
All Other EHBs - Inpatient	Coinsurance after deductible	$595,934.72	$750.00	N/A	20%	$2,850.00	
Total Row		$6,746,632.92					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	$750.00	$750.00	Pass
Copayment	$425.00	$425.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,850.00	$2,850.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$6,741,976.53	99.93%	IP INN Deductible
Copayment	$6,150,698.20	91.17%	IP INN Copayment
Coinsurance	$595,934.72	8.83%	Fail
OOPM	$6,746,632.92	100.00%	IP INN OOPM
Total Projected	$6,746,632.92		

Step 2 Predominant Level

Deductible ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different deductible amounts from smallest to largest.

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$750.00	$6,741,976.53	100.00%	$750.00	
Total	$6,741,976.53	100.00%		

Copayment ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10.00	$4,656.39	0.08%	$10.00	
$425.00	$6,146,041.81	99.92%	$425.00	
Total	$6,150,698.20	100.00%		

Coinsurance ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

OOPM ---- (1) Inpatient, In-Network (IP INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,850.00	$6,746,632.92	100.00%	$2,850.00	
Total	$6,746,632.92	100.00%		

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

Click>>>>> Home | Errors found: 0

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

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

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

Classification	Outpatient - Office Visits	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 8

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	No Cost-Share *(If true,*
Primary Care Visit to Treat an Injury or Illness - Visits 1-2	Copay before and after deductible	$1,106,278.69	$0.00	$1.00	N/A	$2,850.00	
Primary Care Visit to Treat an Injury or Illness - Visits 3+	Copay before and after deductible	$368,759.56	$0.00	$5.00	N/A	$2,850.00	
Specialist Visit	Copay before and after deductible	$1,258,166.47	$0.00	$30.00	N/A	$2,850.00	
Rehabilitative Speech Therapy	Copay before and after deductible	$32,414.83	$0.00	$20.00	N/A	$2,850.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay before and after deductible	$292,194.33	$0.00	$20.00	N/A	$2,850.00	
Preventive Care/Screening/Immunization	No cost share	$1,036,198.52	$0.00	N/A	N/A	$2,850.00	x
Other Practitioner Office Visit	Copay before and after deductible	$14,566.16	$0.00	$5.00	N/A	$2,850.00	
Hearing Exams	Copay before and after deductible	$16,987.01	$0.00	$5.00	N/A	$2,850.00	
Total Row		$4,125,565.57					

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

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$5.00	$20.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,850.00	$2,850.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
Testing has been completed using MH/SUD OV copay for visits 3+, which is higher than the $1 copay for visits 1-2 and thus represents a "safe harbor."

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

Deductible	$0.00	0.00%	Fail
Copayment	$3,089,367.05	74.88%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$4,125,565.57	100.00%	OP-OV INN OOPM
Total Projected	$4,125,565.57		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$4,125,565.57	100.00%		
Total	$4,125,565.57	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$1.00	$1,106,278.69	35.81%	$1.00	
$5.00	$400,312.73	12.96%	$5.00	
$20.00	$324,609.16	10.51%	$20.00	
$30.00	$1,258,166.47	40.73%		
Total	$3,089,367.05	100.00%		

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

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
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 & Smaller	Error Checking
$2,850.00	$4,125,565.57	100.00%	$2,850.00	
Total	$4,125,565.57	100.00%		

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

Click>>>>> Home | Errors found: 0

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

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

Benefit Classification: (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 14

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	No Cost-Share *(If true,*
Imaging (CT/PET Scans, MRIs)	Coinsurance after deductible	$991,726.76	$750.00	N/A	20%	$2,850.00	
Laboratory Outpatient and Professional Services	Copay before and after deductible	$1,355,616.84	$0.00	$20.00	N/A	$2,850.00	
X-rays and Diagnostic Imaging	Copay before and after deductible	$900,412.75	$0.00	$40.00	N/A	$2,850.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay after deductible	$3,754,302.48	$750.00	$325.00	N/A	$2,850.00	
Outpatient Surgery Physician/Surgical Services	Copay after deductible	$785,138.36	$750.00	$120.00	N/A	$2,850.00	
Urgent Care	Copay before and after deductible	$235,671.94	$0.00	$30.00	N/A	$2,850.00	
DME	Coinsurance after deductible	$274,377.75	$750.00	N/A	20%	$2,850.00	
Home Health	Copay before and after deductible	$104,237.96	$0.00	$10.00	N/A	$2,850.00	
Abortion for Which Public Funding Is Prohibited	No cost share	$47,469.20	$0.00	N/A	N/A	$2,850.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$14,090.69	$0.00	N/A	N/A	$2,850.00	x
Hearing Aids	Coinsurance before and after deductible	$6,794.81	$0.00	N/A	20%	$2,850.00	
Artificial Insemination	Coinsurance after deductible	$3,397.40	$750.00	N/A	20%	$2,850.00	
Human Donor Milk	No cost share	$6,794.81	$0.00	N/A	N/A	$2,850.00	x
All Other EHBs - Outpatient	Coinsurance after deductible	$1,464,760.93	$750.00	N/A	20%	$2,850.00	
Total Row		$9,944,792.68					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	$750.00	Pass
Copayment	$10.00	$325.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,850.00	$2,850.00	Pass
Overall			Pass

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

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

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

Deductible	$7,273,703.68	73.14%	OP-AO INN Deductible
Copayment	$7,135,380.33	71.75%	OP-AO INN Copayment
Coinsurance	$2,741,057.65	27.56%	Fail
OOPM	$9,944,792.68	100.00%	OP-AO INN OOPM
Total Projected	$9,944,792.68		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$750.00	$7,273,703.68	100.00%	$750.00	
Total	$7,273,703.68	100.00%		

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10.00	$104,237.96	1.46%	$10.00	
$20.00	$1,355,616.84	19.00%	$20.00	
$30.00	$235,671.94	3.30%	$30.00	
$40.00	$900,412.75	12.62%	$40.00	
$120.00	$785,138.36	11.00%	$120.00	
$325.00	$3,754,302.48	52.62%	$325.00	
Total	$7,135,380.33	100.00%		

Coinsurance ---- (3b) Outpatient - All Other, In-Network (OP-AO INN) Errors found: 0
Does not apply to substantially all medical/surgical benefits in this classification.
DELETE any values in the left-hand column below.

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,850.00	$9,944,792.68	100.00%	$2,850.00	
Total	$9,944,792.68	100.00%		

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

Issuer / Market: Community Health Plan of Washington
Market: Individual

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

PLAN INFORMATION

Plan Name: Community Health Plan of Washington Cascade Select Silver (94% CSR) *<<<<This will auto populate from summary sheet macro*
Plan ID: 18581WA0140002_(94%_CSR) *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: 94% CSR *<<<<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 1: D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	No	Yes			Pass		Pass
Outpatient							
Outpatient - All Services Combined							
Outpatient - Office Visits Separate							
Outpatient - Office Visits	No	Yes			Pass		Pass
Outpatient - All Other	No	Yes			Pass		Pass

A. Benefit Classification	B. Do the MHSUD cost shares match all Medical/Surgical cost shares in the Benefit Classification?	C. Test Required?	D. Test Results
Emergency Care	Yes	No	Pass
Prescription Drugs	Yes	No	Pass

Benefit Classification (1) Inpatient, In-Network (IP INN)

Click>>>>> Home | Errors found: 0

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

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

Benefit Classification: (1) Inpatient, In-Network (IP INN)

Classification	Inpatient	IP
Network (In/Out)	In-Network	INN
Classification Code	1	IP INN
Table Name		tbl_IPINN_P1

Number of Rows: 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,
Inpatient Hospital Services (e.g., Hospital Stay)	Copay per day, max 5 copays per stay, before and after deductible	$3,394,364.91	$0.00	$100.00	N/A	$2,400.00	
Skilled Nursing Facility	Copay per day before and after deductible	$16,947.88	$0.00	$100.00	N/A	$2,400.00	
Hospice	Copay per day before and after deductible	$2,584.49	$0.00	$5.00	N/A	$2,400.00	
All Other EHBs - Inpatient	Coinsurance before and after deductible	$330,768.94	$0.00	N/A	15%	$2,400.00	
Total Row		$3,744,666.22					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$100.00	$100.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,400.00	$2,400.00	Pass
Overall			Pass

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

*If not applicable, enter "N/A"

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

Deductible	$0.00	0.00%	Fail
Copayment	$3,413,897.28	91.17%	IP INN Copayment
Coinsurance	$330,768.94	8.83%	Fail
OOPM	$3,744,666.22	100.00%	IP INN OOPM
Total Projected	$3,744,666.22		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	[illegible]	[illegible]		
Total	$3,744,666.22	100.00%		

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

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$5.00	$2,584.49	0.08%	$5.00	
$100.00	$3,411,312.79	99.92%	$100.00	
Total	$3,413,897.28	100.00%		

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

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

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

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,400.00	$3,744,666.22	100.00%	$2,400.00	
Total	$3,744,666.22	100.00%		

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

Click>>>>> Home | Errors found: 0

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

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

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

Classification	Outpatient - Office Visits	OP-OV
Network (In/Out)	In-Network	INN
Classification Code	3a	OP-OV INN
Table Name		tbl_OPOVINN_P1

Number of Rows: 7

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	No Cost-Share (If true,
Primary Care Visit to Treat an Injury or Illness	Copay before and after deductible	$818,708.53	$0.00	$1.00	N/A	$2,400.00	
Specialist Visit	Copay before and after deductible	$698,335.53	$0.00	$15.00	N/A	$2,400.00	
Rehabilitative Speech Therapy	Copay before and after deductible	$17,991.60	$0.00	$5.00	N/A	$2,400.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay before and after deductible	$162,180.20	$0.00	$5.00	N/A	$2,400.00	
Preventive Care/Screening/Immunization	No cost share	$575,133.94	$0.00	N/A	N/A	$2,400.00	x
Other Practitioner Office Visit	Copay before and after deductible	$8,084.83	$0.00	$1.00	N/A	$2,400.00	
Hearing Exams	Copay before and after deductible	$9,428.51	$0.00	$1.00	N/A	$2,400.00	
Total Row		$2,289,863.14					

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

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$1.00	$5.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,400.00	$2,400.00	Pass
Overall			Pass

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

*If not applicable, enter "N/A"

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

Deductible	$0.00	0.00%	Fail
Copayment	$1,714,729.20	74.88%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$2,289,863.14	100.00%	OP-OV INN OOPM
Total Projected	$2,289,863.14		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	[illegible]	[illegible]		
Total	$2,289,863.14	100.00%		

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

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$1.00	$836,221.87	48.77%	$1.00	
$5.00	$180,171.80	10.51%	$5.00	
$15.00	$698,335.53	40.73%		
Total	$1,714,729.20	100.00%		

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

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

Coinsurance	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	$0.00			
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 & Smaller	Error Checking
$2,400.00	$2,289,863.14	100.00%	$2,400.00	
Total	$2,289,863.14	100.00%		

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

Click>>>>> Home | Errors found: 0

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

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

Benefit Classification: (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 14

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	No Cost-Share (If true,
Imaging (CT/PET Scans, MRIs)	Coinsurance before and after deductible	$550,450.24	$0.00	N/A	15%	$2,400.00	
Laboratory Outpatient and Professional Services	Copay before and after deductible	$752,424.60	$0.00	$5.00	N/A	$2,400.00	
X-rays and Diagnostic Imaging	Copay before and after deductible	$499,767.10	$0.00	$15.00	N/A	$2,400.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay before and after deductible	$2,083,796.44	$0.00	$100.00	N/A	$2,400.00	
Outpatient Surgery Physician/Surgical Services	Copay before and after deductible	$435,784.95	$0.00	$25.00	N/A	$2,400.00	
Urgent Care	Copay before and after deductible	$130,807.88	$0.00	$15.00	N/A	$2,400.00	
DME	Coinsurance before and after deductible	$152,291.24	$0.00	N/A	15%	$2,400.00	
Home Health	Copay before and after deductible	$57,856.47	$0.00	$5.00	N/A	$2,400.00	
Abortion for Which Public Funding Is Prohibited	No cost share	$26,347.41	$0.00	N/A	N/A	$2,400.00	x
Routine Eye Care and Eye Glasses for Children	No cost share	$7,820.93	$0.00	N/A	N/A	$2,400.00	x
Hearing Aids	Coinsurance before and after deductible	$3,771.40	$0.00	N/A	15%	$2,400.00	
Artificial Insemination	Coinsurance before and after deductible	$1,885.70	$0.00	N/A	15%	$2,400.00	
Human Donor Milk	No cost share	$3,771.40	$0.00	N/A	N/A	$2,400.00	x
All Other EHBs - Outpatient	Coinsurance before and after deductible	$813,004.18	$0.00	N/A	15%	$2,400.00	
Total Row		$5,519,779.94					

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

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical/ Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$5.00	$100.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,400.00	$2,400.00	Pass
Overall			Pass

Enter Footnotes (as needed) about MHSUD Cost Shares
N/A

*If not applicable, enter "N/A"

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

Deductible	$0.00	0.00%	Fail
Copayment	$3,960,437.44	71.75%	OP-AO INN Copayment
Coinsurance	$1,521,402.76	27.56%	Fail
OOPM	$5,519,779.94	100.00%	OP-AO INN OOPM
Total Projected	$5,519,779.94		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
	[illegible]	[illegible]		
Total	$5,519,779.94	100.00%		

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

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

Copayment	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$5.00	$810,281.07	20.46%	$5.00	
$15.00	$630,574.98	15.92%	$15.00	
$25.00	$435,784.95	11.00%	$25.00	
$100.00	$2,083,796.44	52.62%	$100.00	
Total	$3,960,437.44	100.00%		

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

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

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

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,400.00	$5,519,779.94	100.00%	$2,400.00	
Total	$5,519,779.94	100.00%		

April 15, 2025

Christine Gibert
Policy Director
Washington Health Benefit Exchange
Via email: Christine.gibert@wahbexchange.org

RE: CERTIFICATION FOR WAHBE 2026 STANDARD PLAN DESIGNS

At the request of the Washington Health Benefit Exchange (WAHBE), Wakely is providing an actuarial value (AV) certification and unique plan justification for the 2026 standardized plan designs. The 2026 benefit designs were modestly adjusted to fit within the parameters of the revised final 2026 federal AV calculator's (AVC) constraints and to include special cost sharing for office visits for primary care and mental health/substance use disorder (MH/SUD). For 2026, Acumen modified the 2026 standardized plan designs to fit within the actuarial value requirements and made adjustments to the federal AVC for unique plan designs that did not fit into the AVC and could be considered material. Wakely completed a review of Acumen's methodology, conducted reasonability checks, and is certifying the unique plan adjustments and plan actuarial values.

While this memo discusses Acumen's methodology at a high level, it primarily focuses on review completed by Wakely to confirm the reasonability of Acumen's AV estimates. Wakely is providing an actuarial certification for the adjusted actuarial values allowed under 45 CFR §156.135(b) (3) in Appendices A and B. The documentation that Acumen provided on their methodology can be found in the Appendix C.

Our understanding is that WAHBE will use the final certification for plan year 2026. Use of this document for other purposes may not be appropriate. This document, and any accompanying files and correspondence, are intended for WAHBE internal use only and are not meant for broad distribution. The estimates presented here are based on emerging data and information available as of the date of this report.

This memo should only be utilized by qualified individuals with an understanding of the assumptions and limitations of the analysis described in the disclosures section of the memo. If disseminated, the memo should only be shared in its entirety. During the review of the memo, if you should have any questions or would like further clarification, please do not hesitate to contact us via email or phone (contact information available below), and we will be happy to provide assistance.

wakely.com

Washington Health Benefit Exchange

2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification

April 15, 2025

Prepared by:
Wakely Consulting Group, LLC

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Senior Consulting Actuary
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Consulting Actuary

Table of Contents

Background

The Affordable Care Act (ACA) requires that non-grandfathered health care coverage provided by issuers in the individual market cover all essential health benefits (EHBs) and have actuarial values that fall under the platinum (90% AV), gold (80% AV), silver (70% AV) or bronze (60% AV) tiers. The ACA allows for a de minimis range around these target AVs. The final 2026 NBPP did not make any changes to the allowable federal AV range relative to the 2025 NBPP, however final 2026 NBPP parameters are listed here for completeness. The final 2026 NBPP finalized a range of -2% to +2% for most plans. For example, any plan design that has an AV from 78% to 82% is considered a gold plan. Similar to the final 2025 NBPP, the final 2026 NBPP is proposing a smaller range on the lower end for on-Exchange silver plans of 0% to +2% (or an AV between 70% and 72%). Off-Exchange silver plans would continue to be subject to the -2% to +2% range. Bronze plan designs meeting certain criteria are eligible for an expanded range of +5% on the higher end, allowing an AV up to 65% compared to a high end at 62%. Plans that meet these criteria include high deductible health plans and plans that cover at least one major service, other than preventive, prior to the deductible.

The ACA also defines AVs for cost-sharing reduction (CSR) plan variations that are available to individuals meeting income and other eligibility criteria and enrolling in a silver level plan in the individual market. These CSR variation AVs are 73%, 87% and 94%. The final 2026 NBPP allows for a 0% to +1% de minimis range around the target AVs for CSR plans (e.g., 73% to 74% AV for a 73% CSR plan). The plan designs developed by Acumen for 2026 comply with this proposed 2026 AV ranges.

The Center for Consumer Information and Insurance Oversight (CCIIO) provides an Actuarial Value Calculator (AVC)[1] that issuers must use to determine the AV of a plan. While CCIIO developed the AVC such to accommodate most plans, some plan designs have features which are not supported by the AVC. In these instances, an actuary can either modify the inputs to most closely represent the plan design, or an actuary can modify the results of the AVC to account for the features not supported by the AVC. An actuarial certification documenting the development of the AV for these plan designs is required.

Washington Health Benefit Exchange (WAHBE) defines standard plan designs that issuers participating on the Exchange must offer. Standard plan designs are defined for the individual market. For 2026, WAHBE is adding one additional gold standard plan design to supplement the existing three individual market designs for gold, silver (with three corresponding CSR plan levels), and expanded bronze levels.

WAHBE contracted with Acumen to assist with the development and validation of the

[1] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

federal AVs for the 2026 standard plan designs. WAHBE contracted with Wakely to assist in reviewing Acumen's development of the 2026 standard plan designs for reasonability and to certify actuarial values of all standard plan designs, including any unique plan designs. Standard expanded bronze, silver and all silver CSR variants are considered to be unique plan designs. Compliance of the benefit designs in relation to other regulatory benefit design constraints has not been evaluated by Wakely.

For the 2026 standard plans, benefit changes were made to the 2025 standard plans to account for the update to trend made to the revised final 2026 federal AV calculator. 2026 standard plan designs reflect design changes requested by WAHBE and necessary updates made to remain compliant with the revised final 2026 federal AV calculator, as well as the addition of a new low cost gold plan called Vital Gold.

A summary of WAHBE's standard plan designs is in Appendix D. Most of the cost sharing features of 2026 standard plan designs can be accommodated by the revised final federal AVC. However, the plan designs have features not supported by the AVC (defined as a "unique" plan design). The unique plan designs features are:

1. Mixed cost sharing applied to Mental Health/Substance Use Disorder (MH/SUD) outpatient services. The expanded bronze and silver standard plan designs (including 73%, 87%, and 94% CSR variants) have variable cost sharing between MH/SUD services provided in an office setting and other outpatient MH/SUD services (non-office visit). As the AVC only allows a single benefit input for all outpatient MH/SUD services, this tiered design also constitutes a unique benefit design.
2. The first two PCP and MH/SUD office visits have a $1 copay. Expanded bronze and silver standard designs (including non-94% CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.

The adjustment made to the AVC by Acumen addresses both unique plan designs features and is described below. A summary of WAHBE's 2026 standard plan designs is included in Appendix D.

Methodology

Wakely is providing an actuarial certification for all standard plan designs, including those that utilize adjusted actuarial values allowed under 45 CFR § 165.135(b)(3) in Appendices A and B. Acumen utilized the revised final 2026 federal AVC to determine the AV for all plans, entering plan designs to the extent that they fit the AVC. Screen shots of the unadjusted AVC inputs and outputs for plan designs that were

accommodated by the AVC and the adjusted AVC screenshots provided and developed by Acumen can both be found in Appendix E. The first set of screenshots displays outputs from the revised final 2026 AVC for each standard plan design. The second set of screenshots, captioned as “Adjusted”, displays output from a custom modified version of the AVC constructed using the methodology described briefly below and in more detail in Appendix C.

Both the complete gold standard and vital gold standard plans have no features deviating from the parameters of the AVC and were entered by Acumen into the AVC with no modifications. Acumen adjusted the other resulting AVs for the plan design features that deviate from the parameters of the AVC. For the expanded bronze standard and silver standard plan designs (including 73%, 87%, and 94% CSR variants), separate cost sharing values will apply for MH/SUD services obtained in an office setting versus other outpatient services. The AVC allows for only a single benefit input for MH/SUD outpatient services. For the expanded bronze and silver standard plans (including the 73% and 87% CSR variants), the AVC does not accommodate plan designs with a specified number of upfront $1 copay visits for MH/SUD visits or for primary care visits. The adjustment that Acumen calculated to account for both unique benefit features is described below.

To modify the AVC to account for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables. In the medical and combined continuance tables in the AVC, Acumen estimated the proportion of utilization and allowed cost attributable to MH/SUD in an office setting and combined the MH/SUD office visits with primary care office visits utilization and allowed cost. Acumen then modified the cost and frequency columns associated with the number of primary care visits exceeding a specified number of visits by applying the original ratio of these quantities to total primary care columns to the modified primary care columns including MH/SUD office visits amounts.

The main assumption made by Acumen is that the number of MH/SUD office visits exceeding a specified number of visits will follow a similar distribution as the primary care visits. Data analyzed by Wakely in the past showed that the large portion of the primary care office visits utilization is between 1-2 visits per year. For MH/SUD office visits services, while utilization is lower due to fewer members seeking the services; however, for members that do use services, the number of services exceed 1-2 per year. The assumption made by Acumen that the distributions are similar results in a larger impact to the AV than it otherwise would, as $1 copay would apply to a higher proportion of the total MH/SUD visits, thus resulting in a higher calculated AV than we think is likely to actually occur.

The sensitivity testing Wakely performed considered the lower and the upper bounds of a reasonable AV range and found the adjusted AV falling in the compliant range for the Silver 87% and 94% plans thus this assumption would not alter the AV categorization of those plans. The Silver 73%, Silver Standard and Bronze plans upper bounds were above the de minimis range and are discussed more later in this certification.

The AVC field "Begin Primary Cost-Sharing After a Set Number of Visits" effectively became "Begin Primary and MH/SUD Cost-Sharing After a Set Number of Visits" with this change, along with revising the $0 copay associated with this feature to a $1 copay. Acumen used the version of the AVC with revised continuance tables to calculate the adjusted AVs. This change was only made for the expanded bronze, silver, and silver CSR variants standard plans since the first two $1 copay PCP and MH/SUD visits feature does not apply to the two gold standard plans.

Table 1 shows the actuarial values determined by the original federal revised final 2026 AVC, including the unadjusted actuarial value for the two standard gold plans that Wakely is certifying and the adjusted actuarial values for the standard silver, standard silver CSR variants, and standard expanded bronze plans, that Acumen calculated and Wakely is certifying after the application of the adjustment factor.

Table 1 – Summary of Original and Adjusted Federal AVs

Standard Plan	AV from Original AVC	AV from Acumen Adjusted AVC	Adjustment Factor
Standard Complete Gold (no adjustment needed)	81.81%		
Standard Vital Gold (no adjustment needed)	78.06%		
Standard Silver*	71.33%	71.84%	1.005
Standard Silver, 73% AV CSR Variation*	73.49%	73.95%	1.005
Standard Silver, 87% AV CSR Variation*	87.78%	87.87%	1.005
Standard Silver, 94% AV CSR Variation	94.76%	94.86%	1.005
Standard Expanded Bronze*	63.64%	64.97%	1.021

** Note that the AVs in these rows were developed with two upfront no-cost PCP visits.*

Wakely believes that the methodology that Acumen used to adjust the AVs is appropriate based on the reasonability testing of Acumen's adjusted AVs. To determine whether the adjusted AVs were reasonable, Wakely tested three alternative plan designs in the original AVC that would serve as the boundary cases for the adjusted AVs. The expectation was that the adjusted AV should fall within the range of AVs produced by these alternative boundary cases. Wakely ran this test for all standard plans that offer the two MH/SUD $1 copay visits (all except the two gold designs). Two boundary designs were needed for all plans other than expanded bronze, where three boundary designs

were considered.

The three alternative boundary plan designs used to test the reasonable AV range were as follows:

1. 2026 standard plan designs for each metal, with the same cost sharing applied to all PCP and outpatient MH/SUD services. For the expanded bronze plan design, two lower boundary designs were included:

    (a) a design with the deductible and coinsurance cost sharing applied to all outpatient MH/SUD services; and

    (b) a design with $40 copay cost sharing applied to all PCP visits and outpatient MH/SUD services.

2. 2026 standard plan designs for each metal, with $0 cost-sharing applied to first two PCP visits and all outpatient MH/SUD services. This is a richer boundary case than $1 copay, but the AVC does not allow for a $1 copay for initial visits. As such, this provides the closest boundary case within the design of AV calculator.

Wakely modeled each of these plan designs in the 2026 federal revised final AV calculator. For the expanded bronze plan, the AV for the mixed cost sharing applied to outpatient MH/SUD services (copay for office visits and deductible and coinsurance for all other services) would be a weighted average of the two AVs produced in (1a) and (1b). The resulting AVs are presented in the Table 2 below.

For all plans above, Acumen's 2026 adjusted AV falls within the AV range produced by the lower and upper boundary plan designs. For expanded bronze plan, the adjusted actuarial value exceeds both lower bound AVs with different types of cost sharing applied to all MH/SUD outpatient services (copays and deductible / coinsurance). Considering the range of AVs created by these two plans was narrow and considering that the adjusted AV logically fell within this range, Wakely deemed the adjusted AVs calculated by Acumen to be reasonable and actuarially sound.

Table 2 – Summary of Original and Adjusted Federal AVs

Standard Plan	2026 Adjusted AV	Low Boundary Plan/s (Standard Copays on all PCP and MH/SUD Visits)	Upper Boundary Plan (Zero Cost Sharing on all MH/SUD Visits and Two PCP Visits)
Standard Silver	71.84%	71.08%	72.13%
Standard Silver, 73% AV CSR Variation	73.95%	73.27%	74.21%
Standard Silver, 87% AV CSR Variation	87.87%	87.74%	87.93%
Standard Silver, 94% AV CSR Variation	94.86%	94.76%	94.91%
Standard Bronze (a) – Ded/Coins for MH/SUD	64.97%	63.08%	65.61%
Standard Expanded Bronze (b) – Copay for MH/SUD	64.97%	64.19%	65.61%

Note that the upper bound of the silver CSR 73% variation, the silver standard, and the standard expanded bronze AVs all fall above the de minimis range. However, the application of normal copays on the PCP and MH/SUD visits after the first two (and for expanded bronze, deductible/coinsurance cost sharing on OP Facility MH/SUD) would decrease the plan richness and the AV below the maximum levels (see below and Table 3 for additional detail).

To test this conclusion, Wakely tested best estimate alternative designs by calculating blended best estimate PCP and MH/SUD copay. We used a percentage of utilization of PCP office visit utilization for the first two visits (56.0% based on silver combined claim probability distribution (CPD) for PCP utilization, 59.2% based on the bronze combined CPD for PCP utilization[2]) and the percentage of OP MH/SUD utilization that is office visits (89.0% based on Acumen estimates and the AV Calculator CPD)[3] as the starting point.

As discussed above, for this plan the Acumen assumption around MH/SUD annual utilization could potentially be impactful, as we think that assumption overstates AVs

[2] These values were calculated by taking the ratio of the final value in the "Silver Combined" or "Bronze combined" sheet PCP Silver Frequency column (J170) and the final value in the "Primary Care >2 Visits" column (CF170) to get the proportion of PCP visits that are the first two visits a member has.

[3] Acumen stated that 90.0% of professional MH/SUD services were office visits and 63.4% of facility MH/SUD services were office visits. Using the AVC Silver Combined sheet cells AV170 and AX170 for MH/SUD facility/professional utilization split, we can see that 96.3% of total MH/SUD visits come from professional services with the remaining 3.7% coming from facility services. Taking the sum-product of those numbers gives us 89.0% of MH/SUD services that are office visits (96.3% x 90.0% + 3.7% x 63.4%).

versus actual experience which will have a lower percentage of office visits be the first two for a member in a given year. We found a revised assumption for that percentage by utilizing our WACA 2019 ACA Data (see Data and Reliance section) to calculate the proportion of MH/SUD office visit utilization that takes place in a member's first two visits (24.1%).

Using these assumptions, a revised blended cost sharing was calculated for a PCP visit for each of the three plans and is presented in Table 3 below. All final calculated AVs are within the de minimis range.

Table 3 – Summary of Calculations for Blended Copay AVs

	Description	Silver 73%	Silver	Expanded Bronze	Calculation
(1)	% of PCP Visits at $1 cost sharing	56.0%	56.0%	59.2%	
(2)	% of PCP Visits at full cost sharing	44.0%	44.0%	40.8%	1-(1)
(3)	Office Visit % of OP MH/SUD Util	89.0%	89.0%	89.0%	
(4)	All Other % of OP MH/SUD Util	11.0%	11.0%	11.0%	1-(3)
(5)	% of OP MH/SUD Office Visits at $1 cost sharing	24.1%	24.1%	24.1%	
(6)	% of OP MH/SUD Office Visits at full cost-sharing	75.9%	75.9%	75.9%	1-(5)
(7)	PCP Copay (after first two visits)	$20	$20	$40	
(8)	OP Office Visit MH/SUD Copay (after first two visits)	$20	$20	$40	
(9)	OP All Other MH/SUD Cost Sharing	$30	$30	Deductible / 40% Coins	
(10)	Estimated Blended PCP Copay	$9.36	$9.36	$16.90	$1x(1) + (7)x(2)
(11)	Estimated Blended OP MH/SUD Office Visit Copay	$15.42	$15.42	$30.60	$1x(5) + (8)x(6)
(12)	Total Blended OP MH/SUD Copay	$17.03	$17.03	NA	(11)x(3) + (9)x(4)
(13)	AV With All Blended Copays (PCP and OP MH/SUD)	**73.8%**	**71.7%**	64.9%	
(14)	Expanded Bronze AV with Ded/Coins for OP MH/SUD	NA	NA	63.6%	
(15)	Expanded Bronze Blended AV	NA	NA	**64.7%**	(13)x(3) + (14)x(4)

Disclosures and Limitations

Responsible Actuary. Ksenia Whittal and Darren Johnson are the actuaries responsible for this communication. We are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the use of WAHBE, Washington Office of the Insurance Commissioner (OIC), Acumen and WAHBE issuers. Wakely does not intend to benefit third parties and assumes no duty or liability to those third parties. Any third parties receiving this work should consult their own experts in interpreting the results. This report, when distributed, must be provided in its entirety and include caveats regarding the variability of results and Wakely's reliance on information provided by WAHBE.

Risks and Uncertainties. The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from any estimates. Wakely does not warrant or guarantee that actual experience will tie to the AV estimated for the placement of plan designs into tiers. The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan or pricing AV used to determine premium rates. Actual AVs will vary based on a plan's specific population, utilization, unit cost, and other variables. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from WAHBE and Acumen.

Data and Reliance. Wakely relied on information supplied by Acumen and WAHBE in this assignment. Wakely has reviewed the data and methodology for reasonableness but has not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, these estimates may be impacted, potentially significantly. Any errors in the data will affect the accuracy of the analysis and the conclusions drawn in this report. When performing financial and actuarial analyses on the current data, assumptions must be made where there is

incomplete data. Improvements in data will allow for more accurate analyses and consistent reporting. Below is a list of data and assumptions provided by others and assumptions required by law.

- The 2026 revised final federal AVC Model was relied on for the AV calculations. While reasonability tests have shown there are some assumptions and methodologies that are not consistent with expectations, the AVC was developed for plan classification and not pricing. Thus, the model is being used as such and Wakely makes no warranties for the accuracy of the AVs that result from the AVC.
- The AVC adjustment methodology provided and developed by Acumen (included in Appendix C).
- The unadjusted and adjusted AVC screenshots provided and developed by Acumen (included in Appendix E).
- 2026 WAHBE standard plan benefit designs provided by WAHBE (included in Appendix D).

In addition, we relied on the Wakely ACA Database (WACA) for our MH/SUD visit assumption. This is an aggregated database based on de-identified EDGE Server input and output files (including enrollment, claims, and pharmacy data) from the 2019 benefit year submitted through April 2020, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 4 million lives from the individual and small group ACA markets. The de-identification applies to identifiers specific to enrollee, issuer, and location. We performed reasonability tests on the data but did not audit or verify the data.

Potential limitations of the WACA data include but are not limited to the following:

- Results will be affected by issuer-specific data management. Omitted claims, erroneously coded claims, erroneous enrollment records, and other data issues may not reflect actual ACA cost and diagnosis experience.
- A subset of issuers nationwide submitted data to the database. We believe the database represents a fair cross-section of nationwide experience, but limitations in this regard will affect results.
- We excluded data for both enrollees in American Indian (limited/no-cost sharing) CSR plans and enrollees in Medicaid Private Option plans (these only occur in a few states).

Contents of Actuarial Report. This document and the supporting exhibits constitute the entirety of the actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in

compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. In developing these standard plan designs and the resulting actuarial certification, Wakely followed applicable Actuarial Standards of Practice (ASOP) including:

ASOP No. 23 Data Quality;
ASOP No. 25 Credibility Procedures;
ASOP No. 41 Actuarial Communications;
ASOP No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act; and
ASOP No. 56 Modeling.

Appendix A contains the formal actuarial certification. If you have any questions regarding this letter or the certification, please contact us.

Sincerely,

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
720-282-4965

Darren Johnson, FSA, MAAA
Consulting Actuary
720-206-1391

Appendix A - Actuarial Value Certification

Washington Health Benefit Exchange Standard Plan Designs Effective January 1, 2026

I, Ksenia Whittal, am associated with the firm of Wakely Consulting Group, LLC, an HMA Company (Wakely), am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by Washington Health Benefit Exchange (WAHBE) to provide a certification of the adjusted actuarial value of the standard plan designs offered through WAHBE that are effective January 1, 2026. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the adjusted actuarial values provided with this certification are considered actuarially sound for purposes of 45 CFR § 156.135(b), according to the following criteria:

- The revised final 2026 federal Actuarial Value Calculator was used to determine the AV for the plan provisions that fit within the calculator parameters;
- Appropriate adjustments were calculated, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator;
- The actuarial values have been developed in accordance with generally accepted actuarial principles and practices; and
- The actuarial values meet the requirements of 45 CFR § 156.135(b).

The assumptions and methodology used to develop the actuarial values have been documented in this report. The actuarial values associated with this certification are for the 2026 WAHBE standard expanded bronze, silver, silver 73% CSR, silver 87% CSR, silver 94% CSR, vital gold and complete gold plan designs that will be effective as of January 1, 2026 for individual coverage sold on the Washington Health Benefit Exchange.

The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan. Actual AVs will vary based on a plan's specific population, utilization, unit cost and other variables.

In developing this opinion, I have relied upon the final federal Actuarial Value calculator and the adjustment methodology provided by Acumen. Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
Wakely Consulting Group, LLC, an HMA Company
April 15, 2025

Appendix B - Unique Plan Design Supporting Documentation and Justification

Applicable Plans: 2026 Standard Silver, the Silver 73% CSR, the Silver 87% CSR, the Silver 94% CSR and the Expanded Bronze Standard Option

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator, and the materiality of those benefits): For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, and Silver 87% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature.

Acceptable alternate method used per 156.135(b) (2) or 156.135(b) (3): Method 156.135(b) (3) was utilized in developing the actuarial values for the plans.

Confirmation that only in-network cost-sharing, including multitier networks, was considered: Only in-network cost sharing was considered in the development of the actuarial values.

Description of the standardized plan population data used: Acumen used the data underlying the continuance tables in the 2026 federal AV calculator.

If the method described in 156.135(b) (2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator: n/a

If the method described in 156.135(b) (3) was used, a description of the data and method used to develop the adjustments: Acumen developed adjustments to the continuance tables in AVC to accommodate the unique plan design features. Wakely did not replicate these changes but rather performed reasonability testing of Acumen's methodology by testing three sets of alternative plan designs in the original AVC that would serve as the boundary cases for the adjusted AVs. The expectation was that the adjusted AV should fall within the range of AVs produced by these alternative boundary cases. Wakely tested all standard plans that offer the first two PCP and two MH/SUD at a $1 copay visits (all except both gold designs).

The three alternative boundary plan designs used to test the reasonable AV range were as follows:

1. 2026 standard plan designs for each metal, with the same cost sharing applied to all PCP and outpatient MH/SUD services. For the expanded bronze plan design, two boundary designs were included:
    (a) a design with the deductible and coinsurance cost sharing applied to all outpatient MH/SUD services; and
    (b) a design with $40 copay cost sharing applied to all PCP visits and outpatient MH/SUD services.
2. 2026 standard plan designs for each metal, with $0 cost-sharing applied to first two PCP

visits and all outpatient MH/SUD services. This is a richer boundary case than $1 copay but the AVC does not allow for a $1 copay for initial visits. As such, this provides the closest boundary case within the design of AV calculator.

Wakely modeled each of these plan designs in the revised final 2026 federal AV calculator. For the expanded bronze plan, the AV for the mixed cost sharing applied to outpatient MH/SUD services (copay for office visits and deductible and coinsurance for all other services) would be a weighted average of the two AVs produced in (1a) and (1b). For all plans above, Acumen's 2026 adjusted AV falls within the AV range produced by the lower and upper boundary plan designs. For the expanded bronze plan, the adjusted actuarial value exceeds both lower bound AVs with different types of cost sharing applied to all MH/SUD outpatient services (copays and deductible / coinsurance). Considering the range of AVs created by these two plans was narrow and considering that the adjusted AV logically fell within this range, Wakely deemed the adjusted AVs calculated by Acumen to be reasonable and actuarially sound.

Note that the upper bound of the silver CSR 73% variation, the silver standard, and the standard expanded bronze AVs all fall above the de minimis range. Wakely tested an alternative design for each of these by calculating a blended best estimate PCP and MH/SUD copay using an alternative assumption for the portion of MH/SUD annual utilization for the first two visits for a member in a given year. For the expanded bronze plan, this result was further blended with the alternative plan design that treated all OP MH/SUD as subject to the deductible and coinsurance. Using these assumptions, a revised blended cost sharing for PCP and MH/SUD yielded close to best estimate actuarial values within the de minimis ranges for each of the three impacted plans. Since both Acumen and Wakely methodologies resulted in compliant AVs we can thus be confident the WAHBE Standard Plans are within the de minimis range.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b) (2) or 156.135(b) (3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV.

The analysis was

(i) conducted by a member of the American Academy of Actuaries; and

(ii) performed in accordance with generally accepted actuarial principles and methodologies.

Actuary signature: 

Actuary Printed Name: Ksenia Whittal, FSA, MAAA

Date: April 15, 2025

Appendix C - Acumen's Actuarial Value Calculator Modification Methodology Memorandum

(Begins on next page)

MEMORANDUM

ACUMEN
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TO: Christine Gibert, Kristin Villas, WAHBE
FROM: Acumen, LLC
DATE: April 4, 2025
SUBJECT: 2026 Actuarial Value Calculator Modification Methodology

Acumen utilized a modified version of the Revised Final 2026 Actuarial Value Calculator (AVC) to estimate the actuarial value (AV) of proposed 2026 standard plan designs, some of which feature unique plan designs. The plan designs in question allow issuers to set different cost sharing for mental health/substance use disorder (MHSUD) office visits and MHSUD outpatient visits as well as allow enrollees to have up to two office visits of each type (primary care and MHSUD) with a $1 copay before the enrollee is responsible for a higher copay. While the standard AVC supports plan designs with a specified number of upfront no-copay visits for primary care, it does not support this feature for MHSUD office visits and it does not support $1 visits followed by a different copay. By utilizing the built-in upfront cost-sharing option for primary care as a starting point, Acumen modified the AVC to account for both types of office visits and for differential copays to calculate the AV of this plan design. In a separate workbook titled *"2026Designs_Screenshots_Revised_Final_2026AVC.xlsx"*, Acumen has included the screenshots of all standard plans for all metal levels to show how these plans are entered in the modified version of the Revised Final 2026 AVC and the original Revised Final 2026 AVC.

Modifications for Office Visit Cost-Sharing

There were three steps in the primary care and MHSUD AVC modification that Acumen performed, following the same methodology utilized to make relevant adjustments to the Final AVCs in previous years. First, in each medical and combined continuance table in the AVC, Acumen estimated the proportion of utilization and spending in the MHSUD professional and facility category that was accounted for by office visits, then combined these office visits with the primary care office visits fields. Acumen then allocated this combined field among the "Primary Care > N Visits" fields to create "Primary Care > N Visits & MHSUD > N Visits" fields. Finally, Acumen modified the algorithm underlying the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost sharing option to instead use $1 copays for the inputted number of visits, rather than having the visits be no-cost to the enrollee. Thus, by modifying the underlying fields and algorithm, Acumen leveraged the existing special cost-sharing feature in the AVC to calculate the AV of the plan design. The remainder of this section provides more details on each of these steps.

The MHSUD columns in each medical and combined continuance table in the AVC describe the frequency and cost of outpatient professional and facility services related to

MHSUD. Office visits are just one component of these fields, so Acumen had to first estimate the proportion of these MHSUD columns that were made up of office visits. To do this, Acumen utilized the EDGE 2021 Limited Dataset (EDGE LDS)[1], which is a claims database reflecting the individual and small group markets nationwide, available for purchase on the CMS website.

Using categorization logic similar to that used in the construction of the continuance tables underlying the AVC, Acumen first identified MHSUD-related claims in the EDGE LDS using a combination of revenue codes, place of service, HCPCs, and diagnoses appearing on the claim. Acumen then further identified the office visit claims among these by using both BETOS and Restructured BETOS Classification System (RBCS) codes. Finally, Acumen reweighted the data using the AVC standard population and calculated the proportion of MHSUD outpatient professional and facility claims that consisted of office visits. Proportions were calculated for utilization as well as costs and can be viewed in Table 1 below[2]. These derived proportions were then applied to the "Mental Health – OP Facility", "Avg. Mental Health – OP Facility Freq.", "Mental Health – OP Prof", and "Avg. Mental Health – OP Prof Freq." columns in the AVC medical and combined continuance tables to estimate MHSUD office visit cost and frequency. Once these values were calculated, they were subtracted from the existing MHSUD columns and added to the existing "Primary Care" and "Avg. Primary Care Freq" columns in the continuance table to create modified versions of these columns.

Table 1: Percentage of MHSUD utilization and cost AVC categories calculated to involve office visits

Category	Percentage of Category Considered Office Visit
MHSUD Outpatient Facility Utilization	63.41%
MHSUD Outpatient Professional Utilization	90.02%
MHSUD Outpatient Facility Allowed Cost	54.29%
MHSUD Outpatient Professional Allowed Cost	83.23%

Next, all "Primary Care > N Visits" and "Primary Care > N Visits Freq." columns were modified. These fields are specifically used by the AVC when an AVC user engages the "Begin

[1] Although the 2022 LDS data was the most recent EDGE LDS dataset available at the time the Revised Final 2026 AV Calculator was released, Acumen chose to use the 2021 EDGE LDS data because it corresponds to the same year of EDGE data used in the Revised Final 2026 AV Calculator.

[2] Compared to the 2025 calculator, MHSUD office visit facility utilization increased from 12.65% to 63.41%, and allowed costs increased from 7.6% to 54.29%. This significant increase is attributable to two factors: (1) the 2025 percentages were calculated using the 2019 EDGE LDS data, whereas the 2026 percentages were based on the 2021 EDGE LDS data; and (2), the 2021 EDGE LDS data shows a sharp decline in non-office visit facility claims, causing overall facility utilization to decline from 24.18 claims per 1,000 member-months in 2019 to 3.51 claims per 1,000 member-months in 2021. Therefore, the large increase in the percentage of MHSUD office visit facility utilization is a result of a shrinking denominator. The overall impact of this increase is small since the proportion of MHSUD facility claims is much smaller compared to MHSUD professional claims.

Primary Care Cost-Sharing After a Set Number of Visits?" special cost-sharing option. This was done by calculating the ratio of these columns to the original values of the "Primary Care" and "Avg. Primary Care Freq." columns, respectively, then multiplying this ratio by the modified versions of the "Primary Care" and "Avg. Primary Care Freq." columns calculated in the previous paragraph. The main assumption is that the additional office visits from MHSUD follow a pattern similar to Primary Care visits. This calculation was done separately for all rows of each medical and combined continuance table. See Figure 1 below for an example of the calculations for the combined office visit cost field and the "> 1 Visit" cost field for a single row of the silver combined continuance table from the Revised Final 2026 AVC.

Figure 1: Example Calculations for Allowed Costs for $10,000 Row of Silver Combined Continuance Table (Revised Final 2026 AVC)

Up To	Primary Care	Primary Care >1 Visit
	Col (1)	Col (2)
$10,000	$155.81	$91.95

	= Col (2) / Col (1)
1-Visit Factor:	59.0%

Up To	Mental Health - OP Facility	Mental Health - OP Prof.
$10,000	$2.80	$159.77

Office Visit Factors:	54.29%	83.23%	*Factors from Table 1*
Office Visit Share of Cost:	$1.52	$132.98	

Total MHSUD Office Visit Cost:	$134.50

Final Calculations:

Up To	Primary Care	MHSUD Office Visits	Combined Office Visits	1-Visit Factor	Combined >1 Visit
	Col (1)	Col (2)	Col (3) = Col (1) + Col (2)	Col (4)	= Col (3) * Col (4)
$10,000	$155.81	$134.50	$290.31	59.0%	$171.32

Once the modified versions of all these columns were calculated, Acumen replaced the original columns in the AVC with these new versions. This resulted in the primary care-related AVC special cost-sharing feature thereby being applied to the combined primary care and MHSUD office visit columns. Because the costs added to primary care were removed from the MHSUD-related columns, total cost and utilization—overall and within each row of the continuance tables—did not change. Additionally, a key feature of the Washington standard plan designs is that primary care and MHSUD cost-sharing for office visits is always the same, so no information is lost by combining these categories together.

Finally, the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost sharing feature was modified to instead use $1 copays that are not subject to the deductible for the set number of visits. This feature currently works by utilizing a $0 copay for the first few visits. By simply swapping this $0 copay for a $1 copay, Acumen was able to modify the algorithm to account for this bespoke plan feature.

Appendix D - WAHBE 2026 Standard Plan Designs

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WAHBE Required 2026 Standard Plan Designs

Individual Market Gold, Silver, and Bronze Plans

Benefits	2026 Standard Complete Gold	2026 Standard Vital Gold	2026 Standard Silver	2026 Standard Bronze
Deductible and Out-of-Pocket Maximum				
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$1,000	$1,900	$2,500	$6,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$7,000	$8,800	$9,750	$10,150
Office Visits				
Preventive Care/Screening/Immunization	$0	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$15	$20***	$40***
Specialist Visit	$40	$40	$65	$100
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$15	$15	$20***	$40***
Emergency/Urgent Care Services				
Emergency Care Services	$450	$800	$800	40%
Urgent Care	$35	$35	$65	$100
Ambulance	$375	$375	$375	40%
Outpatient Services				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350	$350	$600	40%
Outpatient Surgery Physician/Surgical Services	$75	$75	$200	40%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$15	$15	$30	40%
Outpatient Diagnostic Tests				
Laboratory Outpatient and Professional Services	$20	$30	$40	40%
X-rays and Diagnostic Imaging	$30	$30	$65	40%
Advanced Imaging (CT/PET Scans, MRIs)	$300	$300	30%	40%
Inpatient Services				
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$525*	$650*	$800*	40%
Skilled Nursing Facility	$350**	$350**	$800**	40%
Pharmacy				
Generics	$10	$10	$25	$32
Preferred Brand Drugs	$60	$75	$75	40%
Non-Preferred Brand Drugs	$100	$200	$250	40%
Specialty Drugs (i.e. high-cost)	$100	$200	$250	40%
All Other Benefits				
Speech Therapy	$25	$30	$40	40%
Occupational and Physical Therapy	$25	$30	$40	40%
Durable Medical Equipment (DME)	20%	20%	30%	40%
Home Health	$15**	$15**	$30**	$50**
Hospice	$15**	$15**	$30**	$50**
All Other Benefits	20%	20%	30%	40%
AV	81.81%	78.06%	71.84%	64.97%

Shaded Items are not Subject to Deductible.

* Per day copay, maximum of five copays per stay; ** Per day copay; *** Eligible for two visits at $1 copay, after which stated cost-sharing applies.

Note: For all plans except the Complete Gold and Vital Gold standard plans, 2026 AV is based on a modified version of the revised federal 2026 AV Calculator that accounts for unique plan features. Complete Gold and Vital Gold standard plan AV is provided directly by the 2026 AV Calculator.

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Individual Market Silver Plan and CSR Variations

Benefits	2026 Standard Silver 94% AV	2026 Standard Silver 87% AV	2026 Standard Silver 73% AV
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$0	$750	$2,500
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$2,400	$2,850	$7,950
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$1	$5***	$20***
Specialist Visit	$15	$30	$65
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office	$1	$5***	$20***
Emergency/Urgent Care Services			
Emergency Care Services	$150	$425	$800
Urgent Care	$15	$30	$65
Ambulance	$75	$175	$325
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$100	$325	$600
Outpatient Surgery Physician/Surgical Services	$25	$120	$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$5	$10	$30
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$5	$20	$40
X-rays and Diagnostic Imaging	$15	$40	$65
Advanced Imaging (CT/PET Scans, MRIs)	15%	20%	30%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$100*	$425*	$800*
Skilled Nursing Facility	$100**	$425**	$800**
Pharmacy			
Generics	$5	$12	$24
Preferred Brand Drugs	$12	$35	$75
Non-Preferred Brand Drugs	$35	$160	$250
Specialty Drugs (i.e. high-cost)	$35	$160	$250
All Other Benefits			
Speech Therapy	$5	$20	$40
Occupational and Physical Therapy	$5	$20	$40
Durable Medical Equipment (DME)	15%	20%	30%
Home Health	$5**	$10**	$30**
Hospice	$5**	$10**	$30**
All Other Benefits	15%	20%	30%
AV	94.86%	87.87%	73.95%

Shaded Items are not Subject to Deductible.
* Per day copay, maximum of five copays per stay
** Per day copay
*** Eligible for two visits at $1 copay, after which stated cost-sharing applies.
Note: For all plans except the Complete Gold and Vital Gold standard plans, 2026 AV is based on a modified version of the revised federal 2026 AV Calculator that accounts for unique plan features. Complete Gold and Vital Gold standard plan AV is provided directly by the 2026 AV Calculator.

2026 Standard Plans Designs Appendix A

This Appendix applies to standard plan designs at all metal levels unless otherwise designated. These requirements apply only for covered services under the plan.

1. The standard plan designs outline the cost-sharing for the consumer for a given benefit category.
2. The standard plan designs do not address cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have the in-network cost-share amount. For example, out of network emergency care services would have an in-network cost-sharing under the Balance Billing Protection Act.
3. For all services with a co-pay that are not subject to the deductible, the co-pay amount does not accumulate toward the deductible, but the full co-pay amount paid for the service will accumulate toward the maximum out-of-pocket amount.
4. For services with a co-pay that are subject to the deductible, the full amount of first-dollar out-of-pocket spending accrues toward the deductible.
5. Per the essential health benefit base-benchmark plan, the following services must be covered for, at minimum, the identified number of visits:
    a. Chiropractic: 10 visits
    b. Home health care services: 130 days
    c. Hospice respite services: 14 days per lifetime
    d. Outpatient rehabilitation, combined physical, occupational, and speech therapy, services: 25 visits
    e. Outpatient habilitation services: 25 visits
    f. Inpatient rehabilitative services: 30 days
    g. Inpatient habilitative services: 30 days
    h. Skilled nursing facility services: 60 days
6. Co-payments charged to a consumer may never exceed the actual cost for the service. For instance, if a co-pay is $45 and the service is $30, the cost-share responsibility of the consumer would be $30.
7. For prescription drugs in any tier, the cost-share defined is for a 30-day supply. Carriers may determine to allow for mail order prescriptions at a reduced per-unit cost (e.g.; a 90-day supply).
8. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the plan's in-network maximum out-of-pocket.
9. Office visits for the treatment of mental health, behavioral health, or substance use disorder conditions shall be categorized as Mental/Behavioral Health and Substance Use Disorder Outpatient - Office Visits, regardless of provider type. Other Practitioner Office Visits (Nurse, Physician Assistant) shall generally be treated as a Primary Care Visit to Treat an Injury or Illness or Preventive Care/Screening Immunization. A carrier may include in the Other Practitioner category: nurse practitioners, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, and applied behavior analysis therapists. A carrier is not precluded from using another comparable benefit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office

Visits or Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other. The copay for Mental/Behavioral Health and Substance Use Disorder Outpatient Office visits may be applied to Mental/Behavioral Health and Substance Use Disorder Outpatient services provided in an urgent care setting.

10. Services with a co-pay should be charged with the following methodology: one co-pay per benefit category per day per provider. For example, a charge for a lab draw and read at a primary care visit by the same provider would result in one lab co-pay and one primary care office visit co-pay for the individual.
11. For outpatient services where a facility fee and physician/surgical services are not billed separately, an issuer may apply the cost-sharing requirements for both the facility fee and the physician/surgical services to the total charge.
12. For outpatient encounters that include multiple services, an issuer may apply the cost-sharing requirements for each service provided. For instance, an outpatient encounter involving a surgeon, radiologist, and anesthesiologist would result in three cost-share payments for the consumer.
13. For instances where there is a co-pay for Skilled Nursing Facility and All Inpatient Hospital Services, it is a per-day co-pay (with a limit of five co-pays for an inpatient stay). For instance, a two-day stay would result in two co-pays for the consumer.
14. The co-pay for All Inpatient Hospital Services is a bundled fee that covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay the $525 co-pay for Inpatient Hospital Services and no charge for the Inpatient Physician and Surgical Services. Similarly, an individual in the Vital Gold standard plan would pay the $650 co-pay before reaching the deductible. For the Silver and Bronze standard plans, any charges would first accrue to the deductible, and after the deductible is met, the individual would pay the applicable co-pay or co-insurance.
15. The cost share amount for Emergency Care Services covers facility fee and professional services.
16. Unless otherwise noted in this appendix, carriers are permitted to assign any service to any benefit category if permissible under state and federal law.
17. 2026 WA Essential Health Benefits (EHBs) additions are as follows:
    a. Hearing Exams shall be categorized as Primary Care Visits.
    b. Hearing Aids will be subject to the DME category co-insurance amount and will not be subject to the deductible.
    c. Artificial Insemination shall be categorized as All Other Benefits.
    d. Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).
18. While these 2026 standard plan designs do not specify any requirements for virtual care, HBE is exploring this option for future years and is planning to collect existing data from carriers to support this work.

2026 Standard Plans Designs Appendix B Plan and Benefit Template Standardization
These are select categories from the CMS Plan and Benefits Template that the Exchange is standardizing for 2026. Carriers shall file standard plan benefits in the (PBT) with the OIC in accordance with the below chart. The Exchange may standardize more categories in the PBT in future years. The Exchange understands different cost shares may apply depending on the specific service, but the intent is for alignment across carriers at the PBT level. Carriers may opt to file lower cost sharing on a benefit with an approved exception from the Exchange.

Benefit	Complete Gold Cost Share	Vital Gold Cost Share	Silver Cost Sharing	Bronze Cost Share
Primary Care Visit to Treat an Injury or Illness*	$15	$15	$20	$40
Specialist Visit	$40	$40	$65	$100
Other Practitioner Office Visit (Nurse, Physician Assistant)	$15	$15	$20	$40
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350 copay after deductible	$350 copay after deductible	$600 copay after deductible	40% coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	$75 copay after deductible	$75 copay after deductible	$200 copay after deductible	40% coinsurance after deductible
Hospice	$15 copay per day	$15 copay per day	$30 copay per day	$50 copay per day
Urgent Care Centers or Facilities	$35	$35	$65	$100
Home Health Care Services	$15 copay per day	$15 copay per day	$30 copay per day	$50 copay per day
Emergency Room Services	$450 copay after deductible	$800 copay after deductible	$800 copay after deductible	40% coinsurance after deductible
Emergency Transportation/Ambulance	$375 copay	$375 copay	$375 copay	40% coinsurance after deductible
Inpatient Hospital Services (e.g., Hospital Stay)**	$525 copay per day	$650 copay per day	$800 copay per day after deductible	40% coinsurance after deductible
Inpatient Physician and Surgical Services	No charge	No charge	No charge	40% coinsurance after deductible

Skilled Nursing Facility	$350 copay per day after deductible	$350 copay per day after deductible	$800 copay per day after deductible	40% coinsurance after deductible
Prenatal and Post Natal Care	No charge	No charge	No charge	No charge
Delivery and All Inpatient Services for Maternity Care**	$525 copay per day	$650 copay per day	$800 copay after deductible	40% coinsurance after deductible
Mental/Behavioral Health Office Visit*	$15 copay	$15 copay	$20 copay	$40 copay
Mental/Behavioral Health Inpatient Services**	$525 copay per day	$650 copay per day	$800 copay per day after deductible	40% coinsurance after deductible
Substance Abuse Disorder Office Visit*	$15 copay	$15 copay	$20 copay	$40 copay
Substance Abuse Disorder Inpatient Services**	$525 copay per day	$650 copay per day	$800 copay per day after deductible	40% coinsurance after deductible
Generic Drugs	$10	$10	$25	$32
Preferred Brand Drugs	$60	$75	$75	40% coinsurance after deductible
Non-Preferred Brand Drugs	$100	$200 copay after deductible	$250 copay after deductible	40% coinsurance after deductible
Specialty Drugs	$100	$200 copay after deductible	$250 copay after deductible	40% coinsurance after deductible
Outpatient Rehabilitation Services	$25	$30	$40	40% coinsurance after deductible
Habilitation Services	$25	$30	$40	40% coinsurance after deductible
Chiropractic Care*	$15	$15	$20	$40
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Hearing Aids	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance

Imaging (CT/PET Scans, MRIs)	$300 copay after deductible	$300 copay after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Preventive Care/Screening/Immunization	No charge	No charge	No charge	No charge
Acupuncture*	$15	$15	$20	$40
Routine Eye Exam for Children	No charge	No charge	No charge	No charge
Eye Glasses for Children	No charge	No charge	No charge	No charge
Rehabilitative Speech Therapy	$25	$30	$40	40% coinsurance after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$25	$30	$40	40% coinsurance after deductible
Well Baby Visits and Care	No charge	No charge	No charge	No charge
Laboratory Outpatient and Professional Services	$20	$30	$40	40% coinsurance after deductible
X-Rays and Diagnostic Imaging	$30	$30	$65	40% coinsurance after deductible
Abortion for Which Public Funding is Prohibited	No charge	No charge	No charge	No charge
Transplant**	$525 copay per day	$650 copay per day	$800 copay after deductible	40% coinsurance after deductible
Diabetes Education	No charge	No charge	No charge	No charge
Prosthetic Devices	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Nutritional Counseling	No charge	No charge	No charge	No charge
Diabetes Care Management	No charge	No charge	No charge	No charge

*Carrier shall administer benefit such that the first two Primary Care Visits and the first two Mental/Behavioral Health Visits are $1 for Silver and Bronze plans.

**Carrier shall administer copay per day up to 5 days like Inpatient Hospitals for Complete Gold, Vital Gold and Silver plans.

Appendix E – WAHBE 2026 Standard Plans AVC Screenshots (Unadjusted and Adjusted)

(Begins on next page)

Wakely
An HMA Company

Individual Market Standard Complete Gold Plan

User Inputs for Plan Parameters

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

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

ACUMEN

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$450.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$525.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$25.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$25.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$100.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$100.00	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.81%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1094 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Vital Gold Plan

User Inputs for Plan Parameters

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

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

ACUMEN

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$650.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☑			☑	☐
Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$30.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$200.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$200.00	☑	☑			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.06%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1523 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver Plan

User Inputs for Plan Parameters

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

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,750.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.33%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1172 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 73% Plan

User Inputs for Plan Parameters

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

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

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

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			70.00%
MOOP ($)			$7,950.00
MOOP if Separate ($)			

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$24.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):		5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):		2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.49%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1055 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 87% Plan

User Inputs for Plan Parameters

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

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

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

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
MOOP ($)			$2,850.00
MOOP if Separate ($)			

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$425.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$425.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$425.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$325.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$120.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$160.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$160.00	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):	5	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):	2	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.78%
Metal Tier: Gold
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1172 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 94% Plan

User Inputs for Plan Parameters

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

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

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

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$0.00
Coinsurance (%, Insurer's Cost Share)			85.00%
MOOP ($)			$2,400.00
MOOP if Separate ($)			

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$100.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$5.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$5.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$5.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$15.00	☑	☑			☐	☐
Skilled Nursing Facility	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☐		$25.00	☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$12.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$35.00	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.76%
Metal Tier: Platinum
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:
Calculation Time: 0.1055 seconds
Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Expanded Bronze Plan

User Inputs for Plan Parameters

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$32.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):	2	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	63.64%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.1055 seconds

Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver Plan (Adjusted)

User Inputs for Plan Parameters

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

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,750.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.84%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1133 seconds

WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 73% Plan (Adjusted)

User Inputs for Plan Parameters

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

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$7,950.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$800.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$24.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 73.95%
Metal Tier: Silver
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1055 seconds
WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 87% Plan (Adjusted)

User Inputs for Plan Parameters

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

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$2,850.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$425.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$425.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$425.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$325.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$120.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$160.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$160.00	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.87%
Metal Tier: Gold
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1016 seconds
WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 94% Plan (Adjusted)

User Inputs for Plan Parameters

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

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$2,400.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$100.00	☑	☑			☐	☐
Primary Care & MHSUD Office Visits	☐	☐		$1.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$5.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$5.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$5.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$15.00	☑	☑			☐	☐
Skilled Nursing Facility	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐		$100.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☐		$25.00	☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$12.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$35.00	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.86%
Metal Tier: Platinum
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1016 seconds
WAHBE Revised Final 2026 AV Calculator

Wakely
An HMA Company

Individual Market Standard Expanded Bronze Plan (Adjusted)

User Inputs for Plan Parameters

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

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

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$10,150.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care & MHSUD Office Visits	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$100.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$32.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	
Set a Maximum on Oupatient Facility Fee Coinsurance Payments?	☐
Outpatient Facility Fee Coinsurance Maximum:	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d_Coins_Cap

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	64.97%
Metal Tier:	Bronze
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.1055 seconds

WAHBE Revised Final 2026 AV Calculator

COMMUNITY HEALTH PLAN OF WASHINGTON

JUSTIFICATION FOR PROFIT AND RISK LOAD

Individual Exchange Product / Plans

Effective January 1, 2026 – December 31, 2026

Product ID: 18581WA014
Community Health Plan of Washington Cascade Select Complete Gold
Community Health Plan of Washington Cascade Select Vital Gold
Community Health Plan of Washington Cascade Select Silver
Community Health Plan of Washington Cascade Select Bronze

Community Health Plan of Washington (CHPW) has included a 2% contribution to surplus for this product in this rate filing. CHPW is renewing the same plans for 2026 and adding a fourth plan, Community Health Plan of Washington Cascade Select Vital Gold.

This selection was approved for 2026 rates by Stuart Battersby, Chief Financial Officer for CHPW, and is based on the following:

- The OIC expects insurers to maintain premium:reserve levels at less than 8:1.

- With a 2% contribution to surplus, the reserve for this line of business would be expected to reach the minimum 8:1 relationship within about six years:

    - Premium:reserve level target is 8:1 (i.e., reserve is 1/8 or 12.5% of premium)
    - Annual contribution to surplus: 2% of premium
    - Approximate time to reach reserve level: 12.5%/2% = 6.25 years

No margins have been included in any other plan year 2026 rating assumptions for this product.

[May 12, 2025]

Insurance Producer Commission Certification – 2026

Community Health Plan of Washington (CHPW)

CHPW is discontinuing broker commissions for 2026. New sales and renewals of CHPW Cascade Select health plans (any metallic level) by WAHBE-certified and CHPW-appointed insurance producers via the WAHealthPlanFinder exchange with 2026 effective dates will not be eligible for commission.

I, Melissa Stevens, am Vice President Community Engagement and Growth of Community Health Plan of Washington, and am responsible for implementing the commissions schedule for the Individual line of business. I certify, that to the best of my knowledge, this information is accurate as of the time of rate submission.

Melissa Stevens	5/7/25
Melissa Stevens Vice President Community Engagement and Growth	Date

COMMUNITY HEALTH PLAN OF WASHINGTON
FINANCIAL STATEMENT ANALYSIS
(OIC Rates Checklist #26a-26b)

Individual Exchange Product / Plans
Effective January 1, 2026
Product ID: 18581WA014
Community Health Plan of Washington Cascade Select Complete Gold
Community Health Plan of Washington Cascade Select Vital Gold
Community Health Plan of Washington Cascade Select Silver
Community Health Plan of Washington Cascade Select Bronze

Checklist Item #26a

Reconcile to Additional Data Statement (ADS):

Reconcile ADS: Total Revenues (Line 7)			
ADS Line 7		$106,897,143	
ACA RATP Estimate (Payable)	-	($44,124,590)	Reflected in ADS, not URRT/WAC 284-43-6660; consistent with URRT Wksh 1, Section 1
Reinsurance Premium	+	$2,542,091	Reflected in ADS, not URRT/WAC 284-43-6660
	=	**$153,563,824**	
URRT and WAC 284-43-6660		$153,416,318	
Difference		-0.10%	Small difference related to timing (when data was pulled)

Reconcile ADS: Total Hospital and Medical Claims (Line 17)

ADS Line 17		$115,606,049	
Net Reinsurance Recoveries	-	$1,689,622	Reflected in ADS, not URRT/WAC 284-43-6660
	=	**$113,916,427**	
URRT and WAC 284-43-6660		$112,945,234	
Difference		-0.85%	Difference related to timing of run-out estimation

ADS: Administrative Expenses (Line 19 + Line 20)

ADS Line 19 + Line 20		$12,287,182	
Reinsurance Premium	+	$2,542,091	
Net Reinsurance Recoveries	-	$1,689,622	
	=	**$13,139,651**	
WAC 284-43-6660		$13,139,651	
Difference		0.00%	

Compare Average Monthly Membership

ADS Quarterly Snapshots		
First Quarter	23,700	
Second Quarter	28,295	
Third Quarter	32,326	
Fourth Quarter	34,146	
"Average" Monthly Membership	**29,617**	Differences in Average Monthly Membership arise because of the steep monthly growth in total enrollment during the 2024 calendar year, as well as timing of when enrollment was reported. In particular, ADS figures do not reflect retroactive eligibility activity which is included in the WAC 284-43-6660 form.
WAC 284-43-6660		
Member Months	335,501	
Average Monthly Membership	**27,958**	

*Additional Data Statement has been submitted separately with this rate filing in the file “Additional Data Statement 12 31 2024.pdf.”

Checklist Item #26b

Months of Surplus :

Page 3 Line 33	202,448,775
Page 4 Line 18	1,532,206,115
Monthly	0.1321
Months of Surplus	1.5855

*Corresponding pages from the 2024 annual statement have been submitted separately in the file “Plan Stat & Amendment 3.12.2025”.

COMMUNITY HEALTH PLAN OF WASHINGTON
Experience Reconciliation and Summary of Pooled Experience with Adjustments
(OIC Rates Checklist 1a, and 3b)

Individual Exchange Product / Plans
Effective January 1, 2026
Product ID: 18581WA014
Community Health Plan of Washington Cascade Select Complete Gold
Community Health Plan of Washington Cascade Select Vital Gold
Community Health Plan of Washington Cascade Select Silver
Community Health Plan of Washington Cascade Select Bronze

Checklist Item #1: Complete experience

#1a Consistent financial data (URRT Wksh1, Sec I; URRT Wksh2, Sec II; WAC 284-43-6660; Act Memo exhibits):

Premium		
WAC 284-43-6660	Earned Premium	$153,416,318
URRT Wksh1, Sec I	Experience Period Premium	$153,416,318
URRT Wksh2, Sec II	2.8 Premium	$153,416,318
Act Memo Tables	Experience Period Premium	$153,416,318

Incurred Claims		
WAC 284-43-6660	Incurred Claims	$112,945,234
URRT Wksh1, Sec I	2.6 Incurred Claims in Experience Period	$112,945,234
URRT Wksh2, Sec II	Incurred Claims	$112,945,234
Act Memo Tables[(1)]	Reflects difference in estimated ending reserve	$113,477,027

Member Months		
WAC 284-43-6660	Member Months	335,501
URRT Wksh1, Sec I	Experience Period Member Months	335,501
URRT Wksh2, Sec II	2.9 Experience Period Member Months	335,501
Act Memo Tables[(2)]	Member Months	335,324

(1) Table 3.2 incurred and allowed claims are not adjusted for pharmacy rebates or estimated claims IBNP.
(2) Member months differ from the URRT and other filing items due to timing of when the data was pulled and retroactive eligibility changes being applied.

Checklist Item #3: Summary of Pooled Experience with Adjustments

#3b Summary of Pooled Experience with Adjustments (WAC 284-43-6660 summary):

- Experience is not reported for 2022 because CHPW's Cascade Select offering was new effective 1/1/2023.

Summary of Pooled Experience (WAC 284-43-6660)

	Experience Period	
	2023	2024
Member Months	95,487	335,501
Earned Premium	$44,881,022.25	$153,416,318.04
Paid Claims	$28,396,446.59	$103,996,811.49
Beginning Claim Reserve	$2,571,371.91	$5,222,914.00
Ending Claim Reserve	$4,858,234.58	$14,111,009.61
Incurred Claims	$32,178,759.71	$112,945,234.01
Expenses	$5,117,649.32	$13,139,650.98
Gain/Loss	$7,584,613.22	$27,331,433.05
Loss Ratio Percentage	71.70%	73.62%

Adjustments to Pooled Experience

	Experience Period	
	2023	2024
RA transfer amount	-$11,290,576.21	-$45,934,766.89
HCRP transfer amount	$0.00	$2,256,779.00
HCRP assessment	-$161,430.38	-$613,665.27
HHS-RADV adjustments	$0.00	$0.00
Adjusted gain/loss	-$3,867,393.37	-$16,960,220.11
MLR rebates	$0.00	$0.00

ANNUAL STATEMENT

OF THE

COMMUNITY HEALTH PLAN OF WASHINGTON

of

Seattle

in the state of

Washington

2024

TO THE

Insurance Department

OF THE STATE OF

Washington

For the Year Ended
DECEMBER 31, 2024

HEALTH

2024

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $.....247,498 reinsurance ceded)	165,319,453	7,580,492	172,899,945	165,518,093
2.	Accrued medical incentive pool and bonus amounts	2,457,241		2,457,241	7,137,961
3.	Unpaid claims adjustment expenses	4,267,451		4,267,451	5,278,934
4.	Aggregate health policy reserves, including the liability of $.....0 for medical loss ratio rebate per the Public Health Service Act	62,687,864		62,687,864	24,559,390
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	1,637,129		1,637,129	98,793,655
9.	General expenses due or accrued	32,468,639		32,468,639	24,558,792
10.1	Current federal and foreign income tax payable and interest thereon (including $.....0 on realized capital gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $.....0 current) and interest thereon $.....0 (including $.....0 current)				
15.	Amounts due to parent, subsidiaries and affiliates	13,727,540		13,727,540	
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $.....0 authorized reinsurers, $.....0 unauthorized reinsurers and $.....0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified ($.....0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans	6,054,237		6,054,237	14,101,351
23.	Aggregate write-ins for other liabilities (including $.....0 current)				
24.	TOTAL Liabilities (Lines 1 to 23)	288,619,554	7,580,492	296,200,046	339,948,176
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX		
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	14,738,448	14,738,448
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other-than-special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	187,710,327	248,323,386
32.	Less treasury stock, at cost:				
	32.1 .....0 shares common (value included in Line 26 $.....0)	XXX	XXX		
	32.2 .....0 shares preferred (value included in Line 27 $.....0)	XXX	XXX		
33.	TOTAL Capital and Surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	202,448,775	263,061,834
34.	TOTAL Liabilities, Capital and Surplus (Lines 24 and 33)	XXX	XXX	498,648,821	603,010,010
DETAILS OF WRITE-INS					
2301.					
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	TOTALS (Lines 2301 through 2303 plus 2398) (Line 23 above)				
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	TOTALS (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

STATEMENT OF REVENUE AND EXPENSES

		Current Year		Prior Year
		1 Uncovered	2 Total	3 Total
1.	Member Months	XXX	3,888,382	3,789,082
2.	Net premium income (including $.....0 non-health premium income)	XXX	1,615,803,007	1,439,685,900
3.	Change in unearned premium reserves and reserve for rate credits	XXX		
4.	Fee-for-service (net of $.....0 medical expenses)	XXX		
5.	Risk revenue	XXX		
6.	Aggregate write-ins for other health care related revenues	XXX		
7.	Aggregate write-ins for other non-health revenues	XXX		
8.	TOTAL Revenues (Lines 2 to 7)	XXX	1,615,803,007	1,439,685,900
Hospital and Medical:				
9.	Hospital/medical benefits		1,113,663,031	923,250,567
10.	Other professional services		29,023,505	17,522,207
11.	Outside referrals		105,022,236	79,584,665
12.	Emergency room and out-of-area		52,565,789	44,287,012
13.	Prescription drugs		240,719,574	219,048,095
14.	Aggregate write-ins for other hospital and medical			
15.	Incentive pool, withhold adjustments and bonus amounts		(4,368,073)	792,121
16.	Subtotal (Lines 9 to 15)		1,536,626,062	1,284,484,667
Less:				
17.	Net reinsurance recoveries		4,419,947	2,337,963
18.	TOTAL Hospital and Medical (Lines 16 minus 17)		1,532,206,115	1,282,146,704
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $.....16,722,191 cost containment expenses		33,009,869	29,615,009
21.	General administrative expenses		132,128,191	125,735,543
22.	Increase in reserves for life and accident and health contracts (including $.....0 increase in reserves for life only)		5,709,454	3,645,930
23.	TOTAL Underwriting Deductions (Lines 18 through 22)		1,703,053,629	1,441,143,186
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(87,250,622)	(1,457,286)
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		18,762,871	17,728,039
26.	Net realized capital gains (losses) less capital gains tax of $.....0		1,372,494	39,175
27.	Net investment gains (losses) (Lines 25 plus 26)		20,135,365	17,767,214
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $.....0) (amount charged off $.....0)]			
29.	Aggregate write-ins for other income or expenses		67,463	(116)
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	(67,047,794)	16,309,812
31.	Federal and foreign income taxes incurred	XXX		
32.	Net income (loss) (Lines 30 minus 31)	XXX	(67,047,794)	16,309,812
DETAILS OF WRITE-INS				
0601.		XXX		
0602.		XXX		
0603.		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX		
0699.	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX		
0701.		XXX		
0702.		XXX		
0703.		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX		
0799.	TOTALS (Line 0701 through 0703 plus 0798) (Line 7 above)	XXX		
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page			
1499.	TOTALS (Lines 1401 through 1403 plus 1498) (Line 14 above)			
2901.	Other Revenue (Expenses)		67,463	(116)
2902.				
2903.				
2998.	Summary of remaining write-ins for Line 29 from overflow page			
2999.	TOTALS (Line 2901 through 2903 plus 2998) (Line 29 above)		67,463	(116)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL & SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	263,061,834	236,517,711
34.	Net income or (loss) from Line 32	(67,047,794)	16,309,812
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $.....0	8,140,753	10,137,148
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax		
39.	Change in nonadmitted assets	(1,706,018)	97,162
40.	Change in unauthorized and certified reinsurance		
41.	Change in treasury stock		
42.	Change in surplus notes		
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in		
	44.2 Transferred from surplus (Stock Dividend)		
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in		
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders		
47.	Aggregate write-ins for gains or (losses) in surplus		
48.	Net change in capital and surplus (Lines 34 to 47)	(60,613,059)	26,544,123
49.	Capital and surplus end of reporting year (Line 33 plus 48)	202,448,775	263,061,834
DETAILS OF WRITE-INS			
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page		
4799.	TOTALS (Lines 4701 through 4703 plus 4798) (Line 47 above)		

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:	Community Health Plan of Washington
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.

    Response: Not applicable.

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

    Response: Total premium would be impacted to the extent that total enrollment is lower. Individual rates would not be affected.

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**.

Projected with Waiver Enrollment		
Rating Area	**Average Membership**	**Member Months**
1 - King	3,773	45,312
2 - West	729	8,757
3 - South	-	-
4 - Northeast	1,276	15,316
5 - South Sound	4,242	50,896
6 - South Central	2,344	28,119
7 - North Central	1,551	18,602
8 - Northwest	1,370	16,438
9 - Southeast	231	2,757
Total	**15,516**	**186,197**

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.

Projected without Waiver Enrollment		
Rating Area	**Average Membership**	**Member Months**
1 - King	3,541	42,525
2 - West	713	8,563
3 - South	-	-
4 - Northeast	1,263	15,161
5 - South Sound	4,163	49,952
6 - South Central	2,231	26,768
7 - North Central	1,539	18,462
8 - Northwest	1,267	15,196
9 - Southeast	228	2,721
Total	**14,945**	**179,348**

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.

   Response: There are no assumed plan mix differences between the with-waiver and without-waiver enrollment assumptions. CHPW does not have sufficient information regarding IHC consumers to project different with-waiver and without-waiver plan mix assumptions. The total projected 2026 with-waiver enrollment assumptions by plan are reported in the table below.

Plan	Member Months
Community Health Plan of Washington Cascade Select Complete Gold	28,985
Community Health Plan of Washington Cascade Select Vital Gold	14,863
Community Health Plan of Washington Cascade Select Silver 70%	-
Community Health Plan of Washington Cascade Select Silver 73%	-
Community Health Plan of Washington Cascade Select Silver 87%	73,162
Community Health Plan of Washington Cascade Select Silver 94%	40,608
Community Health Plan of Washington Cascade Select Bronze	28,579
Total	**186,197**

Average Membership	**15,516**

Total Premiums

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

Rating Area	Proj. Premium w/ Waiver
1 - King	$29,048,039.00
2 - West	$6,033,820.10
3 - South	$0.00
4 - Northeast	$9,702,682.55
5 - South Sound	$30,494,591.45
6 - South Central	$17,431,862.26
7 - North Central	$12,276,180.75
8 - Northwest	$10,604,815.81
9 - Southeast	$1,714,595.39
Total	**$117,306,587.31**

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

Rating Area	Proj. Premium w/o Waiver
1 - King	$27,340,359.00
2 - West	$5,917,240.97
3 - South	$0.00
4 - Northeast	$9,632,313.66
5 - South Sound	$30,015,691.45
6 - South Central	$16,642,407.08
7 - North Central	$12,219,084.95
8 - Northwest	$9,831,951.83
9 - Southeast	$1,697,108.97
Total	**$113,296,157.91**

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.

   Response: There are no assumed differences in rate development assumptions with and without 1332 waiver enrollees. For purposes of projecting claims costs, CHPW considered the potential morbidity impact of the 1332 waiver enrollees. While these enrollees may have lower initial utilization due to a reluctance to seek care, we would also expect that any deferral of care would result in offsetting higher-intensity services needed later. For this reason, we anticipate that the cost profile of 1332 waiver enrollees would be similar to the cost profile of the remaining ACA population enrolled in marketplace plans. Further, our review of the limited publicly available information regarding IHC enrollees did not result in any compelling support for assuming a higher or lower relative morbidity profile for this population.

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.

    Response: Not applicable.

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

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

Round to the nearest cent.
Use enrollment reported above in #3.

Rating Area	Proj. Allowed w/ Waiver
1 - King	$21,099,549.58
2 - West	$4,077,700.29
3 - South	$0.00
4 - Northeast	$7,131,901.07
5 - South Sound	$23,699,741.24
6 - South Central	$13,093,622.76
7 - North Central	$8,662,028.19
8 - Northwest	$7,654,360.79
9 - Southeast	$1,283,798.07
Total	**$86,702,701.99**

12. What is the reporting issuer's PY 2026 without-waiver total projected medical allowed claims spending (i.e., the sum of incurred claims and member cost shares)?
    Provide the reporting issuer's projected medical spending by rating area as well as summed across the issuer's rating areas.
    Round to the nearest cent.
    Use enrollment reported above in #4.

Rating Area	Proj. Allowed w/o Waiver
1 - King	$19,801,782.00
2 - West	$3,987,364.12
3 - South	$0.00
4 - Northeast	$7,059,725.26
5 - South Sound	$23,260,167.30
6 - South Central	$12,464,529.11
7 - North Central	$8,596,837.14
8 - Northwest	$7,076,023.03
9 - Southeast	$1,267,034.66
Total	**$83,513,462.61**

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.

    Response: Consistent with our response to Q8 above, we assume no differences in the assumptions used to project claims costs with and without 1332 waiver enrollees. While these enrollees may have lower initial utilization due to a reluctance to seek care, we would also expect that any deferral of care would result in offsetting higher-intensity services needed later. For this reason, we anticipate that the cost profile of 1332 waiver enrollees would be similar to the cost profile of the remaining ACA population enrolled in marketplace plans. Further, our review of the limited publicly available information regarding IHC enrollees did not result in any compelling support for assuming a higher or lower relative morbidity profile for this population.

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.

    Response: Consistent with our responses to Q8 and Q13 above, we assume no differences in the assumptions used to project risk adjustment transfers with and without 1332 waiver enrollees. While these enrollees may have lower initial utilization due to a reluctance to seek care, we would also expect that any deferral of care would result in offsetting higher-intensity services needed later. For this reason, we anticipate that the average risk score of 1332 waiver enrollees would be similar to the average risk score of the remaining ACA population enrolled in marketplace plans. Further, our review of the limited publicly available information regarding IHC enrollees did not result in any compelling support for assuming a higher or lower relative risk profile for this population.

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.

    Response: From an administrative expense perspective, CHPW does not anticipate incurring significant additional administrative expenses due to 1332 waiver member enrollment. As shown in our response to Q4 above, we do not anticipate a large volume of IHC consumer enrollment from the 1332 waiver.

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.

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: Community Health Plan of Washington

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
18581WA0140001	Community Health Plan of Washington Cascade Select Complete Gold	Yes, Cascade Select	Gold	81.81%
18581WA0140004	Community Health Plan of Washington Cascade Select Vital Gold	Yes, Cascade Select	Gold	78.06%
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	Yes, Cascade Select	Silver	71.84%
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	Yes, Cascade Select	Bronze	64.97%

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."		
18581WA0140001	Community Health Plan of Washington Cascade Select Complete Gold	No	N/A	No	None
18581WA0140004	Community Health Plan of Washington Cascade Select Vital Gold	No	N/A	No	None
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	Yes	2 initial primary care office visits at $1 copay, 2 initial MH/SUD office visits at $1 copay	No	None
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	Yes	2 initial primary care office visits at $1 copay, 2 initial MH/SUD office visits at $1 copay; separate cost sharing for MH/SUD OP-Other versus MH/SUD OP-Office	No	None

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
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	No	Yes	Primary care visits and generic drugs are not subject to deductible

[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
CHPW Cascade Care Affiliates Network	EPO	Single	May 15, 2025

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

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

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.	**Experience Reconciliation (Checklist 1-3).pdf**	**Page 1**

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	**Part III Rate Filing Documentation and Actuarial Memorandum ("Part III")** **WA Exhibits**	**Exhibit 3. Experience and Current Period Premium, Claims, and Enrollment, Tables 3.1a-d, 3.2** **WA Exhibit 3**
	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.	**Part III** **WA Exhibits**	**Exhibit 3. Experience and Current Period Premium, Claims, and Enrollment, Table 3.2** **WA 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 Exhibits**	**WA Exhibit 2**
	e	Split up experience if you are terminating any counties in 2025 and/or 2026: If you are terminating any counties for plan year 2025 and/or 2026, include a table splitting URRT Worksheet 1, Section I experience between continuing and terminated counties. If you are not terminating any counties, respond "N/A."	**N/A**	**CHPW is not terminating any counties**
2		**Manual EHB Allowed Claims:** If credibility is 100%, respond "N/A" for each item. • If you use a credibility-blended estimate, explain the processes in detail (i) per guidance in URR Instructions 4.4.3.3, to establish the Manual EHB Allowed Claims PMPM for WA and (ii) per 4.4.3.4 to establish the credibility percentage for URRT Worksheet 1, Section II. • Note: if the 2024 experience is 0.00% credible, then the trend, morbidity, demographic, plan design, and other factors in URRT Worksheet 1, Section II can be listed as 1.000. In that case, only analyses of the manual trend and adjustment factors are required.		
	a	Manual data relevance: Explain the relevance of the data used to determine the Manual EHB Allowed Claims PMPM.	**N/A**	**CHPW's experience is fully credible**
	b	Manual EHB allowed claims PMPM: • Show the detailed calculation of the Manual EHB Allowed Claims PMPM entered in URRT Worksheet 1, Section II. • Justify any adjustments made to the data, such as adjustments for trend, morbidity, demographics, plan design, and geographic areas. Your response should clearly identify how your estimate considers	**N/A**	**CHPW's experience is fully credible**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		the cost and utilization characteristics of your individual health plan market service area in the State of Washington. • Note: the manual rate must be developed in a manner consistent with 100% credibility. See #2.c below.		
	c	Credibility of experience data: Describe the credibility methodology and assumptions used, per Actuarial Standard of Practice (ASOP) No. 25. • Identify the actuarially sound and appropriate credibility procedure used to develop your credibility estimate. • At what level is experience determined to be more than 0% credible? • How is partial credibility determined? • At what level is experience determined to be 100% credible?	**N/A**	**CHPW's experience is fully credible**
	d	Show how you estimated credibility of the 2024 allowed claims and member months used in rate development. Use your credibility procedure.	**N/A**	**CHPW's experience is fully credible**
3		**Experience in WAC 284-43-6660 Summary, and Summary of Pooled Experience with Adjustments:**		
	a	WAC 284-43-6660 summary, experience: Complete the WAC 284-43-6660 summary for Individual and Small Group Contract filings. • Provide data to support WAC 284-43-6660 without adjustments for Risk Adjustment and High-Cost Risk Pool (HCRP) receipts and assessments. • Data should be based on the incurred years 2024, 2023, and 2022.	**WAC 284-43-6660**	**Entire file**
	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.	**Experience Reconciliation (Checklist 1-3).pdf**	**"Summary of Pooled Experience with Adjustments"**

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

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.	**N/A**	**N/A**
4	**Plan Level Experience and Current Data:** Document and justify URRT Worksheet 2, Section II Experience Period and Current Plan Level Information. • Explain whether amounts are based on each plan's experience or allocated to plans. If amounts are allocated, demonstrate and justify the allocation method. • Explain any differences between totals in URRT Worksheet 2, Section II and URRT Worksheet 1, Section I.	**Part III**	**Exhibit 3. Experience and Current Period Premiums, Claims, and Enrollment**
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 Exhibits**	**WA Exhibits 3, 4, and 5**

Line		Task	Issuer Response:	
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		template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.		
	b	Allowed claims non-EHB trend analysis: If applicable, include an exhibit that develops the non-EHB allowed claims trend.		**N/A**
	c	Projected allowed claims trend development (EHB & non-EHB): • As outlined in URR Instructions 4.4.3.1, describe how you arrived at your allowed claims trend assumptions, including the data used, credibility of the data used, and any adjustments made to the data. • Provide an overall allowed claims trend estimate as well as EHB breakdowns into URRT worksheet 1 benefit categories (or at least medical and prescription drug categories). ○ Further break the EHB trends down into utilization, unit cost, and service mix/intensity components. ○ Upload relevant EHB details to **WA Exhibit 3**; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. • If your overall trend, indicated in URRT Worksheet 1, Section II, differs materially from the retrospective trend indicated in WA Exhibit 4, provide detailed actuarial support for the difference. Address the following: ○ Actuarial support must provide both qualitative and quantitative bases for the difference. Refer to other WA Exhibits and/or separate issuer-developed actuarial exhibits for support, where appropriate. ○ Prospective trend adjustments should identify all data, assumptions, methods, and models. Note that prospective trend adjustments are NOT exempt from actuarial support 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	**Part III** **WA Exhibits**	**Exhibit 5. Projection Factors** **WA Exhibits 3, 4**

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).	**Part III**	**Exhibit 5. Projection Factors**
6	**Incurred Claims Trends:** • Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more separate non-EHB categories, as applicable. They should also be available for each type of service in the WAC 284-43-6660 trend factor summary. • Incurred claims trends differ from allowed claims trends in that they reflect leveraging of fixed cost-shares. • Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data. • Describe the trend development in the Part III actuarial memorandum.		
a	Incurred claims projected trend (EHB & non-EHB): (see also #32.c of this checklist) • Include an exhibit that develops the incurred claims trend percentages entered in the WAC 284-43-6660 summary. Justify the projected incurred claims trend percentages. • 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	**Part III**	**Exhibit 5. Projection Factors, Table 5.2**

Line	Task	Issuer Response:	
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	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.	**Part III**	**Exhibit 5. Projection Factors** **Exhibit 8. Establishing the Index Rate, Table 8.1**
URRT WORKSHEET 2, SECTION I GENERAL PRODUCT and PLAN INFORMATION, AV METAL VALUES			
8	**AVC Screenshots:** (see also #9 below) • Provide the Actuarial Value Calculator (AVC) screenshots in PDF format showing "Calculation Successful." State the corresponding HIOS Plan ID on each AVC Screenshot. For the 2026 AV Calculator and Methodology, see link: https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html Please do not submit AVC screenshots for every CSR plan variation (i.e., 73%, 87%, and 94%), however, be mindful of the de minimis variation limit of 0/+1 percentage points. NOTE: if you rely on AV Metal Values calculated by the Exchange's actuaries, do not submit your own AVC screenshot copies for standardized plans. Instead, document such reliance in your Part III actuarial memorandum and include in SERFF Supporting Documentation a copy of the Exchange's actuarial certification of AV Metal Values for standardized plans.	**Wakely - WAHBE 2026 Medical AV Certification 78% Gold 202500415.pdf ("Wakely AV Certification")**	**Appendix E**

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	• 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. o Include enough detail for the reviewer to determine whether the methods, assumptions, and results are appropriate and reasonable.		

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	○ 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:	
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		○ *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.	**N/A**	
	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.	**Wakely AV Certification**	**Appendix A (Certification)** **Appendix E (AVC screenshots)** **Main Report (Explanation of adjustments)**

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

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

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

	a	**AV Pricing Value (a.k.a. EHB paid-to-allowed factors) by plan:**
		• Provide the factor for each plan that shows the impact of benefit differences for EHB-only cost sharing.
		• See WAC 284-43-6800(3) for the definition of AV pricing value and WAC 284-43-6800(1) for the definition of AV metal value.
		• Per WAC 284-43-6810(3):
		  o Rate development exhibits should demonstrate compliance with the following:
		  ▪ "The AV pricing value must be within ±2% of a plan's designated AV metal value."
		  ▪ "The allowable range of AV pricing value may be increased or decreased by 1% and must not result in a total adjustment exceeding ±3%, if the plan has significant features that are not considered in the AV metal value calculation. Applicable plan features may include, but are not limited to, an embedded pediatric dental benefit, aggregate family deductible, or significant out-of-network utilization."
		  ▪ If you are requesting the expanded AV Pricing Value range of ±3%, identify this in WA Exhibit 9 and provide supporting documentation for the request. Documentation for this request must show significant plan features impact EHBs, those plan features are excluded from consideration in the federal AV calculator and AV metal value, and those plan features have a material pricing impact supported by actuarial analysis.
			Part III
			
			WA Exhibits
				Exhibit 10. Plan Adjusted Index Rate, Table 10.1
				
				WA Exhibit 9

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		▪ Note that AV pricing value must be actuarially sound, and the ranges referenced above should not be used as an adjustment (i.e., ceiling or floor) to AV pricing values. ▪ AV pricing values should be normalized for impacts of all other allowable plan-level rating adjustments (including subcomponents of the "AV and Cost Sharing Design of Plan") and for use in the calculations of the "AV and Cost Sharing Design of Plan" factors. o The Part III actuarial memorandum in the rate filing must include the following information related to AV metal value and AV pricing value: ▪ Each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values. ▪ The methodology that was used to develop the AV pricing value including that it is based on a standardized population. The carrier must identify all material changes in the AV pricing value development and their impacts. ▪ Note that if you have a commercial or other (e.g., internal) reinsurance/pooling agreement, consider projected recoverable amounts in the overall AV Pricing Value.		
	b	**Induced demand factors (IDFs) by plan:** • Each plan's IDF can vary by plan design but must be consistent with the federal risk adjustment transfer formula per WAC 284-43-6810(2). Therefore, plan IDFs should be determined by the formula (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.	**Part III** **WA Exhibits**	**Exhibit 10. Plan Adjusted Index Rate, Table 10.1** **WA Exhibit 9**

Line	Task	Issuer Response:	
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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.	**Part III** **WA Exhibits**	**Exhibit 10. Plan Adjusted Index Rate, Table 10.1** **WA Exhibits 8, 9**
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.	**Part III**	**Exhibit 8. Establishing the Index Rate** **Exhibit 10. Plan Adjusted Index Rate, Table 10.1**

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
e	**AV and Cost Sharing Design of Plan factors:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3) Discuss and demonstrate the calculation of the final plan adjustment factors used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3, AV and Cost Sharing Design of Plan. See the introduction to this checklist #11 for the AV and Cost Sharing Design of Plan formula using the four subcomponents addressed in WAC 284-43-6810(1).	**Part III**	**Exhibit 10. Plan Adjusted Index Rate, Table 10.1**
f	**Compare the AV Metal Value and the AV Pricing Value:** Provide the comparison of the AV Metal Values and AV Pricing Values in WA Exhibits 6 and 9.	**WA Exhibits**	**WA Exhibits 6, 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)	**Part I Unified Rate Review Template ("URRT")** **Rate Schedule**	**Rate differences are no greater than $0.01**
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.	**URRT** **Part III** **WA Exhibits**	**Wksh 2 – Plan Product Info Section II** **Exhibit 3. Experience and Current Period Premium, Claims, and Enrollment, Table 3.2** **WA Exhibit 7**
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	**N/A**	**CHPW has only one network**

Line	Task	Issuer Response:	
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	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).		
13	**Benefits in Addition to EHB Factors:** (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5) Document and justify these factors. Note that they should be developed as loads on EHB incurred claims. See URR Instructions and 45 CFR §156.115(d) for additional information. Include aggregate actual experience, projections, and actual-to-expected analysis in WA Exhibit 7; see the instructions in the exhibit template. If plans do not include non-EHBs (non-essential health benefits) and all plans are outside the Exchange, please respond "N/A." Notes about abortion services for URRT purposes (see also #11.d & #27 of this checklist): • Exchange plans that include coverage of abortion services for which public funding is prohibited must calculate such abortion services as non-EHBs. • For plans offered Outside Market Only, such abortion services must be calculated as EHBs. Then, only non-EHBs, if applicable, should be addressed as part of Benefits in Addition to EHB.	**Part III** **WA Exhibits**	**Exhibit 10. Plan Adjusted Index Rate, Table 10.3** **WA Exhibit 7**
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**	**CHPW does not offer any catastrophic plans**

Line		Task	Issuer Response:	
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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.	**Part III**	**Exhibit 11. Calibration; Exhibit 12. Consumer Adjusted Premium Rate Development**
	b	Age calibration factors, projected versus prior: Compare the 2026 age calibration factor to the 2023, 2024, and 2025 factors.	**Part III**	**Exhibit 11. Calibration, Table 11.2**
	c	Average age: Show the average age and provide actuarial justification for the methodology employed to calculate the average age.	**Part III**	**Exhibit 11. Calibration, Table 11.2**
16		**Area Factors and Geographic Calibration Factors:** See WAC 284-43-6701 for geographic rating areas effective on or after January 1, 2019. Note, if Area 1 (King County) is in your service area, its factor must be set at 1.0000. If Area 1 (King County) is **not** in your service area, the geographic rating area of the county with the largest enrollment in your service area must be set at 1.0000. If you are an insurer new to the Washington state market, the geographic area with the greatest number of counties must be set at 1.0000.		
	a	Area factor development: Note: if your service area is limited to a single area, please respond "N/A," since the area factor is 1.0000. Demonstrate the build-up of the geographic rating area factors. Document and justify the 2026 factors with details including, but not limited to, the following: • Certify that the following items were not used to establish any geographic rating area factor: o Health status of enrollees or the population in an area. o Medical condition of enrollees or the population in an area including physical, mental, and behavioral health illnesses.	**Part III**	**Exhibit 11. Calibration; Exhibit 12. Consumer Adjusted Premium Rate Development, Table 12.2**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
		○ Claims experience. ○ Health services utilization in the area. ○ Medical history of enrollees or the population in an area. ○ Genetic information of enrollees or the population in an area. ○ Disability status of enrollees or the population in an area. ○ Other evidence of insurability applicable in the area. • Clarify how projected unit cost changes were considered for each area. Also, clarify how credibility was considered. Like trends, you should not solely rely on historical information, especially if it is not considered to be 100% credible or if significant changes are projected in the future.		
	b	Area factors, highest versus lowest: Demonstrate that your geographic rating area factors comply with WAC 284-43-6681 highest to lowest cost ratio requirements of • 1.40 if offering an Exchange QHP in every county, • 1.22 if offering an Exchange QHP in every county in six or more rating areas, or • 1.15 in all other cases.	**Part III**	**Exhibit 11. Calibration, Table 11.3**
	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.	**Part III**	**Exhibit 11. Calibration, Table 11.2**
	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.	**Part III**	**Exhibit 11. Calibration, Table 11.2; Exhibit 12. Consumer Adjusted Premium Rate Development**
	e	Load area factors into URRT: Provide the geographic rating areas and rating factors in URRT Worksheet 3.	**Part III**	**Exhibit 11. Calibration, Table 11.2**

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
17		**Tobacco Use Factor and Tobacco Calibration Factor:**		
	a	Tobacco use factor development: Document and justify the 2026 Tobacco Use factor. • The maximum factor is 1.500 (see 45 CFR §147.102(a)(1)(iv)). • If the factor did not change from the prior filing, indicate when the factor was last evaluated and what data was used in that evaluation. Note: Our opinion is that the factor should be re-evaluated periodically.	**Part III**	**Exhibit 11. Calibration, Tables 11.1 and 11.2; Exhibit 12. Consumer Adjusted Premium Rate Development**
	b	URRT tobacco calibration factor: Provide the calculation of the tobacco calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.13. Note: each calibration factor (age, geographic, and tobacco) must be calculated independently.	**Part III**	**Exhibit 11. Calibration; Exhibit 12. Consumer Adjusted Premium Rate Development**
	c	Tobacco factors, projected versus prior: Compare the 2026 tobacco use factor and calibration factor to amounts for 2023, 2024, and 2025.	**Part III**	**Exhibit 11. Calibration, Table 11.2**
RISK ADJUSTMENT AND HIGH-COST RISK POOL (HCRP)				
18		**Experience Period Risk Adjustment & HCRP:**		
	a	Experience period risk adjustment formula details: Provide the actual 2024 risk adjustment experience and projections in WA Exhibit 10; see the instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. 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.	**Part III** **WA Exhibits**	**Exhibit 9. Development of Market-wide Adjusted Index Rate** **WA Exhibit 10**

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
	b	Experience period risk adjustment & HCRP by plan: (URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.7) Using formulae, please address 2024 risk adjustment transfer amounts, HCRP assessments, and HCRP receipts.	**Part III** **WA Exhibits**	**Exhibit 9. Development of Market-wide Adjusted Index Rate** **WA Exhibit 10**
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.	**Part III** **WA Exhibits**	**Exhibit 9. Development of Market-wide Adjusted Index Rate** **WA Exhibit 10**
	b	Projection period risk adjustment & HCRP for URRT Worksheet 2 (on incurred claims basis), Development and justification: (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16) • Explain in detail in the Part III actuarial memorandum how you estimated the 2026 risk adjustment factors (e.g., PLRS, IDF, GCF, AV, and ARF), including the four membership groupings in (a), as applicable. (See URR Instructions regarding the requirements to provide detailed information and justification for risk adjustment.) • Provide detailed support and rationale for each assumption, including persisting membership, stating the most current data used, its "as of" date, and its source (e.g., internal, CMS, etc.). • Describe how your projections considered the 2026 risk adjustment model changes. • Explain 2026 HCRP estimated assessments and receipts. • 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.	**Part III**	**Exhibit 9. Development of Market-wide Adjusted Index Rate**

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
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.	**Part III**	**Exhibit 9. Development of Market-wide Adjusted Index Rate, Table 9.1**
d	Projected 2026 RADV impacts: Explain in the Part III actuarial memorandum any impacts due to Risk Adjustment Data Validation (RADV) audits. For example, explain any impact to the company or statewide 2026 PLRS projections due to the 2022 RADV audit report.	**Part III**	**Exhibit 9. Development of Market-wide Adjusted Index Rate**
e	HCRP, projected versus prior: Compare (i) actual HCRP receipts and assessments for 2022, 2023, and 2024 versus (ii) projected HCRP receipts and assessments for 2022, 2023, 2024, 2025, and 2026. Explain differences.	**Part III**	**Exhibit 9. Development of Market-wide Adjusted Index Rate, Table 9.2**
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.	**Part III** **WA Exhibits**	**Exhibit 9. Development of Market-wide Adjusted Index Rate** **WA Exhibit 10**

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

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

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

Line		Task	Issuer Response:	
			Document Name	**Section / Page / Exhibit Number**
23		**Company Rate Information and Rate Review Detail:** For the "Company Rate Information" and "View Rate Review Detail" on the Rate/Rule Schedule tab of the SERFF rate filing, provide an exhibit with the following information. • The information should represent your **initial requested rate change**. • Note: If post submission updates are necessary to correct any information, update the exhibit to indicate what was updated and the reason for the update(s). • Issuers with renewal plans must address the items below. For more information related to "Company Rate Information" and "View Rate Review Detail," see SERFF and Rate Filing Instructions.		
	a	SERFF Company Rate Information: Provide the calculation, explanation, and/or source of the information. Note the following: • Number of policy holders affected for this program: The number of subscribers as of March 2025. • Minimum and Maximum % changes: From the initial Uniform Product Modification Justification (UPMJ) Q5 rate changes by plan. • Overall % rate impact: The calculated overall average rate change in UPMJ Q5. • Written Premium for this Program and Written Premium Change for this Program: Annual amounts; see Written Premium in the NAIC glossary.	**View Rate Review Detail.pdf**	**Company Rate Information**
	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)	**View Rate Review Detail.pdf**	**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.	**View Rate Review Detail.pdf**	**Current Enrollment**
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.	**View Rate Review Detail.pdf**	**Projected Enrollment**
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.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 5. Projection Factors**

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.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 5. Projection Factors**
	(iii) The impact of cost-sharing ***changes by major service category***, including actuarial values. Include a discussion of the cost-share changes for each specific benefit category listed in URRT Worksheet 1, Section II.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 10. Plan Adjusted Index Rate**
	(iv) The impact of benefit *changes*, including essential health benefits (EHBs) and non-essential health benefits (non-EHBs). Address the new essential health benefits for non-grandfathered individual and small group health insurance coverage in the State of Washington for plan years beginning on or after January 1, 2026. For each new EHB, describe whether your plan designs already covered the benefit or describe what plan design changes were required. Clearly demonstrate and justify any rate changes due to these new EHBs.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 5. Projection Factors**
	(v) The impact of *changes in* enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 11. Calibration**
	(vi) The impact of any *overestimate or underestimate* of medical trend for prior year periods related to the rate increase. Include a discussion and analysis of actual to expected medical trends.	**Part III**	**Exhibit 2. Proposed Rate Changes**
	(vii) The impact of *changes in* reserve needs. Include a discussion of any change in reserve needs.	**Part III**	**Exhibit 2. Proposed Rate Changes**
	(viii) The impact of *changes in* administrative costs related to programs that improve health care quality. Include a discussion of any such changes.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 10. Plan Adjusted Index Rate**
	(ix) The impact of *changes in* other administrative costs. Include a discussion of any such changes.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 10. Plan Adjusted Index Rate**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
	(x) The impact of ***changes in*** applicable taxes, licensing, or regulatory fees. Include a discussion of any such changes.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 10. Plan Adjusted Index Rate**
	(xi) Medical loss ratio (MLR). Include a projected federal MLR calculation [45 CFR §158.221; see also CMS MLR Filing Instructions]. Note: This is one of only two 45 CFR §154.301(a)(4) items not written in terms of the impact of changes; the other is (xii) for the issuer's capital and surplus. Note: As stated in the Final 2026 NBPP, determination of a "qualifying issuer" is "based on an issuer's 3-year aggregate ratio of net payments related to the risk adjustment program…to earned premiums." See 45 CFR §158.103 for full definition details. • *Issuers who (a)* ***are NOT projected to be qualifying issuers*** *or (b)* ***are projected to be qualifying issuers but opt to follow the unadjusted MLR formula****, as defined in the Final 2026 Notice of Benefit and Payment Parameters (NBPP)*: ○ Numerator: Incurred claims [45 CFR §158.140(a)] – Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that payables subtract negative amounts) + Quality Improvement Expenses [45 CFR §158.150(a)] ○ Denominator: Earned Premiums [45 CFR §158.130] – Taxes & Fees [45 CFR §§ 158.161(a) and 158.162(a)(1) and (b)(1)] – Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR Filing Instructions] • *Issuers who* ***are projected to be qualifying issuers and opt to follow the adjusted MLR formula****, as defined in the Final 2026 Notice of Benefit and Payment Parameters (NBPP)*: (See also the formula below written with variables, copied from the Final 2026 NBPP.) ○ Numerator: Incurred claims [45 CFR §158.140(a)] + Quality Improvement Expenses [45 CFR §158.150(a)]	**Part III**	**Exhibit 2. Proposed Rate Changes**

Line	Task	Issuer Response:	
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	○ Denominator: Earned Premiums [45 CFR §158.130] – Taxes & Fees [45 CFR §§ 158.161(a) and 158.162(a)(1) and (b)(1)] + Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that payables add negative amounts) – Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR filing instructions] • If CBE are included, provide justification that includes the following details: ○ How total CBE are allocated to lines of business (e.g., individual, small group, and large group) ○ For federal tax-exempt issuers: ▪ CBE are limited to the highest of either: • Three percent of earned premium; or • The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market. ▪ Please address the impact, if any, of capping CBE for MLR purposes. ▪ MLR reporting instructions say federal tax-exempt issuers may report a value for both state premium taxes and CBE if reported CBE do not exceed the allowable capped amount (as outlined above). If you are a federal tax-exempt issuer, please confirm this requirement has been met. ○ For non-federal tax-exempt issuers: ▪ CBE are limited to: The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market. ▪ Please address the impact, if any, of capping CBE for MLR purposes. ▪ MLR reporting instructions say non-federal tax-exempt issuers may report a value for state premium taxes or CBE but not both. Issuers may not report zero ($0) CBE in lieu of negative State premium taxes and may not enter CBE more than the allowable capped		

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

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

Line	Task	Issuer Response:	
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	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). o 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**	**Exhibit 2. Proposed Rate Changes**
	(xiii) The impacts of geographic factors and variations.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 12. Consumer Adjusted Premium Rate Development**

Line	Task	Issuer Response:	
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	(xiv) The impact of *changes within* a single risk pool to all products or plans within the risk pool.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 5. Projection Factors**
	(xv) The impact of reinsurance (which is N/A for Washington) and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.	**Part III**	**Exhibit 2. Proposed Rate Changes; Exhibit 9. Development of the Market-wide Adjusted Index Rate**
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.	**N/A**	
26	**Financial Statement Analysis:**		
a	Reconcile to Additional Data Statement (ADS) for the year ending December 31, 2024: • For carriers not required to file an ADS, please respond "N/A." For ease of review for carriers who file an ADS, please include with the rate filing a copy of the ADS pages. • For HMOs and HCSCs, show ADS amounts total revenues (line 7), total hospital and medical claims (line 17), and administrative expenses (line 19 + line 20). • Please include a detailed list of adjustments required to reconcile between ADS amounts and amounts in the Summary of Pooled Experience in the WAC 284-43-6660 summary and in URRT Worksheet 1, Section I. Calculate the amount and percentage unreconciled, and explain any significant unreconciled amounts. • Explain any difference in the projected risk adjustment amount included in the ADS premium amount versus the experience period risk adjustment amount entered in URRT Worksheet 1, Section I.	**Financial Statement Analysis.pdf** **Additional Data Statement 12 31 2024.pdf**	**Reconcile to Additional Data Statement (ADS)**

Line	Task	Issuer Response:	
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	• 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.	**Financial Statement Analysis.pdf** **Plan Statutory pg 34-5.pdf**	**Months of Surplus**
27	**Abortion Services for Which Public Funding is Prohibited:** (see also #11.d & #13 of this checklist) For Exchange filings, document the pricing per member per month (PMPM) for voluntary abortion services and the "EHB Percent of Total Premium" to be listed in the Plans & Benefit Template (PBT) in the 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.	**Part III**	**Exhibit 10. Plan Adjusted Index Rate, Table 10.3**
SEPARATE DOCUMENTS Address the following items together with other relevant items covered elsewhere in this checklist.			
28	**Part I Unified Rate Review Template (URRT):** Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the Exchange User Fee		

Line		Task	Issuer Response:	
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		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.	**Part III** **WA Exhibits**	**Exhibit 9. Development of the Market-wide Adjusted Index Rate, Table 9.1; Exhibit 10. Plan Adjusted Index Rate** **WA Exhibit 11**
	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	**Part III**	**Exhibit 9. Development of the Market-wide Adjusted Index Rate, Table 9.3**

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	apply the plan factors through multiplication; to neutralize the overall impact, URRT Worksheet 1 needs to divide by their aggregate impact.		
c	URRT Worksheet 1, Section II, 2026 versus 2025: Compare the projections in URRT Worksheet 1, Section II in this year's filing for 2026 versus those in last year's filing for 2025.	**WA Exhibits**	**WA Exhibit 5**
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**	
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**	
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.	**Part III** **WA Exhibits**	**Exhibit 18. Effective Rate Review Information, Table 18.1** **WA Exhibit 12**

Line	Task	Issuer Response:	
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	• 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.		
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**	**Exhibit 15. Membership Projections**
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.	**Part III**	**Exhibit 18. Effective Rate Review Information**

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
i	URRT controlled group renewal clarification: Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #30.b and #31.c of this checklist). If not applicable, indicate "N/A." In URRT Worksheet 2 Section I General Product and Plan Information and Section II Experience Period and Current Plan Level Information, for the current and new issuers: • The Plan Name (Field 1.3) and Plan ID (Field 1.4) will be unique to each issuer. • Indicate the plan as a renewing plan (Field 1.7). • Include the current rate from the current issuer (Field 2.11) in the new issuer's URRT. • Use the current rate in the calculation of the rate increase (Field 1.11) in the new issuer's URRT. • For consistency across the worksheets, only include experience in the current issuer's URRT Worksheets 1 and 2.	**N/A**	
29	**Part II Written Description Justifying the Rate Increase:** (a) Follow content guidance outlined in URR Instructions. (b) Include key drivers of the risk pool's rate increase as well as relevant plan details such as those described below. • Changes in Benefits: Consumers tend to view cost-share changes as "benefit changes," so a summary of the cost-share changes should be included in this section along with other significant benefit changes. Note: the cost-share changes in this document should just be an overview of major changes, such as general discussion of the range of deductibles or changes in copays, rather than a repeat of the detailed list in UPMJ Q4a & 4b. • Administrative Costs and Anticipated Margins: Consumers tend to view all retention loads, other than profit, as "administrative costs," so taxes and fees should be included in this section along with other administrative expenses. • Please also note the pool's projected profit & risk load.	**Part II Written Description Justifying the Rate Increase.pdf**	**Entire document**

Line		Task	Issuer Response:	
			Document Name	Section / Page / Exhibit Number
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**	**Exhibit 20. Actuarial Certification**
	b	Controlled group renewal clarification for Part III: Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #28.i and #31.c of this checklist). If not applicable, indicate "N/A." In both the current and new issuers' Part III actuarial memorandums, add a crosswalk detailing the current and renewing plan information. Include: • The name of the current and new issuers offering the plan. • A comparison of the 2025 and 2026 HIOS Plan IDs and plan names. • A comparison of the 2025 counties in the service area for the renewing plan and the 2026 counties offered by the new issuer to demonstrate meeting the requirement to cover a majority of the same service area.	**N/A**	**N/A**

Line		Task	Issuer Response:	
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		• 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**	**Exhibit 18. Effective Rate Review Information**
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.	**UPMJ**	**Q4a, Q4b**
	b	UPMJ Q5: (i) Column 5(d): • Only include enrollment from renewing counties. • If you are exiting any counties, please address the following: Since you are exiting counties, total enrollment in Q5 may not match the UPMJ Q1 total, so include an exhibit in the filing with current enrollment by plan split between renewing and	**UPMJ**	**Q5**

Line	Task	Issuer Response:	
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	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). If not applicable, indicate "N/A." • *Current issuer*: UPMJ Q4a and Q5 will be blank.	**N/A**	**N/A**

Line	Task	Issuer Response:	
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	• *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).	**WAC 284-43-6660**	**Proposed Rate Summary**
b	Components of proposed community rate: • Component (a) Claims should match (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.15 Incurred Claims PMPM) minus (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.16 Risk Adjustment Transfer Amount PMPM). • Component (b) Expenses combined with component (d) Investment Earnings must be consistent with the combined values of (Exchange User Fees in URRT Worksheet 1, Section II) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6 Administrative Expense) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7 Taxes and Fees). • Component (c) Contribution to Surplus Contingency Charges, or Risk Charges must be consistent with (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8 Profit & Risk Load). • Total row (e) must match the Proposed Community Rate from #32.a above (i.e., Proposed rate summary) in the WAC 284-43-6660 summary.	**WAC 284-43-6660**	**Components of Proposed Community Rate**
c	Trend factor summary: (see also #6.b of this checklist)	**WAC 284-43-6660**	**General Information, 1.**

Line	Task	Issuer Response:	
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	• 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.		
d	General Information section #4: Respond with "See Rate Schedule."	**WAC 284-43-6660**	**General Information, 4.**
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.pdf** **Benefit Components DUPLICATE.xlsm**	**Entire file**

Line		Task	Issuer Response:	
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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.	**MHSUD Financial Requirements Certification.pdf**	**Entire document**
	b	MH/SUD parity calculations: Complete an MH/SUD Parity Speed-to-Market Tool that documents MHSUD financial requirement parity testing calculations. See file template "Certification - Rates - 2026 Mental Health and Substance Use Disorder Financial Req Parity Calculations" on the Washington State OIC website. • In the Mapping Information and each MHSUD Parity Testing Worksheet, please use the same benefit descriptions listed (both EHB and non-EHB) in the Benefit Components. The list should include all benefits, including inpatient, emergency care and prescription drugs. • 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.pdf** **MHSUD Parity Calculations DUPLICATE.xlsm**	**Entire document**

Line	Task	Issuer Response:	
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	• 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.	**Commissions Certification.pdf**	**Entire document**

Line	Task	Issuer Response:	
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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.pdf** **Rate Schedule DUPLICATE.xlsm**	**Entire document**
37	**Rate Example:** Submit a rate calculation example on the Rate/Rule Schedule tab in SERFF. Address the following: • Use the rates in the Rate Schedule. • Include a statement that rates are charged to no more than the three **oldest** covered children under 21 for family coverage [45 CFR §147.102(c)(1)]. • If your premium rates adjust for tobacco use, please include in the example at least one family member who uses tobacco and would then be subject to the adjustment.	**Illustrative Rate Calculation.pdf**	**Entire document**
38	**Requirements for Mitigating Inequity in the Health Insurance Market [WAC 284-43-6590]:** If applicable, submit a separate certification detailing the calculation of a fee for excluding any benefit mandated or required by Title 48 RCW or rules adopted by the commissioner. A member of the American Academy of Actuaries (MAAA) must sign the certification. (see also #21.a of this checklist)	**N/A**	

Line	Task	Issuer Response:	
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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**	**No artificial intelligence, machine learning, or predictive modeling used**
40	**1332 waiver checklist:** Complete and submit the file "Checklist – Rates – 2026 Individual Supplemental Checklist for 1332 Waiver Reporting."	**Checklist - Rates - 1332 Waiver Reporting.pdf**	**Entire document**

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Complete Gold
HIOS Plan ID: 18581WA0140001
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	286.76	308.21		283.37	268.01	277.30	295.20	288.58	278.19	286.76	308.21		283.37	268.01	277.30	295.20	288.58	278.19
15	312.25	335.61		308.56	291.83	301.95	321.44	314.23	302.91	312.25	335.61		308.56	291.83	301.95	321.44	314.23	302.91
16	321.99	346.08		318.19	300.94	311.38	331.47	324.04	312.37	321.99	346.08		318.19	300.94	311.38	331.47	324.04	312.37
17	331.74	356.56		327.82	310.05	320.80	341.50	333.85	321.82	331.74	356.56		327.82	310.05	320.80	341.50	333.85	321.82
18	342.23	367.84		338.19	319.86	330.95	352.31	344.41	332.00	342.23	367.84		338.19	319.86	330.95	352.31	344.41	332.00
19	352.73	379.12		348.57	329.67	341.10	363.11	354.97	342.19	352.73	379.12		348.57	329.67	341.10	363.11	354.97	342.19
20	363.60	390.80		359.31	339.83	351.61	374.30	365.91	352.73	363.60	390.80		359.31	339.83	351.61	374.30	365.91	352.73
21	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64
22	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64
23	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64
24	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64	374.85	402.89		370.42	350.34	362.49	385.88	377.23	363.64
25	376.34	404.50		371.90	351.74	363.94	387.42	378.74	365.10	376.34	404.50		371.90	351.74	363.94	387.42	378.74	365.10
26	383.84	412.56		379.31	358.75	371.19	395.14	386.28	372.37	383.84	412.56		379.31	358.75	371.19	395.14	386.28	372.37
27	392.84	422.23		388.20	367.15	379.89	404.40	395.33	381.10	392.84	422.23		388.20	367.15	379.89	404.40	395.33	381.10
28	407.46	437.94		402.65	380.82	394.02	419.45	410.05	395.28	407.46	437.94		402.65	380.82	394.02	419.45	410.05	395.28
29	419.45	450.83		414.50	392.03	405.62	431.80	422.12	406.92	419.45	450.83		414.50	392.03	405.62	431.80	422.12	406.92
30	425.45	457.28		420.43	397.63	411.42	437.97	428.15	412.73	425.45	457.28		420.43	397.63	411.42	437.97	428.15	412.73
31	434.45	466.95		429.32	406.04	420.12	447.24	437.21	421.46	434.45	466.95		429.32	406.04	420.12	447.24	437.21	421.46
32	443.44	476.62		438.21	414.45	428.82	456.50	446.26	430.19	443.44	476.62		438.21	414.45	428.82	456.50	446.26	430.19
33	449.06	482.66		443.76	419.71	434.26	462.28	451.92	435.64	449.06	482.66		443.76	419.71	434.26	462.28	451.92	435.64
34	455.06	489.11		449.69	425.31	440.06	468.46	457.95	441.46	455.06	489.11		449.69	425.31	440.06	468.46	457.95	441.46
35	458.06	492.33		452.65	428.11	442.96	471.55	460.97	444.37	458.06	492.33		452.65	428.11	442.96	471.55	460.97	444.37
36	461.06	495.55		455.62	430.92	445.86	474.63	463.99	447.28	461.06	495.55		455.62	430.92	445.86	474.63	463.99	447.28
37	464.06	498.78		458.58	433.72	448.76	477.72	467.01	450.19	464.06	498.78		458.58	433.72	448.76	477.72	467.01	450.19
38	467.06	502.00		461.54	436.52	451.66	480.81	470.03	453.10	467.06	502.00		461.54	436.52	451.66	480.81	470.03	453.10
39	473.06	508.45		467.47	442.13	457.46	486.98	476.06	458.92	473.06	508.45		467.47	442.13	457.46	486.98	476.06	458.92
40	479.05	514.89		473.40	447.73	463.26	493.15	482.10	464.73	479.05	514.89		473.40	447.73	463.26	493.15	482.10	464.73
41	488.05	524.56		482.29	456.14	471.96	502.42	491.15	473.46	488.05	524.56		482.29	456.14	471.96	502.42	491.15	473.46
42	496.67	533.83		490.81	464.20	480.30	511.29	499.83	481.83	496.67	533.83		490.81	464.20	480.30	511.29	499.83	481.83
43	508.67	546.72		502.66	475.41	491.90	523.64	511.90	493.46	508.67	546.72		502.66	475.41	491.90	523.64	511.90	493.46
44	523.66	562.84		517.48	489.42	506.39	539.07	526.99	508.01	523.66	562.84		517.48	489.42	506.39	539.07	526.99	508.01
45	541.28	581.77		534.89	505.89	523.43	557.21	544.72	525.10	541.28	581.77		534.89	505.89	523.43	557.21	544.72	525.10
46	562.27	604.33		555.63	525.51	543.73	578.82	565.84	545.46	562.27	604.33		555.63	525.51	543.73	578.82	565.84	545.46
47	585.88	629.72		578.97	547.58	566.57	603.13	589.61	568.37	585.88	629.72		578.97	547.58	566.57	603.13	589.61	568.37
48	612.87	658.72		605.64	572.80	592.67	630.91	616.77	594.55	612.87	658.72		605.64	572.80	592.67	630.91	616.77	594.55
49	639.49	687.33		631.94	597.68	618.40	658.31	643.55	620.37	639.49	687.33		631.94	597.68	618.40	658.31	643.55	620.37
50	669.47	719.56		661.57	625.70	647.40	689.18	673.73	649.46	669.47	719.56		661.57	625.70	647.40	689.18	673.73	649.46
51	699.09	751.39		690.83	653.38	676.04	719.67	703.53	678.19	699.09	751.39		690.83	653.38	676.04	719.67	703.53	678.19
52	731.70	786.44		723.06	683.86	707.58	753.24	736.35	709.83	731.70	786.44		723.06	683.86	707.58	753.24	736.35	709.83
53	764.68	821.89		755.66	714.69	739.47	787.20	769.54	741.83	764.68	821.89		755.66	714.69	739.47	787.20	769.54	741.83
54	800.30	860.17		790.85	747.97	773.91	823.85	805.38	776.38	800.30	860.17		790.85	747.97	773.91	823.85	805.38	776.38
55	835.91	898.44		826.04	781.26	808.35	860.51	841.22	810.92	835.91	898.44		826.04	781.26	808.35	860.51	841.22	810.92
56	874.51	939.94		864.19	817.34	845.68	900.26	880.07	848.38	874.51	939.94		864.19	817.34	845.68	900.26	880.07	848.38
57	913.50	981.84		902.72	853.78	883.38	940.39	919.30	886.19	913.50	981.84		902.72	853.78	883.38	940.39	919.30	886.19
58	955.11	1026.56		943.83	892.66	923.62	983.22	961.17	926.56	955.11	1026.56		943.83	892.66	923.62	983.22	961.17	926.56
59	975.72	1048.72		964.21	911.93	943.55	1004.45	981.92	946.56	975.72	1048.72		964.21	911.93	943.55	1004.45	981.92	946.56
60	1017.33	1093.44		1005.32	950.82	983.79	1047.28	1023.79	986.92	1017.33	1093.44		1005.32	950.82	983.79	1047.28	1023.79	986.92
61	1053.32	1132.12		1040.88	984.45	1018.59	1084.32	1060.01	1021.83	1053.32	1132.12		1040.88	984.45	1018.59	1084.32	1060.01	1021.83
62	1076.93	1157.50		1064.22	1006.52	1041.43	1108.63	1083.77	1044.74	1076.93	1157.50		1064.22	1006.52	1041.43	1108.63	1083.77	1044.74
63	1106.54	1189.33		1093.48	1034.20	1070.06	1139.12	1113.57	1073.47	1106.54	1189.33		1093.48	1034.20	1070.06	1139.12	1113.57	1073.47
64 and over	1124.54	1208.67		1111.26	1051.02	1087.46	1157.64	1131.68	1090.92	1124.54	1208.67		1111.26	1051.02	1087.46	1157.64	1131.68	1090.92

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Vital Gold
HIOS Plan ID: 18581WA0140004
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Gold
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	268.82	288.93		265.64	251.24	259.95	276.73	270.53	260.78	268.82	288.93		265.64	251.24	259.95	276.73	270.53	260.78
15	292.71	314.61		289.26	273.57	283.06	301.33	294.57	283.96	292.71	314.61		289.26	273.57	283.06	301.33	294.57	283.96
16	301.85	324.43		298.29	282.11	291.90	310.73	303.77	292.83	301.85	324.43		298.29	282.11	291.90	310.73	303.77	292.83
17	310.98	334.25		307.31	290.65	300.73	320.14	312.96	301.69	310.98	334.25		307.31	290.65	300.73	320.14	312.96	301.69
18	320.82	344.83		317.04	299.85	310.25	330.27	322.86	311.23	320.82	344.83		317.04	299.85	310.25	330.27	322.86	311.23
19	330.66	355.40		326.76	309.04	319.76	340.40	332.76	320.78	330.66	355.40		326.76	309.04	319.76	340.40	332.76	320.78
20	340.85	366.35		336.83	318.57	329.62	350.89	343.02	330.67	340.85	366.35		336.83	318.57	329.62	350.89	343.02	330.67
21	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89
22	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89
23	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89
24	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89	351.39	377.68		347.25	328.42	339.81	361.74	353.63	340.89
25	352.80	379.20		348.64	329.73	341.17	363.19	355.04	342.26	352.80	379.20		348.64	329.73	341.17	363.19	355.04	342.26
26	359.83	386.75		355.58	336.30	347.97	370.42	362.11	349.07	359.83	386.75		355.58	336.30	347.97	370.42	362.11	349.07
27	368.26	395.81		363.91	344.19	356.12	379.10	370.60	357.25	368.26	395.81		363.91	344.19	356.12	379.10	370.60	357.25
28	381.97	410.54		377.46	356.99	369.37	393.21	384.39	370.55	381.97	410.54		377.46	356.99	369.37	393.21	384.39	370.55
29	393.21	422.63		388.57	367.50	380.25	404.79	395.71	381.46	393.21	422.63		388.57	367.50	380.25	404.79	395.71	381.46
30	398.83	428.67		394.13	372.76	385.68	410.57	401.37	386.91	398.83	428.67		394.13	372.76	385.68	410.57	401.37	386.91
31	407.27	437.74		402.46	380.64	393.84	419.26	409.85	395.09	407.27	437.74		402.46	380.64	393.84	419.26	409.85	395.09
32	415.70	446.80		410.79	388.52	401.99	427.94	418.34	403.28	415.70	446.80		410.79	388.52	401.99	427.94	418.34	403.28
33	420.97	452.47		416.00	393.45	407.09	433.36	423.65	408.39	420.97	452.47		416.00	393.45	407.09	433.36	423.65	408.39
34	426.59	458.51		421.56	398.70	412.53	439.15	429.30	413.84	426.59	458.51		421.56	398.70	412.53	439.15	429.30	413.84
35	429.40	461.53		424.34	401.33	415.25	442.05	432.13	416.57	429.40	461.53		424.34	401.33	415.25	442.05	432.13	416.57
36	432.22	464.55		427.11	403.96	417.97	444.94	434.96	419.30	432.22	464.55		427.11	403.96	417.97	444.94	434.96	419.30
37	435.03	467.57		429.89	406.59	420.68	447.83	437.79	422.02	435.03	467.57		429.89	406.59	420.68	447.83	437.79	422.02
38	437.84	470.59		432.67	409.21	423.40	450.73	440.62	424.75	437.84	470.59		432.67	409.21	423.40	450.73	440.62	424.75
39	443.46	476.64		438.23	414.47	428.84	456.51	446.28	430.21	443.46	476.64		438.23	414.47	428.84	456.51	446.28	430.21
40	449.08	482.68		443.78	419.72	434.28	462.30	451.94	435.66	449.08	482.68		443.78	419.72	434.28	462.30	451.94	435.66
41	457.52	491.74		452.12	427.60	442.43	470.98	460.42	443.84	457.52	491.74		452.12	427.60	442.43	470.98	460.42	443.84
42	465.60	500.43		460.10	435.16	450.25	479.30	468.56	451.68	465.60	500.43		460.10	435.16	450.25	479.30	468.56	451.68
43	476.84	512.52		471.21	445.67	461.12	490.88	479.87	462.59	476.84	512.52		471.21	445.67	461.12	490.88	479.87	462.59
44	490.90	527.62		485.10	458.80	474.71	505.35	494.02	476.23	490.90	527.62		485.10	458.80	474.71	505.35	494.02	476.23
45	507.41	545.38		501.42	474.24	490.69	522.35	510.64	492.25	507.41	545.38		501.42	474.24	490.69	522.35	510.64	492.25
46	527.09	566.53		520.87	492.63	509.71	542.61	530.44	511.34	527.09	566.53		520.87	492.63	509.71	542.61	530.44	511.34
47	549.23	590.32		542.75	513.32	531.12	565.40	552.72	532.81	549.23	590.32		542.75	513.32	531.12	565.40	552.72	532.81
48	574.53	617.51		567.75	536.97	555.59	591.44	578.18	557.36	574.53	617.51		567.75	536.97	555.59	591.44	578.18	557.36
49	599.48	644.33		592.40	560.29	579.72	617.13	603.29	581.56	599.48	644.33		592.40	560.29	579.72	617.13	603.29	581.56
50	627.59	674.54		620.18	586.56	606.90	646.07	631.58	608.83	627.59	674.54		620.18	586.56	606.90	646.07	631.58	608.83
51	655.35	704.38		647.62	612.51	633.75	674.64	659.52	635.76	655.35	704.38		647.62	612.51	633.75	674.64	659.52	635.76
52	685.92	737.24		677.83	641.08	663.31	706.11	690.28	665.42	685.92	737.24		677.83	641.08	663.31	706.11	690.28	665.42
53	716.85	770.48		708.38	669.98	693.21	737.95	721.40	695.42	716.85	770.48		708.38	669.98	693.21	737.95	721.40	695.42
54	750.23	806.36		741.37	701.18	725.49	772.31	754.99	727.80	750.23	806.36		741.37	701.18	725.49	772.31	754.99	727.80
55	783.61	842.24		774.36	732.38	757.78	806.68	788.59	760.19	783.61	842.24		774.36	732.38	757.78	806.68	788.59	760.19
56	819.80	881.14		810.13	766.21	792.78	843.94	825.01	795.30	819.80	881.14		810.13	766.21	792.78	843.94	825.01	795.30
57	856.35	920.42		846.24	800.36	828.12	881.56	861.79	830.75	856.35	920.42		846.24	800.36	828.12	881.56	861.79	830.75
58	895.35	962.34		884.79	836.82	865.84	921.71	901.04	868.59	895.35	962.34		884.79	836.82	865.84	921.71	901.04	868.59
59	914.68	983.11		903.88	854.88	884.52	941.61	920.49	887.34	914.68	983.11		903.88	854.88	884.52	941.61	920.49	887.34
60	953.69	1025.04		942.43	891.33	922.24	981.76	959.75	925.18	953.69	1025.04		942.43	891.33	922.24	981.76	959.75	925.18
61	987.42	1061.29		975.76	922.86	954.87	1016.49	993.69	957.91	987.42	1061.29		975.76	922.86	954.87	1016.49	993.69	957.91
62	1009.56	1085.09		997.64	943.55	976.27	1039.28	1015.97	979.38	1009.56	1085.09		997.64	943.55	976.27	1039.28	1015.97	979.38
63	1037.32	1114.92		1025.07	969.50	1003.12	1067.85	1043.91	1006.31	1037.32	1114.92		1025.07	969.50	1003.12	1067.85	1043.91	1006.31
64 and over	1054.17	1133.04		1041.74	985.26	1019.43	1085.22	1060.88	1022.67	1054.17	1133.04		1041.74	985.26	1019.43	1085.22	1060.88	1022.67

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Silver
HIOS Plan ID: 18581WA0140002
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Silver
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	342.56	368.19		338.52	320.16	331.27	352.64	344.74	332.32	342.56	368.19		338.52	320.16	331.27	352.64	344.74	332.32
15	373.01	400.92		368.61	348.62	360.71	383.99	375.38	361.86	373.01	400.92		368.61	348.62	360.71	383.99	375.38	361.86
16	384.65	413.43		380.11	359.50	371.97	395.98	387.10	373.16	384.65	413.43		380.11	359.50	371.97	395.98	387.10	373.16
17	396.29	425.94		391.62	370.39	383.23	407.96	398.81	384.45	396.29	425.94		391.62	370.39	383.23	407.96	398.81	384.45
18	408.83	439.42		404.01	382.10	395.35	420.87	411.43	396.61	408.83	439.42		404.01	382.10	395.35	420.87	411.43	396.61
19	421.37	452.90		416.40	393.82	407.48	433.78	424.05	408.78	421.37	452.90		416.40	393.82	407.48	433.78	424.05	408.78
20	434.36	466.85		429.23	405.96	420.04	447.14	437.12	421.37	434.36	466.85		429.23	405.96	420.04	447.14	437.12	421.37
21	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41
22	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41
23	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41
24	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41	447.79	481.29		442.50	418.51	433.03	460.97	450.64	434.41
25	449.58	483.22		444.27	420.19	434.76	462.82	452.44	436.14	449.58	483.22		444.27	420.19	434.76	462.82	452.44	436.14
26	458.54	492.84		453.13	428.56	443.42	472.04	461.45	444.83	458.54	492.84		453.13	428.56	443.42	472.04	461.45	444.83
27	469.28	504.39		463.75	438.60	453.81	483.10	472.27	455.26	469.28	504.39		463.75	438.60	453.81	483.10	472.27	455.26
28	486.75	523.16		481.00	454.93	470.70	501.08	489.84	472.20	486.75	523.16		481.00	454.93	470.70	501.08	489.84	472.20
29	501.08	538.57		495.16	468.32	484.56	515.83	504.26	486.10	501.08	538.57		495.16	468.32	484.56	515.83	504.26	486.10
30	508.24	546.27		502.24	475.01	491.49	523.20	511.47	493.05	508.24	546.27		502.24	475.01	491.49	523.20	511.47	493.05
31	518.99	557.82		512.86	485.06	501.88	534.27	522.29	503.48	518.99	557.82		512.86	485.06	501.88	534.27	522.29	503.48
32	529.74	569.37		523.48	495.10	512.27	545.33	533.10	513.90	529.74	569.37		523.48	495.10	512.27	545.33	533.10	513.90
33	536.45	576.59		530.12	501.38	518.77	552.25	539.86	520.42	536.45	576.59		530.12	501.38	518.77	552.25	539.86	520.42
34	543.62	584.29		537.20	508.08	525.70	559.62	547.07	527.37	543.62	584.29		537.20	508.08	525.70	559.62	547.07	527.37
35	547.20	588.14		540.74	511.43	529.16	563.31	550.68	530.84	547.20	588.14		540.74	511.43	529.16	563.31	550.68	530.84
36	550.78	591.99		544.28	514.77	532.62	567.00	554.28	534.32	550.78	591.99		544.28	514.77	532.62	567.00	554.28	534.32
37	554.37	595.84		547.82	518.12	536.09	570.68	557.89	537.80	554.37	595.84		547.82	518.12	536.09	570.68	557.89	537.80
38	557.95	599.69		551.36	521.47	539.55	574.37	561.49	541.27	557.95	599.69		551.36	521.47	539.55	574.37	561.49	541.27
39	565.11	607.39		558.44	528.17	546.48	581.75	568.70	548.22	565.11	607.39		558.44	528.17	546.48	581.75	568.70	548.22
40	572.28	615.09		565.52	534.86	553.41	589.12	575.91	555.17	572.28	615.09		565.52	534.86	553.41	589.12	575.91	555.17
41	583.02	626.64		576.14	544.91	563.80	600.19	586.73	565.60	583.02	626.64		576.14	544.91	563.80	600.19	586.73	565.60
42	593.32	637.71		586.32	554.53	573.76	610.79	597.09	575.59	593.32	637.71		586.32	554.53	573.76	610.79	597.09	575.59
43	607.65	653.11		600.48	567.92	587.62	625.54	611.51	589.49	607.65	653.11		600.48	567.92	587.62	625.54	611.51	589.49
44	625.56	672.36		618.18	584.67	604.94	643.98	629.54	606.87	625.56	672.36		618.18	584.67	604.94	643.98	629.54	606.87
45	646.61	694.99		638.98	604.34	625.29	665.64	650.72	627.28	646.61	694.99		638.98	604.34	625.29	665.64	650.72	627.28
46	671.69	721.94		663.76	627.77	649.54	691.46	675.95	651.61	671.69	721.94		663.76	627.77	649.54	691.46	675.95	651.61
47	699.90	752.26		691.64	654.14	676.82	720.50	704.34	678.98	699.90	752.26		691.64	654.14	676.82	720.50	704.34	678.98
48	732.14	786.91		723.50	684.27	708.00	753.69	736.79	710.25	732.14	786.91		723.50	684.27	708.00	753.69	736.79	710.25
49	763.93	821.08		754.91	713.99	738.74	786.42	768.78	741.10	763.93	821.08		754.91	713.99	738.74	786.42	768.78	741.10
50	799.75	859.59		790.31	747.47	773.39	823.30	804.84	775.85	799.75	859.59		790.31	747.47	773.39	823.30	804.84	775.85
51	835.13	897.61		825.27	780.53	807.60	859.71	840.44	810.17	835.13	897.61		825.27	780.53	807.60	859.71	840.44	810.17
52	874.09	939.48		863.77	816.94	845.27	899.82	879.64	847.96	874.09	939.48		863.77	816.94	845.27	899.82	879.64	847.96
53	913.49	981.84		902.71	853.77	883.38	940.38	919.30	886.19	913.49	981.84		902.71	853.77	883.38	940.38	919.30	886.19
54	956.03	1027.56		944.75	893.53	924.51	984.18	962.11	927.46	956.03	1027.56		944.75	893.53	924.51	984.18	962.11	927.46
55	998.57	1073.28		986.79	933.29	965.65	1027.97	1004.92	968.73	998.57	1073.28		986.79	933.29	965.65	1027.97	1004.92	968.73
56	1044.70	1122.85		1032.36	976.39	1010.25	1075.45	1051.33	1013.47	1044.70	1122.85		1032.36	976.39	1010.25	1075.45	1051.33	1013.47
57	1091.27	1172.91		1078.38	1019.92	1055.29	1123.39	1098.20	1058.65	1091.27	1172.91		1078.38	1019.92	1055.29	1123.39	1098.20	1058.65
58	1140.97	1226.33		1127.50	1066.38	1103.35	1174.56	1148.22	1106.87	1140.97	1226.33		1127.50	1066.38	1103.35	1174.56	1148.22	1106.87
59	1165.60	1252.80		1151.84	1089.39	1127.17	1199.91	1173.01	1130.76	1165.60	1252.80		1151.84	1089.39	1127.17	1199.91	1173.01	1130.76
60	1215.30	1306.23		1200.96	1135.85	1175.24	1251.08	1223.03	1178.98	1215.30	1306.23		1200.96	1135.85	1175.24	1251.08	1223.03	1178.98
61	1258.29	1352.43		1243.44	1176.03	1216.81	1295.33	1266.29	1220.68	1258.29	1352.43		1243.44	1176.03	1216.81	1295.33	1266.29	1220.68
62	1286.50	1382.75		1271.32	1202.39	1244.09	1324.37	1294.68	1248.05	1286.50	1382.75		1271.32	1202.39	1244.09	1324.37	1294.68	1248.05
63	1321.88	1420.77		1306.27	1235.46	1278.30	1360.79	1330.28	1282.37	1321.88	1420.77		1306.27	1235.46	1278.30	1360.79	1330.28	1282.37
64 and over	1343.37	1443.87		1327.50	1255.53	1299.08	1382.91	1351.91	1303.22	1343.37	1443.87		1327.50	1255.53	1299.08	1382.91	1351.91	1303.22

Community Health Plan of Washington
RATE SCHEDULE

Plan Information

Plan Name: Community Health Plan of Washington Cascade Select Bronze
HIOS Plan ID: 18581WA0140003
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: In the exchange
Metal Level: Bronze
Plan Type: Standardized Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Clallam, Jefferson, Kitsap, Lewis
3	No	
4	Yes	Ferry, Lincoln, Spokane, Stevens
5	Yes	Mason, Pierce, Thurston
6	Yes	Benton, Franklin, Kittitas, Yakima
7	Yes	Adams, Chelan, Douglas, Grant, Okanogan
8	Yes	Snohomish
9	Yes	Asotin, Columbia, Walla Walla, Whitman

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	202.25	217.38		199.86	189.03	195.58	208.20	203.53	196.20	202.25	217.38		199.86	189.03	195.58	208.20	203.53	196.20
15	220.23	236.70		217.63	205.83	212.97	226.71	221.63	213.65	220.23	236.70		217.63	205.83	212.97	226.71	221.63	213.65
16	227.10	244.09		224.42	212.25	219.61	233.79	228.54	220.31	227.10	244.09		224.42	212.25	219.61	233.79	228.54	220.31
17	233.98	251.48		231.21	218.68	226.26	240.86	235.46	226.98	233.98	251.48		231.21	218.68	226.26	240.86	235.46	226.98
18	241.38	259.44		238.53	225.60	233.42	248.48	242.91	234.16	241.38	259.44		238.53	225.60	233.42	248.48	242.91	234.16
19	248.78	267.39		245.84	232.52	240.58	256.10	250.36	241.34	248.78	267.39		245.84	232.52	240.58	256.10	250.36	241.34
20	256.45	275.63		253.42	239.68	247.99	264.00	258.08	248.78	256.45	275.63		253.42	239.68	247.99	264.00	258.08	248.78
21	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48
22	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48
23	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48
24	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48	264.38	284.16		261.26	247.09	255.66	272.16	266.06	256.48
25	265.44	285.29		262.30	248.08	256.69	273.25	267.12	257.50	265.44	285.29		262.30	248.08	256.69	273.25	267.12	257.50
26	270.72	290.98		267.53	253.02	261.80	278.69	272.44	262.63	270.72	290.98		267.53	253.02	261.80	278.69	272.44	262.63
27	277.07	297.80		273.80	258.95	267.93	285.23	278.83	268.79	277.07	297.80		273.80	258.95	267.93	285.23	278.83	268.79
28	287.38	308.88		283.99	268.59	277.91	295.84	289.21	278.79	287.38	308.88		283.99	268.59	277.91	295.84	289.21	278.79
29	295.84	317.97		292.35	276.50	286.09	304.55	297.72	287.00	295.84	317.97		292.35	276.50	286.09	304.55	297.72	287.00
30	300.07	322.52		296.53	280.45	290.18	308.90	301.98	291.10	300.07	322.52		296.53	280.45	290.18	308.90	301.98	291.10
31	306.42	329.34		302.80	286.38	296.31	315.44	308.36	297.26	306.42	329.34		302.80	286.38	296.31	315.44	308.36	297.26
32	312.76	336.16		309.07	292.31	302.45	321.97	314.75	303.41	312.76	336.16		309.07	292.31	302.45	321.97	314.75	303.41
33	316.73	340.42		312.99	296.02	306.28	326.05	318.74	307.26	316.73	340.42		312.99	296.02	306.28	326.05	318.74	307.26
34	320.96	344.97		317.17	299.97	310.37	330.40	323.00	311.36	320.96	344.97		317.17	299.97	310.37	330.40	323.00	311.36
35	323.07	347.24		319.26	301.95	312.42	332.58	325.12	313.41	323.07	347.24		319.26	301.95	312.42	332.58	325.12	313.41
36	325.19	349.51		321.35	303.93	314.47	334.76	327.25	315.47	325.19	349.51		321.35	303.93	314.47	334.76	327.25	315.47
37	327.30	351.79		323.44	305.90	316.51	336.94	329.38	317.52	327.30	351.79		323.44	305.90	316.51	336.94	329.38	317.52
38	329.42	354.06		325.53	307.88	318.56	339.11	331.51	319.57	329.42	354.06		325.53	307.88	318.56	339.11	331.51	319.57
39	333.65	358.61		329.71	311.83	322.65	343.47	335.77	323.67	333.65	358.61		329.71	311.83	322.65	343.47	335.77	323.67
40	337.88	363.15		333.89	315.79	326.74	347.82	340.02	327.78	337.88	363.15		333.89	315.79	326.74	347.82	340.02	327.78
41	344.22	369.97		340.16	321.72	332.87	354.35	346.41	333.93	344.22	369.97		340.16	321.72	332.87	354.35	346.41	333.93
42	350.30	376.51		346.17	327.40	338.75	360.61	352.53	339.83	350.30	376.51		346.17	327.40	338.75	360.61	352.53	339.83
43	358.76	385.60		354.53	335.31	346.93	369.32	361.04	348.04	358.76	385.60		354.53	335.31	346.93	369.32	361.04	348.04
44	369.34	396.97		364.98	345.19	357.16	380.21	371.68	358.30	369.34	396.97		364.98	345.19	357.16	380.21	371.68	358.30
45	381.76	410.32		377.26	356.80	369.18	393.00	384.19	370.35	381.76	410.32		377.26	356.80	369.18	393.00	384.19	370.35
46	396.57	426.24		391.89	370.64	383.49	408.24	399.09	384.72	396.57	426.24		391.89	370.64	383.49	408.24	399.09	384.72
47	413.22	444.14		408.35	386.21	399.60	425.39	415.85	400.87	413.22	444.14		408.35	386.21	399.60	425.39	415.85	400.87
48	432.26	464.60		427.16	404.00	418.01	444.98	435.01	419.34	432.26	464.60		427.16	404.00	418.01	444.98	435.01	419.34
49	451.03	484.77		445.71	421.54	436.16	464.31	453.90	437.55	451.03	484.77		445.71	421.54	436.16	464.31	453.90	437.55
50	472.18	507.51		466.61	441.31	456.61	486.08	475.18	458.07	472.18	507.51		466.61	441.31	456.61	486.08	475.18	458.07
51	493.07	529.96		487.25	460.83	476.81	507.58	496.20	478.33	493.07	529.96		487.25	460.83	476.81	507.58	496.20	478.33
52	516.07	554.68		509.98	482.33	499.05	531.26	519.35	500.64	516.07	554.68		509.98	482.33	499.05	531.26	519.35	500.64
53	539.33	579.68		532.97	504.07	521.55	555.21	542.76	523.21	539.33	579.68		532.97	504.07	521.55	555.21	542.76	523.21
54	564.45	606.68		557.79	527.55	545.84	581.07	568.04	547.58	564.45	606.68		557.79	527.55	545.84	581.07	568.04	547.58
55	589.57	633.67		582.61	551.02	570.13	606.92	593.31	571.94	589.57	633.67		582.61	551.02	570.13	606.92	593.31	571.94
56	616.80	662.94		609.52	576.47	596.46	634.95	620.72	598.36	616.80	662.94		609.52	576.47	596.46	634.95	620.72	598.36
57	644.29	692.49		636.69	602.17	623.05	663.26	648.39	625.03	644.29	692.49		636.69	602.17	623.05	663.26	648.39	625.03
58	673.64	724.04		665.69	629.60	651.43	693.47	677.92	653.50	673.64	724.04		665.69	629.60	651.43	693.47	677.92	653.50
59	688.18	739.66		680.05	643.19	665.49	708.44	692.55	667.61	688.18	739.66		680.05	643.19	665.49	708.44	692.55	667.61
60	717.52	771.21		709.05	670.61	693.87	738.65	722.08	696.08	717.52	771.21		709.05	670.61	693.87	738.65	722.08	696.08
61	742.91	798.48		734.14	694.33	718.41	764.77	747.63	720.70	742.91	798.48		734.14	694.33	718.41	764.77	747.63	720.70
62	759.56	816.39		750.59	709.90	734.52	781.92	764.39	736.86	759.56	816.39		750.59	709.90	734.52	781.92	764.39	736.86
63	780.45	838.84		771.23	729.42	754.72	803.42	785.41	757.12	780.45	838.84		771.23	729.42	754.72	803.42	785.41	757.12
64 and over	793.14	852.48		783.77	741.27	766.98	816.48	798.18	769.43	793.14	852.48		783.77	741.27	766.98	816.48	798.18	769.43

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:	Community Health Plan of Washington		
HIOS Issuer ID:	18581	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	$131,726,287.66	$392.63
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$112,945,234.01	$336.65
Risk Adjustment	-$44,291,653.16	-$132.02
Experience Period Premium	$153,416,318.04	$457.28
Experience Period Member Months	335,501	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$73.33	1.031	0.995	1.031	0.995	$77.11
Outpatient Hospital	$126.54	1.031	1.010	1.030	1.010	$137.10
Professional	$85.91	0.972	1.000	1.001	1.000	$83.63
Other Medical	$7.40	0.975	1.000	1.004	1.000	$7.24
Capitation	$0.00	1.000	1.000	1.000	1.000	$0.00
Prescription Drug	$99.45	1.100	1.025	1.100	1.025	$126.43
Total	$392.63					**$431.52**

Morbidity Adjustment	1.010
Demographic Shift	1.028
Plan Design Changes	0.984
Other	1.016
Adjusted Trended EHB Allowed Claims PMPM for **1/1/2026**	**$448.40**

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

		Projected Period Totals
Projected Index Rate for **1/1/2026**	**$448.40**	$131,982,952.80
Reinsurance	$0.00	$0.00
Risk Adjustment Payment/Charge	-$163.92	-$48,249,231.52
Exchange User Fees	0.95%	$1,728,600.80
Market Adjusted Index Rate	**$618.20**	**$181,960,785.12**

Projected Member Months	**294,342**

Product-Plan Data Collection

Company Legal Name: **Community Health Plan of Washington**
HIOS Issuer ID: **18581** 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		Community Health Plan of Washington Cascade Select			
1.2	Product ID		18581WA014			
1.3	Plan Name		Community	Community	Community	Community
1.4	Plan ID (Standard Component ID)		18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
1.5	Metal		Gold	Gold	Silver	Bronze
1.6	AV Metal Value		0.818	0.781	0.718	0.650
1.7	Plan Category		Renewing	New	Renewing	Renewing
1.8	Plan Type		EPO	EPO	EPO	EPO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		2.07%	0.00%	31.00%	4.98%
1.12	Product Rate Increase %		23.61%			
1.13	Submission Level Rate Increase %		23.61%			

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information					
	2.1	Plan ID (Standard Component ID)	Total	18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
$131,726,288	2.2	Allowed Claims	$131,726,288	$34,798,111	$0	$89,775,619	$7,152,557
$0	2.3	Reinsurance	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$18,781,054	$4,108,044	$0	$12,500,942	$2,172,068
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0
$112,945,234	2.6	Incurred Claims	$112,945,234	$30,690,067	$0	$77,274,677	$4,980,490
-$44,291,653	2.7	Risk Adjustment Transfer Amount	-$44,291,653	$3,240,040	$0	-$39,816,023	-$7,715,670
$153,416,318	2.8	Premium	$153,416,318	$20,522,607	$0	$120,759,154	$12,134,558
335,501	2.9	Experience Period Member Months	335,501	44,136	0	260,686	30,679
	2.10	Current Enrollment	34,463	4,924	0	24,649	4,890
	2.11	Current Premium PMPM	$504.32	$538.63	$0.00	$516.80	$406.87
	2.12	Loss Ratio	103.50%	129.15%	#DIV/0!	95.47%	112.71%
		Per Member Per Month					
	2.13	Allowed Claims	$392.63	$788.43	#DIV/0!	$344.38	$233.14
	2.14	Reinsurance	$0.00	$0.00	#DIV/0!	$0.00	$0.00
	2.15	Member Cost Sharing	$55.98	$93.08	#DIV/0!	$47.95	$70.80
	2.16	Cost Sharing Reduction	$0.00	$0.00	#DIV/0!	$0.00	$0.00
	2.17	Incurred Claims	$336.65	$695.35	#DIV/0!	$296.43	$162.34
	2.18	Risk Adjustment Transfer Amount	-$132.02	$73.41	#DIV/0!	-$152.74	-$251.50
	2.19	Premium	$457.28	$464.99	#DIV/0!	$463.24	$395.53

	Section III: Plan Adjustment Factors					
3.1	Plan ID (Standard Component ID)		18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
3.2	Market Adjusted Index Rate		$618.20			
3.3	AV and Cost Sharing Design of Plan		0.8145	0.7636	0.9730	0.5745
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB		1.0026	1.0026	1.0026	1.0026
	Administrative Costs					
3.6	Administrative Expense		7.31%	7.31%	7.31%	7.31%
3.7	Taxes and Fees		2.23%	2.23%	2.23%	2.23%
3.8	Profit & Risk Load		2.00%	2.00%	2.00%	2.00%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**		$570.72	$535.01	$681.78	$402.53
3.11	Age Calibration Factor	0.6455	0.6455			
3.12	Geographic Calibration Factor	1.0175	1.0175			
3.13	Tobacco Calibration Factor	1.0000	1.0000			
3.14	**Calibrated Plan Adjusted Index Rate**		$374.85	$351.40	$447.79	$264.38

	Section IV: Projected Plan Level Information					
4.1	Plan ID (Standard Component ID)	Total	18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003
4.2	Allowed Claims	$131,982,401	$20,650,756	$9,952,859	$82,579,729	$18,799,056
4.3	Reinsurance	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$17,141,714	$3,410,936	$2,000,083	$5,006,969	$6,723,726
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0
4.6	Incurred Claims	$114,840,687	$17,239,820	$7,952,776	$77,572,760	$12,075,330
4.7	Risk Adjustment Transfer Amount	-$41,982,680	$941,223	$463,165	-$30,183,630	-$13,203,437
4.8	Premium	$178,989,288	$26,869,773	$12,395,099	$120,903,954	$18,820,462
4.9	Projected Member Months	294,342	47,081	23,168	177,337	46,756
4.10	Loss Ratio	83.82%	61.99%	61.85%	85.51%	214.98%
	Per Member Per Month					
4.11	Allowed Claims	$448.40	$438.62	$429.60	$465.67	$402.07
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$58.24	$72.45	$86.33	$28.23	$143.80
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$390.16	$366.17	$343.27	$437.43	$258.26
4.16	Risk Adjustment Transfer Amount	-$142.63	$19.99	$19.99	-$170.20	-$282.39
4.17	Premium	$608.10	$570.71	$535.01	$681.78	$402.53

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.0748
Rating Area 4	0.9882
Rating Area 5	0.9346
Rating Area 6	0.9670
Rating Area 7	1.0294
Rating Area 8	1.0064
Rating Area 9	0.9701

Part III Actuarial Memorandum

Community Health Plan of Washington
Individual Rate Filing
Effective January 1, 2026

Prepared for:
Community Health Plan of Washington

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TABLE OF CONTENTS

The following table summarizes the exhibits included in this document. Some exhibits may span multiple pages.

EXHIBIT 1. GENERAL INFORMATION

Document Overview

This document contains the Part III Actuarial Memorandum for Community Health Plan of Washington's (CHPW) individual block of business, effective January 1, 2026. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the State of Washington State Office of the Insurance Commissioner, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of CHPW's individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Milliman under any theory of law.

As prescribed by Washington or as instructed by Community Health Plan of Washington the premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded as is described in current regulations and guidance. Future modifications in legislation, regulation and/or court decisions may affect the extent to which the premium rates are neither excessive nor deficient. Community Health Plan of Washington reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed.

At the time of this rate filing submission, we acknowledge there is uncertainty regarding whether the enhanced premium tax credit subsidies introduced through the American Rescue Plan Act (ARPA) will or will not be extended beyond 2025. As instructed by the Washington OIC, we have prepared this alternate set of rate filing materials assuming that these enhanced premium tax credits will be extended into 2026. The expiration versus extension of these subsidies could have a material impact on morbidity, enrollment, and other factors related to the Individual market. If subsequent information becomes available that would materially affect this rate filing submission, we would likely pursue opportunities to revise our pricing assumptions and resubmit this rate filing.

The following is a list of key assumptions that differ from the default rates due to the assumption that enhanced premium tax credits will extend into 2026:

• **Membership Projections** - The 2026 membership projections underlying these rates omit the impact of member disenrollment driven by expiration of enhanced premium tax credits, which impacts both the projected metal mix and demographic composition of CHPW's 2026 membership. Note that these membership projections still reflect the assumed metal mix shift driven by the emergency rule issued by the WA OIC requiring a uniform CSR silver load adjustment (WAC 284-43-6820).

• **Statewide Morbidity** - We removed the assumed impact of market risk pool deterioration (+3%) on the projected morbidity shift from 2024 to 2026.

• **Relative PLRS (CHPW / Market)** - The projected 2026 CHPW PLRS relative to the market omits any impact of member disenrollment due to eAPTC expiration on projected PLRS, including any impacts to CHPW's projected relative risk score profile driven by assumed differences in the member disenrollment impacts on CHPW's population versus the market.

• **Statewide Average Premium** - We adjusted the 2025 to 2026 statewide average premium trend (SWAP) trend used to project the 2026 SWAP to remove the impact of market risk pool deterioration on the SWAP as modeled in the set of rates assuming enhanced premium tax credits expire at the end of 2025.

• **Administrative Costs** - The administrative costs were adjusted to reflect the impact of larger assumed membership defraying the impact of fixed costs.

All other PY 2026 rate development assumptions remain consistent with the assumptions reflected in the set of rates assuming enhanced premium tax credits expire at the end of 2025.

This rate filing submission includes adjustments for the emergency rule issued by the WA OIC requiring a uniform CSR silver load adjustment (WAC 284-43-6820), standardized induced demand factors (WAC 284-43-6810(2)), and pricing actuarial value guardrails (WAC 284-43-6810(3)).

EXHIBIT 1. GENERAL INFORMATION

Company Identifying Information

Company Legal Name: Community Health Plan of Washington
State: The State of Washington has regulatory authority over these policies.
HIOS Issuer ID: 18581
Market: Individual
Effective Date: January 1, 2026

Company Contact Information

Primary Contact Name: Elaine Corrough
Primary Contact Telephone Number: (206) 521-8833
Primary Contact Email Address: elaine.corrough@chpw.org

EXHIBIT 2. PROPOSED RATE CHANGES

The rate projections for 2026 have been updated from the previous year's projections to reflect the most recent information available.

Table 2.1 below describes and quantifies the primary drivers underlying the proposed rate change for 2026, including but not limited to, the estimated impact of enhanced premium tax credit subsidy expiration. This breakdown is intended only for explanatory purposes and is distinct from the development of rates, as described in the subsequent sections of this memorandum.

Table 2.1
Community Health Plan of Washington
Breakdown of Proposed Rate Change

Description	Value
Estimated Changes in Experience	1.068
Additional Year of Trend (2025 to 2026)	1.053
Changes in Net Morbidity and Risk Adjustment	1.091
Changes in Benefits	0.987
Changes in Plan Mix and CSR Rate Load	1.036
Changes in Administrative Costs	0.984

Estimated Changes in Experience

The individual single risk pool experience underlying the rate projections has been updated, including marketplace enrollee mix. This impact reflects the difference between the interim 2024 projection of claims from 2025 rate development and the actual 2024 experience, normalized for changes in population morbidity and plan mix.

Additional Year of Medical and Prescription Drug Utilization and Unit Cost Trend

This impact reflects one additional year of medical and prescription drug utilization and unit cost trend from 2025 to 2026. Please refer to Table 5.1 for a breakdown of these trend assumptions by major service category as reported on Worksheet 1, Section II of the URRT.

Changes in Net Morbidity and Risk Adjustment

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. Risk adjustment transfer experience for calendar year 2024 was projected forward to 2026, including consideration of changes to the statewide average premium, risk adjustment program, and CHPW enrollee population morbidity relative to the Washington single risk pool.

Changes in Plan Benefits

We updated the plan designs to align with the standardized plan designs issued by WAHBE for the 2026 plan year. This impact reflects changes in the standardized plan designs from 2025 to 2026 as measured by changes in projected plan level AV pricing values and induced utilization, holding plan mix constant.

Changes in Plan Mix and CSR Rate Load

We modeled changes in CHPW's projected plan mix between 2025 and 2026 due to the anticipated expiration of enhanced premium tax credit subsidies and the WA OIC's emergency rule requiring issuers to implement a standardized silver CSR rate load. This reflects the residual impact of plan mix changes, normalized for changes in the composite plan rating factor between 2025 and 2026, and the impact of changes in the silver CSR rate load on the rate change.

EXHIBIT 2. PROPOSED RATE CHANGES

New Taxes, Fees and Administrative Expenses

Administrative costs decreased modestly due to restatement in administrative expenses and the impact of fixed administrative costs as a percentage of the higher aggregate premium in 2026. The administrative cost assumptions also reflect the impact of CHPW's smaller membership basis in 2026 increasing the impact of fixed costs. There was no change to the Exchange User Fee ($5.11 PMPM) between 2025 and 2026.

See Exhibit 10 for further details on projected non-benefit expenses.

The variance in the rate changes across plans does not reflect the incorporation of plan-specific morbidity. When projecting plan rating factors, we have assumed the same demographic and risk characteristics for each plan priced. This pricing method excludes expected differences in the morbidity of members assumed to select the plan.

Single Risk Pool

The 2026 rate development is based on the single risk pool set by the State of Washington, which was established according to the requirements in *45 CFR Part 156.80* . The single risk pool is defined as the non-grandfathered individual business in Washington.

Neither the single risk pool for the experience period nor the projection period include members who are eligible to remain enrolled in transitional plans.

Additional Rate Change Information

The following section addresses the requirements contained in item 24 of the Individual Non-Grandfathered Health Plan Checklist.

45 CFR 154.301(a)(4)(i) The impact of medical trend changes by major service categories:
See above and Exhibit 5 for discussion of medical trend changes.

45 CFR 154.301(a)(4)(ii) The impact of utilization changes by major service categories:
See above and Exhibit 5 for discussion of utilization changes.

45 CFR 154.301(a)(4)(iii) The impact of cost-sharing changes by major service categories, including actuarial values:
See Exhibit 10 for discussion of cost-sharing changes.

45 CFR 154.301(a)(4)(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits:
See Exhibit 5 for discussion of the impact of benefit changes.

45 CFR 154.301(a)(4)(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:
See Exhibit 5 and Exhibit 10 for a discussion of the impact of changes in enrollee risk profile and pricing and Exhibit 11 for discussion of the rating limitations for age and tobacco use.

45 CFR 154.301(a)(4)(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase:
This consideration is not directly applicable to CHPW’s 2026 rate development. CHPW’s 2026 rate projections were informed by its 2024 claims experience and expectations regarding trend and other drivers of rate change from 2024 to 2026.
CHPW makes no explicit adjustment for overestimation or underestimation of medical trend.

45 CFR 154.301(a)(4)(vii) The impact of changes in reserve needs:
This consideration is not directly applicable to CHPW’s 2026 rate development. CHPW makes no explicit adjustment due to changes in reserve needs.

EXHIBIT 2. PROPOSED RATE CHANGES

45 CFR 154.301(a)(4)(viii) The impact of changes in administrative costs related to programs that improve health care quality:
See Exhibit 10 for a discussion of administrative costs related to programs that improve health care quality.

45 CFR 154.301(a)(4)(ix) The impact of changes in other administrative costs:
See above and Exhibit 10 for a discussion of other administrative costs.

45 CFR 154.301(a)(4)(x) The impact of changes in applicable taxes, licensing or regulatory fees:
See above and Exhibit 10 for a discussion of applicable taxes, licensing, and regulatory fees.

45 CFR 154.301(a)(4)(xi) Medical loss ratio:
CHPW's 2026 rate projections were informed by the claims experience and quality improvement activities underlying its estimated 2024 MLR. However, its 2026 projected MLR includes independent projections for each component of the MLR formula (including premium), as opposed to a projection directly built off of its 2024 MLR. The claims used in the MLR calculation have been adjusted for quality improvement expenses and provider incentive payments. The pharmacy claims used in the MLR calculation are net of prescription drug rebates. In 2024, prescription drug rebates are $3,105,866 based on CHPW's most recent accrual information.

45 CFR 154.301(a)(4)(xii) The health insurance issuer's capital and surplus:
Contribution to surplus, contingency charges, or risk charges have not changed between 2025 and 2026.

45 CFR 154.301(a)(4)(xiii) The impacts of geographic factors and variations:
See Exhibit 12 for a discussion of the geographic factors.

45 CFR 154.301(a)(4)(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool:
See Exhibit 5 for a discussion of the impact of changes within a single risk pool to all plans within the risk pool.

45 CFR 154.301(a)(4)(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act:
See Exhibit 9 for a discussion of the impact of reinsurance and risk adjustment payments and charges.

EXHIBIT 3. EXPERIENCE AND CURRENT PERIOD PREMIUM, CLAIMS, AND ENROLLMENT

The experience reported on Worksheet 1, Section I of the URRT shows CHPW's earned premium, incurred and paid claims, and enrollment for the period of 1/1/2024 through 12/31/2024, with claims paid through 3/31/2025. Current enrollment and current premium on Worksheet 2, Section II are reported as of 4/1/2025.

Premiums in Experience Period

The premiums earned during the experience and as reported on Worksheet 1, Section I of the URRT are from CHPW's audited financial statements for CY2024. The premiums are not adjusted for MLR rebates.

Method for Determining Allowed Claims

All allowed claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported allowed claims was added to the processed amount to arrive at a final estimate of total allowed claims. No estimate of incurred but not reported claims was added to the prescription drug claims under the assumption that these claims are complete.

Method for Determining Paid Claims

All paid claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported claims was added to the processed amount to arrive at a final estimate of total paid claims. No estimate of incurred but not reported claims was added to the prescription drug claims under the assumption that these claims are complete.

Method for Determining Incurred But Not Reported Paid Claims

Incurred claims were calculated by applying a completion factor to the paid claims from the experience period. The completion factors were developed using the lag development method. The completion factors applied to paid and allowed claims are the same.

Method for Determining Paid Cost Sharing

Paid member cost sharing was determined by subtracting paid claims from allowed claims.

Claims Lags and Experience by Benefit Category (Checklist items 1b and 1c)

Tables 3.1a-d include allowed and incurred claims lags separately for medical and pharmacy for claims incurred in calendar year 2024 and paid through March 2025. Table 3.2 includes allowed and incurred claims by benefit category and month, premiums by month, monthly membership, changes in reserves during the period, and paid-to-allowed ratios.

Documentation and Justification for URRT Worksheet 2, Section II: Experience Period and Current Plan Level Information

The following supports item 4 of the Individual Non-Grandfathered Health Plan Checklist.

"Section II: Experience Period and Current Plan Level Information" from Worksheet 2 of the URRT is based on information as of March 2025 from the following sources:

- Line 2.2, Allowed Claims: Plan-level experience period data, with runout through March 2025. Allowed claims include an estimate for incurred but not paid amounts.
- Line 2.3, Reinsurance: There is no state reinsurance, so this field has been populated with zero for all plans.
- Line 2.4, Member Cost Sharing: Plan-level experience period data, with runout through March 2025.
- Line 2.5, Cost Sharing Reduction: Plan-level experience period data, with runout through March 2025.
- Line 2.6, Incurred Claims: This line is calculated by the URRT. It includes all incurred claims that are the issuer's responsibility.
- Line 2.7, Risk Adjustment Transfer Amount: Based on the CMS "Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025. The Risk Adjustment User Fee is not included in this line, as it is included in the Taxes & Fees line (3.7) of the URRT.
- Line 2.8, Premium: Plan-level experience period data, reported as of March 2025.
- Line 2.9, Experience Period Member Months: Plan-level experience period data, reported as of March 2025.
- Line 2.10, Current Enrollment: Current enrollment by plan as of April 2025.
- Line 2.11, Current Premium PMPM: April 2025 premium by plan divided by enrollment for April 2025.

EXHIBIT 4. BENEFIT CATEGORIES

We assigned the experience data utilization and cost information to benefit categories as shown in Worksheet 1, Section II of the Part 1 URRT based on place and type of service using a detailed claims mapping algorithm summarized as follows:

Inpatient Hospital

The inpatient hospital category 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

The outpatient hospital category 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

The professional category includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based physicians whose payments are included in facility fees.

Other Medical

The other medical category includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation

The capitation category includes all services provided under one or more capitated arrangements.

Prescription Drug

The prescription drug category includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

EXHIBIT 5. PROJECTION FACTORS

This section includes a description of trend factors used to project the experience period Index Rate to the projection period, and supporting information related to the development of those factors. For a demonstration of the trends, please see Table 5.1 below. This section also includes a description of adjustment factors (other than trend) that are applied to the experience period Index Rate in order to develop the projected Index Rate, and supporting information related to the development of those factors.

Trend Factors (Cost/Utilization)

This development of the CY2026 rates reflects an annual trend rate in Year 1 of 4.4% and an annual trend rate in Year 2 of 5.3%, which were developed using the following data source and methodology:

The trend factors reflect CHPW's expectations regarding increases in in-network contractual reimbursement and the impact of trends in both projected in-network and out-of-network costs. The prescription drug trends reflect changes in the drug formulary, expiration of drug patents and introduction of new drugs. Table 5.1 below documents CHPW's projected trends by category and year. The factors only reflect trend applicable to the single risk pool; they have been normalized and/or adjusted when appropriate to account for other changes such as changes in age, benefit changes, seasonality patterns, and non-recurring events.

Table 5.1
Community Health Plan of Washington
Annual Unit Cost and Utilization Trend Assumptions

	Year 1			Year 2		
Service Type	**Cost**	**Util**	**Total**	**Cost**	**Util**	**Total**
Inpatient Hospital	3.1%	-0.5%	2.6%	3.1%	-0.5%	2.5%
Outpatient	3.1%	1.0%	4.1%	3.0%	1.0%	4.0%
Professional	-2.8%	0.0%	-2.8%	0.1%	0.0%	0.1%
Other Medical	-2.5%	0.0%	-2.5%	0.4%	0.0%	0.4%
Capitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prescription Drug	10.0%	2.5%	12.8%	10.0%	2.5%	12.8%
Total			**4.4%**			**5.3%**

Months of Trend Year 1	12.0
Months of Trend Year 2	12.0

The cost trend factors reflect the following:

- Changes in contractual reimbursement between the experience and projection periods for a fixed basket of services. This is based on actual 2024 contracts and ongoing contracting efforts for 2026, controlling for changes in service mix, the geographic distribution of enrollees, and pharmacy rebates.
  - For Plan Year 2026, CHPW has retained and expanded upon the CHPW Cascade Care Affiliates Network. As of the date of submission of this actuarial memorandum, final contract negotiations with physicians and hospitals are largely complete. At this time, CHPW has executed agreements with approximately 92% of the targeted hospitals and over 2,600 provider groups. CHPW has successfully updated all contracts with Community Health Centers (CHCs) to provide primary care services wherever available throughout the network. CHPW is in continued discussions with the remaining targeted providers, with the projected completion of all required contracts by January 1, 2026.
- Average charge trend between the experience and projection periods normalized for demographics, morbidity, and benefit design.
  - Medical charge trends are set equal to anticipated Medicare fee schedule changes, as CHPW contracts on a percentage of FFS Medicare basis.
  - Pharmacy charge trends are informed by the Milliman *Health Cost Guidelines* and a review of CHPW's PBM contracts and reporting.

EXHIBIT 5. PROJECTION FACTORS

The utilization trend factors reflect the following:

- Assumed changes in the mix or intensity of services provided for a fixed level of illness burden.
- Secular utilization trend (the expected force of utilization trend over time for a static population with a fixed set of benefits), normalized for demographics, morbidity, and benefit design, informed by consideration of typical industry trend assumptions and the Milliman *Health Cost Guidelines* .
- Utilization trend is independent from the morbidity adjustments described below. As the utilization trends are on a secular basis and do not include any impact related to population morbidity shifts, there is no overlap between these estimates.

Table 5.2 includes a breakout of utilization and unit cost for the benefit categories shown on URRT Worksheet 1. Table 5.2 shows the development of the claims trends entered in the WAC 284-43-6660 summary.

Morbidity Adjustment

We used the following data source(s) and methodology in order to estimate the changes between the morbidity of the experience population and the projected population, as shown in the Morbidity Adjustment row of Worksheet 1, Section II of the URRT:

Claims were adjusted for estimated differences in morbidity between CHPW's 2024 membership and its projected 2026 membership. The adjustment was based on a review of CHPW's estimated 2024 morbidity levels, with particular consideration given to the large cohort of new members in 2024.

Consistent with the URR instructions, the morbidity adjustment reflects the component of the change in average allowed claims PMPM holding constant the experience period population's demographics (i.e., age, gender, and region), product mix, and all provider network contracts and time parameters.

The morbidity assumption used for projecting claims reflects CHPW's expectations regarding the morbidity of its 2026 membership and is consistent with the relative morbidity assumption used to estimate CHPW's risk transfer payment.

Demographic Shift

We used the following data source(s) and methodology in order to estimate the changes in the demographic and geographic mix of the population, as shown in the Demographic Shift row of Worksheet 1, Section II:

Our rate projection is based on CY2024 experience, and reflects the average demographics and geographic mix of the CY2024 enrollees. Our development of the CY2026 Index Rate reflects the anticipated differences in the demographic and geographic mix of the population, as compared to the CY2024 experience period.

We used the Milliman *Health Cost Guidelines* age/sex factors, utilization area factors, and unit cost area factors applied to both the 2024 and 2026 population to develop the demographic adjustment.

Plan Design Changes

We made the following adjustments to reflect the expected differences in benefits between the experience period and projection period, as shown in the Plan Design Changes row of Worksheet 1, Section II of the URRT:

Experience period claims were adjusted for changes in plan mix and plan design. This adjustment factor reflects anticipated changes in the demand for services due to differences in product mix and cost-sharing from the experience period to the projection period. Population demographics and morbidity were held constant across plan designs for this adjustment to avoid confounding with demographics and morbidity shifts.

We used Milliman's Health Cost Guidelines (HCGs), in conjunction with the historical experience of CHPW's individual block of business, in order to estimate the benefit changes for each of the items listed above.

EXHIBIT 5. PROJECTION FACTORS

The WA OIC introduced new EHBs to the state benchmark plan for CY2026:

- human donor milk,
- hearing aids and hearing exams, and
- artificial insemination

We modeled adjustments to projected claims to reflect the anticipated impact of these new essential health benefits.

Other Adjustments

The Other row of Worksheet 1, Section II contains additional adjustments from those described above. These adjustments have been made to recognize the additional anticipated changes in claims experience between the base period and the projection period. We used the following data sources and methodology in order to estimate these changes:

- The above components are applied at an aggregate level in the claims projection. We measured their mix/interaction impact across service categories and applied the resulting factor as an other adjustment.
- The pricing AV guardrails imposed by WAC 284-43-6800(3) reduced CHPW's aggregate projected AV in such a way that normalization could not restore the aggregate 2026 paid claims to the projected level. We included an offsetting adjustment to projected allowed claims such that projected paid claims are restored to the pre-AV adjustment level.
- Changes in anticipated pediatric vision costs: CHPW is self-insured through VSP for this benefit, and we rely on VSP's estimates of projected claims. The difference between actual experience and VSP's projections are reflected in this factor.

EXHIBIT 6. MANUAL RATE ADJUSTMENTS

Not applicable. CHPW's 2024 experience is fully credible for the purposes of the rate projection.

EXHIBIT 7. CREDIBILITY OF EXPERIENCE

Description of the Credibility Method Used

Credibility is calculated using the following formula:

If Member Months < 66,000: (Member Months / 66,000)^(1/2)
If Member Months ≥ 66,000: 100%

This credibility threshold is based on research into the minimum number of member months required such that the projected allowed PMPM of a group based on historical experience is within 10% of the actual allowed PMPM 95% of the time.

Resulting Credibility Level Assigned to the Base Period Experience

As CHPW had 335,501 member months in the base period, the credibility assigned to the base period experience is 100%.

EXHIBIT 8. ESTABLISHING THE INDEX RATE

The Index Rate for the experience period is a measurement of the average allowed claims PMPM for EHB benefits. The experience period Index Rate reflects the actual mixture of smoker/non-smoker population, area factors, catastrophic/non-catastrophic enrollment, and the actual mixture of risk morbidity that CHPW received in the Single Risk Pool during the experience period. Note that there were additional benefits offered beyond the EHB benefits. The experience period Index Rate has not been adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange User Fees.

The experience period Index Rate is equal to the experience period total allowed claims PMPM minus the total non-EHB allowed claims PMPM.

Per item 11d of the Individual Non-Grandfathered Health Plan Checklist, abortion services are included in the index rate projected in URRT Worksheet 1, Section II as Washington considers these services to be EHBs.

The Index Rate for the projection period is a measurement of the average allowed claims PMPM for EHB benefits. The Projection Period Index Rate reflects the projected CY2026 mixture of area factors, and the projected mixture of risk morbidity that CHPW expects to receive in the Single Risk Pool. Note that there were additional benefits offered beyond the EHB benefits. The Projection Period Index Rate has not been adjusted for payments and charges projected under the risk adjustment program nor for Exchange User Fees.

The Projection Period Index Rate is equal to the projected total allowed claims PMPM minus the total non-EHB allowed claims PMPM.

The following table summarizes the factors applied to the Experience Period Index Rate to determine the Projection Period Index Rate. Please see Exhibit 5 for a description and development of these factors.

Table 8.1
Community Health Plan of Washington
Projection Period Index Rate Development

Description	Experience
2024 Total Allowed Claims PMPM	$392.63
2024 Non-EHB Allowed Claims PMPM	$0.00
2024 EHB Allowed Claims PMPM	$392.63
Trend	1.099
2026 EHB Allowed Claims PMPM	$431.52
Morbidity Adjustment	**1.010**
Risk Pool Deterioration	1.010
Demographic Shift	**1.028**
Demographics	1.024
Geography	1.004
Plan Design Changes	**0.984**
Induced Utilization	0.983
New Essential Health Benefits	1.001
Other	**1.016**
Mix/Interaction	0.977
Aggregate Paid Restoration	1.040
VSP Pediatric Vision Change	1.000
Projected EHB Allowed Claims PMPM	$448.40
Credibility	100%
Projection Period Index Rate PMPM	**$448.40**

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

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

Table 9.1 Community Health Plan of Washington Market-Wide Adjusted Index Rate Development	
2026 Index Rate PMPM	$448.40
Market-Wide Adjustments (paid basis)	
Risk Adjustment Transfer Amount	$142.63
Exchange User Fees	$5.11
Paid-to-Allowed Ratio	0.870
Market-Wide Adjustments (allowed basis)	
Risk Adjustment Transfer Amount	$163.92
Exchange User Fees	$5.87
Market-Wide Adjusted Index Rate PMPM	**$618.20**

The Market-Wide Adjusted Index Rate is not calibrated. This means that this rate reflects the average demographic characteristics of the single risk pool.

Each of the above modifiers were developed as follows:

- Risk Adjustment Transfer Amount
  This factor includes the impact of the estimated risk adjustment transfer payment as addressed in a subsequent section of this Exhibit.

- Exchange User Fee Adjustment
  The Exchange User Fee adjustment was determined as the average of no fee and the WAHBE Exchange User Fee ($5.11 PMPM), weighted using the expected distribution of issuer enrollment sold through versus outside the Exchange.

Experience Period Risk Adjustments PMPM

The following methodology was used to estimate final risk adjustment transfers for CY2024:

The experience period risk adjustment transfer amount was calculated using the HHS risk adjuster formula, as shown below. Factors calculated for CHPW and the State are based on Wakely's Risk Adjustment Reporting based on EDGE data submissions through December 2024. The projected CY2024 risk adjustment transfer reflects anticipated PLRS completion assumptions for both CHPW and the market. The projected CY2024 risk adjustment transfer is a charge of -$132.02 PMPM from CHPW into the risk pool, net of the HCRP receivable and assessment.

"WA Exhibit 10: Summarized Risk Adjustment" includes the calculation of the expected risk adjustment transfer payment amount (gross of risk adjustment fees), using the HHS risk adjuster formula.

Risk Adjustment Payment/Charge

Worksheet 1, Section II of the URRT shows how the anticipated risk adjustment transfer revenue is applied to the Index Rate in the development of the Market-Wide Adjusted Index Rate. The Projected Risk Adjustment Transfer PMPM (-$163.92) is shown on Worksheet 1, Section II on an allowed basis. This amount does not include the 2026 Risk Adjustment User Fee of $0.20 PMPM. The Risk Adjustment User Fee is included with Taxes and Fees on Worksheet 2, line 3.7. "WA Exhibit 10: Summarized Risk Adjustment" includes quantitative support for CHPW's projected 2026 risk adjustment liability.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The state transfer calculation portion of the total risk adjustment transfer is based on the risk adjustment transfer formula, as provided in the Federal Register.

We project each factor in the risk adjustment transfer formula at the metal level using the state's actual historical risk adjustment factors adjusted to the projected population.

For the purpose of our modeling, each of these factors was approximated as follows:

- Statewide Average Premium: The state average premium was assumed to be approximately $589.42 PMPM (net of the 14% administrative cost carve out).

- Plan Liability Risk Score (PLRS): The statewide average risk score (1.292) is projected based on the average PLRS of the single risk pool in 2024, as reported by the U.S. Department of Health and Human Services (HHS) as of March 14, 2025, adjusted for projected changes in the demographics, morbidity, and plan mix of the single risk pool from 2024 to 2026.
  - The average risk score for CHPW's membership (0.863) is projected based on the completed 2024 CHPW PLRS adjusted for changes in the composition of CHPW's population between 2024 and 2026, including the impact to CHPW's relative risk score due to underlying changes in the HHS-HCC risk model.

- Induced Demand Factor (IDF) (1.035 Single Risk Pool; 1.037 CHPW): The statewide average IDF is projected based on the average IDF of the single risk pool in 2024, as reported by HHS as of March 14, 2025.
  - The average IDF for CHPW is projected by applying the induced demand factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11 to CHPW's projected population. Similarly, the projected market IDF is calculated using the same metal level induced demand factors applied to the projected market metal mix. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.
  - The projected average IDF for CHPW and the market reflect the anticipated changes in metal mix driven by the 43.5% mandated silver CSR load. Consistent with the assumptions underlying the OIC's development of the mandated CSR rate load, we assume that all Silver 70% members will migrate to the new low AV Vital Gold plan and that all Silver 73% members will disenroll entirely due to the silver plan premium cost increase.

- Actuarial Value (AV) (0.694 Single Risk Pool; 0.708 CHPW): The statewide average AV is projected based on the average metal level AV of the single risk pool in 2024, as reported by HHS as of March 14, 2025.
  - The average AV for CHPW is projected by applying the metal level AV factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 9 to CHPW's projected population. Similarly, the projected market AV is calculated using the same metal level AV factors applied to the projected market metal mix. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold 0.80, and Platinum 0.90.
  - The projected average AV for CHPW and the market reflect the anticipated changes in metal mix driven by the 43.5% mandated silver CSR load in PY 2026 as described in the development of the projected average IDF assumptions above.

- Allowable Rating Factor (ARF) (1.711 Single Risk Pool; 1.546 CHPW): As stated in the March 11, 2013 Federal Register, page 15433, the ARF adjustment accounts only for age rating.
  - The statewide average ARF is projected based on the average ARF of the single risk pool in 2024, as reported by HHS as of March 14, 2025, adjusted for projected changes in the demographics of the single risk pool from 2024 to 2026.
  - The average ARF for CHPW is projected by applying the 2026 HHS age rating factors to CHPW's projected population.
  - The projected average ARF assumptions for CHPW and the market reflect changes in the assumed demographic profile of the market in 2026.

- Geographic Cost Factor (GCF): The average GCF for CHPW relative to the statewide average was modeled based on historical GCFs by rating areas reported by HHS as of March 14, 2025 and CHPW's projected enrollment by rating area.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The total transfer is calculated as the sum of the state transfer calculation described above and a net transfer for 2026 attributable to the high cost risk pooling (HCRP) program (-$1.09). The projected HCRP receivable (-$1.11) is based on the on the attachment point and coinsurance from the 2026 Notice of Benefit and Payment Parameters (NBPP), and the projected HCRP assessment (-$2.20) is modeled as approximately 0.36% of premium.

The projected transfer amount assumes no impact under the Risk Adjustment Data Validation (RADV) process.

The risk adjustment transfer amount (-$163.92) reported on Worksheet 1 of the URRT is the actual PMPM amount expected in the projection period on an allowed basis. The risk adjustment transfer amount applied to the Index Rate in the development of the Market-Wide Adjusted Index Rate is on an allowed claims basis, as the Index Rate is on an allowed claims basis.

The assumptions used in developing the risk adjustment transfer amount are current as of the date of this filing. The demographic, plan mix, and morbidity assumptions supporting the risk transfer projection are consistent with the demographic, plan mix, and morbidity assumptions used to project claims costs.

Risk Adjustment Data by Metal Level and Risk Model Changes

"WA Exhibit 10: Summarized Risk Adjustment" includes support for the Individual Non-Grandfathered Health Plan Checklist items 18, 19a, 19b, and 19f. WA Exhibit 10 summarizes the 2024 risk adjustment data used to develop CHPW’s projected 2026 risk adjustment transfer liability, including the projected 2026 statewide average premium. In WA Exhibit 10, projected membership and all components of the risk adjustment transfer formula are reported separately by metal level.

We adjusted CHPW's projected relative PLRS to account for changes in the underlying HHS-HCC risk model between 2024 and 2026. We leveraged prevalence exhibits in Wakely's Risk Adjustment Reports to evaluate the impact of risk model changes on CHPW's PLRS relative to the market in 2026. The prevalence exhibits include simulated issuer (CHPW) and market PLRS using both the final 2024 and 2026 HHS-HCC risk models. To isolate the impact of model changes independent of changes in the demographic profile of the single risk pool, the simulated risk scores are calculated using a static 2024 population.

High Cost Risk Pool Receipt/(Assessment)

The HCRP reinsurance program reimburses issuers at 60% of annualized enrollee claims costs in excess of the $1M attachment point. We used an all service category claim probability distribution (CPD) from the Milliman Health Cost Guidelines (HCGs), scaled to the CHPW’s projected annual allowed claims for each benefit plan, to model estimated risk adjustment reinsurance receivables. Changes in CHPW’s contractual reimbursement, demographic composition, and risk profile, among others, will contribute to changes in CHPW’s anticipated HCRP receivables between 2024 and 2026.

The High-Cost Risk Pool (HCRP) reinsurance program assessment fee is based on an assumed 0.36% of premium, consistent with the assessment reported in the final BY 2023 risk adjustment report.

The following table includes the actual (2022-2024) and filed (2022-2026) HCRP receipts and assessments. In 2026, we are projecting a net HCRP payment for CHPW based on historical experience and the anticipated morbidity profile of CHPW's 2026 population.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

Table 9.2
Community Health Plan of Washington
Actual and Projected HCRP Receipt/Assessment PMPM

	2023	2024	2025	2026
High-Cost Risk Pool Receipt				
Actual	$0.00	$6.73	*n/a*	*n/a*
Filed	$1.14	$1.70	$0.91	$1.11
High-Cost Risk Pool Assessment				
Actual	($1.32)	($1.83)	*n/a*	*n/a*
Filed	($1.14)	($1.70)	($1.75)	($2.20)
Net High-Cost Risk Pool Receipt/(Assessment)				
Actual	($1.32)	$4.90	*n/a*	*n/a*
Filed	$0.00	$0.00	($0.84)	($1.09)

The green highlighted cells reconcile to the estimated 2024 and projected 2026 HCRP receipts and assessments in WA Exhibit 10. Negative value implies a net payment and a positive value implied a net receipt, consistent with the sign of the risk adjustment transfers in WA Exhibit 10.

Impact due to Risk Adjustment Data Validation (RADV)

CHPW's 2026 projected risk adjustment transfer does not reflect any assumed impact for RADV.

Paid to Allowed Ratios

The following table provides support for the average projected paid-to-allowed ratio. The average projected allowed and incurred PMPM reflects the member month weighted average from Worksheet 2, Section IV of the URRT.

The following table provides support for the average paid-to-allowed ratio by plan metal level:

Table 9.3
Community Health Plan of Washington
Average Paid to Allowed Factor Support

Metal Level	Member Months	Paid Claims PMPM	Allowed Claims PMPM	Paid-to-Allowed Ratio	AV Metal Value
Gold	70,249	$358.62	$435.64	0.823	80.6%
Silver	177,337	$437.43	$465.67	0.939	71.8%
Bronze	46,756	$258.26	$402.07	0.642	65.0%
Total	**294,342**	**$390.16**	**$448.40**	**0.870**	**72.9%**

The projected paid and allowed claims reflect the member month weighted average by metal level from Worksheet 2, Section IV of the URRT. The average AV metal value is based on AVs calculated using the federal AV calculator, weighted on projected allowable cost by metal level.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

The Market-Wide Adjusted Index Rate is adjusted to compute the Plan Adjusted Index Rate using the following allowable adjustments:

- Actuarial value and cost sharing adjustment
    - Since CHPW only offers standardized plans through the public option, we are relying on AV Calculator AVs from Wakely Consulting Group's Unique Plan Design Certification for the metal AV of Washington standardized benefit designs.
    - The AV and cost sharing pricing adjustment was developed utilizing the HCGs. Relativities between plans were based on the differences in cost and utilization for varying levels of cost sharing, holding morbidity and population constant for all plans.
    - AV pricing values were adjusted to be no more than +/- 2% of the AV metal value, in accordance with WAC 284-43-6810(3).
    - Induced demand factors were calculated based on the federal risk adjustment formula, in accordance with WAC 284-43-6810(2).
    - The AV and cost sharing pricing adjustment reflects full plan liability for CSR subsidies. CSR costs are reflected as a uniform percentage load (43.5%) applied to each Silver ACA-compliant plan (those sold through the Exchange).
    - In accordance with item 11d from the Individual Non-Grandfathered Health Plan Checklist, we removed the impact of coverage of abortion services from the AV and cost sharing factors. This impact is the reciprocal of the abortion adjustment applied to the benefits in addition to the EHBs factor described below.
    - Development of the AV and cost sharing adjustment can be found in Table 10.1.

- Provider network, delivery system and utilization management adjustment
    - There are no expected differences in the provider network and/or utilization management between plans.

- Adjustment for benefits in addition to the EHBs
    - All plans include coverage for elective abortion. In accordance with the URR instructions and checklist item 13, the $1.00 premium adjustment for elective abortion is included in the Benefits in Addition to EHB line of the URRT. Please see Table 10.3 for further details.

- Adjustment for distribution and administrative costs
    - Non-benefit expenses are discussed in detail below.

- There are no catastrophic plans being offered, so there is no eligibility adjustment made for catastrophic plan enrollment.

The following table demonstrates the Plan Adjusted Index Rate development for each plan in the projection period:

Table 10.2
Community Health Plan of Washington
Projection Period Plan Adjusted Index Rate Development

Plan Name	HIOS ID	Market-Wide Adjusted Index Rate	AV & Cost Sharing	Provider Network Adjustment	Benefits In Addition to EHBs	Admin Cost Fee	Catastrophic Eligibility	Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$618.20	0.815	1.000	1.003	1.131	1.000	$570.72
CHPW Vital Gold	18581WA0140004	$618.20	0.764	1.000	1.003	1.131	1.000	$535.01
CHPW Silver	18581WA0140002	$618.20	0.973	1.000	1.003	1.131	1.000	$681.78
CHPW Bronze	18581WA0140003	$618.20	0.574	1.000	1.003	1.131	1.000	$402.53

The Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool and therefore are not calibrated.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

Silver CSR Loading and Subsidized Membership

CHPW received no member cost sharing subsidy payments from HHS in 2024. To reflect the expectation that CHPW will continue to not be reimbursed for cost sharing on Silver CSR plans, CSR costs are included as a percentage load applied to each Silver ACA-compliant plan sold through the Exchange. Per WAC 284-43-6820, the CSR rate load is set to 1.435 for PY2026. As this is higher than our projected impact of CSRs, the revenue-neutral application of this mandated CSR load puts downward pressure on the non-Silver plan premiums.

No explicit projection assumptions are made for the AIAN population due to CHPW's limited membership and claims experience for AIAN enrollees.

Non-Benefit Expenses, Profit, and Risk

The administrative expense load was provided by CHPW. Development of the load shown on URRT Worksheet 2 is shown in WA Exhibit 11. This expense load is based on projected enrollment and is estimated to appropriately cover expenses for overhead, operations, and sales and marketing expenses. The administrative expenses are allocated proportionally by plan on a percentage of premium basis.

Commission expenses have been eliminated from the administrative expense projection for 2026. CHPW is eliminating broker commissions, as noted in the Commissions Certification accompanying this filing.

The taxes and fees which may be subtracted from premiums for purposes of calculating the MLR are listed in WA Exhibit 11. The taxes and fees shown on URRT Worksheet 2 do not include the Exchange User Fee, and are applied on a percentage of premium basis. The development of this amount is shown in WA Exhibit 11.

The Patient Centered Outcomes Research Fee (PCORI) amount of $0.31 shown in WA Exhibit 11 is calculated as follows: $3.47 / 12 * ($16,387 / $15,074) = $0.31 PMPM. The $3.47 annual fee per member for plan years ending October 1, 2024 through September 30, 2025 is first divided by 12 to transfer the fee to a PMPM basis. It is then trended by the projected NHE change from 2024 to 2026 to project the payment for plan years ending 12/31/2026.

The regulatory surchage fee, WSHIP assessment, WAPAL assessment, and insurance fraud surchage fee are also included in WA Exhibit 11.

For 2024, the Risk Adjustment User Fee is included as part of Taxes and Fees on line 3.7 of Worksheet 2 of the URRT.

The profit and risk load was applied proportionally to all products. Development of the load shown on URRT Worksheet 2 is included in WA Exhibit 11. This target profit percentage was provided by CHPW and relied upon in this filing.

EXHIBIT 11. CALIBRATION

A single calibration factor is applied to the Plan Adjusted Index Rates from Exhibit 10 to calibrate rates for the expected age, geographic, and tobacco use distribution expected to enroll in the plan. The single calibration factor is applied uniformly across all plans.

Age Curve Calibration

The approximate weighted average age, rounded to a whole number, for the single risk pool is 47. The weighted average age curve calibration factor is 1.549.

In order to determine the calibration factor for age, the projected distribution of members by age was determined. The weighted average of the factors in the age curve was then calculated using this distribution. The average age was then determined by finding the age of a member that would have the closest factor to the weighted average age curve calibration factor. Prior to applying the allowed rating factors for age, geography, and tobacco, the plan adjusted Index Rates need to be divided by the age curve calibration factor. A development of the age curve calibration factor is shown in Table 11.2.

Additional information regarding the age curve can be found on Exhibit 12.

Geographic Factor Calibration

In order to determine the calibration factor for geography, the projected distribution of members by area was determined. The weighted average of the area factors was then determined using this distribution. The area factors used are reflective of differences in delivery costs (including unit cost and provider practice pattern differences) only, and do not reflect any differences in the the following health-status related factors listed in line 16b of the Individual Non-Grandfathered Health Plan Checklist:

(a) Health status of enrollees or the population in an area
(b) Medical condition of enrollees or the population in an area, including physical, mental and behavioral health illnesses
(c) Claims experience
(d) Health services utilization in the area
(e) Medical history of enrollees or the population in an area
(f) Genetic information of enrollees or the population in an area
(g) Disability status of enrollees or the population in an area
(h) Other evidence of insurability applicable in the area.

Prior to applying the allowed rating factors for age, geography, and tobacco, the plan adjusted Index Rates need to be divided by the geography calibration factor. A development of the geographic calibration factor is shown in Table 11.2.

Additional information regarding the area rating factors can be found on Exhibit 12.

Tobacco Factor Calibration

CHPW will not charge a tobacco surcharge for smokers.

The following tables demonstrate the calibration performed for each plan.

Table 11.1
Community Health Plan of Washington
Calibrated Plan Adjusted Index Rate Development

Plan	HIOS ID	Plan Adjusted Index Rate	Age Calibration Factor	Geographic Calibration Factor	Tobacco Calibration Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$570.72	1.549	0.983	1.000	1.523	$374.85
CHPW Vital Gold	18581WA0140004	$535.01	1.549	0.983	1.000	1.523	$351.40
CHPW Silver	18581WA0140002	$681.78	1.549	0.983	1.000	1.523	$447.79
CHPW Bronze	18581WA0140003	$402.53	1.549	0.983	1.000	1.523	$264.38

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual or family utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. It is the product of the Plan Adjusted Index Rate, the geographic rating factor, the age rating factor and the tobacco status rating factor. All rating factors are described and shown below.

CHPW's CY2026 age and tobacco rating factors are shown below. The age rating factors used by CHPW are identical to those prescribed by CMS. Tobacco factors are uniformly 1.0 as CHPW does not intend to rate for tobacco in PY2026.

Table 12.1
Community Health Plan of Washington
Age and Tobacco Factors

Age Band	Age Rating Factor	Tobacco Factor		Age Band	Age Rating Factor	Tobacco Factor
0-14	0.765	1.000		40	1.278	1.000
15	0.833	1.000		41	1.302	1.000
16	0.859	1.000		42	1.325	1.000
17	0.885	1.000		43	1.357	1.000
18	0.913	1.000		44	1.397	1.000
19	0.941	1.000		45	1.444	1.000
20	0.970	1.000		46	1.500	1.000
21	1.000	1.000		47	1.563	1.000
22	1.000	1.000		48	1.635	1.000
23	1.000	1.000		49	1.706	1.000
24	1.000	1.000		50	1.786	1.000
25	1.004	1.000		51	1.865	1.000
26	1.024	1.000		52	1.952	1.000
27	1.048	1.000		53	2.040	1.000
28	1.087	1.000		54	2.135	1.000
29	1.119	1.000		55	2.230	1.000
30	1.135	1.000		56	2.333	1.000
31	1.159	1.000		57	2.437	1.000
32	1.183	1.000		58	2.548	1.000
33	1.198	1.000		59	2.603	1.000
34	1.214	1.000		60	2.714	1.000
35	1.222	1.000		61	2.810	1.000
36	1.230	1.000		62	2.873	1.000
37	1.238	1.000		63	2.952	1.000
38	1.246	1.000		64+	3.000	1.000
39	1.262	1.000				

CHPW's CY2026 geographic rating factors and their development are shown in Table 12.2. These area factors reflect differences in unit cost by region. They were developed using Milliman's Health Cost Guidelines™ and CHPW's anticipated provider reimbursement by region and have been normalized to remove the impact of differences in population demographics and health status on claim costs.

The geographic area factors do not include the impact of any of the following:

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

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The premium for family coverage is determined by summing the consumer adjusted premium rates for each individual family member, provided at most three child dependents under age 21 are taken into account.

The following table demonstrates the premium rate development for the Consumer Adjusted Premium Rate beginning with the Calibrated Plan Adjusted Index Rate and applying the appropriate age, area, and tobacco factors.

Table 12.3 Community Health Plan of Washington Sample Consumer Adjusted Premium Rate Development	
Community Health Plan of Washington Cascade Select Complete Gold - 18581WA0140001	
Calibrated Plan Adjusted Index Rate	$374.85
Age: 33	1.198
Area: 6	0.967
Tobacco Status: Non-Tobacco User	1.000
Consumer Adjusted Premium Rate	**$434.26**

EXHIBIT 13. PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) is 90.4%. This loss ratio is calculated based on the MLR methodology as prescribed by 45 CFR 158.

The following table summarizes the calculation for the projected federal medical loss ratio:

Table 13.1
Community Health Plan of Washington
Projected Federal Medical Loss Ratio

Member Months	294,342
MLR Numerator Calculations	
Paid Claims PMPM	$390.16
Claim-Related Retention (QI/Health IT) PMPM	$0.00
Prior Rebate	$0.00
Other Claim-Related Adjustments	$0.00
Risk Adjustment Paid (Received) PMPM	$142.63
Market Reinsurance Recoveries (Received) PMPM	$0.00
MLR Numerator Calculations	**$532.79**
MLR Denominator Calculations	
Premium PMPM	$608.10
Other Premium-Related Adjustments	$0.00
Premium-Related Retention (Taxes & Fees) PMPM	$18.69
MLR Denominator	**$589.41**
Medical Loss Ratio	**90.4%**

No additional state-specific projected loss ratio demonstration is required in the State of Washington.

EXHIBIT 14. AV METAL VALUES

The AV Metal Values included in URRT Worksheet 2 were calculated by Wakely Consulting, which provided a Unique Plan Design Certification for the Washington standardized benefit designs. This filing has relied upon that certification, and it is included in the rate filing material for reference. The following reason was provided for the unique plan designs:

- For the Expanded Bronze Standard Option, Mental Health and Substance Use Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services. For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature.

EXHIBIT 15. MEMBERSHIP PROJECTIONS

Enrollment projections were developed by county and metal level through a combination of inputs from CHPW leadership and review of CHPW's current enrollment distribution for Cascade Select. Specifically:

- We developed enrollment projections by county based on the following factors:
  - Current (2025) CHPW Cascade Select membership
  - Anticipated 2026 retention (i.e., current enrollees renewing in CHPW plans)

- Enrollment by metal level and CSR status reflects current CHPW enrollment patterns adjusted for the mandated uniform CSR load.

- As rates were developed, anticipated rate competitiveness in each market was reviewed for potential impact to projected enrollment.

- These inputs were then combined to develop the projected enrollment by county and metal level, which was then rolled up to the rating area and metal level.

As a result, 2026 enrollment is projected at 294,342 member months.

These projections are consistent with company expectations for the product line in 2026. Each plan in this filing has nonzero projected enrollment with the exception of the Silver 70% and 73% variants. Consistent with the assumptions underlying the OIC's development of the mandated CSR rate load, we assume that all Silver 70% members will migrate to the new low AV Vital Gold plan and that all Silver 73% members will disenroll entirely due to the silver plan premium cost increase.

Projected cost sharing reduction (CSR) eligibles are shown in Table 15.1:

Table 15.1
Community Health Plan of Washington
Projected Enrollment (Member Months) by Benefit Level (Silver Plans)

Plan Name	HIOS ID	70%	73%	87%	94%	Total
CHPW Cascade Select Silver	18581WA0140002	0	0	114,040	63,297	177,337

EXHIBIT 16. TERMINATED PRODUCTS

No products will be terminated prior to the effective date.

EXHIBIT 17. PLAN TYPE

There are no differences between the plans of CHPW and the plan type selected in the drop-down box in Worksheet 2, Section I of the URRT.

EXHIBIT 18. EFFECTIVE RATE REVIEW INFORMATION

URRT Worksheet 2, Section IV Projected Allowed Claims, Incurred Claims & Premiums (Checklist item 28f)

Please see Table 18.1 for a calculation of the projected dollar amounts by plan for URRT Worksheet 2, Section IV.

URRT Projected PAIR and Premium PMPM (Checklist item 28h)

The weighted-average Plan Adjusted Index Rates in Field 3.10 of URRT Worksheet 2 matches the aggregate premium PMPM in Field 4.17.

Mental Health and Substance Use Disorder Parity (Checklist item 33)

The Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity Certification has been completed by Elaine Corrough, FSA, MAAA, Senior Director of Actuarial Services, Community Health Plan of Washington. I am relying on Elaine's work and note the following:

- Projected plan and benefit classification/sub-classification dollar amounts are consistent with the actuarial cost model developed for 2026 rate projection, as described earlier in this Actuarial Memorandum;
- The underlying data sources and adjustments are as described earlier in this Actuarial Memorandum;
- There are no differences between the data used to project PY 2026 claims and premium rates, and the data used for MH/SUD parity testing;
- Projections are required to reflect plan-level assumptions – because all plans' rates have been developed from the same allowed claims basis, the same projected allowed cost has been used for MH/SUD parity testing for all plans;
- Dollar amounts used for testing are based on allowed claims, before any member cost-sharing; and
- A reasonable actuarial method was used for the dollar projections for each plan, in accordance with WAC 284-43-7040(1)(c)(ii) and in compliance with applicable Actuarial Standards of Practice.

The Certification ("MHSUD Financial Requirements Certification") and supporting Excel workbook ("MHSUD Parity Calculations Duplicate.xlsm" / "MHSUD Parity Calculations.pdf") have been submitted separately in this rate filing.

Parity calculations reflect the entirety of projected allowed claims for each service category tested. Under 45 CFR 144.103, parity analyses should reflect data at the plan level, rather than the product level. However, per CMS/CCIIO , an issuer "can use data at the product level to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method based on the best available data)." Premium rates for all of CHPW's plans have been developed from the same projection of allowed costs, the development of which is described elsewhere in this memorandum. Projected allowed costs are distributed amongst benefit categories based on the actual distribution reflected in base period experience across all plans. This represents our best estimate of the expected distribution of allowed costs by service category for each plan.

The 2026 standard ("Cascade") plan designs set by WAHBE include reduced copays ($1) for the first two MH/SUD visits, followed by higher standard copays for remaining visits ($30 for Cascade Silver and $50 for Cascade Bronze). Testing in the supporting Excel workbook ("MHSUD Parity Calculations Duplicate.xlsm" / "MHSUD Parity Calculations.pdf") has been completed to reflect these higher copays paid for all visits, even though the first two visits are at a lower copay. This effectively creates a "safe harbor" for the test – if parity is achieved using only the higher copays for all visits, then the actual plans, with reduced copays for the first two visits, should also pass the parity test. This is noted in the Excel workbook.

Differences in the UPMJ and URRT Aggregate Rate Change (Checklist item 30c)

The URRT Worksheet 2 fields 1.12 and 1.13 premium-weight the overall rate change while the Aggregate Rate Change in the UPMJ Q5 weights by current enrollment.

EXHIBIT 19. RELIANCE

In performing this analysis, I relied on data and other information provided by CHPW. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

As permitted by the OIC, we have relied on the Actuarial Value Certification for WAHBE 2026 Standard Medical Plan designs performed by Wakely Consulting Group. We have relied on the certification by Wakely Consulting Group since we do not have access to the underlying data used in their assessment of the Actuarial Value for these plans which the OIC has indicated must be matched. Documentation of the analysis performed by Wakely Consulting Group is included in Exhibit 14.

Table 19.1
Community Health Plan of Washington
Reliance

Data / Assumption	Source
2024 individual QHP claims and membership experience	Elaine Corrough, CHPW
2024 interim risk adjustment transfer receivable/payment	"Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025, CMS; "HHS public and carrier-specific interim 2024 risk adjustment reports", provided by Elaine Corrough, CHPW "Wakely National Risk Adjustment Reporting", provided by Elaine Corrough, CHPW
Other 2024 individual QHP marketplace revenue and expenditures	Elaine Corrough, CHPW
2024 IBNP estimate	Elaine Corrough, CHPW
2024 Plan Liability Risk Score associated with Individual QHP claims and membership experience	Elaine Corrough, CHPW
2025 emerging individual QHP membership	Elaine Corrough, CHPW
Utilization trends	Milliman (*Health Cost Guidelines*)
Unit cost trends	CMS; Milliman (*Health Cost Guidelines*)
Administrative costs, taxes, and fees	Elaine Corrough, CHPW
Broker fees and commissions	Elaine Corrough, CHPW
County Rating Areas	Elaine Corrough, CHPW
Community Health Plan of Washington service areas	Elaine Corrough, CHPW
Expected reimbursement by Rating Area	Elaine Corrough, CHPW
3:1 age band Factors	HHS
2026 pediatric vision administrative fees and claims cost	VSP
Prescription drug AWP discounts, dispensing fees, rebates, and retail/mail utilization assumptions	Elaine Corrough, CHPW
2026 Exchange user fee	Washington Health Benefits Exchange
WSHIP assessment	Elaine Corrough, CHPW
WAPAL assessment	Elaine Corrough, CHPW
Contribution to surplus % of premium	Elaine Corrough, CHPW
SHB 1979 impacts	Elaine Corrough, CHPW

EXHIBIT 20. ACTUARIAL CERTIFICATION

I am a Consulting Actuary with the firm of Milliman, Inc. Community Health Plan of Washington engaged me to provide the opinion herein.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I certify to the best of my knowledge and judgment:

1. The projected Index Rate is
   - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102)
   - Developed in compliance with the applicable Actuarial Standards of Practice
   - Reasonable in relation to the benefits provided and the population anticipated to be covered
   - Neither excessive nor deficient based on my best estimates of the 2026 individual market.

2. 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.

3. The geographic rating factors shown in Worksheet 3 of the URRT reflect only differences in the cost of delivery, and do not include differences for population morbidity by geographic area.

4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans.

The URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The 2026 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2026 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendments, court decisions, or decisions by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. At the time of this rate filing submission, we acknowledge there is uncertainty regarding the expiration of the enhanced premium subsidies first introduced through the American Rescue Plan Act (ARPA) and later extended by the Inflation Reduction Act (IRA). Consistent with WA OIC instructions for this alternate filing, we have assumed that these subsidies will be extended into 2026. However, I have made no prediction or estimate of the likelihood of these events. As more information becomes known about the 2026 subsidies, it is possible we would need to adjust the rates in order to result in premiums that are neither excessive nor deficient.

Signed: 

Name: Jordan Pettibon, FSA, MAAA

Title: Consulting Actuary

Date: May 12, 2025

Table 2.1
Community Health Plan of Washington
Breakdown of Proposed Rate Change

Description	Value
Estimated Changes in Experience	1.068
Additional Year of Trend (2025 to 2026)	1.053
Changes in Net Morbidity and Risk Adjustment	1.091
Changes in Benefits	0.987
Changes in Plan Mix and CSR Rate Load	1.036
Changes in Administrative Costs	0.984

Table 3.1a
Community Health Plan of Washington
Allowed Claims - Medical
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$693,132	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$693,132
202402	$2,475,876	$1,003,004	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,478,879
202403	$403,882	$2,645,588	$971,241	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,020,710
202404	$175,299	$1,089,088	$3,789,813	$1,385,779	$0	$0	$0	$0	$0	$0	$0	$0	$6,439,979
202405	$98,281	$188,854	$807,784	$4,189,584	$1,243,421	$0	$0	$0	$0	$0	$0	$0	$6,527,924
202406	$81,727	$92,255	$338,419	$1,409,505	$3,756,689	$1,119,462	$0	$0	$0	$0	$0	$0	$6,798,057
202407	$22,582	$119,330	$119,044	$366,142	$2,011,312	$4,770,791	$1,968,365	$0	$0	$0	$0	$0	$9,377,565
202408	$66,975	$61,467	$147,407	$184,397	$213,385	$779,792	$4,230,311	$1,285,792	$0	$0	$0	$0	$6,969,526
202409	$10,119	$55,455	$54,736	$177,524	$157,562	$225,789	$1,347,014	$4,797,572	$1,156,518	$0	$0	$0	$7,982,289
202410	$8,690	-$7,852	$4,767,700	$60,381	$56,873	$160,489	$232,935	$1,773,358	$4,905,291	$2,019,055	$0	$0	$13,976,919
202411	$12,324	$11,166	$144,499	$74,854	$79,017	$85,403	$133,250	$244,991	$728,771	$4,921,708	$1,661,892	$0	$8,097,874
202412	$10,059	$22,739	$40,778	$104,314	$49,000	$69,417	$99,967	$307,144	$216,895	$2,179,422	$5,721,310	$2,544,215	$11,365,261
202501	$4,037	-$98,823	$2,125	$34,053	$33,625	-$10,432	$26,366	-$15,696	$208,015	$181,872	$1,067,632	$4,526,329	$5,959,105
202502	-$8,514	$63,985	$40,755	$36,367	-$10,316	$29,262	$99,960	$126,209	$140,395	$395,851	$500,440	$1,409,301	$2,823,695
202503	$703	$3,171	$26,172	-$9,377	$27,468	$11,200	$38,975	$30,376	$37,080	$128,858	$249,891	$250,893	$795,410
Total	$4,055,170	$5,249,428	$11,250,472	$8,013,522	$7,618,037	$7,241,173	$8,177,144	$8,549,746	$7,392,965	$9,826,767	$9,201,165	$8,730,738	$95,306,326

IBNP Adjustment	$3,045,900
Other EHB Incurred Claims (VSP Experience)	$8,025
Member Months	335,501
Experience Period Index Rate PMPM (Medical Only Subtotal)	$293.17

Table 3.1b
Community Health Plan of Washington
Allowed Claims - Rx
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$1,440,352	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,440,352
202402	$307,227	$1,516,090	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,823,317
202403	$4,218	$364,050	$2,236,545	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,604,813
202404	$35	$4,274	-$2,639	$2,354,616	$0	$0	$0	$0	$0	$0	$0	$0	$2,356,286
202405	$0	$2,505	-$367	$176,681	$2,537,623	$0	$0	$0	$0	$0	$0	$0	$2,716,442
202406	$0	$0	$1,099	-$1,189	$264,039	$2,955,589	$0	$0	$0	$0	$0	$0	$3,219,538
202407	$0	$0	$963	$166	$1,380	-$211,969	$3,000,410	$0	$0	$0	$0	$0	$2,790,950
202408	$0	$0	$9	$81	$321	-$720	$315,352	$3,596,349	$0	$0	$0	$0	$3,911,393
202409	$388	$0	$220	$54	$3,050	$1,242	$4,728	-$174,185	$3,728,909	$0	$0	$0	$3,564,406
202410	$1,219	$0	$430	$2,824	$1,007	$1,692	$3,138	-$1,270	$150,556	$3,267,734	$0	$0	$3,427,331
202411	$0	$0	$0	$0	$0	$683	$761	$3,233	$1,251	$630,726	$3,921,574	$0	$4,558,229
202412	$0	$0	$0	$0	$0	$0	$0	$0	$11,128	$1,033	-$162,167	$3,822,277	$3,672,271
202501	$0	$2,287	$860	$0	$0	$0	$52	$777	-$316	-$4,046	$3,337	$380,750	$383,702
202502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,358	$1,131	$2,490
202503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35	$36	$315	$386
Total	$1,753,438	$1,889,208	$2,237,120	$2,533,235	$2,807,420	$2,746,516	$3,324,441	$3,424,904	$3,891,528	$3,895,483	$3,764,138	$4,204,473	$36,471,903

Rx Rebates	$3,105,866
Member Months	335,501
Experience Period Index Rate PMPM (Prescription Drug Only)	$99.45

Table 3.1c
Community Health Plan of Washington
Paid Claims - Medical
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$449,211	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$449,211
202402	$1,954,603	$698,632	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,653,235
202403	$326,976	$2,122,458	$688,502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,137,936
202404	$120,333	$894,812	$3,108,705	$982,847	$0	$0	$0	$0	$0	$0	$0	$0	$5,106,696
202405	$90,403	$150,684	$671,761	$3,554,028	$897,648	$0	$0	$0	$0	$0	$0	$0	$5,364,524
202406	$75,602	$74,387	$253,786	$1,284,700	$3,114,776	$818,991	$0	$0	$0	$0	$0	$0	$5,622,242
202407	$5,724	$111,905	$102,962	$306,873	$1,831,544	$3,960,859	$1,512,756	$0	$0	$0	$0	$0	$7,832,621
202408	$71,170	$56,769	$127,534	$178,514	$154,904	$665,165	$3,529,233	$970,727	$0	$0	$0	$0	$5,754,017
202409	$9,692	$51,047	$46,540	$86,840	$138,954	$167,483	$1,068,308	$4,016,552	$858,650	$0	$0	$0	$6,444,065
202410	$21,772	$42,511	$4,798,472	$88,089	$67,762	$121,032	$188,486	$1,588,224	$4,103,330	$1,533,923	$0	$0	$12,553,601
202411	$10,240	$8,844	$143,923	$67,651	$74,534	$67,056	$106,446	$168,284	$627,544	$4,280,586	$1,287,858	$0	$6,842,966
202412	$6,649	$9,907	$18,354	$93,733	$45,049	$61,993	$78,910	$212,584	$183,120	$1,808,174	$4,880,917	$2,012,622	$9,412,011
202501	$149,293	$11,650	$89,714	$130,217	$95,025	$69,027	$122,980	$51,576	$229,960	$146,748	$943,888	$3,911,422	$5,951,499
202502	$9,377	$64,940	$39,867	$39,931	-$3,770	$30,504	$86,173	$118,840	$123,138	$348,409	$422,763	$1,242,690	$2,522,861
202503	$490	$3,490	$26,247	-$5,415	$23,631	$9,849	$30,462	$21,474	$24,306	$116,713	$213,416	$179,597	$644,260
Total	$3,301,535	$4,302,034	$10,116,365	$6,808,008	$6,440,055	$5,971,959	$6,723,753	$7,148,261	$6,150,047	$8,234,553	$7,748,842	$7,346,332	$80,291,744

Table 3.1d
Community Health Plan of Washington
Paid Claims - Rx
Checklist Items 1b

Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	Total
202401	$1,274,542	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,274,542
202402	$295,340	$1,322,140	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,617,480
202403	$3,671	$334,273	$1,979,407	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,317,351
202404	$9	$4,076	$2,656	$2,130,718	$0	$0	$0	$0	$0	$0	$0	$0	$2,137,458
202405	$0	$2,430	-$485	$162,179	$2,296,160	$0	$0	$0	$0	$0	$0	$0	$2,460,283
202406	$0	$0	$943	-$1,446	$240,377	$2,677,983	$0	$0	$0	$0	$0	$0	$2,917,857
202407	$0	$0	$963	$166	$971	-$184,990	$2,726,618	$0	$0	$0	$0	$0	$2,543,727
202408	$0	$0	$3	$66	$182	-$682	$296,332	$3,274,577	$0	$0	$0	$0	$3,570,478
202409	$388	$0	$37	$18	$2,566	$993	$3,423	-$154,110	$3,412,287	$0	$0	$0	$3,265,602
202410	$1,942	$0	$408	$2,711	$970	$1,637	$3,097	-$1,262	$145,329	$2,991,666	$0	$0	$3,146,497
202411	$0	$0	$0	$0	$0	$623	$584	$3,090	$1,011	$584,446	$3,598,913	$0	$4,188,667
202412	$0	$0	$0	$0	$0	$0	$0	$0	$10,962	$636	-$152,638	$3,524,785	$3,383,745
202501	$0	$2,031	$566	$0	$0	$0	$23	$593	-$211	-$3,846	$2,768	$357,180	$359,103
202502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,267	$978	$2,245
202503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14	$3	$231	$248
Total	$1,575,891	$1,664,950	$1,984,497	$2,294,412	$2,541,225	$2,495,563	$3,030,076	$3,122,888	$3,569,379	$3,572,917	$3,450,312	$3,883,173	$33,185,283

Table 3.2
Community Health Plan of Washington
Experience by Benefit Category
Checklist Items 1b, 1c & 11h

Allowed Claims by Benefit Category and Month

Benefit Category	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
Inpatient Hospital	$733,427	$1,043,240	$6,272,042	$2,188,203	$1,666,461	$1,411,777	$1,386,753	$1,496,781	$1,145,445	$2,542,926	$2,121,556	$1,830,615
Outpatient Hospital	$1,918,786	$2,436,590	$2,889,401	$3,423,870	$3,354,558	$3,372,661	$4,028,642	$4,245,457	$3,531,526	$4,074,997	$4,080,522	$4,011,630
Professional	$1,298,260	$1,665,676	$1,927,893	$2,219,290	$2,404,294	$2,265,770	$2,554,377	$2,646,460	$2,558,057	$2,964,037	$2,740,707	$2,684,546
Other Medical	$104,697	$103,922	$161,135	$182,160	$192,725	$190,965	$207,373	$161,049	$157,936	$244,806	$258,379	$203,947
Capitation												
Prescription Drug	$1,753,438	$1,889,208	$2,237,120	$2,533,235	$2,807,420	$2,746,516	$3,324,441	$3,424,904	$3,891,528	$3,895,483	$3,764,138	$4,204,473

Paid Claims by Benefit Category and Month

Benefit Category	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
Inpatient Hospital	$701,220	$979,622	$6,153,671	$2,030,616	$1,559,790	$1,331,742	$1,239,443	$1,334,968	$1,078,650	$2,240,734	$2,039,626	$1,703,475
Outpatient Hospital	$1,488,226	$1,898,221	$2,263,621	$2,820,877	$2,760,684	$2,654,340	$3,251,821	$3,507,596	$2,860,233	$3,338,885	$3,257,633	$3,254,283
Professional	$1,027,816	$1,347,987	$1,574,970	$1,808,694	$1,960,730	$1,829,820	$2,066,419	$2,175,610	$2,080,143	$2,445,387	$2,228,349	$2,224,517
Other Medical	$84,273	$76,204	$124,103	$147,821	$158,852	$156,056	$166,070	$130,088	$131,021	$209,548	$223,235	$164,056
Capitation												
Prescription Drug	$1,575,891	$1,664,950	$1,984,497	$2,294,412	$2,541,225	$2,495,563	$3,030,076	$3,122,888	$3,569,379	$3,572,917	$3,450,312	$3,883,173

Member Months[1]	16,913	21,085	23,156	25,117	26,809	28,379	29,515	30,956	32,276	33,188	33,948	33,982
Total Premium	$7,713,959	$9,735,535	$10,690,878	$11,541,847	$12,276,142	$12,940,329	$13,597,935	$14,088,103	$14,696,448	$15,126,412	$15,493,490	$15,515,240

Benefit Category	Experience Member Months	Paid Claims[2]	Incurred Claims[3]	Beginning Claim Reserve	Ending Claim Reserve	Paid to Allowed Factor	Allowed Claims	Paid PMPM	Incurred PMPM	Allowed PMPM
Inpatient Hospital	335,324	$19,589,367	$22,393,557	$1,354,973	$3,791,174	0.939	$23,839,227	$58.42	$66.78	$71.09
Outpatient Hospital	335,324	$29,412,363	$33,356,419	$2,018,306	$5,647,159	0.806	$41,368,640	$87.71	$99.48	$123.37
Professional	335,324	$20,699,462	$22,770,440	$1,377,777	$3,854,979	0.815	$27,929,366	$61.73	$67.91	$83.29
Other Medical	335,324	$1,471,933	$1,771,327	$107,178	$299,881	0.817	$2,169,092	$4.39	$5.28	$6.47
Capitation	335,324	$0	$0	$0	$0		$0	$0.00	$0.00	$0.00
Prescription Drug	335,324	$32,823,687	$33,185,283	$364,679	$517,817	0.910	$36,471,903	$97.89	$98.96	$108.77

(1) Member months differ from the URRT and other filing items due to timing of when the data was pulled and retroactive eligibility changes being applied..
(2) Paid claims include claims incurred through 12/31/2024, paid in calendar year 2024. All other amounts are incurred 1/1/2024 through 12/31/2024, paid through 3/31/2025.
(3) Incurred and allowed claims recorded are not adjusted for pharmacy rebates or estimated claims IBNP.

Table 5.1
Community Health Plan of Washington
Annual Unit Cost and Utilization Trend Assumptions
Checklist Item 5b

	Year 1			Year 2		
Service Type	**Cost**	**Utilization**	**Total**	**Cost**	**Utilization**	**Total**
Inpatient Hospital	3.1%	-0.5%	2.6%	3.1%	-0.5%	2.5%
Outpatient Hospital	3.1%	1.0%	4.1%	3.0%	1.0%	4.0%
Professional	-2.8%	0.0%	-2.8%	0.1%	0.0%	0.1%
Other Medical	-2.5%	0.0%	-2.5%	0.4%	0.0%	0.4%
Capitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prescription Drug	10.0%	2.5%	12.8%	10.0%	2.5%	12.8%
Total			**4.4%**			**5.3%**

Months of Trend Year 1	12.0
Months of Trend Year 2	12.0

Table 5.2
Community Health Plan of Washington
Incurred Claims Projected Trend for WAC 284-43-6660 Summary
Checklist Item 6a

WAC Trend Category	Experience Incurred PMPM	Incurred Cost Trend	Incurred Util Trend	WAC Percentages	
				Annual Trend Assumed	Portion of Claim Dollars
Hospital	$171.48	1.031	1.005	3.53%	49.50%
Professional	$70.04	0.987	1.000	-1.33%	18.36%
Prescription Drugs	$89.66	1.100	1.025	12.75%	30.70%
Dental	n/a	n/a	n/a	n/a	n/a
Other	$5.47	0.989	1.000	-1.06%	1.44%
Total	$336.65	1.039	1.009	4.90%	100.00%

URRT WS1 Section I, Experience Incurred PMPM:	$336.65
URRT WS2 Section IV, Field 4.15, Projected Incurred PMPM:	$390.16
Annual Incurred Claims Projected Trend[(1)]:	7.66%

Notes:

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

Table 8.1 Community Health Plan of Washington Projection Period Index Rate Development	
Description	**Experience**
2024 Total Allowed Claims PMPM	$392.63
2024 Non-EHB Allowed Claims PMPM	$0.00
2024 EHB Allowed Claims PMPM	$392.63
Trend	1.099
2026 EHB Allowed Claims PMPM	$431.52
Morbidity Adjustment	**1.010**
Risk Pool Deterioration	1.010
Demographic Shift	**1.028**
Demographics	1.024
Geography	1.004
Plan Design Changes	**0.984**
Induced Utilization	0.983
New Essential Health Benefits	1.001
Other	**1.016**
Mix/Interaction	0.977
Aggregate Paid Restoration	1.040
VSP Pediatric Vision Change	1.000
Projected EHB Allowed Claims PMPM	$448.40
Credibility	100%
Projection Period Index Rate PMPM	**$448.40**

Table 9.1 Community Health Plan of Washington Market-Wide Adjusted Index Rate Development Checklist Item 28a	
2025 Index Rate PMPM	$448.40
<u>Market-Wide Adjustments (paid basis)</u>	
Risk Adjustment Transfer Amount	$142.63
Exchange User Fees	$5.11
Paid-to-Allowed Ratio	0.870
<u>Market-Wide Adjustments (allowed basis)</u>	
Risk Adjustment Transfer Amount	$163.92
Exchange User Fees	$5.87
Market-Wide Adjusted Index Rate PMPM	**$618.20**

Table 9.2
Community Health Plan of Washington
Actual and Projected HCRP Receipt/Assessment PMPM
Checklist Item 19c & 19e

High-Cost Risk Pool Receipt

	2023	2024	2025	2026
Actual	$0.00	$6.73	*n/a*	*n/a*
Filed	$1.14	$1.70	$0.91	$1.11

High-Cost Risk Pool Assessment

	2023	2024	2025	2026
Actual	($1.32)	($1.83)	*n/a*	*n/a*
Filed	($1.14)	($1.70)	($1.75)	($2.20)

Net High-Cost Risk Pool Receipt/(Assessment)

	2023	2024	2025	2026
Actual	($1.32)	$4.90	*n/a*	*n/a*
Filed	$0.00	$0.00	($0.84)	($1.09)

Notes:

(1) Green highlighted cells tie to actual 2024 risk adjustment transfer and projected 2026 risk adjustment transfer in WA Exhibit 10.

(2) Negative value implies a net payment and a positive value implied a net receipt, consistent with the sign of the risk adjustment transfers in WA Exhibit 10.

Table 9.3
Community Health Plan of Washington
Average Paid to Allowed Factor Support
Checklist Item 28b

Metal Level	Member Months	Paid Claims PMPM	Allowed Claims	Paid-to-Allowed Ratio	AV Metal Value
Gold	70,249	$358.62	$435.64	0.823	80.6%
Silver	177,337	$437.43	$465.67	0.939	71.8%
Bronze	46,756	$258.26	$402.07	0.642	65.0%
Total	**294,342**	**$390.16**	**$448.40**	**0.870**	**72.9%**

Table 10.1
Community Health Plan of Washington
Development of AV & Cost Sharing Relativities
Checklist Items 11a-11e

Plan ID Plan Name	18581WA0140001 Community Health Plan of Washington Cascade Select Complete Gold	18581WA0140004 Community Health Plan of Washington Cascade Select Vital Gold	18581WA0140002 Community Health Plan of Washington Cascade Select Silver	18581WA0140003 Community Health Plan of Washington Cascade Select Bronze	Total
Projected Member Months	47,081	23,168	177,337	46,756	294,342
AV Pricing Value	0.835	0.799	0.733	0.642	0.740
Induced Demand Factors (IDFs)	1.102	1.079	1.044	1.010	1.051
Normalized IDFs	1.049	1.027	0.994	0.961	1.000
Removal of Abortion Services	0.997	0.997	0.997	0.997	0.997
CSR Non-funding Rate Load	1.000	1.000	1.435	1.000	1.262
Unnormalized AV and Cost Sharing Factor	0.873	0.819	1.043	0.616	0.930
Aggregate Paid-to-Allowed					0.868
AV and Cost Sharing Factor	0.815	0.764	0.973	0.574	0.868

(1) Induced utilization is removed from the AV and cost sharing factor to compare directly to the AV metal values.
(2) The pricing methodology values the pricing AVs differently than the AV Calculator due to known limitations of the federal AV Calculator.

Table 10.2 Community Health Plan of Washington Projection Period Plan Adjusted Index Rate Development								
Plan Name	HIOS ID	Market-Wide Adjusted Index Rate	AV & Cost Sharing	Provider Network Adjustment	Benefits In Addition to EHBs	Admin Cost Fee	Catastrophic Eligibility	Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$618.20	0.815	1.000	1.003	1.131	1.000	$570.72
CHPW Vital Gold	18581WA0140004	$618.20	0.764	1.000	1.003	1.131	1.000	$535.01
CHPW Silver	18581WA0140002	$618.20	0.973	1.000	1.003	1.131	1.000	$681.78
CHPW Bronze	18581WA0140003	$618.20	0.574	1.000	1.003	1.131	1.000	$402.53

Table 10.3
Community Health Plan of Washington
Development of Benefits in Addition to EHB Factor & Non-EHB Claims PMPM
Checklist Items 13 & 27

		(a)	(b)	(c) = (a)*((b)-1)	(d)	(e) = (c)*(d)/(a)
Plan ID	**Plan Name**	**Market-Wide Adjusted Index Rate**	**Benefits in Addition to EHB**	**Non-EHB Component of MAIR**	**Projected Incurred PMPM (All Plans)**	**Non-EHB Incurred Claims**
18581WA0140001	Community Health Plan of Washington Cascade Select Complete Gold	$618.20	1.0026	$1.59	$390.16	$1.00
18581WA0140004	Community Health Plan of Washington Cascade Select Vital Gold	$618.20	1.0026	$1.59	$390.16	$1.00
18581WA0140002	Community Health Plan of Washington Cascade Select Silver	$618.20	1.0026	$1.59	$390.16	$1.00
18581WA0140003	Community Health Plan of Washington Cascade Select Bronze	$618.20	1.0026	$1.59	$390.16	$1.00

Table 11.1
Community Health Plan of Washington
Calibrated Plan Adjusted Index Rate Development

Plan	HIOS ID	Plan Adjusted Index Rate	Age Calibration Factor	Geographic Calibration Factor	Tobacco Calibration Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate
CHPW Complete Gold	18581WA0140001	$570.72	1.549	0.983	1.000	1.523	$374.85
CHPW Vital Gold	18581WA0140004	$535.01	1.549	0.983	1.000	1.523	$351.40
CHPW Silver	18581WA0140002	$681.78	1.549	0.983	1.000	1.523	$447.79
CHPW Bronze	18581WA0140003	$402.53	1.549	0.983	1.000	1.523	$264.38

Table 11.2
Community Health Plan of Washington
Development of Composite & Calibrated Rating Factors
Checklist Items 15, 16 & 17

Composite Factors

	2023	2024	2025	2026
Composite Age Factor	1.6798	1.6126	1.5319	1.5492
Composite Area Factor	0.9803	0.9864	0.9806	0.9828
Tobacco Factor	1.2000	1.2000	1.2000	1.0000
Composite Tobacco Use Factor	1.0070	1.0050	1.0078	1.0000

Calibration Factors

	2023	2024	2025	2026
Calibration Age Factor	0.5953	0.6201	0.6528	0.6455
Calibration Area Factor	1.0201	1.0138	1.0198	1.0175
Calibration Tobacco Use Factor	0.9930	0.9950	0.9923	1.0000

Rating Area Factors

Region	2023	2024	2025	2026
Rating Area 1	1.0000	1.0000	1.0000	1.0000
Rating Area 2	1.0695	1.0755	1.0719	1.0748
Rating Area 4	0.9552	0.9617	0.9855	0.9882
Rating Area 5	0.9797	0.9584	0.9321	0.9346
Rating Area 6	0.9552	0.9625	0.9636	0.9670
Rating Area 7	1.0398	1.0526	1.0292	1.0294
Rating Area 8	0.9564	0.9617	1.0059	1.0064
Rating Area 9	0.9300	0.9783	0.9654	0.9701
Total	**0.9803**	**0.9864**	**0.9806**	**0.9828**

2026 Rating Area Factors

Counties	Region	Actual MMs	Percent Distribution	Area Factor[1)(2)]
King	Rating Area 1	71,487	24.3%	1.0000
Challam, Jefferson, Kitsap, Lewis	Rating Area 2	14,018	4.8%	1.0748
Ferry, Lincoln, Spokane, Stevens	Rating Area 4	24,175	8.2%	0.9882
Mason, Pierce, Thurston	Rating Area 5	80,482	27.3%	0.9346
Benton, Franklin, Kittitas, Yakima	Rating Area 6	44,352	15.1%	0.9670
Adams, Chelan, Douglas, Grant, Okanogan	Rating Area 7	29,483	10.0%	1.0294
Snohomish	Rating Area 8	25,975	8.8%	1.0064
Asotin, Columbia, Walla Walla, Whitman	Rating Area 9	4,370	1.5%	0.9701
Total		**294,342**	**100%**	**0.9828**

Max / Min[4)]	1.1500

2026 Age and Tobacco Factors

Age Band	Distribution	Age Factor[3)]	Non-Tobacco	Tobacco	Tobacco Factor[5)]
0-1	0.33%	0.765	0.33%	0.00%	1.000
2-6	0.64%	0.765	0.64%	0.00%	1.000
7-18	2.27%	0.801	2.27%	0.00%	1.000
19-20	4.92%	0.956	4.92%	0.00%	1.000
21-24	8.00%	1.000	8.00%	0.00%	1.000
25-29	12.94%	1.056	12.94%	0.00%	1.000
30-34	12.77%	1.178	12.77%	0.00%	1.000
35-39	11.22%	1.240	11.22%	0.00%	1.000
40-44	10.00%	1.332	10.00%	0.00%	1.000
45-49	8.76%	1.570	8.76%	0.00%	1.000
50-54	8.14%	1.956	8.14%	0.00%	1.000
55-59	8.29%	2.430	8.29%	0.00%	1.000
60-63	7.73%	2.837	7.73%	0.00%	1.000
64+	4.00%	3.000	4.00%	0.00%	1.000
Total	**100.00%**	**1.549**	**100.00%**	**0.00%**	**1.000**

Notes:
(1) Factors comply with limit of 1.15 ratio between highest cost area factor and lowest cost area factor (WAC 284-43-6681).
(2) Area factors weighted so that King County (Washington Rating Area 1) is equal to 1.00 (WAC 284-43-6681).
(3) The nearest whole age corresponding to the composite factor is 47. The age rating curve is shown on Table 12.1.
(4) Rating Area factors satisfy the 1.15 maximum to minimum threshold.
(5) CHPW is not rating based on tobacco use in 2026. There is assumed to be zero tobacco membership and all tobacco factors are set to 1.0.

Table 11.3
Community Health Plan of Washington
Rating Area Relativities
Checklist Item 16b

		Relativities (Versus Area 1)							
	Statewide	**Area 1**	**Area 2**	**Area 4**	**Area 5**	**Area 6**	**Area 7**	**Area 8**	**Area 9**
Util / 1,000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Unit Cost	1.0000	1.0000	1.1326	0.9797	0.8899	0.9438	1.0513	1.0110	0.9490
Raw Area Factors	1.0000	1.0000	1.1326	0.9797	0.8899	0.9438	1.0513	1.0110	0.9490
Final Area Factors[(1)]	1.0000	1.0000	1.0748	0.9882	0.9346	0.9670	1.0294	1.0064	0.9701

Max / Min	1.1500

Notes:
(1) Rating Area factors are compressed to satisfy the 1.15 maximum to minimum threshold.

Table 12.1 Community Health Plan of Washington Age and Tobacco Factors						
Age Band	**Age Rating Factor**	**Tobacco Factor**		**Age Band**	**Age Rating Factor**	**Tobacco Factor**
0-14	0.765	1.000		40	1.278	1.000
15	0.833	1.000		41	1.302	1.000
16	0.859	1.000		42	1.325	1.000
17	0.885	1.000		43	1.357	1.000
18	0.913	1.000		44	1.397	1.000
19	0.941	1.000		45	1.444	1.000
20	0.970	1.000		46	1.500	1.000
21	1.000	1.000		47	1.563	1.000
22	1.000	1.000		48	1.635	1.000
23	1.000	1.000		49	1.706	1.000
24	1.000	1.000		50	1.786	1.000
25	1.004	1.000		51	1.865	1.000
26	1.024	1.000		52	1.952	1.000
27	1.048	1.000		53	2.040	1.000
28	1.087	1.000		54	2.135	1.000
29	1.119	1.000		55	2.230	1.000
30	1.135	1.000		56	2.333	1.000
31	1.159	1.000		57	2.437	1.000
32	1.183	1.000		58	2.548	1.000
33	1.198	1.000		59	2.603	1.000
34	1.214	1.000		60	2.714	1.000
35	1.222	1.000		61	2.810	1.000
36	1.230	1.000		62	2.873	1.000
37	1.238	1.000		63	2.952	1.000
38	1.246	1.000		64+	3.000	1.000
39	1.262	1.000				

Table 12.2 Community Health Plan of Washington Geographic Rating Factors Checklist Item 16a	
Area	**Area Rating Factor**
Rating Area 1	1.000
Rating Area 2	1.075
Rating Area 4	0.988
Rating Area 5	0.935
Rating Area 6	0.967
Rating Area 7	1.029
Rating Area 8	1.006
Rating Area 9	0.970

Table 12.3 Community Health Plan of Washington Sample Consumer Adjusted Premium Rate Development	
Community Health Plan of Washington Cascade Select Complete Gold - 18581WA0140001	
Calibrated Plan Adjusted Index Rate	$374.85
Age: 33	1.198
Area: 6	0.967
Tobacco Status: Non-Tobacco User	1.000
Consumer Adjusted Premium Rate	**$434.26**

Table 13.1 Community Health Plan of Washington Projected Federal Medical Loss Ratio	
Member Months	294,342
MLR Numerator Calculations	
Paid Claims PMPM	$390.16
Claim-Related Retention (QI/Health IT) PMPM	$0.00
Prior Rebate	$0.00
Other Claim-Related Adjustments	$0.00
Risk Adjustment Paid (Received) PMPM	$142.63
Market Reinsurance Recoveries (Received) PMPM	$0.00
MLR Numerator Calculations	**$532.79**
MLR Denominator Calculations	
Premium PMPM	$608.10
Other Premium-Related Adjustments	$0.00
Premium-Related Retention (Taxes & Fees) PMPM	$18.69
MLR Denominator	**$589.41**
Medical Loss Ratio	**90.4%**

Table 15.1
Community Health Plan of Washington
Projected Enrollment (Member Months) by Benefit Level (Silver Plans)

Plan Name	HIOS ID	70%	73%	87%	94%	Total
CHPW Cascade Select Silver	18581WA0140002	0	0	114,040	63,297	177,337

Table 18.1
Community Health Plan of Washington
Development of URRT Worksheet 2, Section IV Values
Checklist Item 28f

Plan ID			18581WA0140001	18581WA0140004	18581WA0140002	18581WA0140003	
Component	URRT Reference		Community Health Plan of Washington Cascade Select Complete Gold	Community Health Plan of Washington Cascade Select Vital Gold	Community Health Plan of Washington Cascade Select Silver	Community Health Plan of Washington Cascade Select Bronze	Total
Projected Member Months	WS2, Field 4.9	(a)	47,081	23,168	177,337	46,756	294,342
Plan Adjusted Index Rate	WS2, Field 3.10	(b)	$570.72	$535.01	$681.78	$402.53	$608.10
Allowed Claims PMPM	WS2, Field 4.11	(c)	$438.62	$429.60	$465.67	$402.07	$448.40
Reinsurance PMPM	WS2, Field 4.12	(d)	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Sharing PMPM	WS2, Field 4.13	(e)	$72.45	$86.33	$28.23	$143.80	$58.24
Cost Sharing Reduction PMPM	WS2, Field 4.14	(f)	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	WS2, Field 4.15	(g)	$366.17	$343.27	$437.43	$258.26	$390.16
Risk Adjustment Transfer Amount PMPM	WS2, Field 4.16	(h)	$19.99	$19.99	($170.20)	($282.39)	($142.63)
Premium PMPM	WS2, Field 4.17	(i)	$570.71	$535.01	$681.78	$402.53	$608.10
Retention PMPM	n/a	(j) + … + (m)	$70.68	$66.26	$84.43	$49.85	$75.31
Administrative Expense	n/a	(j)	$41.72	$39.11	$49.84	$29.43	$44.45
Taxes and Fees	n/a	(k)	$12.75	$11.95	$15.23	$8.99	$13.58
Profit & Risk Load	n/a	(l)	$11.41	$10.70	$13.64	$8.05	$12.16
Exchange User Fee	n/a	(m)	$4.80	$4.50	$5.73	$3.38	$5.11
Total Allowed Claims	WS2, Field 4.2	(a) x (c)	$20,650,756	$9,952,859	$82,579,729	$18,799,056	$131,982,401
Total Reinsurance	WS2, Field 4.3	(a) x (d)	$0	$0	$0	$0	$0
Total Member Cost Sharing	WS2, Field 4.4	(a) x (e)	$3,410,936	$2,000,083	$5,006,969	$6,723,726	$17,141,714
Total Cost Sharing Reduction	WS2, Field 4.5	(a) x (f)	$0	$0	$0	$0	$0
Total Incurred Claims	WS2, Field 4.6	(a) x (g)	$17,239,820	$7,952,776	$77,572,760	$12,075,330	$114,840,687
Total Risk Adjustment Transfer Amount	WS2, Field 4.7	(a) x (h)	$941,223	$463,165	($30,183,630)	($13,203,437)	($41,982,680)
Total Premium	WS2, Field 4.8	(a) x (i)	$26,869,773	$12,395,099	$120,903,954	$18,820,462	$178,989,288
Actual Incurred Claims PMPM	WS2, Field 4.15	(g)	$366.17	$343.27	$437.43	$258.26	$390.16
Calculated Incurred Claims PMPM	n/a	(n)	$520.03	$488.75	$427.14	$70.29	$390.16
Difference PMPM[1]	n/a	(g) - (n)	($153.85)	($145.48)	$10.29	$187.98	$0.00

Notes:
(1) Differences at the plan level are driven by the use of plan-level risk adjustment transfers in CHPW's rate development as opposed to the aggregate PMPM risk transfer allocated to the plan level using a percent of premium allocation approach.

Table 19.1 Community Health Plan of Washington Reliance	
Data / Assumption	**Source**
2024 individual QHP claims and membership experience	Elaine Corrough, CHPW
2024 interim risk adjustment transfer receivable/payment	"Interim Summary Report on Individual and Small Group Market Risk Adjustment for the 2024 Benefit Year", released March 14, 2025, CMS; "HHS public and carrier-specific interim 2024 risk adjustment reports", provided by Elaine Corrough, CHPW "Wakely National Risk Adjustment Reporting", provided by Elaine Corrough, CHPW
Other 2024 individual QHP marketplace revenue and expenditures	Elaine Corrough, CHPW
2024 IBNP estimate	Elaine Corrough, CHPW
2024 Plan Liability Risk Score associated with Individual QHP claims and membership experience	Elaine Corrough, CHPW
2025 emerging individual QHP membership	Elaine Corrough, CHPW
Basic tables of utilization, cost, claims probability distributions, pricing adjustment factors, and primary care/specialty care utilization distribution	Milliman (Health Cost Guidelines)
Utilization trends	Milliman (Health Cost Guidelines)
Unit cost trends	CMS; Milliman (Health Cost Guidelines)
Administrative costs, taxes, and fees	Elaine Corrough, CHPW
Broker fees and commissions	Elaine Corrough, CHPW
County Rating Areas	Elaine Corrough, CHPW
Community Health Plan of Washington service areas	Elaine Corrough, CHPW
Expected reimbursement by Rating Area	Elaine Corrough, CHPW
3:1 age band Factors	HHS
2026 pediatric vision administrative fees and claims cost	VSP
Prescription drug AWP discounts, dispensing fees, rebates, and retail/mail utilization assumptions	Elaine Corrough, CHPW
2026 Exchange user fee	Washington Health Benefits Exchange
WSHIP assessment	Elaine Corrough, CHPW
WAPAL assessment	Elaine Corrough, CHPW
Contribution to surplus % of premium	Elaine Corrough, CHPW
SHB 1979 impacts	Elaine Corrough, CHPW