Filing at a Glance

Company:	BridgeSpan Health Company
Product Name:	2026 Nongrandfathered Individual Rate Filing BridgeSpan Washington
State:	Washington
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Rate
Date Submitted:	05/15/2025
SERFF Tr Num:	RGWA-134499023
SERFF Status:	Assigned
State Tr Num:	484721
State Status:	Review Pending
Co Tr Num:	WA OIC# 500823
Effective Date Requested:	01/01/2026
Author(s):	Paul Harmon, Daniel Boeder, Isaac Justus, Julia Shabalov, Lisa Mudgett, Janessa Sanchez, Chris Jasperson, Brittany Chan, Jaakob Sundberg, Andy Seymore, Mary Katayama, Summer Baek, Trey Norton
Reviewer(s):	Rocky Patterson II (primary), Amy Peach
Disposition Date:	
Disposition Status:	
Effective Date:	
Destruction Date:	

State Filing Description:

State: *Washington* ***Filing Company:*** *BridgeSpan Health Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *2026 Nongrandfathered Individual Rate Filing BridgeSpan Washington*
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: 18.38%

Deemer Date:
Submitted By: Jaakob Sundberg

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/15/2025
State Status Changed: 05/15/2025
Created By: Jaakob Sundberg
Corresponding Filing Tracking Number: RGWA-WA26-125119775, RGWA-134490492

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions:

Exchange only

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

Company and Contact

Filing Contact Information

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

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

Filing Company Information

BridgeSpan Health Company
2890 E. Cottonwood Pkwy
Salt Lake City, UT 84121
(800) 422-7076 ext. [Phone]

CoCode: 95303
Group Code:
Group Name:
FEIN Number: 87-0388069

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

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

Filing Fees

State Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

State Specific

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

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

Correspondence Summary

Filing Notes

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

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

Note To Filer

Created By:

Rocky Patterson II on 05/19/2025 05:52 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:25 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:**	BridgeSpan Health Company
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005C Individual - Other		
Product Name:	2026 Nongrandfathered Individual Rate Filing BridgeSpan Washington		
Project Name/Number:	/		

Reviewer Note

Created By:

Kelli Armfield on 05/27/2025 12:24 PM

Last Edited By:

Gail Jones

Submitted On:

05/27/2025 12:25 PM

Subject:

Rate Request Summary

Comments:

See attached

BridgeSpan Health Company – 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:	18.38% *average**
Requested effective date:	Jan. 1, 2026
Plans impacted:	BridgeSpan Health Company's Individual plans
People impacted:	376
Counties:	Benton, Clark, Columbia, Franklin, King, Kitsap, Klickitat, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla and Yakima

Key information used to develop the rate request

(Jan. 2024 - Dec. 2024)

Premiums	$4,524,562
Claims	$7,347,110
Administrative expenses	$491,551
Risk adjustment	$2,120,570
Company lost	**-$1,193,529**

The company expects its annual medical costs to increase 10.2%.

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:

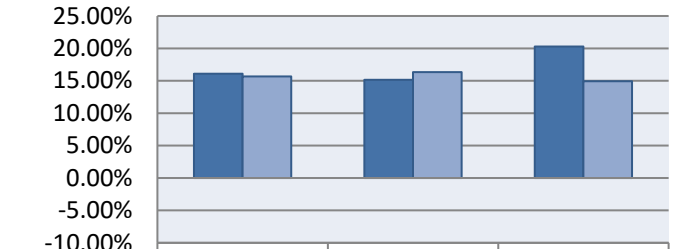
Claims:	86.73**%**
Administration:	9.77**%**
Profit:	3.50**%**

Are there any benefit changes?

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

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

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



	2023	2024	2025
Requested	16.10%	15.15%	20.28%
Accepted	15.68%	16.35%	14.92%

Need Help?

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

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

Rate Information

Rate data applies to filing.

Filing Method:	Electronic
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	14.920%
Effective Date of Last Rate Revision:	01/01/2025
Filing Method of Last Filing:	Electronic
SERFF Tracking Number of Last Filing:	RGWA-134064630

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):
BridgeSpan Health Company	Increase	18.380%	18.380%	$-886,477	264	$5,672,551	47.460%	-1.510%

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

Rate Review Detail

COMPANY:

Company Name: BridgeSpan Health Company
HHS Issuer Id: 53732

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
BridgeSpan Exchange EPO	53732WA079		376

Trend Factors: This filing uses an overall annual trend of 10.2%

FORMS:

New Policy Forms:
Affected Forms: N/A
Other Affected Forms: WWB0126PSDEPOE

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 6,108
Benefit Change: None
Percent Change Requested: Min: -1.5 Max: 47.5 Avg: 18.4

PRIOR RATE:

Total Earned Premium: 5,672,551.00
Total Incurred Claims: 6,191,808.00
Annual $: Min: 300.00 Max: 2,535.00 Avg: 896.00

REQUESTED RATE:

Projected Earned Premium: 4,786,074.00
Projected Incurred Claims: 4,582,613.00
Annual $: Min: 333.00 Max: 2,894.00 Avg: 1,061.00

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		2026 BHC Rate Sheets	WWB0126PSDEPOE	Revised	Previous State Filing Number: RGWA-134064630 Percent Rate Change Request: 18.38	BHC IND Rating Example.pdf, Rate Schedule Duplicate.xlsx, Rate Schedule.pdf,

Rating Example

Individual rates are determined by multiplying the:

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

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

Example 1:
Subscriber only policy, age 35, tobacco user, living in Rating Area 1, choosing the BridgeSpan Cascade Complete Gold Plan.

Member	(A) Plan Base Rate	(B) Age Factor	(C) Tobacco Factor	(D) Rating Area Factor	Final Rate = (A) x (B) x (C) x (D)
Subscriber - Age 35, Tobacco user	$639.96	1.222	1.00	1.000	$782.03

Example 2:
Family policy including: the subscriber, age 47, non-tobacco user, living in Rating Area 1;
spouse, age 46, tobacco user;
dependent, age 24, tobacco user;
dependent, age 14, non-tobacco user;
dependent, age 12, non-tobacco user;
dependent, age 8, non-tobacco user; and
dependent, age 6, non-tobacco user;
choosing the BridgeSpan Cascade Complete Gold Plan.

Family Member	(A) Plan Base Rate	(B) Age Factor	(C) Tobacco Factor	(D) Rating Area Factor	Final Rate = (A) x (B) x (C) x (D)
Subscriber - Age 47, Non-tobacco user	$639.96	1.563	1.00	1.000	$1,000.26
Spouse - Age 46, Tobacco user	$639.96	1.500	1.00	1.000	$959.94
Dependent - Age 24, Tobacco user	$639.96	1.000	1.00	1.000	$639.96
Dependent - Age 14, Non-tobacco user	$639.96	0.765	1.00	1.000	$489.57
Dependent - Age 12, Non-tobacco user	$639.96	0.765	1.00	1.000	$489.57
Dependent - Age 8, Non-tobacco user	$639.96	0.765	1.00	1.000	$489.57
Dependent - Age 6, Non-tobacco user	$639.96	0.000	1.00	1.000	$0.00
		Total = Sum of Individual Rates =			$4,068.87

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

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Bronze
HIOS Plan ID: 53732WA0790026
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Bronze
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	336.62	380.72	361.53	332.58	349.07	351.77		355.13	373.98	336.62	380.72	361.53	332.58	349.07	351.77		355.13	373.98
15	366.54	414.56	393.66	362.14	380.10	383.03		386.70	407.23	366.54	414.56	393.66	362.14	380.10	383.03		386.70	407.23
16	377.98	427.50	405.95	373.44	391.97	394.99		398.77	419.94	377.98	427.50	405.95	373.44	391.97	394.99		398.77	419.94
17	389.42	440.43	418.24	384.75	403.83	406.94		410.84	432.65	389.42	440.43	418.24	384.75	403.83	406.94		410.84	432.65
18	401.74	454.37	431.47	396.92	416.60	419.82		423.84	446.33	401.74	454.37	431.47	396.92	416.60	419.82		423.84	446.33
19	414.06	468.30	444.70	409.09	429.38	432.69		436.83	460.02	414.06	468.30	444.70	409.09	429.38	432.69		436.83	460.02
20	426.82	482.73	458.40	421.70	442.61	446.03		450.30	474.20	426.82	482.73	458.40	421.70	442.61	446.03		450.30	474.20
21	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86
22	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86
23	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86
24	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86	440.02	497.66	472.58	434.74	456.30	459.82		464.22	488.86
25	441.78	499.65	474.47	436.48	458.13	461.66		466.08	490.82	441.78	499.65	474.47	436.48	458.13	461.66		466.08	490.82
26	450.58	509.61	483.92	445.17	467.25	470.86		475.36	500.59	450.58	509.61	483.92	445.17	467.25	470.86		475.36	500.59
27	461.14	521.55	495.26	455.61	478.20	481.89		486.50	512.33	461.14	521.55	495.26	455.61	478.20	481.89		486.50	512.33
28	478.30	540.96	513.69	472.56	496.00	499.82		504.61	531.39	478.30	540.96	513.69	472.56	496.00	499.82		504.61	531.39
29	492.38	556.88	528.82	486.47	510.60	514.54		519.46	547.03	492.38	556.88	528.82	486.47	510.60	514.54		519.46	547.03
30	499.42	564.84	536.38	493.43	517.90	521.89		526.89	554.86	499.42	564.84	536.38	493.43	517.90	521.89		526.89	554.86
31	509.98	576.79	547.72	503.86	528.85	532.93		538.03	566.59	509.98	576.79	547.72	503.86	528.85	532.93		538.03	566.59
32	520.54	588.73	559.06	514.29	539.80	543.96		549.17	578.32	520.54	588.73	559.06	514.29	539.80	543.96		549.17	578.32
33	527.14	596.20	566.15	520.81	546.64	550.86		556.13	585.65	527.14	596.20	566.15	520.81	546.64	550.86		556.13	585.65
34	534.18	604.16	573.71	527.77	553.94	558.22		563.56	593.47	534.18	604.16	573.71	527.77	553.94	558.22		563.56	593.47
35	537.70	608.14	577.49	531.25	557.59	561.90		567.27	597.38	537.70	608.14	577.49	531.25	557.59	561.90		567.27	597.38
36	541.22	612.12	581.27	534.73	561.25	565.57		570.99	601.30	541.22	612.12	581.27	534.73	561.25	565.57		570.99	601.30
37	544.74	616.10	585.05	538.20	564.90	569.25		574.70	605.21	544.74	616.10	585.05	538.20	564.90	569.25		574.70	605.21
38	548.26	620.08	588.83	541.68	568.55	572.93		578.41	609.12	548.26	620.08	588.83	541.68	568.55	572.93		578.41	609.12
39	555.31	628.06	596.40	548.65	575.86	580.30		585.85	616.95	555.31	628.06	596.40	548.65	575.86	580.30		585.85	616.95
40	562.35	636.02	603.96	555.60	583.16	587.66		593.28	624.77	562.35	636.02	603.96	555.60	583.16	587.66		593.28	624.77
41	572.91	647.96	615.31	566.04	594.11	598.69		604.42	636.50	572.91	647.96	615.31	566.04	594.11	598.69		604.42	636.50
42	583.03	659.41	626.17	576.03	604.60	609.27		615.10	647.75	583.03	659.41	626.17	576.03	604.60	609.27		615.10	647.75
43	597.11	675.33	641.30	589.94	619.20	623.98		629.95	663.39	597.11	675.33	641.30	589.94	619.20	623.98		629.95	663.39
44	614.71	695.24	660.20	607.33	637.45	642.37		648.52	682.94	614.71	695.24	660.20	607.33	637.45	642.37		648.52	682.94
45	635.39	718.63	682.41	627.77	658.90	663.98		670.34	705.92	635.39	718.63	682.41	627.77	658.90	663.98		670.34	705.92
46	660.03	746.49	708.87	652.11	684.45	689.73		696.33	733.29	660.03	746.49	708.87	652.11	684.45	689.73		696.33	733.29
47	687.75	777.85	738.64	679.50	713.20	718.70		725.58	764.09	687.75	777.85	738.64	679.50	713.20	718.70		725.58	764.09
48	719.43	813.68	772.67	710.80	746.05	751.80		759.00	799.29	719.43	813.68	772.67	710.80	746.05	751.80		759.00	799.29
49	750.67	849.01	806.22	741.66	778.44	784.45		791.96	833.99	750.67	849.01	806.22	741.66	778.44	784.45		791.96	833.99
50	785.88	888.83	844.04	776.45	814.96	821.24		829.10	873.11	785.88	888.83	844.04	776.45	814.96	821.24		829.10	873.11
51	820.64	928.14	881.37	810.79	851.00	857.57		865.78	911.73	820.64	928.14	881.37	810.79	851.00	857.57		865.78	911.73
52	858.92	971.44	922.48	848.61	890.70	897.57		906.16	954.26	858.92	971.44	922.48	848.61	890.70	897.57		906.16	954.26
53	897.64	1015.23	964.07	886.87	930.85	938.03		947.01	997.28	897.64	1015.23	964.07	886.87	930.85	938.03		947.01	997.28
54	939.44	1062.51	1008.96	928.17	974.20	981.71		991.11	1043.72	939.44	1062.51	1008.96	928.17	974.20	981.71		991.11	1043.72
55	981.24	1109.78	1053.85	969.47	1017.55	1025.40		1035.21	1090.16	981.24	1109.78	1053.85	969.47	1017.55	1025.40		1035.21	1090.16
56	1026.57	1161.05	1102.54	1014.25	1064.55	1072.77		1083.03	1140.52	1026.57	1161.05	1102.54	1014.25	1064.55	1072.77		1083.03	1140.52
57	1072.33	1212.81	1151.68	1059.46	1112.01	1120.58		1131.31	1191.36	1072.33	1212.81	1151.68	1059.46	1112.01	1120.58		1131.31	1191.36
58	1121.17	1268.04	1204.14	1107.72	1162.65	1171.62		1182.83	1245.62	1121.17	1268.04	1204.14	1107.72	1162.65	1171.62		1182.83	1245.62
59	1145.37	1295.41	1230.13	1131.63	1187.75	1196.91		1208.37	1272.51	1145.37	1295.41	1230.13	1131.63	1187.75	1196.91		1208.37	1272.51
60	1194.21	1350.65	1282.58	1179.88	1238.40	1247.95		1259.89	1326.77	1194.21	1350.65	1282.58	1179.88	1238.40	1247.95		1259.89	1326.77
61	1236.46	1398.44	1327.96	1221.62	1282.21	1292.10		1304.47	1373.71	1236.46	1398.44	1327.96	1221.62	1282.21	1292.10		1304.47	1373.71
62	1264.18	1429.79	1357.73	1249.01	1310.95	1321.07		1333.71	1404.50	1264.18	1429.79	1357.73	1249.01	1310.95	1321.07		1333.71	1404.50
63	1298.94	1469.10	1395.06	1283.35	1347.00	1357.39		1370.38	1443.12	1298.94	1469.10	1395.06	1283.35	1347.00	1357.39		1370.38	1443.12
64 and over	1320.06	1492.98	1417.74	1304.22	1368.90	1379.46		1392.66	1466.58	1320.06	1492.98	1417.74	1304.22	1368.90	1379.46		1392.66	1466.58

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Vital Gold
HIOS Plan ID: 53732WA0790030
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	444.58	502.82	477.48	439.25	461.03	464.59		469.03	493.93	444.58	502.82	477.48	439.25	461.03	464.59		469.03	493.93
15	484.10	547.52	519.92	478.29	502.01	505.88		510.73	537.84	484.10	547.52	519.92	478.29	502.01	505.88		510.73	537.84
16	499.21	564.61	536.15	493.22	517.68	521.67		526.67	554.62	499.21	564.61	536.15	493.22	517.68	521.67		526.67	554.62
17	514.32	581.70	552.38	508.15	533.35	537.46		542.61	571.41	514.32	581.70	552.38	508.15	533.35	537.46		542.61	571.41
18	530.59	600.10	569.85	524.22	550.22	554.47		559.77	589.49	530.59	600.10	569.85	524.22	550.22	554.47		559.77	589.49
19	546.86	618.50	587.33	540.30	567.09	571.47		576.94	607.56	546.86	618.50	587.33	540.30	567.09	571.47		576.94	607.56
20	563.72	637.57	605.44	556.96	584.58	589.09		594.72	626.29	563.72	637.57	605.44	556.96	584.58	589.09		594.72	626.29
21	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66
22	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66
23	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66
24	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66	581.15	657.28	624.16	574.18	602.65	607.30		613.11	645.66
25	583.47	659.90	626.65	576.47	605.06	609.73		615.56	648.24	583.47	659.90	626.65	576.47	605.06	609.73		615.56	648.24
26	595.10	673.06	639.14	587.96	617.12	621.88		627.83	661.16	595.10	673.06	639.14	587.96	617.12	621.88		627.83	661.16
27	609.05	688.84	654.12	601.74	631.58	636.46		642.55	676.65	609.05	688.84	654.12	601.74	631.58	636.46		642.55	676.65
28	631.71	714.46	678.46	624.13	655.08	660.14		666.45	701.83	631.71	714.46	678.46	624.13	655.08	660.14		666.45	701.83
29	650.31	735.50	698.43	642.51	674.37	679.57		686.08	722.49	650.31	735.50	698.43	642.51	674.37	679.57		686.08	722.49
30	659.61	746.02	708.42	651.69	684.02	689.29		695.89	732.83	659.61	746.02	708.42	651.69	684.02	689.29		695.89	732.83
31	673.55	761.79	723.39	665.47	698.47	703.86		710.60	748.31	673.55	761.79	723.39	665.47	698.47	703.86		710.60	748.31
32	687.50	777.56	738.38	679.25	712.94	718.44		725.31	763.81	687.50	777.56	738.38	679.25	712.94	718.44		725.31	763.81
33	696.22	787.42	747.74	687.87	721.98	727.55		734.51	773.50	696.22	787.42	747.74	687.87	721.98	727.55		734.51	773.50
34	705.52	797.94	757.73	697.05	731.62	737.27		744.32	783.83	705.52	797.94	757.73	697.05	731.62	737.27		744.32	783.83
35	710.17	803.20	762.72	701.65	736.45	742.13		749.23	789.00	710.17	803.20	762.72	701.65	736.45	742.13		749.23	789.00
36	714.81	808.45	767.71	706.23	741.26	746.98		754.12	794.15	714.81	808.45	767.71	706.23	741.26	746.98		754.12	794.15
37	719.46	813.71	772.70	710.83	746.08	751.84		759.03	799.32	719.46	813.71	772.70	710.83	746.08	751.84		759.03	799.32
38	724.11	818.97	777.69	715.42	750.90	756.69		763.94	804.49	724.11	818.97	777.69	715.42	750.90	756.69		763.94	804.49
39	733.41	829.49	787.68	724.61	760.55	766.41		773.75	814.82	733.41	829.49	787.68	724.61	760.55	766.41		773.75	814.82
40	742.71	840.01	797.67	733.80	770.19	776.13		783.56	825.15	742.71	840.01	797.67	733.80	770.19	776.13		783.56	825.15
41	756.66	855.78	812.65	747.58	784.66	790.71		798.28	840.65	756.66	855.78	812.65	747.58	784.66	790.71		798.28	840.65
42	770.02	870.89	827.00	760.78	798.51	804.67		812.37	855.49	770.02	870.89	827.00	760.78	798.51	804.67		812.37	855.49
43	788.62	891.93	846.98	779.16	817.80	824.11		831.99	876.16	788.62	891.93	846.98	779.16	817.80	824.11		831.99	876.16
44	811.87	918.22	871.95	802.13	841.91	848.40		856.52	901.99	811.87	918.22	871.95	802.13	841.91	848.40		856.52	901.99
45	839.18	949.11	901.28	829.11	870.23	876.94		885.33	932.33	839.18	949.11	901.28	829.11	870.23	876.94		885.33	932.33
46	871.73	985.93	936.24	861.27	903.98	910.96		919.68	968.49	871.73	985.93	936.24	861.27	903.98	910.96		919.68	968.49
47	908.34	1027.33	975.56	897.44	941.95	949.22		958.30	1009.17	908.34	1027.33	975.56	897.44	941.95	949.22		958.30	1009.17
48	950.18	1074.65	1020.49	938.78	985.34	992.94		1002.44	1055.65	950.18	1074.65	1020.49	938.78	985.34	992.94		1002.44	1055.65
49	991.44	1121.32	1064.81	979.54	1028.12	1036.05		1045.97	1101.49	991.44	1121.32	1064.81	979.54	1028.12	1036.05		1045.97	1101.49
50	1037.93	1173.90	1114.74	1025.47	1076.33	1084.64		1095.02	1153.14	1037.93	1173.90	1114.74	1025.47	1076.33	1084.64		1095.02	1153.14
51	1083.84	1225.82	1164.04	1070.83	1123.94	1132.61		1143.45	1204.15	1083.84	1225.82	1164.04	1070.83	1123.94	1132.61		1143.45	1204.15
52	1134.40	1283.01	1218.35	1120.79	1176.37	1185.45		1196.79	1260.32	1134.40	1283.01	1218.35	1120.79	1176.37	1185.45		1196.79	1260.32
53	1185.55	1340.86	1273.28	1171.32	1229.42	1238.90		1250.76	1317.15	1185.55	1340.86	1273.28	1171.32	1229.42	1238.90		1250.76	1317.15
54	1240.76	1403.30	1332.58	1225.87	1286.67	1296.59		1309.00	1378.48	1240.76	1403.30	1332.58	1225.87	1286.67	1296.59		1309.00	1378.48
55	1295.96	1465.73	1391.86	1280.41	1343.91	1354.28		1367.24	1439.81	1295.96	1465.73	1391.86	1280.41	1343.91	1354.28		1367.24	1439.81
56	1355.82	1533.43	1456.15	1339.55	1405.99	1416.83		1430.39	1506.32	1355.82	1533.43	1456.15	1339.55	1405.99	1416.83		1430.39	1506.32
57	1416.26	1601.79	1521.06	1399.26	1468.66	1479.99		1494.15	1573.46	1416.26	1601.79	1521.06	1399.26	1468.66	1479.99		1494.15	1573.46
58	1480.77	1674.75	1590.35	1463.00	1535.56	1547.40		1562.21	1645.14	1480.77	1674.75	1590.35	1463.00	1535.56	1547.40		1562.21	1645.14
59	1512.73	1710.90	1624.67	1494.58	1568.70	1580.80		1595.93	1680.64	1512.73	1710.90	1624.67	1494.58	1568.70	1580.80		1595.93	1680.64
60	1577.24	1783.86	1693.96	1558.31	1635.60	1648.22		1663.99	1752.31	1577.24	1783.86	1693.96	1558.31	1635.60	1648.22		1663.99	1752.31
61	1633.03	1846.96	1753.87	1613.43	1693.45	1706.52		1722.85	1814.30	1633.03	1846.96	1753.87	1613.43	1693.45	1706.52		1722.85	1814.30
62	1669.64	1888.36	1793.19	1649.60	1731.42	1744.77		1761.47	1854.97	1669.64	1888.36	1793.19	1649.60	1731.42	1744.77		1761.47	1854.97
63	1715.55	1940.29	1842.50	1694.96	1779.03	1792.75		1809.91	1905.98	1715.55	1940.29	1842.50	1694.96	1779.03	1792.75		1809.91	1905.98
64 and over	1743.45	1971.84	1872.47	1722.53	1807.95	1821.90		1839.33	1936.97	1743.45	1971.84	1872.47	1722.53	1807.95	1821.90		1839.33	1936.97

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Complete Gold
HIOS Plan ID: 53732WA0790024
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	489.57	553.70	525.80	483.70	507.68	511.60		516.50	543.91	489.57	553.70	525.80	483.70	507.68	511.60		516.50	543.91
15	533.09	602.92	572.54	526.69	552.81	557.08		562.41	592.26	533.09	602.92	572.54	526.69	552.81	557.08		562.41	592.26
16	549.73	621.74	590.41	543.13	570.07	574.47		579.97	610.75	549.73	621.74	590.41	543.13	570.07	574.47		579.97	610.75
17	566.36	640.55	608.27	559.56	587.32	591.85		597.51	629.23	566.36	640.55	608.27	559.56	587.32	591.85		597.51	629.23
18	584.28	660.82	627.52	577.27	605.90	610.57		616.42	649.14	584.28	660.82	627.52	577.27	605.90	610.57		616.42	649.14
19	602.20	681.09	646.76	594.97	624.48	629.30		635.32	669.04	602.20	681.09	646.76	594.97	624.48	629.30		635.32	669.04
20	620.76	702.08	666.70	613.31	643.73	648.69		654.90	689.66	620.76	702.08	666.70	613.31	643.73	648.69		654.90	689.66
21	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00
22	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00
23	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00
24	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00	639.96	723.79	687.32	632.28	663.64	668.76		675.16	711.00
25	642.52	726.69	690.07	634.81	666.29	671.43		677.86	713.84	642.52	726.69	690.07	634.81	666.29	671.43		677.86	713.84
26	655.32	741.17	703.81	647.46	679.57	684.81		691.36	728.06	655.32	741.17	703.81	647.46	679.57	684.81		691.36	728.06
27	670.68	758.54	720.31	662.63	695.50	700.86		707.57	745.13	670.68	758.54	720.31	662.63	695.50	700.86		707.57	745.13
28	695.64	786.77	747.12	687.29	721.38	726.94		733.90	772.86	695.64	786.77	747.12	687.29	721.38	726.94		733.90	772.86
29	716.12	809.93	769.11	707.53	742.62	748.35		755.51	795.61	716.12	809.93	769.11	707.53	742.62	748.35		755.51	795.61
30	726.35	821.50	780.10	717.63	753.22	759.04		766.30	806.97	726.35	821.50	780.10	717.63	753.22	759.04		766.30	806.97
31	741.71	838.87	796.60	732.81	769.15	775.09		782.50	824.04	741.71	838.87	796.60	732.81	769.15	775.09		782.50	824.04
32	757.07	856.25	813.09	747.99	785.08	791.14		798.71	841.10	757.07	856.25	813.09	747.99	785.08	791.14		798.71	841.10
33	766.67	867.10	823.40	757.47	795.04	801.17		808.84	851.77	766.67	867.10	823.40	757.47	795.04	801.17		808.84	851.77
34	776.91	878.69	834.40	767.59	805.66	811.87		819.64	863.15	776.91	878.69	834.40	767.59	805.66	811.87		819.64	863.15
35	782.03	884.48	839.90	772.65	810.97	817.22		825.04	868.84	782.03	884.48	839.90	772.65	810.97	817.22		825.04	868.84
36	787.15	890.27	845.40	777.70	816.27	822.57		830.44	874.52	787.15	890.27	845.40	777.70	816.27	822.57		830.44	874.52
37	792.27	896.06	850.90	782.76	821.58	827.92		835.84	880.21	792.27	896.06	850.90	782.76	821.58	827.92		835.84	880.21
38	797.39	901.85	856.40	787.82	826.89	833.27		841.25	885.90	797.39	901.85	856.40	787.82	826.89	833.27		841.25	885.90
39	807.63	913.43	867.39	797.94	837.51	843.97		852.05	897.28	807.63	913.43	867.39	797.94	837.51	843.97		852.05	897.28
40	817.87	925.01	878.39	808.06	848.13	854.67		862.85	908.65	817.87	925.01	878.39	808.06	848.13	854.67		862.85	908.65
41	833.23	942.38	894.89	823.23	864.06	870.73		879.06	925.72	833.23	942.38	894.89	823.23	864.06	870.73		879.06	925.72
42	847.95	959.03	910.70	837.77	879.32	886.11		894.59	942.07	847.95	959.03	910.70	837.77	879.32	886.11		894.59	942.07
43	868.43	982.19	932.69	858.01	900.56	907.51		916.19	964.83	868.43	982.19	932.69	858.01	900.56	907.51		916.19	964.83
44	894.02	1011.14	960.18	883.29	927.10	934.25		943.19	993.26	894.02	1011.14	960.18	883.29	927.10	934.25		943.19	993.26
45	924.10	1045.16	992.48	913.01	958.29	965.68		974.93	1026.68	924.10	1045.16	992.48	913.01	958.29	965.68		974.93	1026.68
46	959.94	1085.69	1030.98	948.42	995.46	1003.14		1012.74	1066.49	959.94	1085.69	1030.98	948.42	995.46	1003.14		1012.74	1066.49
47	1000.26	1131.29	1074.28	988.26	1037.27	1045.27		1055.27	1111.29	1000.26	1131.29	1074.28	988.26	1037.27	1045.27		1055.27	1111.29
48	1046.33	1183.40	1123.76	1033.77	1085.04	1093.41		1103.88	1162.47	1046.33	1183.40	1123.76	1033.77	1085.04	1093.41		1103.88	1162.47
49	1091.77	1234.79	1172.56	1078.67	1132.17	1140.90		1151.82	1212.96	1091.77	1234.79	1172.56	1078.67	1132.17	1140.90		1151.82	1212.96
50	1142.97	1292.70	1227.55	1129.25	1185.26	1194.40		1205.83	1269.84	1142.97	1292.70	1227.55	1129.25	1185.26	1194.40		1205.83	1269.84
51	1193.53	1349.88	1281.85	1179.21	1237.69	1247.24		1259.17	1326.01	1193.53	1349.88	1281.85	1179.21	1237.69	1247.24		1259.17	1326.01
52	1249.20	1412.85	1341.64	1234.21	1295.42	1305.41		1317.91	1387.86	1249.20	1412.85	1341.64	1234.21	1295.42	1305.41		1317.91	1387.86
53	1305.52	1476.54	1402.13	1289.85	1353.82	1364.27		1377.32	1450.43	1305.52	1476.54	1402.13	1289.85	1353.82	1364.27		1377.32	1450.43
54	1366.31	1545.30	1467.42	1349.91	1416.86	1427.79		1441.46	1517.97	1366.31	1545.30	1467.42	1349.91	1416.86	1427.79		1441.46	1517.97
55	1427.11	1614.06	1532.72	1409.98	1479.91	1491.33		1505.60	1585.52	1427.11	1614.06	1532.72	1409.98	1479.91	1491.33		1505.60	1585.52
56	1493.03	1688.62	1603.51	1475.11	1548.27	1560.22		1575.15	1658.76	1493.03	1688.62	1603.51	1475.11	1548.27	1560.22		1575.15	1658.76
57	1559.58	1763.88	1674.99	1540.87	1617.28	1629.76		1645.36	1732.69	1559.58	1763.88	1674.99	1540.87	1617.28	1629.76		1645.36	1732.69
58	1630.62	1844.23	1751.29	1611.05	1690.95	1704.00		1720.30	1811.62	1630.62	1844.23	1751.29	1611.05	1690.95	1704.00		1720.30	1811.62
59	1665.82	1884.04	1789.09	1645.83	1727.46	1740.78		1757.44	1850.73	1665.82	1884.04	1789.09	1645.83	1727.46	1740.78		1757.44	1850.73
60	1736.85	1964.38	1865.38	1716.01	1801.11	1815.01		1832.38	1929.64	1736.85	1964.38	1865.38	1716.01	1801.11	1815.01		1832.38	1929.64
61	1798.29	2033.87	1931.36	1776.71	1864.83	1879.21		1897.20	1997.90	1798.29	2033.87	1931.36	1776.71	1864.83	1879.21		1897.20	1997.90
62	1838.61	2079.47	1974.67	1816.55	1906.64	1921.35		1939.73	2042.70	1838.61	2079.47	1974.67	1816.55	1906.64	1921.35		1939.73	2042.70
63	1889.16	2136.64	2028.96	1866.49	1959.06	1974.17		1993.06	2098.86	1889.16	2136.64	2028.96	1866.49	1959.06	1974.17		1993.06	2098.86
64 and over	1919.88	2171.37	2061.95	1896.84	1990.92	2006.27		2025.47	2132.99	1919.88	2171.37	2061.95	1896.84	1990.92	2006.27		2025.47	2132.99

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Silver
HIOS Plan ID: 53732WA0790025
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Silver
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	567.32	641.64	609.30	560.51	588.31	592.85		598.52	630.29	567.32	641.64	609.30	560.51	588.31	592.85		598.52	630.29
15	617.74	698.66	663.45	610.33	640.60	645.54		651.72	686.31	617.74	698.66	663.45	610.33	640.60	645.54		651.72	686.31
16	637.03	720.48	684.17	629.39	660.60	665.70		672.07	707.74	637.03	720.48	684.17	629.39	660.60	665.70		672.07	707.74
17	656.31	742.29	704.88	648.43	680.59	685.84		692.41	729.16	656.31	742.29	704.88	648.43	680.59	685.84		692.41	729.16
18	677.07	765.77	727.17	668.95	702.12	707.54		714.31	752.22	677.07	765.77	727.17	668.95	702.12	707.54		714.31	752.22
19	697.84	789.26	749.48	689.47	723.66	729.24		736.22	775.30	697.84	789.26	749.48	689.47	723.66	729.24		736.22	775.30
20	719.34	813.57	772.57	710.71	745.96	751.71		758.90	799.19	719.34	813.57	772.57	710.71	745.96	751.71		758.90	799.19
21	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91
22	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91
23	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91
24	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91	741.59	838.74	796.47	732.69	769.03	774.96		782.38	823.91
25	744.56	842.10	799.66	735.63	772.11	778.07		785.51	827.21	744.56	842.10	799.66	735.63	772.11	778.07		785.51	827.21
26	759.39	858.87	815.58	750.28	787.49	793.56		801.16	843.68	759.39	858.87	815.58	750.28	787.49	793.56		801.16	843.68
27	777.19	879.00	834.70	767.86	805.95	812.16		819.94	863.46	777.19	879.00	834.70	767.86	805.95	812.16		819.94	863.46
28	806.11	911.71	865.76	796.44	835.94	842.38		850.45	895.59	806.11	911.71	865.76	796.44	835.94	842.38		850.45	895.59
29	829.84	938.55	891.25	819.88	860.54	867.18		875.48	921.95	829.84	938.55	891.25	819.88	860.54	867.18		875.48	921.95
30	841.70	951.96	903.99	831.60	872.84	879.58		887.99	935.13	841.70	951.96	903.99	831.60	872.84	879.58		887.99	935.13
31	859.50	972.09	923.10	849.19	891.30	898.18		906.77	954.90	859.50	972.09	923.10	849.19	891.30	898.18		906.77	954.90
32	877.30	992.23	942.22	866.77	909.76	916.78		925.55	974.68	877.30	992.23	942.22	866.77	909.76	916.78		925.55	974.68
33	888.42	1004.80	954.16	877.76	921.29	928.40		937.28	987.03	888.42	1004.80	954.16	877.76	921.29	928.40		937.28	987.03
34	900.29	1018.23	966.91	889.49	933.60	940.80		949.81	1000.22	900.29	1018.23	966.91	889.49	933.60	940.80		949.81	1000.22
35	906.22	1024.93	973.28	895.35	939.75	947.00		956.06	1006.81	906.22	1024.93	973.28	895.35	939.75	947.00		956.06	1006.81
36	912.16	1031.65	979.66	901.21	945.91	953.21		962.33	1013.41	912.16	1031.65	979.66	901.21	945.91	953.21		962.33	1013.41
37	918.09	1038.36	986.03	907.07	952.06	959.40		968.58	1020.00	918.09	1038.36	986.03	907.07	952.06	959.40		968.58	1020.00
38	924.02	1045.07	992.40	912.93	958.21	965.60		974.84	1026.59	924.02	1045.07	992.40	912.93	958.21	965.60		974.84	1026.59
39	935.89	1058.49	1005.15	924.66	970.52	978.01		987.36	1039.77	935.89	1058.49	1005.15	924.66	970.52	978.01		987.36	1039.77
40	947.75	1071.91	1017.88	936.38	982.82	990.40		999.88	1052.95	947.75	1071.91	1017.88	936.38	982.82	990.40		999.88	1052.95
41	965.55	1092.04	1037.00	953.96	1001.28	1009.00		1018.66	1072.73	965.55	1092.04	1037.00	953.96	1001.28	1009.00		1018.66	1072.73
42	982.61	1111.33	1055.32	970.82	1018.97	1026.83		1036.65	1091.68	982.61	1111.33	1055.32	970.82	1018.97	1026.83		1036.65	1091.68
43	1006.34	1138.17	1080.81	994.26	1043.57	1051.63		1061.69	1118.04	1006.34	1138.17	1080.81	994.26	1043.57	1051.63		1061.69	1118.04
44	1036.00	1171.72	1112.66	1023.57	1074.33	1082.62		1092.98	1151.00	1036.00	1171.72	1112.66	1023.57	1074.33	1082.62		1092.98	1151.00
45	1070.86	1211.14	1150.10	1058.01	1110.48	1119.05		1129.76	1189.73	1070.86	1211.14	1150.10	1058.01	1110.48	1119.05		1129.76	1189.73
46	1112.39	1258.11	1194.71	1099.04	1153.55	1162.45		1173.57	1235.87	1112.39	1258.11	1194.71	1099.04	1153.55	1162.45		1173.57	1235.87
47	1159.11	1310.95	1244.88	1145.20	1202.00	1211.27		1222.86	1287.77	1159.11	1310.95	1244.88	1145.20	1202.00	1211.27		1222.86	1287.77
48	1212.50	1371.34	1302.23	1197.95	1257.36	1267.06		1279.19	1347.09	1212.50	1371.34	1302.23	1197.95	1257.36	1267.06		1279.19	1347.09
49	1265.15	1430.88	1358.77	1249.97	1311.96	1322.08		1334.73	1405.58	1265.15	1430.88	1358.77	1249.97	1311.96	1322.08		1334.73	1405.58
50	1324.48	1497.99	1422.49	1308.59	1373.49	1384.08		1397.33	1471.50	1324.48	1497.99	1422.49	1308.59	1373.49	1384.08		1397.33	1471.50
51	1383.07	1564.25	1485.42	1366.47	1434.24	1445.31		1459.14	1536.59	1383.07	1564.25	1485.42	1366.47	1434.24	1445.31		1459.14	1536.59
52	1447.58	1637.21	1554.70	1430.21	1501.14	1512.72		1527.20	1608.26	1447.58	1637.21	1554.70	1430.21	1501.14	1512.72		1527.20	1608.26
53	1512.84	1711.02	1624.79	1494.69	1568.82	1580.92		1596.05	1680.77	1512.84	1711.02	1624.79	1494.69	1568.82	1580.92		1596.05	1680.77
54	1583.29	1790.70	1700.45	1564.29	1641.87	1654.54		1670.37	1759.04	1583.29	1790.70	1700.45	1564.29	1641.87	1654.54		1670.37	1759.04
55	1653.75	1870.39	1776.13	1633.91	1714.94	1728.17		1744.71	1837.32	1653.75	1870.39	1776.13	1633.91	1714.94	1728.17		1744.71	1837.32
56	1730.13	1956.78	1858.16	1709.37	1794.14	1807.99		1825.29	1922.17	1730.13	1956.78	1858.16	1709.37	1794.14	1807.99		1825.29	1922.17
57	1807.25	2044.00	1940.99	1785.56	1874.12	1888.58		1906.65	2007.85	1807.25	2044.00	1940.99	1785.56	1874.12	1888.58		1906.65	2007.85
58	1889.57	2137.10	2029.40	1866.90	1959.48	1974.60		1993.50	2099.31	1889.57	2137.10	2029.40	1866.90	1959.48	1974.60		1993.50	2099.31
59	1930.36	2183.24	2073.21	1907.20	2001.78	2017.23		2036.53	2144.63	1930.36	2183.24	2073.21	1907.20	2001.78	2017.23		2036.53	2144.63
60	2012.68	2276.34	2161.62	1988.53	2087.15	2103.25		2123.38	2236.09	2012.68	2276.34	2161.62	1988.53	2087.15	2103.25		2123.38	2236.09
61	2083.87	2356.86	2238.08	2058.86	2160.97	2177.64		2198.48	2315.18	2083.87	2356.86	2238.08	2058.86	2160.97	2177.64		2198.48	2315.18
62	2130.59	2409.70	2288.25	2105.02	2209.42	2226.47		2247.77	2367.09	2130.59	2409.70	2288.25	2105.02	2209.42	2226.47		2247.77	2367.09
63	2189.17	2475.95	2351.17	2162.90	2270.17	2287.68		2309.57	2432.17	2189.17	2475.95	2351.17	2162.90	2270.17	2287.68		2309.57	2432.17
64 and over	2224.77	2516.21	2389.40	2198.07	2307.09	2324.88		2347.13	2471.72	2224.77	2516.21	2389.40	2198.07	2307.09	2324.88		2347.13	2471.72

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

URRT

State Determination

Review Status:	Incomplete

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

URRT Items

Item Name	Attachment(s)
Unified Rate Review Template	*PartIUnifiedRateReviewTemplateDuplicate.xml*
Actuarial Memorandum	*PartIIIRateFilingDocumentationandActuarialMemorandum.pdf*
Actuarial Memorandum - Redacted	*PartIIIRateFilingDocumentationandActuarialMemorandumRedacted.pdf*
Consumer Justification Narrative	*PartIIWrittenDescriptionJustifyingtheRateIncrease.pdf*
Other Supporting Documents	*PartIUnifiedRateReviewTemplate_v1.pdf, BHCINDPartIIIAppendix_v1.pdf*

BridgeSpan Health Company – Individual
Actuarial Memorandum and Certification – Part III
Rates Effective January 1, 2026

Table of Contents

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

4.1: Redacted Actuarial Memorandum

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

4.2: General Information

Company Identifying Information

- Company Legal Name: BridgeSpan Health Company
- State: Washington
- HIOS Issuer ID: 53732
- Market: Individual
- Effective Date: January 1, 2026

Company Contact Information

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

Purpose

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

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

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

Per the Unified Rate Review Instructions released March 2022, the actuary may state: *"The URRT does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers."*

4.3: Proposed Rate Changes

This filing proposes an average annual rate change of 18.38% on January 1, 2026, for the Individual line of business, as shown in "Exhibit A1: Development of 2026 Rate Change." The 2026 projected average premium is $1060.74 per member per month (PMPM).

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

This filing assumes Cost Sharing Reduction (CSR) payments will not be paid in 2026. If changes are made to the premium subsidies, risk adjustment, or reinsurance, the proposed rates in this filing may need to change materially to ensure adequacy with expected market costs. This filing also assumes that enhanced Premium Tax Credits (ePTC) will no longer be available in 2026.

Factor Changes

This filing includes updates to the plan and area factors. Rating factor tables and changes since the last filing are shown in the "Rate Factors" document. The average annual rate change impact of 18.38% includes the impact of these factor changes and is on a member-weighted basis.

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

Based on OIC guidance, only on-exchange Silver plan premium should be increased to cover the additional costs associated with providing benefits to all Silver plan enrollees, in the event the CSR subsidies are not funded. See the "CSR Funding" section for more detail.

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

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

Pool Base Rate

The pool base rate is $691.85 as of January 1, 2026. The pool base rate is the starting amount such that multiplying the base rate by the member's rating factors (plan, age, and area) and adjusting for family composition results in the member's premium.

Reasons for Proposed Rate Change

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

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

Financial Experience: Each year BridgeSpan evaluates the most recent financial results in the Washington Individual market and incorporates that information into pricing. The experience also includes the impacts of pooling BridgeSpan with Regence BlueShield (RBS).

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

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

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

Contributing Factor	Approximate Impact
Changes due to Medical Trend and Utilization	10%
Changes due to Financial Experience[1]	-6%
Changes Due to Market wide Average Morbidity	4%
Changes due to Product Design[2]	10%
Total	**18%**

[1] Includes the impact of overestimate or underestimate of medical trend, and impacts of pooling with RBS

[2]Includes changes in CSR load, cost sharing, plan mappings, and benefit factors

4.4: Market Experience

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

4.4.1: Experience Period Premium, Claims, and Enrollment

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

BridgeSpan enrollment decreased from the prior year and is no longer considered a fully credible block. For rate development purposes, experience from BridgeSpan Individual was combined with RBS which had over 22,000 lives in 2023 and is considered fully credible.

BridgeSpan analyzes financial performances for each company and line of business regularly and over/under-projections are corrected for in the rate development the following year. Overall, premium and claims experience is unfavorable compared to expectations in 2024.

In completing the Experience Period Data section of the URRT, Worksheet 1, only BridgeSpan information is reflected, as required by the instructions. The combined RBS and BridgeSpan company experience projected to 2025 appears in the Manual EHB Allowed Claims section of the URRT, Worksheet 1, as described in the Credibility of Experience section of this memorandum.

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

Review and Analyze Data

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

Develop UCL Estimates Using Multiple Methods

- Basic Claims Development Method
- Paid PMPM Method

Determine UCL for Recent Incurred Months

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

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

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

4.4.2: Benefit Categories

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

4.4.3: Projection Factors

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

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

4.4.3.1: Trend Factors

Projected Rating Trend

The trend factor used in rate development is shown on the "Trend Factor to Rating Period" line in "Exhibit A1: Development of 2026 Rate Change," reflecting twenty-four months of trend at an annual rate of 10.2%. The table below shows the expected components of the annual trend used to project incurred claims costs to the rating period. Note that the leverage component does not impact allowed claims; this trend applies to incurred, paid claims.

Components of Projected Trend

Reimbursement	5.00%
Utilization	2.10%
Mix/Intensity	1.20%
Leverage	1.90%

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

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

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

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

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

A few examples of new or expanded initiatives include:

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

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

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

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

Normalized Experience Trend
BridgeSpan reviews experience trend by calculating rolling twelve month historical paid claims trend on both an observed and underlying basis. In order to differentiate between the observed trend and the underlying trend, claims are normalized for differences in demographics, health risk, and large claims. Demographic adjustments are developed using the current filed factors for age and area and health risk adjustments are developed using risk score data.

A summary of the underlying allowed experience is included in "WA Exh 4 – Normalized Trend" within the "BHC IND OIC Health Exhibits." The analysis shows an underlying average allowed claim trend of 20.93% when comparing calendar year 2024 to calendar year 2023. This estimate of recent underlying trend experience is a single point of reference and is not the sole predictor of future trends.

4.4.3.2: Adjustments to Trended EHB Allowed Claims PMPM

4.4.3.2(a): Morbidity Adjustment

This assumption reflects the anticipated change in morbidity from calendar year 2024 ("base period") to calendar year 2026 ("projection period") for BridgeSpan Individual ACA plans. The morbidity adjustment reflects a change in the expected health risk of the pool regardless of the underlying demographics.

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

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

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

Morbidity Level of Base Period Company Experience

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

BridgeSpan Individual Morbidity Change from Base Period to Projection Period

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

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

An estimate for the projected morbidity change between the base period and projection period is shown in "WA Exh 10 - Risk Adjustment" within "BHC IND OIC Health Exhibits." Changes to each of the risk adjustment transfer components between 2024 and 2026 are shown in the exhibit. The projection of 2026 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2024 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This

implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts. The calculation of the 2026 transfer payments reflects the 14 percent administrative cost reduction to state average premium.

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

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

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

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

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

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

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

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

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

Experience period covered benefits for ACA plans satisfy Washington's 2026 requirements. Therefore, no specific experience period adjustments are applied to ACA plan experience. Pediatric dental benefits are excluded from all 2026 ACA products offered.

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

Other Benefits
This adjustment reflects anticipated differences in non-EHB benefits between the experience period and projection period. There are no material differences that require an adjustment. For 2026, Gene Therapy is now considered an Essential Health Benefit.

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

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

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

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

A proprietary network model is used to determine the projected cost relativities between different networks, based on historical experience projected to the rating period. The model allows the inclusion or exclusion of providers on a group-by-group basis. As a provider group is excluded from the network, the services that were delivered by that group are redistributed to other providers within the same specialty. As care is shifted among providers, adjustments are made to reflect utilization efficiency and unit cost differences between the providers. For plans paired with an accountable health network, the relativities also reflect expected savings due to managed care and provider incentive arrangements.

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

The RealValue network will be discontinued in 2026. In 2026, BridgeSpan will offer plans on the new Individual Value network. The Individual Value network is a statewide network offered in all of the covered service areas.

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

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

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

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

4.4.3.3: Manual Rate Adjustments

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

For purposes of completing the URRT, Worksheet 1, all BridgeSpan non-grandfathered Individual experience was included to develop the Adjusted Trended EHB Allowed Claims PMPM. Combined BridgeSpan and RBS experience used to develop rates was reflected in the Manual EHB Allowed Claims PMPM item in the URRT, Worksheet 1. A detailed summary is included in "Exhibit E1: Development of 2026 Index Rate."

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

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

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

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

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

- Estimate a relative value for the base period experience for BridgeSpan and RBS (a)
- Estimate BridgeSpan individual relative value for the projection period (b)
- The adjustment applied to each experience pool is equal to (b) divided by (a)

Due to credibility concerns, for morbidity, BridgeSpan morbidity was projected to the RBS morbidity factors and transfer amounts.

The claims cost weight assigned to each experience pool is shown in "Exhibit A1: Development of the 2026 Rate Change." The resulting overall projected incurred claims cost is $1015.65 PMPM.
For purposes of completing the URRT, the credibility percentage applied to the experience included in the Manual EHB Allowed Claims PMPM section is consistent with the weights for rate development. The resulting projected allowed claims cost is $1125.00 PMPM.

4.4.3.5: Establishing the Index Rate
The experience period index rate is $1342.67 PMPM; the projected period index rate is $1125.00 PMPM. Non-EHB benefit categories are excluded from the calculation based upon the benefit category code assigned automatically within the data warehouse. Individual Assistance Program (IAP) and voluntary termination of pregnancy benefits are excluded from all plans. Please note the index rate does not demonstrate the process used to develop the rates; it was prepared for reporting purposes and is calculated consistently with the results of the underlying rate development process.

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

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

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

4.4.3.6: Development of the Market-wide Adjusted Index Rate

The market-wide adjusted index rate is $1029.93 PMPM. It is calculated as the projection period index rate adjusted for the following allowable market-wide modifiers:

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

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

4.4.3.6(a): Reinsurance

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

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

4.4.3.6(b): Risk Adjustment Payment/Charge

2024 risk adjustment transfers are populated in the "Risk Adjustment Transfer Amount" line of the URRT, Worksheet 2, Section II. Amounts were allocated by plan in proportion to premium. The risk adjustment user fee for 2024 was $0.21 PMPM. The experience period risk adjustment transfer PMPM, including net HCRP receipts and before reduction for the risk adjustment user fee, is $342.98 as shown in "WA Exh 10 - Risk Adjustment" within the "BHC IND OIC Health Exhibits." Due to credibility concerns, for morbidity, BridgeSpan morbidity was projected to the RBS morbidity factors and transfer amounts.

The URRT, Worksheet 1 shows the experience period risk adjustment PMPM as $347.18 because it is calculated as the projected 2024 risk adjustment transfer divided by the 2024 experience period membership. The risk adjustment transfer PMPM shown in "WA Exh 10 - Risk Adjustment" within the "BHC IND OIC Health Exhibits" is calculated as the projected 2024 risk adjustment transfer divided by the billable member months. Experience period member months differ from the billable member months due to differences in counting billable member months and total member months, and due to differences in the run out period.

The projected risk adjustment PMPM reflects the difference in projection period expected relative risk between the BridgeSpan block of business and the overall market. The estimated risk adjustment transfer used for rate development is shown on the "Risk Adjustment Transfer" line in "Exhibit A1: Development of 2026 Rate Change." The risk adjustment user fee for 2026 is $0.20 PMPM and is shown in the "Retention Development" section of Exhibit A1. Information regarding the transfer estimate is

shown in "WA Exh 10 - Risk Adjustment" within the "BHC IND OIC Health Exhibits," including the detailed internal data and projections by metal level used to develop the estimate. A positive amount represents an anticipated risk adjustment payment receipt, and a negative amount represents an anticipated risk adjustment charge.

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

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

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

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

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

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

program assessment, an estimated value of 0.50% of premium is used in rate development. For the purposes of populating the URRT, the HCRP assessment is added to the risk adjustment transfer amount. The premium charge for the HCRP is not finalized; this amount is based on an estimate developed by an external consultant.

BridgeSpan anticipates $87K in HCRP recoveries for claims paid in 2024. BridgeSpan had $85k and $27k in HCRP recoveries in 2023 and 2022 respectively.

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

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

4.4.3.6(c): Exchange User Fees
The 2026 marketplace user fee is $5.11 PMPM, and projected marketplace enrollment is 100% of total projected enrollment. Therefore, the filing reflects exchange user fees of $5.11 PMPM.

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

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

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

The components of the AV and cost-sharing design factors are Induced Demand Factors, EHB Paid to Allowed Factors, and Projected CSR Adjustment factors as shown in Exhibit E2. Induced Demand Factors for 2026 are prescribed by emergency rule CR-103E (R 2025-01) and included in "WA Exh 9 – AV and Cost-Share" within the "BHC IND OIC Health Exhibits." EHB Paid to Allowed Factors are derived values for the purpose of the URRT and are not used in rate development. See section 4.6.5 for detail on the Projected CSR Adjustment.

The base product factors shown in "Exhibit E2: Plan Adjusted Index Rate Development" were developed using a proprietary benefit relativity model that does not account for health status. The base product factor is used to normalize the projected average premium to get to the pool base rate in Exhibit A1. These factors are based on paid claims. The base product factor is the pricing value based on benefit design only, before network adjustments and non-EHB benefits.

4.4.5: Calibration

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

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

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

Age Curve Calibration

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

Geographic Factor Calibration

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

Tobacco Use Rating Factor Calibration
In 2026 Tobacco use status is not used as a rating factor for BridgeSpan Individual products.

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

- Plan
- Age
- Area
- Family status

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

The 2026 pool base rate of $691.85 and the average factors for normalization are shown in "Exhibit A1: Development of 2026 Rate Change."

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

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

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

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

4.4.7(a): Administrative Expense Load
The administrative expense load is comprised of expected plan operating expenses and commissions paid to agents and brokers, offset by investment earnings on claim reserves.

Operating expenses for 2026 are projected at $65.13 PMPM or 6.14% of premium. Operating expenses are developed by the cost accounting department consistent with company policy and were reviewed for reasonability compared to prior results. When possible, operating expenses are assigned directly as a claim or non-claim related expense to the appropriate line of business. When costs cannot be assigned

directly to a specific line of business, the expenses are allocated based upon appropriate objective statistical measures. As such, reliance is placed on the internal cost accounting department's expertise in developing these estimates.

Commission expenses for 2026 are projected at $6.78 PMPM or 0.64% of premium. Historical utilization of distribution channels was analyzed against the 2026 commission schedule. Commissions may apply to members purchasing both on and off exchange if a broker is utilized.

Investment earnings on claim reserves are projected to impact premiums by -$1.70 PMPM or -0.16% of premium. This value reflects a projected T-bill rate of 2.38% applied to the claim reserves. Earnings are expressed as a percentage of premium.

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

2026 Administrative Expense Components

Component	Percent of Premium	PMPM
Administrative Expenses	6.14%	$65.13
Commissions	0.64%	$6.78
Investment Earnings	-0.16%	-$1.70
Total Administrative Expense Load	6.62%	$70.21

2026 Projected Average Premium PMPM: $1060.74

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

4.4.7(b): Profit and Risk Load

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

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

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

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

Risk and Contingency Margin	
Filing Year	2026
Percent of Premium	3.5%
PMPM	$37.13

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

4.4.7(c): Taxes and Fees

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

- State premium tax is set at 2.0% by the state of Washington.
- BridgeSpan is subject to federal income taxes. As this filing includes no explicit contribution to surplus, no adjustment is made for income taxes.
- The estimated PCORI fee for 2026 plans is $0.32 PMPM. The PCORI fee is calculated as the $3.00 annual fee for plan years ending October 1, 2024 through September 30, 2025, divided by 12, and trended for 2 years at an annual rate of 4.9% and 5.0%, the projected trend from the National Health Expenditures, and rounded to the nearest penny.
- This filing reflects exchange user fees of $5.11 PMPM because all products will be offered only on the exchange in 2026. On the URRT, this amount is already included in the MAIR and is not included in the Taxes and Fees section.
- The risk adjustment program fee for 2026 is $0.20 PMPM.
- This filing assumes an HCRP assessment of 0.50% of premium, as discussed in section 4.4.3.6(b). On the URRT, this amount is included in the risk transfer amounts and is not included in the Taxes and Fees section.
- An amount of $0.32 PMPM is included in this filing for the WSHIP assessment. This is based on WSHIP's preliminary financial projection anticipating total 2026 assessments of $6 million. The following table shows the development of this amount starting from WSHIP's anticipated total assessment.

- The regulatory surcharge from RCW 48.02.190 is calculated to be 0.08% of premium by using the 2025 fee as a proxy for 2026.
- The insurance fraud surcharge from RCW 48.02.190 is calculated to be 0.00% of premium by using the 2025 fee as a proxy for 2026.
- The WPAL fee, which is a new fee funding the WA Partnership Access Line, is calculated to be $0.07 PMPM by using the projected annual program costs divided by WSHIP enrollment as a proxy.

WSHIP Assessment Allocation

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

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

2026 Taxes & Fees Components

Component	Percent of Premium	PMPM
Premium Tax	2.00%	$21.21
PCORI Fee	0.03%	$0.32
Risk Adjustment Program Fee	0.02%	$0.20
WSHIP Assessment	0.03%	$0.32
Regulatory Surcharge	0.08%	$0.81
Insurance Fraud Surcharge	0.00%	$0.04
WPAL Fee	0.01%	$0.07
Total Taxes & Fees	2.17%	$22.97

2026 Projected Average Premium PMPM: $1060.74

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

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

4.5: Projected Loss Ratio

The projected federal loss ratio calculated using federally-prescribed methodology for medical loss ratio (MLR) rebates calculations is 89.5%, which is greater than the federally prescribed MLR requirement of

80.0%. Due to the complexity of the federal MLR rebate methodology, which is beyond the scope of this filing, the only adjustment reflected is subtracting projected taxes and fees from the premium denominator. This simplified MLR calculation is strictly less than or equal to the federal MLR methodology, so the federal MLR must also be greater than 80.0%. The numerator for this ratio is projected incurred claims net of projected risk adjustment transfers, $920.01 PMPM. The denominator of this simplified calculation is equal to projected average premium, less the Total Taxes & Fees PMPM described in the preceding Taxes & Fees section: $1027.42.

BridgeSpan considered potential impacts resulting from the 2026 MLR reporting regulation changes and deemed no changes in rating methodology to be required.

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

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

4.6: Plan Product Information

4.6.1: AV Metal Values

BridgeSpan will only offer Cascade Care standard plans in 2026. The AV certification for standardized plans has been provided by Wakely Consulting Group. BridgeSpan has included that certification as justification of the AV for the non-standard cost shares for those plans and is utilizing the AV provided as the minimum for all non-standard silver health plans as required under RCW 43.71.095(2)(b)(iii).

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

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

4.6.2: Membership Projections

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

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

Projected enrollment by subsidy level for each Silver plan is included in "WA Exh 8 - CSR Experience" within "BridgeSpan IND OIC Health Exhibits." The portion of the projected enrollment that will be eligible for cost-sharing reduction subsidies at each subsidy level is estimated assuming 2026 subsidy

level distributions will be similar to Cambia's exchange market enrollment. As described in Section 4.3 of this memo, this filing assumes CSR payments will not be paid in 2026.

4.6.3: Terminated Plans and Products
BridgeSpan will be terminating a plan in 2026. Members enrolled in terminating on-exchange plans at the end of 2025 will be mapped to the closest plan design offered in 2026. Terminated plan mappings are provided in "Exhibit D2: Terminated Plan Mapping."

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

4.6.5: CSR Funding
This filing assumes CSR payments will not be funded in 2026. The 2026 CSR load for BridgeSpan is 43.5% as prescribed by emergency rule CR-103E (R 2025-01).

The following information is included at the request of CMS For plan year 2026:

- Estimated actual CSR payments for enrollees for plan year 2024 were $137K based on a re-adjudication of the claims for CSR eligible enrollees under the base plan and taking the difference between the actual and re-adjudicated plan paid amounts.
- The 2024 silver CSR load for BridgeSpan was 9.8% and was developed by replicating the process recommended by the Academy of Actuaries in their September 8, 2022 letter to the Center for Consumer Information & insurance Oversight. First, experience year claims for silver on exchange plans are re-adjudicated as though all variants (Base, 73%, 87%, 94%) were all paid under the "Base" plan benefit structure. Next, the PMPM difference between the re-adjudicated and normally adjudicated claims is calculated for the base and variants; this represents the federal government's unfunded CSR liability. Then projected distribution of enrollment among the Base and variants is estimated using experience enrollment and Washington Health Benefit Exchange (WAHBE) data. Finally the load was calculated by taking the sumproduct of the projected enrollment distribution and the unfunded claims PMPM divided by the sumproduct of the projected enrollment distribution and the normally adjudicated claims PMPM by variant.
- BridgeSpan estimates the 2024 CSR subsidy revenue was $132K. Assuming a 43.5% CSR load applied to silver on-exchange premium implies a 2026 projected subsidy revenue of $858K.

4.7 Miscellaneous Instructions

4.7.1: Effective Rate Review Information and Additional Requirements
This rate filing includes information meeting Washington's rate filing speed-to-market requirements:

- Benefit Components
- Commission Certification
- Filing Checklist
- Mental Health and Substance Use Disorder Financial Requirement Certification
- OIC Health Exhibits
- Part I Unified Rate Review Data Template
- Part II Written Description Justifying the Rate Increase

- Part III Rate Filing Documentation and Actuarial Memorandum
- Rate Factors
- Rate Review Detail in SERFF
- Rate Schedule
- Rating Example
- Supplemental Exhibits
- Uniform Product Modification Justification
- WAC 284-43-6660
- Certification for WAHBE 2026 Standard Plan Designs
- 1332 Waiver Checklist

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

A table summarizing the plan-level factors used to adjust the market adjusted index rate to the plan adjusted index rates can be found in "Exhibit E4: Plan Variation from Market Adjusted Index Rate for Renewal Plans." The table includes each renewal plan in 2026 and the applicable factors from the 2025 and 2026 filings. Plan-level factors adjusting the market adjusted index rate to the plan adjusted index rate will always vary from year-to-year due to routine calculation updates following the URRT required calculation methodology. Factor changes are attributable to plan pricing updates, network relativity updates, differences in non-EHB estimates, and differences in administrative costs.

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

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

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

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

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

In the URRT, Worksheet 2, Section IV, the projected enrollment is generally set equal to the current enrollment with adjustments where necessary for account for terminating plans. The notable exception is that members currently in plans offered off-exchange will be discontinued.

A summary of the age, area, and tobacco factors used in the 2022 - 2026 filings is included in "Exhibit C3: Demographic Factor Comparison."

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

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

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

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

Regarding checklist items 11 and 27, voluntary abortion services are priced at 0.2% of premium to reflect the minimum required amount under 45 CFR §156.280(e)(4). The actual estimated cost of these services is less than one dollar per enrollee, per month. The EHB percent listed in the binder filing is 0.2%. Field 3.5 in the URRT Worksheet 2 includes the voluntary abortion services as indicated in the URR instructions. Abortion services for which public funding is prohibited are excluded from rate development for AV and Cost Share Design factors and are included as non-EHB items in row 3.5 of the worksheet 2 of the Unified Rate Review Template.

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

Regarding checklist item 6(a), the Proportion of Claim Dollars for trends in the WAC 284-43-6660 summary is calculated using the information in section II of "Wksh 1 – Market Experience" in the Unified

Rate Review Template. The Experience Period Index Rates PMPM for each benefit category are compared to the total PMPM to derive the proportion of claim dollars.

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

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

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

4.7.2: Reliance

BridgeSpan relied on The Wakely Group for the AV certification for 2026 standard plans. BridgeSpan relied on the Washington Office of the Commissioner for setting the 2026 silver load as prescribed by emergency rule CR-103E (R 2025-01). Other than as previously identified, I did not rely on any other information or underlying assumptions provided by another individual in preparing the Part I Unified Rate Review Template.

Caveats and Limitations

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

4.7.3: Actuarial Certification

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

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

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations
    - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
    - Reasonable in relation to the benefits provided and the population anticipated to be covered
    - Neither excessive nor deficient
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates
- The factor representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, was calculated in accordance with actuarial standards of practice
- Geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2. Unique plan designs were fit appropriately in accordance with generally accepted actuarial principles and methodologies, as detailed in a separate certification.
- This rate filing is consistent with internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures*
- ASOP No. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*
- Professional Code of Conduct

Daniel Boeder Digitally signed by Daniel Boeder
Date: 2025.05.15 08:05:36 -07'00'

Daniel Boeder, FSA, MAAA
Manager, Actuarial Pricing
Cambia Health Solutions, on behalf of BridgeSpan Health Company

BridgeSpan Health Company – Individual
Actuarial Memorandum and Certification – Part III
Rates Effective January 1, 2026

Table of Contents

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

4.1: Redacted Actuarial Memorandum

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

4.2: General Information

Company Identifying Information

- Company Legal Name: BridgeSpan Health Company
- State: Washington
- HIOS Issuer ID: 53732
- Market: Individual
- Effective Date: January 1, 2026

Company Contact Information

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

Purpose

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

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

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

Per the Unified Rate Review Instructions released March 2022, the actuary may state: *"The URRT does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers."*

4.3: Proposed Rate Changes

This filing proposes an average annual rate change of 18.38% on January 1, 2026, for the Individual line of business, as shown in "Exhibit A1: Development of 2026 Rate Change." The 2026 projected average premium is $1060.74 per member per month (PMPM).

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

This filing assumes Cost Sharing Reduction (CSR) payments will not be paid in 2026. If changes are made to the premium subsidies, risk adjustment, or reinsurance, the proposed rates in this filing may need to change materially to ensure adequacy with expected market costs. This filing also assumes that enhanced Premium Tax Credits (ePTC) will no longer be available in 2026.

Factor Changes

This filing includes updates to the plan and area factors. Rating factor tables and changes since the last filing are shown in the "Rate Factors" document. The average annual rate change impact of 18.38% includes the impact of these factor changes and is on a member-weighted basis.

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

Based on OIC guidance, only on-exchange Silver plan premium should be increased to cover the additional costs associated with providing benefits to all Silver plan enrollees, in the event the CSR subsidies are not funded. See the "CSR Funding" section for more detail.

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

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

Pool Base Rate

The pool base rate is $691.85 as of January 1, 2026. The pool base rate is the starting amount such that multiplying the base rate by the member's rating factors (plan, age, and area) and adjusting for family composition results in the member's premium.

Reasons for Proposed Rate Change

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

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

Financial Experience: Each year BridgeSpan evaluates the most recent financial results in the Washington Individual market and incorporates that information into pricing. The experience also includes the impacts of pooling BridgeSpan with Regence BlueShield (RBS).

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

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

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

Contributing Factor	Approximate Impact
Changes due to Medical Trend and Utilization	10%
Changes due to Financial Experience[1]	-6%
Changes Due to Market wide Average Morbidity	4%
Changes due to Product Design[2]	10%
Total	**18%**

[1] Includes the impact of overestimate or underestimate of medical trend, and impacts of pooling with RBS

[2]Includes changes in CSR load, cost sharing, plan mappings, and benefit factors

4.4: Market Experience

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

4.4.1: Experience Period Premium, Claims, and Enrollment

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

BridgeSpan enrollment decreased from the prior year and is no longer considered a fully credible block. For rate development purposes, experience from BridgeSpan Individual was combined with RBS which had over 22,000 lives in 2023 and is considered fully credible.

BridgeSpan analyzes financial performances for each company and line of business regularly and over/under-projections are corrected for in the rate development the following year. Overall, premium and claims experience is unfavorable compared to expectations in 2024.

In completing the Experience Period Data section of the URRT, Worksheet 1, only BridgeSpan information is reflected, as required by the instructions. The combined RBS and BridgeSpan company experience projected to 2025 appears in the Manual EHB Allowed Claims section of the URRT, Worksheet 1, as described in the Credibility of Experience section of this memorandum.

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

Review and Analyze Data

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

Develop UCL Estimates Using Multiple Methods

- Basic Claims Development Method
- Paid PMPM Method

Determine UCL for Recent Incurred Months

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

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

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

4.4.2: Benefit Categories

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

4.4.3: Projection Factors

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

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

4.4.3.1: Trend Factors

Projected Rating Trend

The trend factor used in rate development is shown on the "Trend Factor to Rating Period" line in "Exhibit A1: Development of 2026 Rate Change," reflecting twenty-four months of trend at an annual rate of 10.2%. The table below shows the expected components of the annual trend used to project incurred claims costs to the rating period. Note that the leverage component does not impact allowed claims; this trend applies to incurred, paid claims.

Components of Projected Trend

Reimbursement	5.00%
Utilization	2.10%
Mix/Intensity	1.20%
Leverage	1.90%

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

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

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

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

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

A few examples of new or expanded initiatives include:

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

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

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

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

Normalized Experience Trend
BridgeSpan reviews experience trend by calculating rolling twelve month historical paid claims trend on both an observed and underlying basis. In order to differentiate between the observed trend and the underlying trend, claims are normalized for differences in demographics, health risk, and large claims. Demographic adjustments are developed using the current filed factors for age and area and health risk adjustments are developed using risk score data.

A summary of the underlying allowed experience is included in "WA Exh 4 – Normalized Trend" within the "BHC IND OIC Health Exhibits." The analysis shows an underlying average allowed claim trend of 20.93% when comparing calendar year 2024 to calendar year 2023. This estimate of recent underlying trend experience is a single point of reference and is not the sole predictor of future trends.

4.4.3.2: Adjustments to Trended EHB Allowed Claims PMPM

4.4.3.2(a): Morbidity Adjustment

This assumption reflects the anticipated change in morbidity from calendar year 2024 ("base period") to calendar year 2026 ("projection period") for BridgeSpan Individual ACA plans. The morbidity adjustment reflects a change in the expected health risk of the pool regardless of the underlying demographics.

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

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

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

Morbidity Level of Base Period Company Experience

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

BridgeSpan Individual Morbidity Change from Base Period to Projection Period

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

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

An estimate for the projected morbidity change between the base period and projection period is shown in "WA Exh 10 - Risk Adjustment" within "BHC IND OIC Health Exhibits." Changes to each of the risk adjustment transfer components between 2024 and 2026 are shown in the exhibit. The projection of 2026 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2024 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This

implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts. The calculation of the 2026 transfer payments reflects the 14 percent administrative cost reduction to state average premium.

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

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

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

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

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

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

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

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

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

Experience period covered benefits for ACA plans satisfy Washington's 2026 requirements. Therefore, no specific experience period adjustments are applied to ACA plan experience. Pediatric dental benefits are excluded from all 2026 ACA products offered.

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

Other Benefits
This adjustment reflects anticipated differences in non-EHB benefits between the experience period and projection period. There are no material differences that require an adjustment. For 2026, Gene Therapy is now considered an Essential Health Benefit.

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

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

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

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

A proprietary network model is used to determine the projected cost relativities between different networks, based on historical experience projected to the rating period. The model allows the inclusion or exclusion of providers on a group-by-group basis. As a provider group is excluded from the network, the services that were delivered by that group are redistributed to other providers within the same specialty. As care is shifted among providers, adjustments are made to reflect utilization efficiency and unit cost differences between the providers. For plans paired with an accountable health network, the relativities also reflect expected savings due to managed care and provider incentive arrangements.

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

The RealValue network will be discontinued in 2026. In 2026, BridgeSpan will offer plans on the new Individual Value network. The Individual Value network is a statewide network offered in all of the covered service areas.

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

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

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

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

4.4.3.3: Manual Rate Adjustments

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

For purposes of completing the URRT, Worksheet 1, all BridgeSpan non-grandfathered Individual experience was included to develop the Adjusted Trended EHB Allowed Claims PMPM. Combined BridgeSpan and RBS experience used to develop rates was reflected in the Manual EHB Allowed Claims PMPM item in the URRT, Worksheet 1. A detailed summary is included in "Exhibit E1: Development of 2026 Index Rate."

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

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

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

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

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

- Estimate a relative value for the base period experience for BridgeSpan and RBS (a)
- Estimate BridgeSpan individual relative value for the projection period (b)
- The adjustment applied to each experience pool is equal to (b) divided by (a)

Due to credibility concerns, for morbidity, BridgeSpan morbidity was projected to the RBS morbidity factors and transfer amounts.

The claims cost weight assigned to each experience pool is shown in "Exhibit A1: Development of the 2026 Rate Change." The resulting overall projected incurred claims cost is $1015.65 PMPM.
For purposes of completing the URRT, the credibility percentage applied to the experience included in the Manual EHB Allowed Claims PMPM section is consistent with the weights for rate development. The resulting projected allowed claims cost is $1125.00 PMPM.

4.4.3.5: Establishing the Index Rate
The experience period index rate is $1342.67 PMPM; the projected period index rate is $1125.00 PMPM. Non-EHB benefit categories are excluded from the calculation based upon the benefit category code assigned automatically within the data warehouse. Individual Assistance Program (IAP) and voluntary termination of pregnancy benefits are excluded from all plans. Please note the index rate does not demonstrate the process used to develop the rates; it was prepared for reporting purposes and is calculated consistently with the results of the underlying rate development process.

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

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

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

4.4.3.6: Development of the Market-wide Adjusted Index Rate

The market-wide adjusted index rate is $1029.93 PMPM. It is calculated as the projection period index rate adjusted for the following allowable market-wide modifiers:

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

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

4.4.3.6(a): Reinsurance

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

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

4.4.3.6(b): Risk Adjustment Payment/Charge

2024 risk adjustment transfers are populated in the "Risk Adjustment Transfer Amount" line of the URRT, Worksheet 2, Section II. Amounts were allocated by plan in proportion to premium. The risk adjustment user fee for 2024 was $0.21 PMPM. The experience period risk adjustment transfer PMPM, including net HCRP receipts and before reduction for the risk adjustment user fee, is $342.98 as shown in "WA Exh 10 - Risk Adjustment" within the "BHC IND OIC Health Exhibits." Due to credibility concerns, for morbidity, BridgeSpan morbidity was projected to the RBS morbidity factors and transfer amounts.

The URRT, Worksheet 1 shows the experience period risk adjustment PMPM as $347.18 because it is calculated as the projected 2024 risk adjustment transfer divided by the 2024 experience period membership. The risk adjustment transfer PMPM shown in "WA Exh 10 - Risk Adjustment" within the "BHC IND OIC Health Exhibits" is calculated as the projected 2024 risk adjustment transfer divided by the billable member months. Experience period member months differ from the billable member months due to differences in counting billable member months and total member months, and due to differences in the run out period.

The projected risk adjustment PMPM reflects the difference in projection period expected relative risk between the BridgeSpan block of business and the overall market. The estimated risk adjustment transfer used for rate development is shown on the "Risk Adjustment Transfer" line in "Exhibit A1: Development of 2026 Rate Change." The risk adjustment user fee for 2026 is $0.20 PMPM and is shown in the "Retention Development" section of Exhibit A1. Information regarding the transfer estimate is

shown in "WA Exh 10 - Risk Adjustment" within the "BHC IND OIC Health Exhibits," including the detailed internal data and projections by metal level used to develop the estimate. A positive amount represents an anticipated risk adjustment payment receipt, and a negative amount represents an anticipated risk adjustment charge.

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

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

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

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

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

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

program assessment, an estimated value of 0.50% of premium is used in rate development. For the purposes of populating the URRT, the HCRP assessment is added to the risk adjustment transfer amount. The premium charge for the HCRP is not finalized; this amount is based on an estimate developed by an external consultant.

BridgeSpan anticipates $87K in HCRP recoveries for claims paid in 2024. BridgeSpan had $85k and $27k in HCRP recoveries in 2023 and 2022 respectively.

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

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

4.4.3.6(c): Exchange User Fees
The 2026 marketplace user fee is $5.11 PMPM, and projected marketplace enrollment is 100% of total projected enrollment. Therefore, the filing reflects exchange user fees of $5.11 PMPM.

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

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

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

The components of the AV and cost-sharing design factors are Induced Demand Factors, EHB Paid to Allowed Factors, and Projected CSR Adjustment factors as shown in Exhibit E2. Induced Demand Factors for 2026 are prescribed by emergency rule CR-103E (R 2025-01) and included in "WA Exh 9 – AV and Cost-Share" within the "BHC IND OIC Health Exhibits." EHB Paid to Allowed Factors are derived values for the purpose of the URRT and are not used in rate development. See section 4.6.5 for detail on the Projected CSR Adjustment.

The base product factors shown in "Exhibit E2: Plan Adjusted Index Rate Development" were developed using a proprietary benefit relativity model that does not account for health status. The base product factor is used to normalize the projected average premium to get to the pool base rate in Exhibit A1. These factors are based on paid claims. The base product factor is the pricing value based on benefit design only, before network adjustments and non-EHB benefits.

4.4.5: Calibration

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

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

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

Age Curve Calibration

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

Geographic Factor Calibration

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

Tobacco Use Rating Factor Calibration
In 2026 Tobacco use status is not used as a rating factor for BridgeSpan Individual products.

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

- Plan
- Age
- Area
- Family status

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

The 2026 pool base rate of $691.85 and the average factors for normalization are shown in "Exhibit A1: Development of 2026 Rate Change."

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

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

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

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

4.4.7(a): Administrative Expense Load
The administrative expense load is comprised of expected plan operating expenses and commissions paid to agents and brokers, offset by investment earnings on claim reserves.

Operating expenses for 2026 are projected at $65.13 PMPM or 6.14% of premium. Operating expenses are developed by the cost accounting department consistent with company policy and were reviewed for reasonability compared to prior results. When possible, operating expenses are assigned directly as a claim or non-claim related expense to the appropriate line of business. When costs cannot be assigned

directly to a specific line of business, the expenses are allocated based upon appropriate objective statistical measures. As such, reliance is placed on the internal cost accounting department's expertise in developing these estimates.

Commission expenses for 2026 are projected at $6.78 PMPM or 0.64% of premium. Historical utilization of distribution channels was analyzed against the 2026 commission schedule. Commissions may apply to members purchasing both on and off exchange if a broker is utilized.

Investment earnings on claim reserves are projected to impact premiums by -$1.70 PMPM or -0.16% of premium. This value reflects a projected T-bill rate of 2.38% applied to the claim reserves. Earnings are expressed as a percentage of premium.

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

2026 Administrative Expense Components

Component	Percent of Premium	PMPM
Administrative Expenses	6.14%	$65.13
Commissions	0.64%	$6.78
Investment Earnings	-0.16%	-$1.70
Total Administrative Expense Load	6.62%	$70.21

2026 Projected Average Premium PMPM: $1060.74

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

4.4.7(b): Profit and Risk Load

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

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

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

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

Risk and Contingency Margin	
Filing Year	2026
Percent of Premium	3.5%
PMPM	$37.13

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

4.4.7(c): Taxes and Fees

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

- State premium tax is set at 2.0% by the state of Washington.
- BridgeSpan is subject to federal income taxes. As this filing includes no explicit contribution to surplus, no adjustment is made for income taxes.
- The estimated PCORI fee for 2026 plans is $0.32 PMPM. The PCORI fee is calculated as the $3.00 annual fee for plan years ending October 1, 2024 through September 30, 2025, divided by 12, and trended for 2 years at an annual rate of 4.9% and 5.0%, the projected trend from the National Health Expenditures, and rounded to the nearest penny.
- This filing reflects exchange user fees of $5.11 PMPM because all products will be offered only on the exchange in 2026. On the URRT, this amount is already included in the MAIR and is not included in the Taxes and Fees section.
- The risk adjustment program fee for 2026 is $0.20 PMPM.
- This filing assumes an HCRP assessment of 0.50% of premium, as discussed in section 4.4.3.6(b). On the URRT, this amount is included in the risk transfer amounts and is not included in the Taxes and Fees section.
- An amount of $0.32 PMPM is included in this filing for the WSHIP assessment. This is based on WSHIP's preliminary financial projection anticipating total 2026 assessments of $6 million. The following table shows the development of this amount starting from WSHIP's anticipated total assessment.

- The regulatory surcharge from RCW 48.02.190 is calculated to be 0.08% of premium by using the 2025 fee as a proxy for 2026.
- The insurance fraud surcharge from RCW 48.02.190 is calculated to be 0.00% of premium by using the 2025 fee as a proxy for 2026.
- The WPAL fee, which is a new fee funding the WA Partnership Access Line, is calculated to be $0.07 PMPM by using the projected annual program costs divided by WSHIP enrollment as a proxy.

WSHIP Assessment Allocation

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

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

2026 Taxes & Fees Components

Component	Percent of Premium	PMPM
Premium Tax	2.00%	$21.21
PCORI Fee	0.03%	$0.32
Risk Adjustment Program Fee	0.02%	$0.20
WSHIP Assessment	0.03%	$0.32
Regulatory Surcharge	0.08%	$0.81
Insurance Fraud Surcharge	0.00%	$0.04
WPAL Fee	0.01%	$0.07
Total Taxes & Fees	2.17%	$22.97

2026 Projected Average Premium PMPM: $1060.74

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

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

4.5: Projected Loss Ratio

The projected federal loss ratio calculated using federally-prescribed methodology for medical loss ratio (MLR) rebates calculations is 89.5%, which is greater than the federally prescribed MLR requirement of

80.0%. Due to the complexity of the federal MLR rebate methodology, which is beyond the scope of this filing, the only adjustment reflected is subtracting projected taxes and fees from the premium denominator. This simplified MLR calculation is strictly less than or equal to the federal MLR methodology, so the federal MLR must also be greater than 80.0%. The numerator for this ratio is projected incurred claims net of projected risk adjustment transfers, $920.01 PMPM. The denominator of this simplified calculation is equal to projected average premium, less the Total Taxes & Fees PMPM described in the preceding Taxes & Fees section: $1027.42.

BridgeSpan considered potential impacts resulting from the 2026 MLR reporting regulation changes and deemed no changes in rating methodology to be required.

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

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

4.6: Plan Product Information

4.6.1: AV Metal Values

BridgeSpan will only offer Cascade Care standard plans in 2026. The AV certification for standardized plans has been provided by Wakely Consulting Group. BridgeSpan has included that certification as justification of the AV for the non-standard cost shares for those plans and is utilizing the AV provided as the minimum for all non-standard silver health plans as required under RCW 43.71.095(2)(b)(iii).

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

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

4.6.2: Membership Projections

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

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

Projected enrollment by subsidy level for each Silver plan is included in "WA Exh 8 - CSR Experience" within "BridgeSpan IND OIC Health Exhibits." The portion of the projected enrollment that will be eligible for cost-sharing reduction subsidies at each subsidy level is estimated assuming 2026 subsidy

level distributions will be similar to Cambia's exchange market enrollment. As described in Section 4.3 of this memo, this filing assumes CSR payments will not be paid in 2026.

4.6.3: Terminated Plans and Products
BridgeSpan will be terminating a plan in 2026. Members enrolled in terminating on-exchange plans at the end of 2025 will be mapped to the closest plan design offered in 2026. Terminated plan mappings are provided in "Exhibit D2: Terminated Plan Mapping."

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

4.6.5: CSR Funding
This filing assumes CSR payments will not be funded in 2026. The 2026 CSR load for BridgeSpan is 43.5% as prescribed by emergency rule CR-103E (R 2025-01).

The following information is included at the request of CMS For plan year 2026:

- Estimated actual CSR payments for enrollees for plan year 2024 were $137K based on a re-adjudication of the claims for CSR eligible enrollees under the base plan and taking the difference between the actual and re-adjudicated plan paid amounts.
- The 2024 silver CSR load for BridgeSpan was 9.8% and was developed by replicating the process recommended by the Academy of Actuaries in their September 8, 2022 letter to the Center for Consumer Information & insurance Oversight. First, experience year claims for silver on exchange plans are re-adjudicated as though all variants (Base, 73%, 87%, 94%) were all paid under the "Base" plan benefit structure. Next, the PMPM difference between the re-adjudicated and normally adjudicated claims is calculated for the base and variants; this represents the federal government's unfunded CSR liability. Then projected distribution of enrollment among the Base and variants is estimated using experience enrollment and Washington Health Benefit Exchange (WAHBE) data. Finally the load was calculated by taking the sumproduct of the projected enrollment distribution and the unfunded claims PMPM divided by the sumproduct of the projected enrollment distribution and the normally adjudicated claims PMPM by variant.
- BridgeSpan estimates the 2024 CSR subsidy revenue was $132K. Assuming a 43.5% CSR load applied to silver on-exchange premium implies a 2026 projected subsidy revenue of $858K.

4.7 Miscellaneous Instructions

4.7.1: Effective Rate Review Information and Additional Requirements
This rate filing includes information meeting Washington's rate filing speed-to-market requirements:

- Benefit Components
- Commission Certification
- Filing Checklist
- Mental Health and Substance Use Disorder Financial Requirement Certification
- OIC Health Exhibits
- Part I Unified Rate Review Data Template
- Part II Written Description Justifying the Rate Increase

- Part III Rate Filing Documentation and Actuarial Memorandum
- Rate Factors
- Rate Review Detail in SERFF
- Rate Schedule
- Rating Example
- Supplemental Exhibits
- Uniform Product Modification Justification
- WAC 284-43-6660
- Certification for WAHBE 2026 Standard Plan Designs
- 1332 Waiver Checklist

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

A table summarizing the plan-level factors used to adjust the market adjusted index rate to the plan adjusted index rates can be found in "Exhibit E4: Plan Variation from Market Adjusted Index Rate for Renewal Plans." The table includes each renewal plan in 2026 and the applicable factors from the 2025 and 2026 filings. Plan-level factors adjusting the market adjusted index rate to the plan adjusted index rate will always vary from year-to-year due to routine calculation updates following the URRT required calculation methodology. Factor changes are attributable to plan pricing updates, network relativity updates, differences in non-EHB estimates, and differences in administrative costs.

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

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

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

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

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

In the URRT, Worksheet 2, Section IV, the projected enrollment is generally set equal to the current enrollment with adjustments where necessary for account for terminating plans. The notable exception is that members currently in plans offered off-exchange will be discontinued.

A summary of the age, area, and tobacco factors used in the 2022 - 2026 filings is included in "Exhibit C3: Demographic Factor Comparison."

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

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

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

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

Regarding checklist items 11 and 27, voluntary abortion services are priced at 0.2% of premium to reflect the minimum required amount under 45 CFR §156.280(e)(4). The actual estimated cost of these services is less than one dollar per enrollee, per month. The EHB percent listed in the binder filing is 0.2%. Field 3.5 in the URRT Worksheet 2 includes the voluntary abortion services as indicated in the URR instructions. Abortion services for which public funding is prohibited are excluded from rate development for AV and Cost Share Design factors and are included as non-EHB items in row 3.5 of the worksheet 2 of the Unified Rate Review Template.

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

Regarding checklist item 6(a), the Proportion of Claim Dollars for trends in the WAC 284-43-6660 summary is calculated using the information in section II of "Wksh 1 – Market Experience" in the Unified

Rate Review Template. The Experience Period Index Rates PMPM for each benefit category are compared to the total PMPM to derive the proportion of claim dollars.

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

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

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

4.7.2: Reliance

BridgeSpan relied on The Wakely Group for the AV certification for 2026 standard plans. BridgeSpan relied on the Washington Office of the Commissioner for setting the 2026 silver load as prescribed by emergency rule CR-103E (R 2025-01). Other than as previously identified, I did not rely on any other information or underlying assumptions provided by another individual in preparing the Part I Unified Rate Review Template.

Caveats and Limitations

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

4.7.3: Actuarial Certification

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

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

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations
    - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
    - Reasonable in relation to the benefits provided and the population anticipated to be covered
    - Neither excessive nor deficient
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates
- The factor representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, was calculated in accordance with actuarial standards of practice
- Geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2. Unique plan designs were fit appropriately in accordance with generally accepted actuarial principles and methodologies, as detailed in a separate certification.
- This rate filing is consistent with internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures*
- ASOP No. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*
- Professional Code of Conduct

Daniel Boeder Digitally signed by Daniel Boeder
Date: 2025.05.15 08:05:36 -07'00'

Daniel Boeder, FSA, MAAA
Manager, Actuarial Pricing
Cambia Health Solutions, on behalf of BridgeSpan Health Company

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

BridgeSpan Health Company (BridgeSpan) is filing a rate change request for its Individual metallic products. These plans comply with federal Affordable Care Act (ACA) plan design and benefit requirements, and BridgeSpan has approximately 400 members enrolled in this line of business as of March 2025. BridgeSpan is projecting total enrollment for 2026 to be approximately 4,500 member months. This filing is based on claims experience from January 2024 through December 2024, with claims paid through March 2025.

Rate Change

The projected average rate change for plans effective in 2026 is 18.38%, which is an average rate change of about $165 per member per month (pmpm). Because 18.38% (or about $165) is an average, it is possible to have a different rate change. Rate changes vary from about -3.1% to 48.2% and this variability in rate changes is driven by plan design and geographic factor changes. Factors affecting a member's premium are age, family composition, plan, and geographic area. Expected cost differences by product are updated every year to ensure premium differences are appropriate. The table below shows the breakout of the factors contributing to the increase.

Contributing Factor	Approximate Impact
Medical Trend	10%
Product Design, Mapping, Silver Load	10%
Market-wide Average Morbidity	4%
Experience and Pooling	-6%
Total	**18%**

Contributing Factors - Medical Trend

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

Contributing Factors - Higher than Expected Claims

The 2026 premium increase reflects the 2026 claims expectations based on actual 2024 claims experience which was higher than expected. Pooling the experience with a larger block reduced the overall increase.

Contributing Factors - Other

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

Administrative expenses are expected to be 6.6% of premium, compared to 7.4% in the 2025 rates. Regulatory payments including taxes and fees required by the ACA are expected to be 2.2%, compared to 2.2% in the 2025 rates. Provisions for adverse deviation estimates to account for inherent variability in predicting future claims and anticipated contribution to surplus are included as 3.5% of premium, compared to 3.5% in the 2025 rates.

Changes in Benefits

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

Financial Experience

The 2024 estimated incurred claims net of pharmacy rebates and excluding non-claims expenses were $1203 pmpm, compared to unadjusted average premium revenue of $741 pmpm. This resulted in 2024 claims being paid out as 162% of premium. Premium revenue will be adjusted by the 2024 Risk Adjustment transfer and net HCRP receipts, a receipt of $343 pmpm. The 2024 Risk Adjustment transfer amount and net HCRP receipts are estimates.

BridgeSpan expects to pay out 96% of premium as claims in 2026, prior to any adjustments for the federal MLR methodology. When using Federally prescribed methodology, which excludes some taxes from the denominator, the loss ratio exceeds 80%. With the approval of the requested rate change we expect average premium revenue of $1061 pmpm. 2026 incurred claims net of pharmacy rebates and excluding non-claim expenses are projected to be $1016 pmpm. The expected 2026 risk adjustment and estimated HCRP assessment results in a receivable amount of $90 pmpm. As a tax paying not-for-profit, BridgeSpan does not project any profit for 2026.

Summary of Pooled Experience

	Experience Period				First Prior Period			
	From	1/1/2024	To	12/31/2024	From	1/1/2023	To	12/31/2023
Member Months				6,108				11,690
Earned Premium				$4,524,562				$7,311,511
Paid Claims				$8,458,047				$9,959,728
Beginning Claim Reserve				$1,706,389				$1,206,944
Ending Claim Reserve				$595,452				$1,706,389
Incurred Claims				$7,347,110				$10,459,174
Expenses				$491,551				$917,162
Gain/Loss				-$3,314,098				-$4,064,826
Loss Ratio Percentage				162.38%				143.05%

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

Summary of Pooled Experience with Adjustments

	2024 Experience Period	2023 Experience Period	2022 Experience Period
Member Months	6,108	11,690	21,156
Earned Premium	$4,524,562	$7,311,511	$11,028,411
Paid Claims	$8,458,047	$9,959,728	$12,184,329
Beginning Claim Reserve	$1,706,389	$1,206,944	$2,303,662
Ending Claim Reserve	$595,452	$1,706,389	$1,206,944
Incurred Claims	$7,347,110	$10,459,174	$11,087,611
Expenses	$491,551	$917,162	$1,415,817
Ceded Claims	$0	$0	$0
Gain/Loss	-$3,314,098	-$4,064,826	-$1,475,017
Loss Ratio Percentage	162.38%	143.05%	100.54%
Risk Adjustment	$2,049,880	$1,193,766	$276,538
HCRP Assessment	-$16,087	-$26,334	-$40,247
HCRP Transfer	$86,777	$85,360	$26,521
RADV	$0	$0	$0
Gain/Loss with Risk Adj	-$1,193,528	-$2,812,034	-$1,212,204

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

Unified Rate Review v6.1

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

Company Legal Name:	BridgeSpan Health Company		
HIOS Issuer ID:	53732	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	$8,217,438.64	$1,345.36
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$7,347,109.72	$1,202.87
Risk Adjustment	$2,120,570.07	$347.18
Experience Period Premium	$4,524,562.08	$740.76
Experience Period Member Months	6,108	

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	$156.56	1.050	1.024	1.050	1.024	$181.10
Outpatient Hospital	$473.22	1.050	1.024	1.050	1.024	$547.41
Professional	$160.05	1.050	1.024	1.050	1.024	$185.14
Other Medical	$15.66	1.050	1.024	1.050	1.024	$18.11
Capitation	$0.00	1.050	1.024	1.050	1.024	$0.00
Prescription Drug	$537.18	1.050	1.041	1.050	1.041	$642.37
Total	$1,342.67					**$1,574.14**

Morbidity Adjustment		0.751
Demographic Shift		0.997
Plan Design Changes		1.073
Other		1.002
Adjusted Trended EHB Allowed Claims PMPM for	**1/1/2026**	**$1,266.60**

Manual EHB Allowed Claims PMPM	$1,122.11
Applied Credibility %	2.00%

			Projected Period Totals
Projected Index Rate for	**1/1/2026**	**$1,125.00**	$5,076,000.00
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		$100.26	$452,383.34
Exchange User Fees		0.50%	$23,427.27
Market Adjusted Index Rate		**$1,029.93**	**$4,647,043.93**

Projected Member Months	**4,512**

Product-Plan Data Collection

Company Legal Name: **BridgeSpan Health Company**
HIOS Issuer ID: **53732** 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		BridgeSpan Exchange EPO No Ped Dental				
1.2	Product ID		53732WA079				
1.3	Plan Name		BridgeSpan	BridgeSpan	BridgeSpan	BridgeSpan	Bronze Essential
1.4	Plan ID (Standard Component ID)		53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
1.5	Metal		Gold	Gold	Silver	Bronze	Bronze
1.6	AV Metal Value		0.818	0.781	0.718	0.650	0.623
1.7	Plan Category		Renewing	New	Renewing	Renewing	Terminated
1.8	Plan Type		EPO	EPO	EPO	EPO	EPO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes	No
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		-1.51%	0.00%	47.46%	7.05%	0.00%
1.12	Product Rate Increase %		19.22%				
1.13	Submission Level Rate Increase %		19.22%				

Worksheet 1 Totals	Section II: Experience Period and Current Plan Level Information						
	2.1 Plan ID (Standard Component ID)	Total	53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
$8,217,439	2.2 Allowed Claims	$8,217,439	$1,606,697	$0	$3,623,045	$1,593,360	$1,394,336
$0	2.3 Reinsurance	$0	$0	$0	$0	$0	$0
	2.4 Member Cost Sharing	$870,329	$123,366	$0	$264,226	$192,561	$290,176
	2.5 Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$7,347,110	2.6 Incurred Claims	$7,347,110	$1,483,331	$0	$3,358,819	$1,400,799	$1,104,161
$2,120,570	2.7 Risk Adjustment Transfer Amount	$2,120,570	$1,142,521	$0	$1,361,609	-$128,803	-$254,757
$4,524,562	2.8 Premium	$4,524,562	$788,578	$0	$1,345,978	$889,100	$1,500,906
6,108	2.9 Experience Period Member Months	6,108	849	0	1,623	1,221	2,415
	2.10 Current Enrollment	376	64	0	119	193	0
	2.11 Current Premium PMPM	$883.89	$986.78	$0.00	$953.18	$807.04	$0.00
	2.12 Loss Ratio	110.56%	76.81%	#DIV/0!	124.05%	184.24%	88.61%
	Per Member Per Month						
	2.13 Allowed Claims	$1,345.36	$1,892.46	#DIV/0!	$2,232.31	$1,304.96	$577.36
	2.14 Reinsurance	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00
	2.15 Member Cost Sharing	$142.49	$145.31	#DIV/0!	$162.80	$157.71	$120.16
	2.16 Cost Sharing Reduction	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00
	2.17 Incurred Claims	$1,202.87	$1,747.15	#DIV/0!	$2,069.51	$1,147.26	$457.21
	2.18 Risk Adjustment Transfer Amount	$347.18	$1,345.73	#DIV/0!	$838.95	-$105.49	-$105.49
	2.19 Premium	$740.76	$928.83	#DIV/0!	$829.31	$728.17	$621.49

	Section III: Plan Adjustment Factors						
3.1	Plan ID (Standard Component ID)		53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
3.2	Market Adjusted Index Rate		$1,029.93				
3.3	AV and Cost Sharing Design of Plan		1.0134	0.9203	1.1743	0.6968	0.0000
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.5	Benefits in Addition to EHB		1.0020	1.0020	1.0020	1.0020	0.0000
	Administrative Costs						
3.6	Administrative Expense		6.62%	6.62%	6.62%	6.62%	0.00%
3.7	Taxes and Fees		2.17%	2.17%	2.17%	2.17%	0.00%
3.8	Profit & Risk Load		3.50%	3.50%	3.50%	3.50%	0.00%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.10	**Plan Adjusted Index Rate**		$1,192.32	$1,082.75	$1,381.66	$819.81	$0.00
3.11	Age Calibration Factor	0.5562	0.5562				
3.12	Geographic Calibration Factor	0.965	0.9650				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$639.96	$581.15	$741.58	$440.02	$0.00

	Section IV: Projected Plan Level Information						
4.1	Plan ID (Standard Component ID)	Total	53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
4.2	Allowed Claims	$5,086,137	$899,584	$14,279	$1,620,546	$2,551,729	$0
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$503,524	$114,611	$2,046	$91,204	$295,663	$0
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$4,582,613	$784,972	$12,233	$1,529,342	$2,256,065	$0
4.7	Risk Adjustment Transfer Amount	$167,253	$219,005	$3,476	$296,051	-$351,280	$0
4.8	Premium	$4,786,074	$901,392	$12,993	$1,973,014	$1,898,675	$0
4.9	Projected Member Months	4,512	756	12	1,428	2,316	0
4.10	Loss Ratio	92.52%	70.06%	74.28%	67.40%	145.80%	#DIV/0!
	Per Member Per Month						
4.11	Allowed Claims	$1,127.25	$1,189.93	$1,189.93	$1,134.84	$1,101.78	#DIV/0!
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.13	Member Cost Sharing	$111.60	$151.60	$170.48	$63.87	$127.66	#DIV/0!
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.15	Incurred Claims	$1,015.65	$1,038.32	$1,019.44	$1,070.97	$974.12	#DIV/0!
4.16	Risk Adjustment Transfer Amount	$37.07	$289.69	$289.69	$207.32	-$151.68	#DIV/0!
4.17	Premium	$1,060.74	$1,192.32	$1,082.75	$1,381.66	$819.81	#DIV/0!

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.1310
Rating Area 3	1.0740
Rating Area 4	0.9880
Rating Area 5	1.0370
Rating Area 6	1.0450
Rating Area 8	1.0550
Rating Area 9	1.1110

PART III APPENDIX
Table of Contents

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

EXHIBIT A1: DEVELOPMENT OF 2026 RATE CHANGE
BridgeSpan Health Company - Individual

Experience Period: 1/1/2024 - 12/31/2024 Projection Period: 1/1/2026 - 12/31/2026	BridgeSpan Health Company Individual 2026 Projection		Projected Claim Cost Development by Experience Pool BridgeSpan Health Company Individual ACA Experience		Regence BlueShield Individual ACA Experience	
Experience	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**
Member Months			6,108		337,351	
Earned Premium			$4,524,562	$740.76	$225,934,085	$669.73
Estimated Incurred Claims			$7,921,038	$1,296.83	$270,788,274	$802.69
BlueCard Access Fees			$0	$0.00	$0	$0.00
HCRP Receipts			$86,795	$14.21	$195,664	$0.58
Adjusted Estimated Incurred Claims			$7,834,243	$1,282.62	$270,592,611	$802.11

Projected Claims Cost Development	**Factors**	**PMPM**	**Factors**	**PMPM**	**Factors**	**PMPM**
Average Experience Morbidity Factor			*1.799*		*1.287*	
Average Projected Morbidity Factor			*1.284*		*1.284*	
Changes in Morbidity			0.714		0.998	
Average Experience Benefits Factor			*0.715*		*0.746*	
Average Projected Benefits Factor			*0.824*		*0.824*	
Changes in Benefits			1.152		1.105	
Average Experience Demographics Factor			*1.871*		*1.821*	
Average Projected Demographics Factor			*1.863*		*1.863*	
Changes in Demographics			0.996		1.023	
Average Experience Network Arrangements Factor			*0.951*		*0.957*	
Average Projected Network Arrangements Factor			*0.944*		*0.944*	
Changes in Network Arrangements			0.994		0.987	
Pharmacy Rebates			0.934		0.934	
Reinsurance Receipts			1.000		1.000	
Trend Factor to Rating Period			1.214		1.214	
Projected Claims Cost by Pool				$1,183.67		$1,012.22
Overall Projected Claims Cost		$1,015.65	2%		98%	
Risk Adjustment Transfer		$95.64				
Net Projected Claims Cost		**$920.01**				

Retention Development	**Percent**	**PMPM**
Risk Adjustment Program Fee	0.02%	$0.20
Operating Expenses	6.14%	$65.13
Commission Expenses	0.64%	$6.78
Federal HCRP Charge	0.50%	$5.30
Investment Earnings	-0.16%	-$1.70
Regulatory Surcharge	0.08%	$0.81
Insurance Fraud Surcharge	0.00%	$0.04
Risk and Profit	3.50%	$37.13
Premium Tax	2.00%	$21.21
Insurer Tax	0.00%	$0.00
Patient-Centered Outcomes Research Fee	0.03%	$0.32
Marketplace Fee	0.48%	$5.11
WSHIP	0.03%	$0.32
WPAL	0.01%	$0.07
Vendor Fees	0.00%	$0.00
Total Retention	13.3%	**$140.73**

Base Rate Development and Rate Change	**Total**	**PMPM**
Projected Average Premium		**$1,060.74**
Average Plan Factor	0.8229	
Average Area Factor	1.0363	
Average Tobacco Factor	1.0000	
Age Curve Factor	1.7979	
Composite Rating Factor	1.5332	
2026 Pool Base Rate		$691.85
Average Annual Rate Change (from UPMJ #5)		**18.38%**
Projected Federal Loss Ratio	89.5%	

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

Commission Expenses Development	
2026 PMPM Commission Rate	**$20.00**
Projected Broker Utilization Percentage	33.9%
2026 PMPM Assumption	**$6.78**

Marketplace Fee Development	
2026 Fee	$5.11
Projected 2026 On-Exchange Membership	376
Projected 2026 Total Membership	376
2026 Assumption	**$5.11**

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

EXHIBIT C1: AGE CURVE AND TOBACCO CALIBRATION FACTORS
BridgeSpan Health Company - Individual

		Distribution			
Member Age	**Age Factor**	**Non-Tobacco**	**Tobacco**	**Total**	**Total Prior Year**
Capped 0-14	0.000	0.0%	0.0%	0.0%	0.0%
Capped 15	0.000	0.0%	0.0%	0.0%	0.0%
Capped 16	0.000	0.0%	0.0%	0.0%	0.0%
Capped 17	0.000	0.0%	0.0%	0.0%	0.0%
Capped 18	0.000	0.0%	0.0%	0.0%	0.0%
Capped 19	0.000	0.0%	0.0%	0.0%	0.0%
Capped 20	0.000	0.0%	0.0%	0.0%	0.0%
0-14	0.765	8.2%	0.0%	8.2%	6.7%
15	0.833	0.8%	0.0%	0.8%	0.5%
16	0.859	0.5%	0.0%	0.5%	0.6%
17	0.885	0.3%	0.0%	0.3%	1.0%
18	0.913	1.1%	0.0%	1.1%	0.8%
19	0.941	0.5%	0.0%	0.5%	0.8%
20	0.970	0.5%	0.0%	0.5%	0.7%
21	1.000	0.3%	0.0%	0.3%	1.9%
22	1.000	2.1%	0.0%	2.1%	0.8%
23	1.000	0.3%	0.0%	0.3%	0.7%
24	1.000	0.5%	0.0%	0.5%	0.7%
25	1.004	0.8%	0.0%	0.8%	0.7%
26	1.024	0.5%	0.0%	0.5%	1.0%
27	1.048	0.5%	0.0%	0.5%	1.0%
28	1.087	1.6%	0.0%	1.6%	1.6%
29	1.119	1.3%	0.0%	1.3%	2.5%
30	1.135	2.1%	0.0%	2.1%	1.9%
31	1.159	1.6%	0.0%	1.6%	1.1%
32	1.183	1.1%	0.0%	1.1%	1.2%
33	1.198	1.6%	0.0%	1.6%	1.9%
34	1.214	1.3%	0.0%	1.3%	2.4%
35	1.222	3.2%	0.0%	3.2%	1.8%
36	1.230	1.9%	0.0%	1.9%	1.7%
37	1.238	2.1%	0.0%	2.1%	2.1%
38	1.246	2.1%	0.0%	2.1%	1.9%
39	1.262	2.1%	0.0%	2.1%	2.2%
40	1.278	2.7%	0.0%	2.7%	2.0%
41	1.302	2.4%	0.0%	2.4%	2.5%
42	1.325	1.9%	0.0%	1.9%	1.3%
43	1.357	1.6%	0.0%	1.6%	1.2%
44	1.397	1.6%	0.0%	1.6%	1.6%
45	1.444	1.9%	0.0%	1.9%	1.8%
46	1.500	1.9%	0.0%	1.9%	1.4%
47	1.563	1.6%	0.0%	1.6%	1.1%
48	1.635	1.1%	0.0%	1.1%	0.7%
49	1.706	0.3%	0.0%	0.3%	1.0%
50	1.786	1.1%	0.0%	1.1%	1.8%
51	1.865	1.9%	0.0%	1.9%	2.0%
52	1.952	1.6%	0.0%	1.6%	1.9%
53	2.040	1.6%	0.0%	1.6%	2.3%
54	2.135	2.1%	0.0%	2.1%	2.1%
55	2.230	2.4%	0.0%	2.4%	1.8%
56	2.333	1.3%	0.0%	1.3%	1.3%
57	2.437	2.1%	0.0%	2.1%	2.1%
58	2.548	2.9%	0.0%	2.9%	2.9%
59	2.603	3.2%	0.0%	3.2%	2.8%
60	2.714	2.9%	0.0%	2.9%	3.6%
61	2.810	4.3%	0.0%	4.3%	4.8%
62	2.873	4.3%	0.0%	4.3%	4.3%
63	2.952	4.8%	0.0%	4.8%	4.4%
64+	3.000	7.7%	0.0%	7.7%	7.1%
Total Percent of Members		100.0%	0.0%	100.0%	100.0%
Age Curve Factor				**1.7979**	**1.7992**
Age Curve Factor, No Dependent Limit				**1.7979**	**1.7992**
3-Child Limit Factor				**1.0000**	**1.0000**
Tobacco Surcharge		**1.0000**	**1.0000**		

Nearest whole age corresponding to the calibration factor:	50
Age Factor assuming all members are charged a premium:	1.7979
Family Rating Adjustment for three child dependent limit:	1.0000
Tobacco Factor	1.0000

Overall Average Age	43
Average Age of Individuals 0-14	9
Average Age of Individuals 65+	67
Distribution of Individuals age 64	6.54%
Distribution of Individuals age 65+	1.31%

EXHIBIT C2: GEOGRAPHIC FACTORS
BridgeSpan Health Company - Individual

Rating Area	Geographic Factor	March 2025 Membership	Distribution	Prior Year Distribution
1	1.000	101	26.9%	30.4%
2	1.131	9	2.4%	3.3%
3	1.074	77	20.5%	21.6%
4	0.988	37	9.8%	2.1%
5	1.037	62	16.5%	20.2%
6	1.045	59	15.7%	11.7%
8	1.055	21	5.6%	8.8%
9	1.111	10	2.7%	2.0%
Average Geographic Factor Projected	**1.0363**			
Average Geographic Factor Experience	**1.0398**			

Geographic Factor Analysis

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

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

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

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

(i) Health status of enrollees or the population in an area;

(ii) Medical condition of enrollees or the population in an area, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Health services utilization in the area;

(v) Medical history of enrollees or the population in an area;

(vi) Genetic information of enrollees or the population in an area;

(vii) Disability status of enrollees or the population in an area;

(viii) Other evidence of insurability applicable in the area.

	A	B	C	D	E	F	G	H	I
Area	Current Allowed/RVU Relativities	Prior Year Final Area factors	March 2025 Membership	Adjusted Prior Year Final Area factors	% Change, capped	2026 Provider Contracting Impacts	Preliminary Factor	Area Factor	Final Factor
Rate Area 1	0.965	0.964	64,074	0.965	0.1%	0.3%	0.967	0.968	1.000
Rate Area 2	1.080	1.094	9,313	1.095	-1.3%	-0.1%	1.079	1.095	1.131
Rate Area 3	1.048	1.041	15,988	1.042	0.7%	-0.9%	1.038	1.040	1.074
Rate Area 4	0.952	0.963	3,461	0.964	-1.1%	0.2%	0.954	0.956	0.988
Rate Area 5	1.004	1.007	19,557	1.008	-0.3%	-0.1%	1.003	1.004	1.037
Rate Area 6	1.009	1.008	3,521	1.009	0.1%	0.1%	1.011	1.012	1.045
Rate Area 7	1.327	1.089	1,069	1.090	2.0%	0.2%	1.114	1.095	
Rate Area 8	1.019	1.021	23,270	1.022	-0.2%	0.1%	1.020	1.021	1.055
Rate Area 9	1.038	1.093	620	1.094	-2.0%	0.2%	1.074	1.075	1.111

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

B: 2025 final area factors.

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

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

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

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

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

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

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

Rating Area	2024 Geographic Factor	2025 Geographic Factor	2026 Geographic Factor	2024 to 2025 Change	2025 to 2026 Change
1	1.000	1.000	1.000	0.0%	0.0%
2	1.111	1.135	1.131	2.2%	-0.4%
3	1.092	1.080	1.074	-1.1%	-0.6%
4	0.970	0.999	0.988	3.0%	-1.1%
5	1.041	1.045	1.037	0.4%	-0.8%
6	1.059	1.046	1.045	-1.2%	-0.1%
8	1.046	1.059	1.055	1.2%	-0.4%
9	1.111	1.134	1.111	2.1%	-2.0%

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

EXHIBIT C3: DEMOGRAPHIC FACTOR COMPARISON
BridgeSpan Health Company - Individual

Description	2023	2024	2025	2026
Age Curve Factor	1.7825	1.8291	1.8049	1.7979
Geographic Factor	1.0536	1.0452	1.0437	1.0363
3-Child Limit Factor		1.0000	1.0000	1.0000
Tobacco Factor	1.0047	1.0041	1.0040	1.0000

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

Description	Calibration Factors*
Age Curve Calibration Factor	0.5562
Geographic Calibration Factor	0.9650
3-Child Limit Calibration Factor	1.0000
Tobacco Calibration Factor	1.0000

EXHIBIT C4: NETWORK FACTOR CHANGE

BridgeSpan Health Company - Individual

Network	2024 Network Factor	2024 Enrollment Distribution	2026 Network Factor	2026 Enrollment Distribution
RealValue	0.951	100.0%		
Individual Value			0.944	100.0%
Average Network Factor		0.951		0.944

EXHIBIT D1: 2026 AVERAGE CHANGE IN PLAN BASE RATES
BridgeSpan Health Company - Individual

2025 Plan ID	2025 Plan Name	2026 Plan ID	March 2025 Membership	Renewal or Mapped Plan	2025 AV Pricing Value	2026 AV Pricing Value	2025 Plan Base Rate	2026 Plan Base Rate	Experience Impact (Other than Demographic Changes)	Benefit Rate Change	Cost Share Rate Change	Plan Base Rate Change	Average Change in Area Factor	Average Change in Age Factor	Average Rate Change to Renewal or Mapped Plan
53732WA0790007	Bronze Essential 8500	53732WA0790026	-	Mapped	0.6090	0.6360	$392.65	$440.02	7.30%	0.00%	4.43%	12.06%	0.00%	0.00%	12.06%
53732WA0790024	BridgeSpan Cascade Gold	53732WA0790024	64	Renewal	0.9429	0.9250	$647.26	$639.96	0.40%	0.00%	-1.90%	-1.13%	-0.39%	0.00%	-1.51%
53732WA0790025	BridgeSpan Cascade Silver	53732WA0790025	119	Renewal	1.0621	1.0719	$500.53	$741.59	46.12%	0.00%	0.92%	48.16%	-0.47%	0.00%	47.46%
53732WA0790026	BridgeSpan Cascade Bronze	53732WA0790026	193	Renewal	0.6408	0.6360	$409.19	$440.02	7.86%	0.00%	-0.75%	7.53%	-0.45%	0.00%	7.05%
		Total Enrollment	376												18.38%

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

EXHIBIT D2: TERMINATED PLAN MAPPING
BridgeSpan Health Company - Individual

		TERMINATED PLAN				MAPPED PLAN	
2024 Offered	**2025 Offered**	**Plan ID**	**Plan Name**	**Year**	**2025 Plan ID**	**2026 Plan ID**	**2026 Plan Name**
Yes	Yes	53732WA0790007	Bronze Essential 8500	2025	53732WA0790007	53732WA0790026	BridgeSpan Cascade Bronze

EXHIBIT E1: DEVELOPMENT OF 2026 INDEX RATE
BridgeSpan Health Company - Individual

	Experience - Total		Experience		Manual - Total		Credibility Manual	
	BridgeSpan Health Company		BridgeSpan Health Company		**Regence BlueShield**		Regence BlueShield	
Experience Period: 1/1/2024 - 12/31/2024	**Individual**		Individual		**Individual**		Individual	
Projection Period: 1/1/2026 - 12/31/2026	**Total**		ACA Experience		**Total**		ACA Experience	
URRT, Section I: Experience Period Data	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**	**Total**	**PMPM**
Earned Premium	$4,524,562	$740.76	$4,524,562	$740.76	$225,934,085	$669.73	$225,934,085	$669.73
MLR Rebates	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Risk Adjustment Transfers[1]	$2,049,880	$331.54	$2,049,880	$331.54	$32,400,000	$95.21	$32,400,000	$95.21
HCRP Receipts	$86,795	$14.21	$86,795	$14.21	$195,664	$0.58	$195,664	$0.58
Premiums (net of MLR Rebate) in Experience Period	**$6,661,237**	**$1,086.51**	$6,661,237	$1,086.51	$258,529,749	**$765.52**	$258,529,749	$765.52
Incurred Claims Paid through March 2025	$7,911,021	$1,295.19	$7,911,021	$1,295.19	$264,479,810	$783.99	$264,479,810	$783.99
Incurred Claims UCL	$10,017	$1.64	$10,017	$1.64	$6,308,464	$18.70	$6,308,464	$18.70
Estimated Incurred Claims	$7,921,038	$1,296.83	$7,921,038	$1,296.83	$270,788,274	$802.69	$270,788,274	$802.69
Pharmacy Rebates	$573,928	$93.96	$573,928	$93.96	$25,172,936	$74.62	$25,172,936	$74.62
BlueCard Access Fees	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Reinsurance	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Incurred Claims in Experience Period	**$7,347,110**	**$1,202.87**	$7,347,110	$1,202.87	**$245,615,339**	**$728.07**	$245,615,339	$728.07
Allowed Claims Paid through March 2025	$8,780,311	$1,437.51	$8,780,311	$1,437.51	$316,178,851	$937.24	$316,178,851	$937.24
Allowed Claims UCL	$11,055	$1.81	$11,055	$1.81	$7,509,433	$22.26	$7,509,433	$22.26
Estimated Allowed Claims	$8,791,367	$1,439.32	$8,791,367	$1,439.32	$323,688,285	$959.50	$323,688,285	$959.50
Pharmacy Rebates	$573,928	$93.96	$573,928	$93.96	$25,172,936	$74.62	$25,172,936	$74.62
BlueCard Access Fees	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00
Allowed Claims	**$8,217,439**	**$1,345.36**	$8,217,439	$1,345.36	**$298,515,349**	**$884.88**	$298,515,349	$884.88
Experience EHB Percent[4]		99.8%		99.8%		99.8%		99.8%
Index Rate		**$1,342.67**		$1,342.67		**$883.11**		$883.11
Member Months	**6,108**		6,108		**337,351**		337,351	
URRT, Section II: Projections	**Factor**	**PMPM**	**Factor**	**PMPM**	**Factor**	**PMPM**	**Factor**	**PMPM**
Experience Period Allowed Claims		$1,342.67		$1,342.67		$883.11		$883.11
Medical / Rx Cost Trend	**1.050**	**1.050**	**1.050**	**1.050**	**0.000**	**0.000**		
Medical / Rx Utilization Trend	**1.024**	**1.041**	**1.024**	**1.041**	**0.000**	**0.000**		
Overall Cost Trend	**1.050**		1.050		**1.050**		1.050	
Overall Utilization Trend	**1.031**		1.031		**1.031**		1.031	
Trended Allowed Claims PMPM		$1,574.14		$1,574.14		$1,035.36		$1,035.36
Pop'l risk Morbidity	**0.751**		0.751		**0.998**		0.998	
Demographic Shift	**0.997**		0.997		**1.020**		1.020	
Plan Design Changes	**1.073**		1.073		**1.051**		1.051	
Other	**1.002**		1.002		**1.013**		1.013	
Network		0.995		0.995		0.989		0.989
Pharmacy Rebates		1.007		1.007		1.024		1.024
Projected EHB Change		1.000		1.000		1.000		1.000
Adjusted Trended EHB Allowed Claims PMPM		**$1,266.60**		$1,266.60		**$1,122.11**		$1,122.11
Weighting	**2%**		2%		**98%**		98%	

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

Development of Market Adjusted Index Rate	
Index Rate for Projection Period	$1,125.00
Reinsurance Program Adjustment[3]	$0.00
Risk Adjustment[3]	$100.26
Marketplace User Fee Adjustment[3]	0.50%
Market Adjusted Index Rate	$1,029.93

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

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

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

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

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

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

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

EXHIBIT E2: PLAN ADJUSTED INDEX RATE DEVELOPMENT
BridgeSpan Health Company - Individual

					AV PRICING VALUE COMPONENTS					PLAN ADJUSTMENTS TO MARKET ADJUSTED INDEX RATE								
2026 Plan ID	2026 Plan Name	Projected Member Months	AV Pricing Value[1]	Projected Benefit Factor	Base Product[2]	CSR Load	Network	Benefits in Addition to EHB	Market Adjusted Index Rate	AV and Cost-Sharing Design[3]	Projected CSR Adjustment	EHB Paid To Allowed Factor	Network (Normalized)[4]	Elective Abortion in Addition to EHB Factor[7]	Other Benefits in Addition to EHB Factor	Benefits in Addition to EHB[5]	Administrative Costs[6]	Plan Adjusted Index Rate
53732WA0790024	BridgeSpan Cascade Complete Gold	756	0.9250	0.9250	0.9232	1.0000	1.0000	1.0020	$1,029.93	1.0134	1.0000	0.9211	1.0000	0.0020	0.0000	1.0020	1.1401	**$1,192.35**
53732WA0790030	BridgeSpan Cascade Vital Gold	12	0.8400	0.8400	0.8383	1.0000	1.0000	1.0020	$1,029.93	0.9203	1.0000	0.9044	1.0000	0.0020	0.0000	1.0020	1.1401	**$1,082.78**
53732WA0790025	BridgeSpan Cascade Silver	1,428	1.0719	0.7470	0.7455	1.4350	1.0000	1.0020	$1,029.93	1.1743	1.4350	0.9501	1.0000	0.0020	0.0000	1.0020	1.1401	**$1,381.70**
53732WA0790026	BridgeSpan Cascade Bronze	2,316	0.6360	0.6360	0.6347	1.0000	1.0000	1.0020	$1,029.93	0.6968	1.0000	0.8642	1.0000	0.0020	0.0000	1.0020	1.1401	**$819.83**
Total / Average		**4,512**	**0.8229**	**0.7201**	**0.7187**	**1.1377**	**1.0000**	**1.0020**	**$1,029.93**	**0.9016**	**1.1377**	**0.9010**	**1.0000**	**0.0020**	**0.0000**	**1.0020**	**1.1401**	$1,060.77

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

[1]The AV Pricing Value is the plan factor that is multiplied by the 2025 Base Rate, age factor and geographic factor to arrive at a member rate.

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

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

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

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

[6]Administrative Costs calculated using percentages from Exhibit A1: 1/[1-(Total Retention % - Marketplace Fee % - Federal HCRP Charge %)].
Due to the expectation that CSR payments will not be made for 2025, the AV Pricing Value is adjusted for on-exchange silver plans

[7]The elective abortions factor is applied along with the other non-EHB factor to the Market Adjusted Index rate (which excludes non-EHBs) for on exchange plans.

EXHIBIT E3: PLAN ADJUSTED INDEX RATE TO BASE RATE MAPPING
BridgeSpan Health Company - Individual

		(A)	(B)	(C)	(D)	(A) / [(B) * (C) * (D)]									
2026 Plan ID	**2026 Plan Name**	**Plan Adjusted Index Rate[1]**	**Age Curve Factor**	**Geographic Factor**	**Tobacco Factor**	**2026 Plan Base Rate**	**Calibrated Plan Adjusted Index Rate**	**Difference in Rate**	**Projected Member Months**	**Allowed Claims for URRT Section IV**	**Incurred Claims for URRT Section IV**	**Member Cost Sharing for URRT Section IV**	**Risk Adjustment Transfer Amount for URRT Section IV**	**Premium for URRT Section IV**	**Retention for URRT Section IV**
53732WA0790024	BridgeSpan Cascade Complete Gold	**$1,192.35**	1.7979	1.0363	1.0000	$639.96	$639.96	$0.00	756	$887,914	$784,972	$102,942	$219,005	$901,417	$114,623
53732WA0790030	BridgeSpan Cascade Vital Gold	**$1,082.78**	1.7979	1.0363	1.0000	$581.15	$581.15	$0.00	12	$14,094	$12,233	$1,861	$3,476	$12,993	$1,658
53732WA0790025	BridgeSpan Cascade Silver	**$1,381.70**	1.7979	1.0363	1.0000	$741.59	$741.58	$0.01	1,428	$1,599,525	$1,529,342	$70,183	$296,051	$1,973,068	$249,735
53732WA0790026	BridgeSpan Cascade Bronze	**$819.83**	1.7979	1.0363	1.0000	$440.02	$440.02	$0.00	2,316	$2,518,628	$2,256,065	$262,563	-$351,280	$1,898,726	$245,138
Total										**$5,086,137**	**$4,582,613**	**$503,524**	**$167,253**	**$4,786,074**	**$611,154**
Total (PMPM)										**$1,127.25**	**$1,015.65**	**$111.60**	**$37.07**	**$1,060.74**	**$135.45**

Index Rate for Projection Period: 1124.996744

Metal	Induced Demand Factor[2]
Bronze	0.96
Silver	0.99
Gold	1.04
Platinum	0.00

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

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

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

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

APPENDIX

BridgeSpan Health Company - Individual

		ADJUSTMENTS FROM 2025 MARKET ADJUSTED INDEX RATE				ADJUSTMENTS FROM 2026 MARKET ADJUSTED INDEX RATE			
2026 Plan ID	2026 Plan Name	AV and Cost-Sharing Design	Network (Normalized)	Benefits in Addition to EHB	Administrative Costs	AV and Cost-Sharing Design	Network (Normalized)	Benefits in Addition to EHB	Administrative Costs
53732WA0790024	BridgeSpan Cascade Complete Gold	1.2370	1.0000	1.0020	1.1509	1.0134	1.0000	1.0020	1.1401
53732WA0790025	BridgeSpan Cascade Silver	0.9566	1.0000	1.0020	1.1509	1.1743	1.0000	1.0020	1.1401
53732WA0790026	BridgeSpan Cascade Bronze	0.7820	1.0000	1.0020	1.1509	0.6968	1.0000	1.0020	1.1401

EXHIBIT E7: BENEFIT FACTOR EXPERIENCE
BridgeSpan Health Company - Individual

2024 Product	2024 Membership	2024 Experience Benefit Factor
Cascade Gold	849	1.020
Cascade Bronze	1,221	0.639
Cascade Silver	1,623	0.783
Bronze Essential 8500 Exchange	2,415	0.602
Average Benefit Factor		0.715

EXHIBIT F1: CHECKLIST VALUE COMPARISON
BridgeSpan Health Company - Individual

	URRT Wksh 2	View Rate Review Detail[5]	Part II	UPMJ	WAC 284-43-6660	Part III Appendix: Exhibit A1	2026 Average Change in Plan Base Rates: Exhibit D1	Plan Adjusted Index Rate Development: Exhibit E2
Renewing Plan Rate Change[1]	19.21%	18.38%	18.38%	18.38%	18.38%	18.38%		
Number of Members Affected for this Program:	376	376	400	376			376	
Current Policyholder Count		264						
Projected Enrollment	4,512	4,512						4,512

Financial Data Summary as of March 2025

	URRT Wksh 1	WAC 284-43-6660
2024 Member Months	6,108	6,108
2024 Earned Premium	$4,524,562.08	$4,524,562.08
2022 Incurred Claims[2]	$7,347,109.72	$7,347,109.72

	View Rate Review Detail[5]	URRT Wksh 2	WAC 284-43-6660	URRT Worksheet 2 3.10 Weighted Average
2025 Average PMPM3	$928.71		$896.05	
Proposed Community Rate[4]	$1,060.74	$1,060.74	$1,060.74	$1,060.74

	View Rate Review Detail[5]	UPMJ Q5	URRT Wksh 2
Minimum Rate Change[6]	-1.51%	-1.51%	-1.51%
Maximum Rate Change[6]	47.46%	47.46%	47.46%

	View Rate Review Detail[5]	2025 Rate Schedule
Minimum Rate PMPM Prior	$300.08	$300.08
Maximum Rate PMPM Prior	$2,534.50	$2,534.52

Product Name	Product ID	Continuing Membership	New Membership
BridgeSpan Exchange EPO No Ped Dental	53732WA079	376	0

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

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

[3]Requested rate less requested rate change

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

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

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

EXHIBIT F3: Medical and Drug Trend Assumptions
BridgeSpan Health Company - Individual

	Trend Assumptions by Major Type of Service		
Trend Component	Medical	Prescription Drugs	**Total[1]**
Unit Cost	5.0%	5.0%	**5.0%**
Utilization	1.8%	2.8%	**2.1%**
Mix/Intensity	0.9%	1.9%	**1.2%**
Leverage	2.1%	1.5%	**1.9%**
Total	**9.8%**	**11.2%**	**10.2%**

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

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

Supporting Document Schedules

Bypassed - Item:	Written Description Justifying the Rate Increase
Bypass Reason:	Uploaded only to URRT tab per OIC guidance.
Attachment(s):	
Item Status:	
Status Date:	

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

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

Satisfied - Item:	Rating Documents for Extended ARPA Subsidies
Comments:	

SERFF Tracking #:	*RGWA-134499023*	***State Tracking #:***	*484721*	***Company Tracking #:***	*WA OIC# 500823*

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

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

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

Instructions:

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

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

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

Section I – General Information:

Carrier: BridgeSpan Health Company

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
53732WA0790024	BridgeSpan Cascade Complete Gold	No	Gold	81.81%
53732WA0790025	BridgeSpan Cascade Silver	No	Silver	71.84%
53732WA0790026	BridgeSpan Cascade Bronze	No	Bronze	64.97%
53732WA0790030	BridgeSpan Cascade Vital Gold	No	Gold	78.06%

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."		
53732WA0790024	BridgeSpan Cascade Complete Gold	No	See Footnote	No	N/A
53732WA0790025	BridgeSpan Cascade Silver	Yes	See Footnote	No	N/A
53732WA0790026	BridgeSpan Cascade Bronze	Yes	See Footnote	No	N/A
53732WA0790030	BridgeSpan Cascade Vital Gold	No	See Footnote	No	N/A

For Cascade Plans, please see the "Standard Plan Unique Design and AV Screenshots" document for description of unique benefit designs.

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
53732WA0790026	BridgeSpan Cascade Bronze	No	Yes	Generic Drugs, Primary Care

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

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

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

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

☒ No

☐ Yes. We are making the following changes:

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

F. **Network Information:**

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

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

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

Section II – Experience Data and Projections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
c	**Cost-sharing reduction (CSR) silver load factors by plan:** • Note: In this case, references to "CSR" subsidies include subsidies for the AIAN population. Include actual experience and the projected CSR silver load factor in WA Exhibit 8; see the instructions in the exhibit template. • Consult WAC 284-43-6820 for guidance on the uniform CSR silver load adjustment factor for plan year 2026.	BHC IND OIC Health Exhibits	WA Exh 8 - CSR Experience
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 I Unified Rate Review Template	Worksheet 2 - Plan Product Info / Row 3.5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line	Task	Issuer Response:	
		Document Name	**Section / Page / Exhibit Number**
26	**Financial Statement Analysis:**		
a	Reconcile to Additional Data Statement (ADS) for the year ending December 31, 2024: • For carriers not required to file an ADS, please respond "N/A." For ease of review for carriers who file an ADS, please include with the rate filing a copy of the ADS pages. • For HMOs and HCSCs, show ADS amounts total revenues (line 7), total hospital and medical claims (line 17), and administrative expenses (line 19 + line 20). • Please include a detailed list of adjustments required to reconcile between ADS amounts and amounts in the Summary of Pooled Experience in the WAC 284-43-6660 summary and in URRT Worksheet 1, Section I. Calculate the amount and percentage unreconciled, and explain any significant unreconciled amounts. • Explain any difference in the projected risk adjustment amount included in the ADS premium amount versus the experience period risk adjustment amount entered in URRT Worksheet 1, Section I. • Also, compare the average monthly membership from the WAC 284-43-6660 summary's 2024 experience period with the average monthly membership calculated from the quarter ending enrollment listed in the ADS. Explain any significant differences.	BHC IND Additional Data Reconciliation	Entire Document
b	Months of surplus: For all issuers, please provide a calculation of your company's Months of Surplus using information in the 2024 annual statement and one of the following formulas, with one decimal place of accuracy. Health Statement: Months of Surplus = [(Annual Statement Page 3, Line 33: Total capital and surplus) / (Page 4, Line 18: Total hospital and medical (Lines 16 minus 17))] * 12. Life Statement: Months of Surplus = [(Annual Statement Page 3, Line 38: Total (Lines 29, 30, & 37)) / (Page 4, Line 20: Total (Lines 10 to 19))] * 12.	Part III Rate Filing Documentation and BHC IND Supp Exhibits	Part III: "Contribution to Surplus & Risk Margin" / Section 4.4.7(b) "Reliance" / Section 4.7.2; Supp Exhibits: "Months of Surplus"
27	**Abortion Services for Which Public Funding is Prohibited:** (see also #11.d & #13 of this checklist) For Exchange filings, document the pricing per member per month (PMPM) for voluntary abortion services and the "EHB Percent of Total Premium" to be listed in the Plans & Benefit Template (PBT) in the	Part III Actuarial Memorandum	"Effective Rate Review Information and Additional Requirements" / Section 4.7.1

Line	Task	Issuer Response:	
		Document Name	Section / Page / Exhibit Number
	binder filing [45 CFR §156.280(e)(4)]. See also QHP Application Instructions for EHB Percent of Total Premium calculation guidance. Note: The Index Rates in URRT Worksheet 1, Section II must include allowed claims for abortion services even for Exchange plans. Voluntary abortion services are *only* considered a non-EHB for Exchange plans in the percentages listed in the PBT and in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5. Otherwise, the State of Washington considers voluntary abortion services as EHBs for Exchange plans. Additionally, non-Exchange plans will consistently consider voluntary abortion services as EHBs.		
SEPARATE DOCUMENTS Address the following items together with other relevant items covered elsewhere in this checklist.			
28	**Part I Unified Rate Review Template (URRT):** Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the Exchange User Fee input for URRT Worksheet 1 Section II, please use and reference the applicable amount(s) calculated in the URRT. Please do not disable the macros in the Excel version of the URRT; please submit a macro-enabled URRT workbook. The URRT worksheets allow up to 16 characters including decimal places. Only apply rounding to amounts directly loaded into the URRT and only to the extent necessary to meet the 16-character limitation. Do not round any intermediate amounts.		
a	URRT Exchange User Fees: (URRT Worksheet 1, Section II Projections) If the issuer is only outside the exchange, please respond "N/A." The Exchange user fee for 2026 is $5.11 PMPM. • For issuers marketing both inside and outside the Exchange, confirm that the Exchange user fees, or Exchange assessment fees, are spread across the entire pool.	Part III Rate Filing Documentation and Actuarial Memorandum, BHC IND Part III Appendix	Part III: "Exchange User Fees" / Section 4.4.3.6(c); Part III Appendix: "Exhibit A1: Development of 2026 Rate Change"

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

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

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

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

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

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

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

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

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

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

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

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

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790024	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade Complete Gold	Line 1.4	**Cost-Share Reduction (CSR) Plan?**		Line 1.6	**New or Renewing**	Renewing

Section 2: Plan Design Information

Line 2.1	**Unique Plan Design**	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**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Value

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

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays: Amount	Copays: Applies	Copays: Accrues toward Deductible?	Coinsurance: Amount	Coinsurance: Applies	Coinsurance: Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services		Yes	$ 450	After Deductible					Note 1	
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				Note 2	
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 25	Before and After Deductible	No				Note 2	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible						
Laboratory Outpatient and Professional Services		No	$ 20	Before and After Deductible	No					
X-rays and Diagnostic Imaging		No	$ 30	Before and After Deductible	No					
Skilled Nursing Facility		Yes	$ 350	After Deductible					Note 3	
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				Note 1	
Other EHB Categories										
Infertility Treatment		Yes				20%	After Deductible			
Cosmetic Surgery		Yes				20%	After Deductible		Note 6	
Acupuncture		No	$ 15	Before and After Deductible	No					
Chiropractic Care		No	$ 15	Before and After Deductible	No					
Hearing Aids		No				20%	Before and After Deductible	No		
Routine Foot Care		Yes				20%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 5	
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No	$ -	Before and After Deductible						
Diabetes Care Management		Yes				20%	After Deductible			
Inherited Metabolic Disorder - PKU		Yes				20%	After Deductible			
Virtual Care - Store & Forward		No	$ 15	Before and After Deductible	No				Note 7	
Virtual Care - Telehealth		No	$ 15	Before and After Deductible	No					
Non-EHB Benefits										
Gender Affirming Care		Yes				20%	After Deductible			
Orthognathic Surgery		Yes				20%	After Deductible		Note 4	

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 10	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 30	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		No	$ 60	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Mail Order)		No	$ 180	Before and After Deductible	No					
Brand Drugs (Tier 3) (Retail)		No	$ 100	Before and After Deductible	No					
Brand Drugs (Tier 3) (Mail Order)		No	$ 300	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 100	Before and After Deductible	No					
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				20%	After Deductible			

Notes

Note 1 Out of service area coverage is available.
Note 2 25 visits per year
Note 3 Coverage is limited to 60-inpatient days/year.
Note 4 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 5 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 6 Covers cosmetic surgery when medically necessary.
Note 7 Only Member to Provider (not Provider to Provider)

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790025	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade 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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Value

	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					Note 4	
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 1	
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 1	
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				Note 2	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible					Note 2	
Laboratory Outpatient and Professional Services	No	No	$ 40	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 65	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 800	After Deductible					Note 3	
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 4	
Emergency Transportation	No	No	$ 375	Before and After Deductible	No				Note 4	
Other EHB Categories										
Infertility Treatment	No	Yes								
Cosmetic Surgery	No	Yes							Note 7	
Acupunture	No	No	$ 20	Before and After Deductible	No					
Chiropractic Care	No	No	$ 20	Before and After Deductible	No					
Hearing Aids	No	No				30%	Before and After Deductible	No		
Routine Foot Care	No	Yes				30%	After Deductible			
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Well Baby Visits and Care	No	No	$ -	Before and After Deductible					Note 6	
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Diabetes Education	No	No	$ -	Before and After Deductible						
Diabetes Care Management	No	Yes				30%	After Deductible			
Inherited Metabolic Disorder - PKU	No	Yes				30%	After Deductible			
Virtual Care - Store & Forward	Yes	No	$ 20	Before and After Deductible	No				Note 8	
Virtual Care - Telehealth	Yes	No	$ 20	Before and After Deductible	No				Note 1	
Non-EHB Benefits										
Gender Affirming Care	No	Yes				30%	After Deductible			
Orthognathic Surgery	No	Yes				30%	After Deductible		Note 5	

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 25	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 75	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		No	$ 75	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Mail Order)		No	$ 225	Before and After Deductible	No					
Brand Drugs (Tier 3) (Retail)		Yes	$ 250	After Deductible						
Brand Drugs (Tier 3) (Mail Order)		Yes	$ 750	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 250	After Deductible						
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				30%	After Deductible			

Notes

Note 1 First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)
Note 2 25 visits per year
Note 3 Coverage is limited to 60-inpatient days/year.
Note 4 Out of service area coverage is available.
Note 5 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 6 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 7 Covers cosmetic surgery when medically necessary.
Note 8 Only Member to Provider (not Provider to Provider). First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790025	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade 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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Value

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

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays: Amount	Copays: Applies	Copays: Accrues toward Deductible?	Coinsurance: Amount	Coinsurance: Applies	Coinsurance: Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services	No	Yes	$ 800	After Deductible					Note 4	
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 1	
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 1	
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				Note 2	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible					Note 2	
Laboratory Outpatient and Professional Services	No	No	$ 40	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 65	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 800	After Deductible					Note 3	
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 4	
Emergency Transportation	No	No	$ 325	Before and After Deductible	No				Note 4	
Other EHB Categories										
Infertility Treatment	No	Yes				30%	After Deductible			
Cosmetic Surgery	No	Yes				30%	After Deductible		Note 7	
Acupuncture	No	No	$ 20	Before and After Deductible	No					
Chiropractic Care	No	No	$ 20	Before and After Deductible	No					
Hearing Aids	No	No				30%	Before and After Deductible	No		
Routine Foot Care	No	Yes				30%	After Deductible			
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Well Baby Visits and Care	No	No	$ -	Before and After Deductible					Note 6	
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Diabetes Education	No	No	$ -	Before and After Deductible						
Diabetes Care Management	No	Yes				30%	After Deductible			
Inherited Metabolic Disorder - PKU	No	Yes				30%	After Deductible			
Virtual Care - Store & Forward	Yes	No	$ 20	Before and After Deductible	No				Note 8	
Virtual Care - Telehealth	Yes	No	$ 20	Before and After Deductible	No				Note 1	
Non-EHB Benefits										
Gender Affirming Care	No	Yes				30%	After Deductible			
Orthognathic Surgery	No	Yes				30%	After Deductible		Note 5	

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 24	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 72	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		No	$ 75	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Mail Order)		No	$ 225	Before and After Deductible	No					
Brand Drugs (Tier 3) (Retail)		Yes	$ 250	After Deductible						
Brand Drugs (Tier 3) (Mail Order)		Yes	$ 750	After Deductible						
Specialty Drugs (Tier 4)		Yes	$ 250	After Deductible						
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				30%	After Deductible			

Notes

Note 1 First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)
Note 2 25 visits per year
Note 3 Coverage is limited to 60-inpatient days/year.
Note 4 Out of service area coverage is available.
Note 5 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 6 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 7 Covers cosmetic surgery when medically necessary.
Note 8 Only Member to Provider (not Provider to Provider). First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790025	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade 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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Value

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

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	$ 425	After Deductible					Note 4	
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 1	
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 1	
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				Note 2	
Preventive Care/Screening/Immunization	No	No	$ -	Before and After Deductible					Note 2	
Laboratory Outpatient and Professional Services	No	No	$ 20	Before and After Deductible	No					
X-rays and Diagnostic Imaging	No	No	$ 40	Before and After Deductible	No					
Skilled Nursing Facility	No	Yes	$ 425	After Deductible					Note 3	
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 4	
Emergency Transportation	No	No	$ 175	Before and After Deductible	No				Note 4	
Other EHB Categories										
Infertility Treatment	No	Yes				20%	After Deductible			
Cosmetic Surgery	No	Yes							Note 7	
Acupunture	No	No	$ 5	Before and After Deductible	No					
Chiropractic Care	No	No	$ 5	Before and After Deductible	No					
Hearing Aids	No	No			No	20%	Before and After Deductible	No		
Routine Foot Care	No	Yes				20%	After Deductible			
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Well Baby Visits and Care	No	No	$ -	Before and After Deductible					Note 6	
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Diabetes Education	No	No	$ -	Before and After Deductible						
Diabetes Care Management	No	Yes				20%	After Deductible			
Inherited Metabolic Disorder - PKU	No	Yes				20%	After Deductible			
Virtual Care - Store & Forward	Yes	No	$ 5	Before and After Deductible	No				Note 8	
Virtual Care - Telehealth	Yes	No	$ 5	Before and After Deductible	No				Note 1	
Non-EHB Benefits										
Gender Affirming Care	No	Yes				20%	After Deductible			
Orthognathic Surgery	No	Yes				20%	After Deductible		Note 5	

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 12	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 36	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		No	$ 35	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Mail Order)		No	$ 105	Before and After Deductible	No					
Brand Drugs (Tier 3) (Retail)		No	$ 160	Before and After Deductible	No					
Brand Drugs (Tier 3) (Mail Order)		No	$ 480	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 160	Before and After Deductible	No					
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				20%	After Deductible			

Notes

Note 1 First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)
Note 2 25 visits per year
Note 3 Coverage is limited to 60-inpatient days/year.
Note 4 Out of service area coverage is available.
Note 5 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 6 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 7 Covers cosmetic surgery when medically necessary.
Note 8 Only Member to Provider (not Provider to Provider). First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790025	Line 1.3	**Metal Level**	Silver	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade 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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Value

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

Medical Benefits	Upfront Visits or Copays?	Subject to Deductible?	Copays: Amount	Copays: Applies	Copays: Accrues toward Deductible?	Coinsurance: Amount	Coinsurance: Applies	Coinsurance: Accrues toward Deductible?	Comments	Errors/ Warnings
Emergency Room Services		No	$ 150	Before and After Deductible	No				Note 3	
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				Note 1	
Preventive Care/Screening/Immunization		No	$ -	Before and After Deductible					Note 1	
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				Note 2	
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 3	
Emergency Transportation		No	$ 75	Before and After Deductible	No				Note 3	
Other EHB Categories										
Infertility Treatment		No								
Cosmetic Surgery		No							Note 6	
Acupunture		No	$ 1	Before and After Deductible	No					
Chiropractic Care		No	$ 1	Before and After Deductible	No					
Hearing Aids		No				15%	Before and After Deductible	No		
Routine Foot Care		No								
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 5	
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No	$ -	Before and After Deductible						
Diabetes Care Management		No				15%	Before and After Deductible	No		
Inherited Metabolic Disorder - PKU		No				15%	Before and After Deductible	No		
Virtual Care - Store & Forward		No	$ 1	Before and After Deductible	No				Note 7	
Virtual Care - Telehealth		No	$ 1	Before and After Deductible	No					
Non-EHB Benefits										
Gender Affirming Care		No				15%	Before and After Deductible	No		
Orthognathic Surgery		No				15%	Before and After Deductible	No	Note 4	

Drug Benefit Tiers (add/modify descriptions as necessary)	Maximum Coinsurance	Subject to Deductible?	Amount	Applies	Accrues toward Deductible?	Amount	Applies	Accrues toward Deductible?	Comments	Errors/ Warnings
Generic Drugs (Tier 1) (Retail)		No	$ 5	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 15	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		No	$ 12	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Mail Order)		No	$ 36	Before and After Deductible	No					
Brand Drugs (Tier 3) (Retail)		No	$ 35	Before and After Deductible	No					
Brand Drugs (Tier 3) (Mail Order)		No	$ 105	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 35	Before and After Deductible	No					
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				15%	After Deductible			

Notes

Note 1 25 visits per year
Note 2 Coverage is limited to 60-inpatient days/year.
Note 3 Out of service area coverage is available.
Note 4 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 5 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 6 Covers cosmetic surgery when medically necessary.
Note 7 Only Member to Provider (not Provider to Provider)

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790026	Line 1.3	**Metal Level**	Expanded Bronze	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade 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?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
Line 3.3	**In-Network Tiers (#)**	1
Line 3.4	**Tier 1 Utilization**	100.00%
Line 3.5	**Tier 2 Utilization**	
Line 3.6	**Tier 3 Utilization**	
Line 3.7	**Out-of-Network Benefits?**	No

Section 4: Cost-Share Designs

Line 4.1 In-Network Tier 1: Individual Value

	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		Note 4	
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 1	
Specialist Visit	No	Yes	$ 100	After Deductible						
Mental Health & Substance Use Disorder Office Visits	Yes	No	$ 40	Before and After Deductible	No				Note 1	
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		Note 2	
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	Yes				40%	After Deductible		Note 2	
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		Note 3	
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 4	
Emergency Transportation	No	Yes				40%	After Deductible		Note 4	
Other EHB Categories										
Infertility Treatment	No	Yes				40%	After Deductible			
Cosmetic Surgery	No	Yes				40%	After Deductible		Note 7	
Acupuncture	No	No	$ 40	Before and After Deductible	No					
Chiropractic Care	No	No	$ 40	Before and After Deductible	No					
Hearing Aids	No	No				40%	Before and After Deductible	No		
Routine Foot Care	No	No	$ -	Before and After Deductible						
Routine Eye Exam for Children	No	No	$ -	Before and After Deductible						
Eye Glasses for Children	No	No	$ -	Before and After Deductible						
Well Baby Visits and Care	No	No	$ -	Before and After Deductible					Note 6	
Abortion for Which Public Funding is Prohibited	No	No	$ -	Before and After Deductible						
Diabetes Education	No	No	$ -	Before and After Deductible						
Diabetes Care Management	No	Yes				40%	After Deductible			
Inherited Metabolic Disorder - PKU	No	Yes				40%	After Deductible			
Virtual Care - Store & Forward	Yes	No	$ 40	Before and After Deductible	No				Note 8	
Virtual Care - Telehealth	Yes	No	$ 40	Before and After Deductible	No				Note 1	
Non-EHB Benefits										
Gender Affirming Care	No	Yes				40%	After Deductible			
Orthognathic Surgery	No	Yes				40%	After Deductible		Note 5	
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1) (Retail)		No	$ 32	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 96	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		Yes				40%	After Deductible			
Preferred Brand Drugs (Tier 2) (Mail Order)		Yes				40%	After Deductible			
Brand Drugs (Tier 3) (Retail)		Yes				40%	After Deductible			
Brand Drugs (Tier 3) (Mail Order)		Yes				40%	After Deductible			
Specialty Drugs (Tier 4)		Yes				40%	After Deductible			
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				40%	After Deductible			

Notes

Note 1 First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)
Note 2 25 visits per year
Note 3 Coverage is limited to 60-inpatient days/year.
Note 4 Out of service area coverage is available.
Note 5 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 6 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 7 Covers cosmetic surgery when medically necessary.
Note 8 Only Member to Provider (not Provider to Provider). First two in-person visits covered at $1 copay, then regular copay amounts apply. This two-visit allowance is shared with Other Practitioner Office Visit (Nurse, Physician Assistant)

Benefit Components

Worksheet Controls

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

Section 1: Plan Information

Line 1.1	**HIOS Plan ID**	53732WA0790030	Line 1.3	**Metal Level**	Gold	Line 1.5	**Exchange Status**	On Exchange
Line 1.2	**Plan Name**	BridgeSpan Cascade 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**	N/A
Line 2.8	**Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?**	N/A
Line 2.9	**HSA Plan?**	No
Line 2.10	**HSA Employer Contribution Amount**	
Line 2.11	**Different Cost-Sharing for Virtual vs Non-Virtual Care?**	No
Line 2.12	**Pediatric Dental Embedded?**	No
Line 2.13	**Includes Non-EHBs?**	Yes

Section 3: Network and Tier Information

Line 3.1	**Network Type**	EPO
Line 3.2	**Network Name**	Individual Value
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: [Insert Tier Name/Description]

	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					Note 1	
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				Note 2	
Rehabilitative Occupational and Rehabilitative Physical Therapy		No	$ 30	Before and After Deductible	No				Note 2	
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					
Emergency Transportation		No	$ 375	Before and After Deductible	No				Note 1	
Other EHB Categories										
Infertility Treatment		Yes				20%	After Deductible			
Cosmetic Surgery		Yes				20%	After Deductible		Note 6	
Acupuncture		No	$ 15	Before and After Deductible	No					
Chiropractic Care		No	$ 15	Before and After Deductible	No					
Hearing Aids		No				20%	Before and After Deductible	No		
Routine Foot Care		Yes				20%	After Deductible			
Routine Eye Exam for Children		No	$ -	Before and After Deductible						
Eye Glasses for Children		No	$ -	Before and After Deductible						
Well Baby Visits and Care		No	$ -	Before and After Deductible					Note 5	
Abortion for Which Public Funding is Prohibited		No	$ -	Before and After Deductible						
Diabetes Education		No	$ -	Before and After Deductible						
Diabetes Care Management		Yes				20%	After Deductible			
Inherited Metabolic Disorder - PKU		Yes				20%	After Deductible			
Virtual Care - Store & Forward		No	$ 15	Before and After Deductible					Note 7	
Virtual Care - Telehealth		No	$ 15	Before and After Deductible						
Non-EHB Benefits										
Gender Affirming Care		Yes				20%	After Deductible			
Orthognathic Surgery		Yes				20%	After Deductible		Note 4	
Drug Benefit Tiers (add/modify descriptions as necessary)	**Maximum Coinsurance**	**Subject to Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Amount**	**Applies**	**Accrues toward Deductible?**	**Comments**	**Errors/ Warnings**
Generic Drugs (Tier 1) (Retail)		No	$ 10	Before and After Deductible	No					
Generic Drugs (Tier 1) (Mail Order)		No	$ 30	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Retail)		No	$ 75	Before and After Deductible	No					
Preferred Brand Drugs (Tier 2) (Mail Order)		No	$ 225	Before and After Deductible	No					
Brand Drugs (Tier 3) (Retail)		No	$ 200	Before and After Deductible	No					
Brand Drugs (Tier 3) (Mail Order)		No	$ 600	Before and After Deductible	No					
Specialty Drugs (Tier 4)		No	$ 200	Before and After Deductible	No					
Opioid Rescue Medication Value List		No	$ -	Before and After Deductible						
Rx Chemo		Yes				20%	After Deductible			

Notes

Note 1 Out of service area coverage is available.
Note 2 25 visits per year
Note 3 Coverage is limited to 60-inpatient days/year.
Note 4 Coverage due to temporomandibular joint disorder, injury, sleep apnea or congenital and developmental anomalies
Note 5 Human donor milk must be covered as it is covered by the state base benchmark plan
Note 6 Covers cosmetic surgery when medically necessary.
Note 7 Only Member to Provider (not Provider to Provider)

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:	BridgeSpan Health Company
Applicable Market:	Individual Medical
Plan Year:	2026

Section I – Please provide a response for each item.

General Assumptions

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

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

    ☐ Yes ☒ No

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

    ☐ Yes ☒ No

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

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

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

Enrollment

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

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

Rating Area	**PY 2026 Enrollment**
Area 1	101
Area 2	9
Area 3	77
Area 4	37
Area 5	62
Area 6	59
Area 8	21
Area 9	10
Whole State	376

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

Rating Area	**PY 2026 Enrollment**
Area 1	101
Area 2	9
Area 3	77

Area 4	37
Area 5	62
Area 6	59
Area 8	21
Area 9	10
Whole State	376

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

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

Plan ID	PY 2026 Projected Enrollment
53732WA0790024	63
53732WA0790030	1
53732WA0790025	119
53732WA0790026	193

Total Premiums

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

Use enrollment reported above in #3.

Rating Area	**PY 2026 Premium**
Area 1	$1,285,621.05
Area 2	$114,560.29
Area 3	$980,126.94
Area 4	$470,970.09
Area 5	$789,193.12
Area 6	$751,006.36
Area 8	$267,307.35
Area 9	$127,289.21
Whole State	$4,786,074.41

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

Rating Area	**PY 2026 Premium**
Area 1	$1,285,621.05
Area 2	$114,560.29
Area 3	$980,126.94
Area 4	$470,970.09
Area 5	$789,193.12
Area 6	$751,006.36
Area 8	$267,307.35

Area 9	$127,289.21
Whole State	$4,786,074.41

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

None.

Service Area

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

   ☐ Yes ☒ No

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

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

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

Use enrollment reported above in #3.

Rating Area	**PY 2026 Allowed Claims**
Area 1	$1,366,223.05
Area 2	$121,742.65
Area 3	$1,041,575.99
Area 4	$500,497.55
Area 5	$838,671.57
Area 6	$798,090.69
Area 8	$284,066.18
Area 9	$135,269.61
Whole State	$5,086,137.28

12. What is the reporting issuer's PY 2026 without-waiver total projected medical allowed claims spending (i.e., the sum of incurred claims and member cost shares)?
    Provide the reporting issuer's projected medical spending by rating area as well as summed across the issuer's rating areas.
    Round to the nearest cent.
    Use enrollment reported above in #4.

Rating Area	**PY 2026 Allowed Claims**
Area 1	$1,366,223.05
Area 2	$121,742.65
Area 3	$1,041,575.99
Area 4	$500,497.55

Area 5	$838,671.57
Area 6	$798,090.69
Area 8	$284,066.18
Area 9	$135,269.61
Whole State	$5,086,137.28

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.

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

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

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

15. For the reporting issuer's PY 2026 Administrative Expense projections, please describe how with-waiver and without-waiver assumptions and methodologies differ.
    Please also describe expected impacts.
    If differences are not expected, please explain.
    BridgeSpan not anticipate any substantive impact from the inclusion of the 1332 wavier and no adjustments to administrative expenses were made to account for it.

Section II - For Informational Purposes as Background Information

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

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

(i) Reports of the total enrollment estimates for individual health insurance coverage, both with and without the waiver for the upcoming plan year;

(j) An explanation of why the experience for the upcoming plan year may vary from previous estimates and how assumptions used to estimate the impact have changed. This includes an explanation of changes in the estimated impact of the waiver on aggregate premiums, the estimated impact to the SLCSP rates, and the estimated impact on enrollment. The state should also explain changes to the estimated state subsidy program estimates relative to prior estimates.

BridgeSpan Health Company
Individual - WA
Claims

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

Additional Data Statement (ADS) Paid Claims	**$**	**6,812,508**
Change In UCL[(a)]	$	1,324,000
Risk Sharing Expense[(b)]	$	(27,098)
Miscellaneous Claims Exp.[(c)]	$	(1,365)
Legal Settlements[(d)]	$	164
CSR Settlement[(e)]	$	405,183
Net Cost Containment Adj.[(f)]	$	(782)
Total Claims Adjustments	**$**	**1,700,101**
Difference between Actuarial and ADS due to incurred dates[1]	$	(1,550,774)
Difference between Actuarial and ADS due to pharmacy rebates	$	(58,601)
Difference between Actuarial and ADS due to paid dates[2]	$	448,138
Incurred Claims UCL[3]	$	10,017
Total Other Adjustments	**$**	**(1,151,219)**
Additional Data Statement Paid Claims	$	6,812,508
Total Claims Adjustments	$	1,700,101
Total Other Adjustments	$	(1,151,219)
Adjusted Additional Data Statement Incurred Claims	**$**	**7,361,390**
Total Actuarial Incurred Claims in Experience Period		**7,347,110**
Unexplained difference between ADS and Actuarial Incurred Claims	**$**	**14,280**
% Unexplained difference between ADS and Actuarial Incurred Claims		**0.21%**

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

BridgeSpan Health Company
Individual - WA
Premium

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

Additional Data Statement (ADS) Premium	**$**	**6,414,320**
ACA 3Rs Programs[(a)]	$	(1,885,521)
Premium Ceded/Assumed[(b)]	$	2,369
Misc Premium[(c)]	$	(14,460)
Total Premium Adjustments	**$**	**(1,897,612)**
Difference between Actuarial and ADS due to incurred dates[1]	$	25,200
Difference between Actuarial and ADS due to paid dates[2]	$	(8,646)
Total Other Adjustments	**$**	**16,555**
Additional Data Statement Premium	$	6,414,320
Total Premium Adjustments	$	(1,897,612)
Total Other Adjustments	$	16,555
Total Adjusted Additional Data Statement Premium	**$**	**4,533,262**
Total Actuarial Premium	**$**	**4,524,562**
Unexplained difference between ADS and Actuarial Premium[3]	**$**	**8,700**
% Unexplained difference between ADS and Actuarial Premium[3]		**0.14%**

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

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

(c) Retroactive premium and member write off adjustments

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

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

(3) Actuarial premium is not used in rate development

BridgeSpan Health Company
Individual - WA
Enrollment

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

Additional Data Statement (ADS)	
First Quarter	544
Second Quarter	521
Third Quarter	488
Fourth Quarter	462
Average	504
Actuarial Unadjusted Average Enrollment	
Average 2024 Enrollment	509
% Unexplained difference between ADS and Actuarial Enrollment[1,2]	**-1.04%**

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

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

BridgeSpan Health Company
Individual - WA
Expenses

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

Additional Data Statement (ADS)		
Claims adjustment and general administrative expenses	$	484,414
Ceded reinsurance premium adjustment	$	2,369
Adjusted Additional Data Statement Expenses	**$**	**486,783**
Actuarial Expenses	**$**	**509,617**
% Unexplained difference between ADS and Actuarial Expenses*		**-4.69%**

*Difference is due to cost containment expenses and various tax related expenses

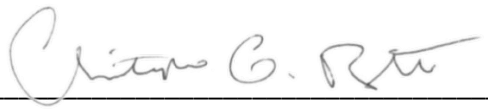
BridgeSpan Health Company
Individual Plans

Commissions are paid to licensed producers supporting enrollment for eligible individual members. Standard commissions are paid as per member per month (PMPM) to provide transparency and better cost control.

The standard commissions schedule effective 1/1/2026 for the Individual block of business is as follows:

- $20 PMPM

I, Christopher Blanton, am an officer of BridgeSpan Health Company and responsible for implementing the commissions schedule for the Individual line of business. I certify, that to the best of my knowledge, the provided schedule will be implemented effective 1/1/2026.



Christopher G. Blanton
President, BridgeSpan Health Company

05/02/2025
Date

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:	BridgeSpan Health Company
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:

BHC IND MHSUD Exhibit Duplicate.xlsx
BHC IND MHSUD Exhibit.pdf

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

I, Janessa Sanchez, FSA, MAAA, certify the following:
☒ I am an employee of Regence BlueShield or
☐ I am a consultant associated with the firm of N/A;

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

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

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

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

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

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

☒ Cost-share accuracy:
For the 2026 plan year, I certify the accuracy of the cost shares for both medical/surgical and MHSUD benefits that are used to evaluate parity of MHSUD financial requirements as loaded into the calculation workbook (*BHC IND MHSUD Exhibit Duplicate.xlsx*) and as otherwise discussed in this rate filing.

☒ Projected plan dollar amounts:
I attest to the following related to dollar amounts used to test MHSUD financial requirement parity:
- ☒ Projected dollar amounts are consistent with plan-specific projected allowed amounts used elsewhere in this rate filing, or
  - ☐ Projected dollar amounts differ from plan-specific projected allowed amounts used elsewhere in this rate filing as explained in the Part III actuarial memorandum.
- ☒ Projected dollar amounts reflect what the plan allows before reductions for enrollee cost sharing.
- ☒ Plan-level dollar amounts do not reflect aggregate data for the book of business.
- ☒ A reasonable actuarial method was used to project amounts for each plan in accordance with WAC 284-43-7040(1)(c)(ii) and applicable Actuarial Standards of Practice (ASOPs).
- ☒ Additional data details are available on the 'Data Information' tab in the Excel workbook of MHSUD financial requirement parity calculations.

☒ Financial requirement parity:
I attest to parity between MHSUD benefits and medical/surgical benefits in
- ☒ Financial requirements as outlined in Chapter 284-43 WAC Subchapter K Mental Health and Substance Use Disorder and
- ☒ Financial accumulators, such as deductibles and out-of-pocket maximums, by plan and classification. [Note especially WAC 284-43-7040(3).]

☒ Substantially all and predominance:
I certify that each plan submitted in this rate filing meets the "substantially all" and "predominant" / "predominant level" financial requirement parity testing requirements under MHPAEA and Chapter 284-43 WAC, Subchapter K Mental Health and Substance Use Disorder.
- ☒ Type: I attest that for each plan, the type of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) applies to at least two-thirds of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).
- ☒ Level: I attest that for each plan, the level of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) is no more restrictive than the level of financial

requirement imposed upon more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).

☒ I attest that if a single financial requirement did not meet the one-half threshold for a particular plan and classification (or applicable subclassification), then the level of financial requirement imposed upon MHSUD benefits was determined after combining levels until the combination of levels covered more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification), as described in WAC 284-43-7040(2)(b)(ii) and (iii).

☒ I attest that the above statements are supported by details in the complementary MHSUD financial requirement calculation workbook (cited above) and submitted as part of this rate filing.

☒ Parity across tiers:

- WAC 284-43-7020(5)(a): A plan or issuer must treat the least restrictive level of the financial requirement that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to MHSUD benefits in the same classification.
  - ☒ I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the financial requirements do not vary by provider tier.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(5)(b): If a plan or issuer classifies providers into tiers and varies cost-sharing by tier, the criteria for classification must be applied to generalists and specialists providing MHSUD services no more restrictively than such criteria are applied to medical/surgical benefit providers.
  - ☒ I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the cost-sharing does not vary by provider tier.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(6)(b): A plan or issuer may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers if the tiering is based on reasonable factors and without regard to whether a provider is an MHSUD provider or a medical/surgical provider.
  - ☒ I certify that this does not apply to plans in this rate filing. The plans do not use network tiers.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(6)(c): After network tiers are established, the plan or issuer may not impose any financial requirement on MHSUD benefits in any tier that is more restrictive than the predominant financial requirement that applies to substantially all medical/surgical benefits in that tier.
  - ☒ I certify that this does not apply to any plans in this rate filing. The plans do not use network tiers.
  - ☐ This situation applies to at least one plan in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

- WAC 284-43-7020(6)(d): If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to MHSUD benefits, the plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.
  ☒ I certify that none of the plans in this rate filing use prohibited prescription drug tiers. Prescription drug tiers are based only on the reasonable factors listed above and without regard to whether a drug is prescribed for medical/surgical or MHSUD benefits.

☒ No prohibited exclusions:
WAC 284-43-7080 (*including rule updates effective January 1, 2022, for gender affirming treatment*): A plan may not exclude MHSUD treatments or services for any of the reasons documented in WAC 284-43-7080.
☒ I certify that none of the plans in this rate filing apply exclusions prohibited by WAC 284-43-7080.

☒ I attest that, to the best of my knowledge, each of the plans otherwise satisfy the requirements under MHPAEA and Chapter 284-43 WAC, Subchapter K.

Actuary's Name & Designations: Janessa Sanchez, FSA, MAAA

Signature: Janessa Sanchez Digitally signed by Janessa Sanchez Date: 2025.05.14 00:26:24 -07'00'

Title: Manager, Actuarial Pricing

Contact Information: Janessa.sanchez@cambiahealth.com, (206) 332-5272

Date of Attestation: 5/14/2025

MHSUD Financial Requirement Parity Testing -- Summary

Issuer and Filing Information

Issuer Name:	BridgeSpan Health Company
HIOS Issuer ID:	53732
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
53732WA0790030	BridgeSpan Cascade Vital Gold	Pass	On Exchange
53732WA0790024	BridgeSpan Cascade Complete Gold	Pass	On Exchange
53732WA0790025	BridgeSpan Cascade Silver	Pass	On Exchange. This plan has $1 copays for the first 2 PCP visits and $30 copay for subsequent visits. PCP visits (both in person and virtual) have been projected separately for the first 2 and subsquent visits for MHP Testing.
53732WA0790025_(73)	BridgeSpan Cascade Silver (73)	Pass	On Exchange. This plan has $1 copays for the first 2 PCP visits and $30 copay for subsequent visits. PCP visits (both in person and virtual) have been projected separately for the first 2 and subsquent visits for MHP Testing.
53732WA0790025_(87)	BridgeSpan Cascade Silver (87)	Pass	On Exchange. This plan has $1 copays for the first 2 PCP visits and $10 copay for subsequent visits. PCP visits (both in person and virtual) have been projected separately for the first 2 and subsquent visits for MHP Testing.
53732WA0790025_(94)	BridgeSpan Cascade Silver (94)	Pass	On Exchange. This plan has $1 copays for the first 2 PCP visits and $5 copay for subsequent visits. PCP visits (both in person and virtual) have been projected separately for the first 2 and subsquent visits for MHP Testing.
53732WA0790026	BridgeSpan Cascade Bronze	Pass	On Exchange. This plan has $1 copays for the first 2 PCP visits and $50 copay for subsequent visits. PCP visits (both in person and virtual) have been projected separately for the first 2 and subsquent visits for MHP Testing.

MHSUD Financial Requirement Parity Testing Testing Data Information

Instructions: Provide information about the data used to test parity.

Item #	Task
1	Identify the data source used to estimate allowed claims for the purpose of MHSUD financial requirement parity testing. This refers to the allowed amounts by service entered in Part 1 of each plan's testing worksheet.
	Cambia Washington individual market claims data.
2	Identify the period (i.e., date range) represented in the data.
	Incurred from 1/1/2024 to 12/31/2024, paid through 3/31/2025
3	Address the credibility of the data used in your MHSUD financial requirement parity testing.
	Cambia Washington individual market claims data are considered fully credible for MHSUD parity testing.
4	Identify whether the data is consistent with the data in your URRT. If not, explain why the data is not consistent, why the data is appropriate, and summarize material adjustments made to the data.
	The data is consistant with the data used in the rate development and URRT.
5	If data other than State of Washington plan data was used, what is the source, and why is it appropriate for MHSUD financial requirement parity testing purposes?
	Only Washington plan data was used.

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

Instructions

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

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

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

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

Notes column: Explain any differences by plan.

Mapping Table

A. Service Description	B. Mapped Benefit Classification for MHSUD Parity Testing	C. Mapped Benefit in corresponding Benefit Components document (If applicable)	Notes
Primary Care Visit to Treat an Injury or Illness	Outpatient - Office Visits	Primary Care Visit to Treat an Injury or Illness	Some plans do not use the outpatient office visit subclassification.
Specialist Visit	Outpatient - Office Visits	Specialist Visit	Some plans do not use the outpatient office visit subclassification.
Urgent Care	Outpatient - Office Visits	Urgent Care	Some plans do not use the outpatient office visit subclassification.
Preventive Care/Screening/Immunization (OV)	Outpatient - Office Visits	Preventive Care/Screening/Immunization	Some plans do not use the outpatient office visit subclassification.
Virtual Visits	Outpatient - Office Visits	Virtural Care - Telehealth	Some plans do not use the outpatient office visit subclassification.
Hospital / Surgery OP	Outpatient - All Other	Outpatient Surgery Physician/Surgical Services	
Imaging (CT/PET Scans, MRIs)	Outpatient - All Other	Imaging (CT/PET Scans, MRIs)	
X-rays and Diagnostic Imaging	Outpatient - All Other	X-rays and Diagnostic Imaging	
	Outpatient - All Other	Laboratory Outpatient and Professional Services	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient - All Other	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Acupunture/Spinal Manipulations	Outpatient - All Other	Acupunture	
	Outpatient - All Other	Chiropractic Care	
Emergency Transportation	Outpatient - All Other	Emergency Transportation	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Outpatient - All Other	Rehabilitative Occupational and Rehabilitative Physical Therapy	
	Outpatient - All Other	Rehabilitative Speech Therapy	
Reproductive Healthcare	Outpatient - All Other	Reproductive Health Care	Includes Diagnostic and Supplemental Breast Examinations
Virtual Care (Store and Forward)	Outpatient - All Other	Virtual Care - Store & Forward	
Hearing Aids	Outpatient - All Other	Hearing Aids	
Preventive Care for Specified Chronic Conditions	Outpatient - All Other	Preventive Care for Specified Chronic Conditions	Not applicable for Cascade Plans
Pediatric Dental - Class 1 Preventive	Outpatient - All Other	Dental Check-Up for Children	Broken out for plans that include Pediatric Dental
Pediatric Dental - Class 2 Basic	Outpatient - All Other	Basic Dental Care – Child	Broken out for plans that include Pediatric Dental
Pediatric Dental - Class 3 Major	Outpatient - All Other	Major Dental Care – Child	Broken out for plans that include Pediatric Dental
	Outpatient - All Other	Orthodontia – Child	
Preventive Care/Screening/Immunization (Other)	Outpatient - All Other	Routine Eye Exam for Children	
	Outpatient - All Other	Eye Glasses for Children	
	Outpatient - All Other	Well Baby Visits and Care	
	Outpatient - All Other	Diabetes Education	
	Outpatient - All Other	Embedded IAP	
	Outpatient - All Other	Abortion for Which Public Funding is Prohibited	
Other	Outpatient - All Other	Skilled Nursing Facility	
	Outpatient - All Other	Infertility Treatment	
	Outpatient - All Other	Cosmetic Surgery	
	Outpatient - All Other	Routine Foot Care	
	Outpatient - All Other	Diabetes Care Management	
	Outpatient - All Other	Inherited Metabolic Disorder - PKU	
	Outpatient - All Other	Gender Affirming Care	
	Outpatient - All Other	Travel Immunizations	
	Outpatient - All Other	Orthognathic Surgery	
	Outpatient - All Other	Palliative Care (Home Health Aide Care)	
	Outpatient - All Other	Repair of Teeth Due to Injury	

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Vital Gold — *<<<<This will auto populate from summary sheet macro*
Plan ID: 53732WA0790030 — *<<<<This will auto populate from summary sheet macro*
CSR Variant Description: — *<<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.*

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: **Pass**

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

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

Testing Options

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

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

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

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

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

Click>>>>> Home

Errors found:	0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

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

Number of Rows: 21

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

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share *(If true, enter "x")*
Primary Care Visit to Treat an Injury or Illness	Copay	$705.73	$0.00	$15.00	N/A	$8,800.00	
Specialist Visit	Copay	$545.04	$0.00	$40.00	N/A	$8,800.00	
Urgent Care	Copay	$37.90	$0.00	$35.00	N/A	$8,800.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$124.06	$0.00	N/A	N/A	$8,800.00	x
Virtual Visits	Copay	$163.61	$0.00	$15.00	N/A	$8,800.00	
Hospital / Surgery OP	Copay	$2,573.29	$1,900.00	$75.00	N/A	$8,800.00	
Imaging (CT/PET Scans, MRIs)	Copay	$177.40	$1,900.00	$300.00	N/A	$8,800.00	
X-rays and Diagnostic Imaging	Copay	$485.14	$0.00	$30.00	N/A	$8,800.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay	$1,244.20	$1,900.00	$350.00	N/A	$8,800.00	
Hearing Aids	Coinsurance	$0.02	$0.00	N/A	20%	$8,800.00	
Acupunture/Spinal Manipulations	Copay	$43.53	$0.00	$15.00	N/A	$8,800.00	
Emergency Transportation	Copay	$33.36	$0.00	$375.00	N/A	$8,800.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay	$207.16	$0.00	$25.00	N/A	$8,800.00	
Reproductive Healthcare	Covered in Full	$28.15	$0.00	N/A	N/A	$8,800.00	x
Virtual Care (Store and Forward)	Copay	$0.29	$0.00	$15.00	N/A	$8,800.00	
Preventive Care/Screening/Immunization (Other)	Covered in Full	$331.90	$0.00	N/A	N/A	$8,800.00	x
Other	Deductible and	$1,962.63	$1,900.00	N/A	20%	$8,800.00	
Home Health	Copay	$89.47	$0.00	$15.00	N/A	$8,800.00	
Outpatient Hospice	Copay	$5.21	$0.00	$15.00	N/A	$8,800.00	
Outpatient Lab	Copay	$88.60	$0.00	$30.00	N/A	$8,800.00	
Skilled Nursing Facility	Copay	$11.20	$1,900.00	$350.00	N/A	$8,800.00	
Total Row		$8,857.89					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	N/A	$1,900.00	Pass
Copayment	$15.00	$75.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$8,800.00	$8,800.00	Pass
Overall			Pass

Enter Footnotes
xx

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

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

Deductible	$5,968.73	67.38%	OP INN Deductible
Copayment	$6,411.13	72.38%	OP INN Copayment
Coinsurance	$1,962.65	22.16%	Fail
OOPM	$8,857.89	100.00%	OP INN OOPM
Total Projected	$8,857.89		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$0.00	$2,889.16	32.62%	$0.00	
$1,900.00	$5,968.73	67.38%	$1,900.00	
Total	$8,857.89	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	$1,007.85	15.72%	$15.00	
$25.00	$207.16	3.23%	$25.00	
$30.00	$573.74	8.95%	$30.00	
$35.00	$37.90	0.59%	$35.00	
$40.00	$545.04	8.50%	$40.00	
$75.00	$2,573.29	40.14%	$75.00	
$300.00	$177.40	2.77%		
$350.00	$1,255.40	19.58%		
$375.00	$33.36	0.52%		
Total	$6,411.13	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
	$1,962.65	100.00%	20%	
	$0.00			
	$0.00			
	$0.00			
Total	$1,962.65	100.00%		

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$8,800.00	$8,857.89	100.00%	$8,800.00	
	$0.00			
	$0.00			
	$0.00			
Total	$8,857.89	100.00%		

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

Benefit Classification: (3) Outputient, In-Network (OP INN)

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Complete Gold <<<<This will auto populate from summary sheet macro
Plan ID: 53732WA0790024 <<<<This will auto populate from summary sheet macro
CSR Variant Description: <<<<If the abm is a CSR variant, identify it here. Otherwise, leave the field blank.

Click>>>> Home

Errors found: 0

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: Pass

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

Move to IP INN	Move to IP OON	Move to OP INN	Move to OP OV INN	Move to OP AD INN
Move to IP NON	Move to IP OV OON	Move to OP AD OON	Move to ER	Move to SK

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

Testing Options

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

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

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

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

Classification	Outpatient	OP
Network (in/Out)	In-Network	INN
Classification Code		OP INN
Table Name		ISS_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) (If True, enter "x")	No Cost-Share (If True, enter "x")
Primary Care Visit to Treat an Injury or Illness	Copay	$44,465.27	$0.00	$15.00	N/A	$7,000.00	
Specialist Visit	Copay	$34,337.33	$0.00	$40.00	N/A	$7,000.00	
Urgent Care	Copay	$2,397.67	$0.00	$35.00	N/A	$7,000.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$7,810.33	$0.00	N/A	N/A	$7,000.00	x
Virtual Visits	Copay	$33,355.33	$0.00	$15.00	N/A	$7,000.00	
Hospital / Surgery OP	Copay	$162,117.67	$0.00	$75.00	N/A	$7,000.00	
Imaging (CT/PET Scans, MRIs)	Copay	$11,176.00	$1,000.00	$300.00	N/A	$7,000.00	
X-rays and Diagnostic Imaging	Copay	$30,563.84	$0.00	$30.00	N/A	$7,000.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay	$78,184.73	$1,000.00	$200.00	N/A	$7,000.00	
Imaging (Ultrasound)	Coinsurance	$0.00	$0.00	N/A	20%	$7,000.00	
Preventive Panel Manipulation	Copay	$2,784.84	$0.00	$15.00	N/A	$7,000.00	
Emergency Treatment (ER)	Copay	$2,163.45	$0.00	$275.00	N/A	$7,000.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay	$13,052.21	$0.00	$30.00	N/A	$7,000.00	
Reproductive Healthcare	Covered in Full	$1,773.33	$0.00	N/A	N/A	$7,000.00	x
Virtual Care (Store and Forward)	Copay	$19.53	$0.00	$15.00	N/A	$7,000.00	
Preventive Care/Screening/Immunization (Other)	Covered in Full	$20,509.01	$0.00	N/A	N/A	$7,000.00	x
Other	Deductible and	$123,646.90	$1,000.00	N/A	20%	$7,000.00	
Home Health	Copay	$5,626.43	$0.00	$15.00	N/A	$7,000.00	
Outpatient Hospice	Copay	$318.61	$0.00	$15.00	N/A	$7,000.00	
Outpatient Lab	Copay	$5,193.00	$0.00	$20.00	N/A	$7,000.00	
Skilled Nursing Facility	Copay	$756.37	$1,000.00	$150.00	N/A	$7,000.00	
Total Row		$558,046.92					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	N/A	$1,000.00	Pass
Copayment	$15.00	$75.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,000.00	$7,000.00	Pass
Overall			Pass

"If not applicable, enter "N/A"

Enter Footnotes
--

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

Deductible	$376,029.74	67.38%	OP INN Deductible
Copayment	$403,901.47	72.38%	OP INN Copayment
Coinsurance	$123,646.90	22.16%	Fail
OOPM	$558,046.92	100.00%	OP INN OOPM
Total Projected	$558,046.92		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$0.00	$182,017.18	32.62%	$0.00	
$1,000.00	$376,029.74	67.38%	$1,000.00	
Total	$558,046.92	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	$62,494.45	15.72%	$15.00	
$20.00	$5,162.04	1.30%	$20.00	
$30.00	$43,614.85	10.80%	$30.00	
$35.00	$2,397.67	0.56%	$35.00	
$40.00	$34,337.33	8.64%	$40.00	
$75.00	$162,117.66	40.14%	$75.00	
$200.00	$11,176.00	2.77%		
$250.00	$79,080.07	19.58%		
$275.00	$2,101.44	0.52%		
Total	$403,901.47	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
	$123,646.90	100.00%	20%	
	$0.00			
	$0.00			
	$0.00			
Total	$123,646.90	100.00%		

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$7,000.00	$558,046.92	100.00%	$7,000.00	
	$0.00			
	$0.00			
	$0.00			
Total	$558,046.92	100.00%		

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Silver — *<<<<This will auto populate from summary sheet macro*
Plan ID: 53732WA0790025 — *<<<<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 T... D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All S	No	Yes			Pass		Pass
Outpatient - Office Visits Separate							

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

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

Click>>>>> Home

Errors found:	0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

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

Number of Rows: 25

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 (first 2 visits)	$20 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$26,454.45	$0.00	$1.00	N/A	$9,750.00	
Primary Care Visit to Treat an Injury or Illness (3+visits)	$20 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$57,527.94	$0.00	$20.00	N/A	$9,750.00	
Specialist Visit	Copay	$64,859.19	$0.00	$65.00	N/A	$9,750.00	
Urgent Care	Copay	$4,510.05	$0.00	$65.00	N/A	$9,750.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$14,763.38	$0.00	N/A	N/A	$9,750.00	x
Virtual Visits (PCP first 2 visits)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$4,720.64	$0.00	$1.00	N/A	$9,750.00	
Virtual Visits (PCP 3+ visits)	**$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)**	$10,265.51	$0.00	$20.00	N/A	$9,750.00	
Virtual Visits (SPC)	Copay	$4,483.63	$0.00	$65.00	N/A	$9,750.00	
Hospital / Surgery OP	Copay	$306,221.75	$2,500.00	$200.00	N/A	$9,750.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$21,110.98	$2,500.00	N/A	30%	$9,750.00	
X-rays and Diagnostic Imaging	Copay	$57,731.33	$0.00	$65.00	N/A	$9,750.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay	$148,060.04	$2,500.00	$600.00	N/A	$9,750.00	
Hearing Aids	Coinsurance	$1.86	$0.00	N/A	30%	$9,750.00	
Acupunture/Spinal Manipulations	Copay	$5,179.78	$0.00	$20.00	N/A	$9,750.00	
Emergency Transportation	Copay	$3,969.41	$0.00	$375.00	N/A	$9,750.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay	$24,652.28	$0.00	$40.00	N/A	$9,750.00	
Reproductive Healthcare	Covered in Full	$3,349.37	$0.00	N/A	N/A	$9,750.00	x
Virtual Care (Store and Forward)	**$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)**	$11.02	$0.00	$1.00	N/A	$9,750.00	
Virtual Care (Store and Forward)	**$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)**	$23.97	$0.00	$20.00	N/A	$9,750.00	
Preventive Care/Screening/Immunization (Other)	Covered in Full	$39,495.62	$0.00	N/A	N/A	$9,750.00	x
Other	Deductible and Coinsurance	$233,553.40	$2,500.00	N/A	30%	$9,750.00	
Home Health	Copay	$10,646.60	$0.00	$30.00	N/A	$9,750.00	
Outpatient Hospice	Copay	$620.32	$0.00	$30.00	N/A	$9,750.00	
Outpatient Lab	Copay	$10,543.78	$0.00	$40.00	N/A	$9,750.00	
Skilled Nursing Facility	Copay	$1,332.32	$2,500.00	$800.00	N/A	$9,750.00	
Total Row		$1,054,088.62					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	N/A	$2,500.00	Pass
Copayment	$30.00	$200.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$9,750.00	$9,750.00	Pass
Overall			Pass

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

Enter Footnotes
xx

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

Deductible	$710,278.49	67.38%	OP INN Deductible
Copayment	$741,814.01	70.37%	OP INN Copayment
Coinsurance	$254,666.24	24.16%	Fail
OOPM	$1,054,088.62	100.00%	OP INN OOPM
Total Projected	$1,054,088.62		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$0.00	$343,810.14	32.62%	$0.00	
$2,500.00	$710,278.49	67.38%	$2,500.00	
Total	$1,054,088.62	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
$1.00	$31,186.11	4.20%	$1.00	
$20.00	$72,997.20	9.84%	$20.00	
$30.00	$11,266.92	1.52%	$30.00	
$40.00	$35,196.06	4.74%	$40.00	
$65.00	$131,584.20	17.74%	$65.00	
$200.00	$306,221.75	41.28%	$200.00	
$375.00	$3,969.41	0.54%		
$600.00	$148,060.04	19.96%		
$800.00	$1,332.32	0.18%		
Total	$741,814.01	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
	$254,666.24	100.00%	30%	
	$0.00			
	$0.00			
	$0.00			
Total	$254,666.24	100.00%		

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$9,750.00	$1,054,088.62	100.00%	$9,750.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,054,088.62	100.00%		

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Silver (73) *<<<<This will auto populate from summary sheet macro*
Plan ID: 53732WA0790025_(73) *<<<<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 T D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All S	No	Yes			Pass		Pass
Outpatient - Office Visits Separate							

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

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

Click>>>>> Home

Errors found:	0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

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

Number of Rows: 25

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 (first 2 visits)	$30 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$26,454.45	$0.00	$1.00	N/A	$7,950.00	
Primary Care Visit to Treat an Injury or Illness (3+visits)	$30 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$57,527.94	$0.00	$20.00	N/A	$7,950.00	
Specialist Visit	Copay	$64,859.19	$0.00	$65.00	N/A	$7,950.00	
Urgent Care	Copay	$4,510.05	$0.00	$65.00	N/A	$7,950.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$14,763.38	$0.00	N/A	N/A	$7,950.00	x
Virtual Visits (PCP first 2 visits)	$30 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$4,720.64	$0.00	$1.00	N/A	$7,950.00	
Virtual Visits (PCP 3+ visits)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$10,265.51	$0.00	$20.00	N/A	$7,950.00	
Virtual Visits (SPC)	Copay	$4,483.63	$0.00	$65.00	N/A	$7,950.00	
Hospital / Surgery OP	Copay	$306,221.75	$2,500.00	$200.00	N/A	$7,950.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$21,110.98	$2,500.00	N/A	30%	$7,950.00	
X-rays and Diagnostic Imaging	Copay	$57,731.33	$0.00	$65.00	N/A	$7,950.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay	$148,060.04	$2,500.00	$600.00	N/A	$7,950.00	
Hearing Aids	Coinsurance	$1.86	$0.00	N/A	30%	$7,950.00	
Acupunture/Spinal Manipulations	Copay	$5,179.78	$0.00	$20.00	N/A	$7,950.00	
Emergency Transportation	Copay	$3,969.41	$0.00	$325.00	N/A	$7,950.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay	$24,652.28	$0.00	$40.00	N/A	$7,950.00	
Reproductive Healthcare	Covered in Full	$3,349.37	$0.00	N/A	N/A	$7,950.00	x
Virtual Care (Store and Forward)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$11.02	$0.00	$1.00	N/A	$7,950.00	
Virtual Care (Store and Forward)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$23.97	$0.00	$20.00	N/A	$7,950.00	
Preventive Care/Screening/Immunization (Other)	Covered in Full	$39,495.62	$0.00	N/A	N/A	$7,950.00	x
Other	Deductible and Coinsurance	$233,553.40	$2,500.00	N/A	30%	$7,950.00	
Home Health	Copay	$10,646.60	$0.00	$30.00	N/A	$7,950.00	
Outpatient Hospice	Copay	$620.32	$0.00	$30.00	N/A	$7,950.00	
Outpatient Lab	Copay	$10,543.78	$0.00	$40.00	N/A	$7,950.00	
Skilled Nursing Facility	Copay	$1,332.32	$2,500.00	$800.00	N/A	$7,950.00	
Total Row		$1,054,088.62					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	N/A	$2,500.00	Pass
Copayment	$30.00	$200.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$7,950.00	$7,950.00	Pass
Overall			Pass

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

Enter Footnotes
xx

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

Deductible	$710,278.49	67.38%	OP INN Deductible
Copayment	$741,814.01	70.37%	OP INN Copayment
Coinsurance	$254,666.24	24.16%	Fail
OOPM	$1,054,088.62	100.00%	OP INN OOPM
Total Projected	$1,054,088.62		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$0.00	$343,810.14	32.62%	$0.00	
$2,500.00	$710,278.49	67.38%	$2,500.00	
Total	$1,054,088.62	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
$1.00	$31,186.11	4.20%	$1.00	
$20.00	$72,997.20	9.84%	$20.00	
$30.00	$11,266.92	1.52%	$30.00	
$40.00	$35,196.06	4.74%	$40.00	
$65.00	$131,584.20	17.74%	$65.00	
$200.00	$306,221.75	41.28%	$200.00	
$325.00	$3,969.41	0.54%		
$600.00	$148,060.04	19.96%		
$800.00	$1,332.32	0.18%		
Total	$741,814.01	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
	$254,666.24	100.00%	30%	
	$0.00			
	$0.00			
	$0.00			
Total	$254,666.24	100.00%		

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$7,950.00	$1,054,088.62	100.00%	$7,950.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,054,088.62	100.00%		

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Silver (87) *<<<<This will auto populate from summary sheet macro*
Plan ID: 53732WA0790025_(87) *<<<<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 1 D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All S	No	Yes			Pass		Pass
Outpatient - Office Visits Separate							

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

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

Click>>>>> Home

Errors found:	0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

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

Number of Rows: 25

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 (first 2 visits)	$5 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$26,454.45	$0.00	$1.00	N/A	$2,850.00	
Primary Care Visit to Treat an Injury or Illness (3+visits)	$5 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$57,527.94	$0.00	$5.00	N/A	$2,850.00	
Specialist Visit	Copay	$64,859.19	$0.00	$30.00	N/A	$2,850.00	
Urgent Care	Copay	$4,510.05	$0.00	$30.00	N/A	$2,850.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$14,763.38	$0.00	N/A	N/A	$2,850.00	x
Virtual Visits (PCP first 2 visits)	$5 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$4,720.64	$0.00	$1.00	N/A	$2,850.00	
Virtual Visits (PCP 3+ visits)	$5 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$10,265.51	$0.00	$5.00	N/A	$2,850.00	
Virtual Visits (SPC)	Copay	$4,483.63	$0.00	$30.00	N/A	$2,850.00	
Hospital / Surgery OP	Copay	$306,221.75	$750.00	$120.00	N/A	$2,850.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$21,110.98	$750.00	N/A	20%	$2,850.00	
X-rays and Diagnostic Imaging	Copay	$57,731.33	$0.00	$40.00	N/A	$2,850.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay	$148,060.04	$750.00	$325.00	N/A	$2,850.00	
Hearing Aids	Coinsurance	$1.86	$0.00	N/A	20%	$2,850.00	
Acupunture/Spinal Manipulations	Copay	$5,179.78	$0.00	$5.00	N/A	$2,850.00	
Emergency Transportation	Copay	$3,969.41	$0.00	$175.00	N/A	$2,850.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay	$24,652.28	$0.00	$20.00	N/A	$2,850.00	
Reproductive Healthcare	Covered in Full	$3,349.37	$0.00	N/A	N/A	$2,850.00	x
Virtual Care (Store and Forward)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$11.02	$0.00	$1.00	N/A	$2,850.00	
Virtual Care (Store and Forward)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$23.97	$0.00	$20.00	N/A	$2,850.00	
Preventive Care/Screening/Immunization (Other)	Covered in Full	$39,495.62	$0.00	N/A	N/A	$2,850.00	x
Other	Deductible and Coinsurance	$233,553.40	$750.00	N/A	20%	$2,850.00	
Home Health	Copay	$10,646.60	$0.00	$10.00	N/A	$2,850.00	
Outpatient Hospice	Copay	$620.32	$0.00	$10.00	N/A	$2,850.00	
Outpatient Lab	Copay	$10,543.78	$0.00	$20.00	N/A	$2,850.00	
Skilled Nursing Facility	Copay	$1,332.32	$750.00	$425.00	N/A	$2,850.00	
Total Row		$1,054,088.62					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	N/A	$750.00	Pass
Copayment	$10.00	$120.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,850.00	$2,850.00	Pass
Overall			Pass

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

Enter Footnotes
xx

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

Deductible	$710,278.49	67.38%	OP INN Deductible
Copayment	$741,814.01	70.37%	OP INN Copayment
Coinsurance	$254,666.24	24.16%	Fail
OOPM	$1,054,088.62	100.00%	OP INN OOPM
Total Projected	$1,054,088.62		

Step 2 Predominant Level

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

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

Deductible	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$0.00	$343,810.14	32.62%	$0.00	
$750.00	$710,278.49	67.38%	$750.00	
Total	$1,054,088.62	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
$1.00	$31,186.11	4.20%	$1.00	
$5.00	$72,973.23	9.84%	$5.00	
$10.00	$11,266.92	1.52%	$10.00	
$20.00	$35,220.02	4.75%	$20.00	
$30.00	$73,852.88	9.96%	$30.00	
$40.00	$57,731.33	7.78%	$40.00	
$120.00	$306,221.75	41.28%	$120.00	
$175.00	$3,969.41	0.54%		
$325.00	$148,060.04	19.96%		
$425.00	$1,332.32	0.18%		
Total	$741,814.01	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			
	$0.00			
	$0.00			
	$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
$2,850.00	$1,054,088.62	100.00%	$2,850.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,054,088.62	100.00%		

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Silver (94) <<<<This will auto populate from summary sheet macro
Plan ID: 53732WA0790025_(94) <<<<This will auto populate from summary sheet macro
CSR Variant Description: <<<<If the plan is a CSR variant, identify it here. Otherwise, leave the field blank.

PARITY PASS/FAIL RESULTS, BY BENEFIT CLASSIFICATION

Overall Result: Pass

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

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

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

Testing Options

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

Column Options
Update Columns
Hide/Unhide All Columns

No Errors found?
TRUE

Results By Benefit Classification

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

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

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

Click>>>> Home

Errors found: 0

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

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

Classification	Outpatient	OP
Network (in/Out)	In-Network	INN
Classification Code		OP INN
Table Name		SG_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	$63,982.39	$0.00	$15.00	N/A	$2,400.00	
Specialist Visit	Copay	$64,850.19	$0.00	$15.00	N/A	$2,400.00	
Urgent Care	Copay	$4,510.09	$0.00	$15.00	N/A	$2,400.00	
Preventive Care/Screening/Immunization (NA)	Covered in Full	$14,763.38	$0.00	N/A	N/A	$2,400.00	x
Virtual Visits	Copay	$19,469.79	$0.00	21.00	N/A	$2,400.00	
Hospital / Surgery OP	Copay	$206,212.77	$0.00	$25.00	N/A	$2,400.00	
Imaging (CT/PET Scans, MRIs)	Coinsurance	$31,330.98	$0.00	N/A	15%	$2,400.00	
X-rays and Diagnostic Imaging	Copay	$17,791.33	$0.00	$10.00	N/A	$2,400.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Copay	$148,360.64	$0.00	$100.00	N/A	$2,400.00	
Hearing Aids	Coinsurance	$1.86	$0.00	N/A	15%	$2,400.00	
Acupuncture/Spinal Manipulations	Copay	$1,179.78	$0.00	$1.00	N/A	$2,400.00	
Emergency Transportation	Copay	$1,969.41	$0.00	$75.00	N/A	$2,400.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy	Copay	$24,462.28	$0.00	$5.00	N/A	$2,400.00	
Reproductive Healthcare	Covered in Full	$1,169.37	$0.00	N/A	N/A	$2,400.00	x
Virtual Care (Store and Forward)	Copay	$24.09	$0.00	$1.00	N/A	$2,400.00	
Preventive Care/Screening/Immunization (Other)	Covered in Full	$39,495.62	$0.00	N/A	N/A	$2,400.00	x
Other	Coinsurance	$233,353.40	$0.00	N/A	15%	$2,400.00	
Home Health	Copay	$19,146.40	$0.00	$1.00	N/A	$2,400.00	
Outpatient Hospice	Copay	$820.23	$0.00	$1.00	N/A	$2,400.00	
Outpatient Lab	Copay	$10,143.79	$0.00	$1.00	N/A	$2,400.00	
Skilled Nursing Facility	Copay	$1,837.23	$0.00	$100.00	N/A	$2,400.00	
Total Raw		$1,054,088.62					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares	Predominant Level for	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$5.00	$25.00	Pass
Coinsurance	N/A	Fail	Pass
OOPM	$2,400.00	$2,400.00	Pass
Overall			**Pass**

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

Enter Footnotes
**

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

Deductible	$0.00	0.00%	Fail
Copayment	$741,914.03	70.37%	OP INN Copayment
Coinsurance	$254,668.24	24.16%	Fail
OOPM	$1,054,088.62	100.00%	OP INN OOPM
Total Projected	$1,054,088.62		

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
	$1,054,088.62	100.00%	$0.00	
Total	$1,054,088.62	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
	$108,666.94	14.65%	$1.00	
100%				
$5.00	$46,462.98	6.26%	$5.00	
$10.00	$127,320.53	17.16%	$15.00	
$25.00	$306,223.75	41.28%	$25.00	
$75.00	$3,908.43	0.54%		
$100.00	$149,302.38	20.14%		
Total	$741,914.03	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
	$254,668.24	100.00%	15%	
	$0.00			
	$0.00			
	$0.00			
Total	$254,668.24	100.00%		

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

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$2,400.00	$1,054,088.62	100.00%	$2,400.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,054,088.62	100.00%		

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

Issuer / Market: BridgeSpan Health Company
Market: Individual

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

PLAN INFORMATION

Plan Name: BridgeSpan Cascade Bronze — *<<<<This will auto populate from summary sheet macro*
Plan ID: 53732WA0790026 — *<<<<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 T D1. In-Network	D2. Out-of-Network	E. Test Results
Inpatient	Yes	No			Pass		Pass
Outpatient							
Outpatient - All S							
Outpatient - Office Visits Separate							
	No	Yes			Pass		Pass
	No	Yes			Pass		Pass

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

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

Click>>>>> Home — Errors found: 0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

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

Classification	Outpatient - Office Visit	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 (OOPM)	No Cost-Share (If true, enter "x")
Primary Care Visit to Treat an Injury or Illness (first 2 visits)	$40 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$42,905.12	$0.00	$1.00	N/A	$10,150.00	
Primary Care Visit to Treat an Injury or Illness (3+visits)	$40 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$93,301.62	$0.00	$40.00	N/A	$10,150.00	
Specialist Visit	$100 Subject to Deductible	$105,191.79	$6,000.00	$100.00	N/A	$10,150.00	
Urgent Care	Copay	$7,314.62	$0.00	$100.00	N/A	$10,150.00	
Preventive Care/Screening/Immunization (OV)	Covered in Full	$23,943.97	$0.00	N/A	N/A	$10,150.00	x
Virtual Visits (PCP first 2 visits)	$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$7,656.16	$0.00	$1.00	N/A	$10,150.00	
Virtual Visits (PCP 3+ visits)	**$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)**	**$16,649.10**	**$0.00**	**$40.00**	**N/A**	**$10,150.00**	
Virtual Visits (SPC)	**$100 Subject to Deductible**	**$7,271.78**	**$6,000.00**	**$100.00**	**N/A**	**$10,150.00**	
Total Row		$304,234.16					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

Financial Parity for (3a) Outpatient - Office Visits, In-Network (OP-OV INN)

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical / Surgical	MHSUD Financial Parity Result
Deductible	N/A	Fail	Pass
Copayment	$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
xx

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

Deductible	$112,463.57	36.97%	Fail
Copayment	$280,290.19	92.13%	OP-OV INN Copayment
Coinsurance	$0.00	0.00%	Fail
OOPM	$304,234.16	100.00%	OP-OV INN OOPM
Total Projected	$304,234.16		

Step 2 Predominant Level

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

Deductible	Allowed Claims	Portion	Predominant &	Error Checking
	$191,770.59	63.03%	$0.00	
	$112,463.57	36.97%		
Total	$304,234.16	100.00%		

Copayment ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different copayment amounts from smallest to largest.

Copayment	Allowed Claims	Portion	Predominant &	Error Checking
$1.00	$50,561.28	18.04%	$1.00	
$40.00	$109,950.72	39.23%	$40.00	
$100.00	$119,778.19	42.73%		
	$0.00			
Total	$280,290.19	100.00%		

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

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

OOPM ---- (3a) Outpatient - Office Visits, In-Network (OP-OV INN) — Errors found: 0
Applies to substantially all medical/surgical benefits in this classification.
ENTER different oopm amounts from smallest to largest.

OOPM	Allowed Claims	Portion	Predominant &	Error Checking
$10,150.00	$304,234.16	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$304,234.16	100.00%		

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

Click>>>>> Home — Errors found: 0

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

PART 1

COST SHARES FOR MEDICAL/SURGICAL BENEFITS, BY BENEFIT CLASSIFICATION

Benefit Classification (3b) Outpatient - All Other, In-Network (OP-AO INN)
Notes: *Use this table if you are separately testing outpatient office visits and all other outpatient services.*

Classification	Outpatient - All Other	OP-AO
Network (In/Out)	In-Network	INN
Classification Code	3b	OP-AO INN
Table Name		tbl_OPAOINN_P1

Number of Rows: 17

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

Service Description	Cost-Share Description	Plan Projected Allowed Amount	Deductible	Copayment	Coinsurance	Out-of-Pocket Maximum (OOPM)	No Cost-Share (If true, enter "x")
Hospital / Surgery OP	Deductible and Coinsurance	$496,645.36	$6,000.00	N/A	40%	$10,150.00	
Imaging (CT/PET Scans, MRIs)	Deductible and Coinsurance	$34,238.82	$6,000.00	N/A	40%	$10,150.00	
X-rays and Diagnostic Imaging	Deductible and Coinsurance	$93,631.48	$6,000.00	N/A	40%	$10,150.00	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Deductible and Coinsurance	$240,130.99	$6,000.00	N/A	40%	$10,150.00	
Hearing Aids	Coinsurance	$3.01	$0.00	N/A	40%	$10,150.00	
Acupunture/Spinal Manipulations	Copay	$8,400.83	$0.00	$40.00	N/A	$10,150.00	
Emergency Transportation	**Deductible and Coinsurance**	**$6,437.79**	**$6,000.00**	**N/A**	**40%**	**$10,150.00**	
Rehabilitative Occupational and Rehabilitative Physical Therapy	**Deductible and Coinsurance**	**$39,982.27**	**$6,000.00**	**N/A**	**40%**	**$10,150.00**	
Reproductive Healthcare	**Covered in Full**	**$5,432.18**	**$0.00**	**N/A**	**N/A**	**$10,150.00**	**x**
Virtual Care (Store and Forward)	**$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)**	**$17.87**	**$0.00**	**$1.00**	**N/A**	**$10,150.00**	
Virtual Care (Store and Forward)	**$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)**	**$39.49**	**$0.00**	**$40.00**	**N/A**	**$10,150.00**	
Preventive Care/Screening/Immunization (Other)	**Covered in Full**	**$64,055.93**	**$0.00**	**N/A**	**N/A**	**$10,150.00**	**x**
Other	**Deductible and Coinsurance**	**$378,788.28**	**$6,000.00**	**N/A**	**40%**	**$10,150.00**	
Home Health	**Copay**	**$17,267.17**	**$0.00**	**$50.00**	**N/A**	**$10,150.00**	
Outpatient Hospice	**Copay**	**$1,006.07**	**$0.00**	**$50.00**	**N/A**	**$10,150.00**	
Outpatient Lab	**Deductible and Coinsurance**	**$17,100.42**	**$6,000.00**	**N/A**	**40%**	**$10,150.00**	
Skilled Nursing Facility	**Deductible and**	**$2,160.83**	**$6,000.00**	**N/A**	**40%**	**$10,150.00**	
Total Row		$1,405,338.77					

PART 2

ANALYSIS OF MHSUD FINANCIAL REQUIREMENT PARITY, BY BENEFIT CLASSIFICATION

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

Cost-Share Type	MHSUD Cost Shares in Plan Design*	Predominant Level for Medical / Surgical	MHSUD Financial Parity Result
Deductible	$6,000.00	$6,000.00	Pass
Copayment	N/A	Fail	Pass
Coinsurance	40%	40%	Pass
OOPM	$10,150.00	$10,150.00	Pass
Overall			**Pass**

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

Enter Footnotes (as needed) about
xx

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

Deductible	$1,309,116.22	93.15%	OP-AO INN Deductible
Copayment	$26,731.43	1.90%	Fail
Coinsurance	$1,309,119.23	93.15%	OP-AO INN Coinsurance
OOPM	$1,405,338.77	100.00%	OP-AO INN OOPM
Total Projected	$1,405,338.77		

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
$0.00	$96,222.55	6.85%	$0.00	
$6,000.00	$1,309,116.22	93.15%	$6,000.00	
Total	$1,405,338.77	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
	$17.87	0.07%	$1.00	
	$8,440.32	31.57%	$40.00	
	$18,273.24	68.36%	$50.00	
	$0.00			
Total	$26,731.43	100.00%		

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%	$1,309,119.23	100.00%	40%	
	$0.00			
	$0.00			
	$0.00			
Total	$1,309,119.23	100.00%		

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

OOPM	Allowed Claims	Portion	Predominant & Smaller	Error Checking
$10,150.00	$1,405,338.77	100.00%	$10,150.00	
	$0.00			
	$0.00			
	$0.00			
Total	$1,405,338.77	100.00%		

WA Exhibit 1: Experience Data

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

2024 CLAIMS BUILD-UP, TOTAL

Incurred Month yyyymm	Member Months	Incurred & Paid Claims	IBNP for Incurred Claims	Ultimate Incurred Claims	Allowed Claims (without IBNP)	IBNP for Allowed Claims	Ultimate Allowed Claims
202401	600	$517,399	$835	$518,234	$536,716	$921	$537,638
202402	557	$505,153	$835	$505,987	$524,013	$921	$524,934
202403	536	$990,248	$835	$991,083	$1,027,219	$921	$1,028,141
202404	523	$598,001	$835	$598,836	$620,328	$921	$621,249
202405	513	$707,180	$835	$708,015	$733,583	$921	$734,504
202406	514	$490,512	$835	$491,346	$508,825	$921	$509,746
202407	499	$476,338	$835	$477,173	$494,122	$921	$495,044
202408	492	$881,798	$835	$882,633	$914,720	$921	$915,641
202409	479	$658,875	$835	$659,710	$683,474	$921	$684,395
202410	473	$688,312	$835	$689,146	$714,010	$921	$714,931
202411	468	$576,144	$835	$576,979	$597,655	$921	$598,576
202412	454	$821,062	$835	$821,897	$851,717	$921	$852,638
CY2024	6,108	$7,911,023	$10,017	$7,921,040	$8,206,383	$11,055	$8,217,439

2024 ULTIMATE ALLOWED CLAIMS, TOTAL

Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Capitation	Prescription Drug before Drug Rebates	Prescription Drug Rebates (Negative $)	Non-EHBs	Total EHB Allowed	Total Allowed (EHB + non-EHB)	Check Total Allowed (should be $0)
$62,565	$189,111	$63,960	$6,258	$0	$214,671	($47,827)	$1,073	$488,737	$489,810	$47,827
$61,087	$184,642	$62,449	$6,110	$0	$209,598	($47,827)	$1,048	$476,059	$477,107	$47,827
$119,646	$361,642	$122,313	$11,968	$0	$410,521	($47,827)	$2,052	$978,261	$980,313	$47,827
$72,295	$218,520	$73,907	$7,231	$0	$248,055	($47,827)	$1,240	$572,182	$573,422	$47,827
$85,475	$258,357	$87,380	$8,550	$0	$293,276	($47,827)	$1,466	$685,211	$686,677	$47,827
$59,320	$179,300	$60,642	$5,933	$0	$203,534	($47,827)	$1,017	$460,902	$461,919	$47,827
$57,609	$174,128	$58,893	$5,762	$0	$197,663	($47,827)	$988	$446,228	$447,216	$47,827
$106,554	$322,071	$108,929	$10,658	$0	$365,602	($47,827)	$1,828	$865,986	$867,814	$47,827
$79,644	$240,732	$81,419	$7,966	$0	$273,269	($47,827)	$1,366	$635,202	$636,568	$47,827
$83,197	$251,472	$85,052	$8,322	$0	$285,461	($47,827)	$1,427	$665,677	$667,104	$47,827
$69,657	$210,545	$71,210	$6,967	$0	$239,002	($47,827)	$1,195	$549,554	$550,749	$47,827
$99,222	$299,910	$101,434	$9,925	$0	$340,446	($47,827)	$1,702	$803,109	$804,811	$47,827
$956,269	$2,890,431	$977,586	$95,651	$0	$3,281,099	($573,928)	$16,402	$7,627,109	$7,643,511	$573,928

2024 CLAIMS BUILD-UP, PMPM

Incurred Month yyyymm	Member Months	Incurred & Paid Claims	IBNP for Incurred Claims	Ultimate Incurred Claims	Allowed Claims (without IBNP)	IBNP for Allowed Claims	Ultimate Allowed Claims
202401		$862.33	$1.39	$863.72	$894.53	$1.54	$896.06
202402		$906.92	$1.50	$908.42	$940.78	$1.65	$942.43
202403		$1,847.48	$1.56	$1,849.04	$1,916.45	$1.72	$1,918.17
202404		$1,143.41	$1.60	$1,145.00	$1,186.10	$1.76	$1,187.86
202405		$1,378.52	$1.63	$1,380.15	$1,429.99	$1.80	$1,431.78
202406		$954.30	$1.62	$955.93	$989.93	$1.79	$991.72
202407		$954.59	$1.67	$956.26	$990.23	$1.85	$992.07
202408		$1,792.27	$1.70	$1,793.97	$1,859.19	$1.87	$1,861.06
202409		$1,375.52	$1.74	$1,377.26	$1,426.88	$1.92	$1,428.80
202410		$1,455.20	$1.76	$1,456.97	$1,509.53	$1.95	$1,511.48
202411		$1,231.08	$1.78	$1,232.86	$1,277.04	$1.97	$1,279.01
202412		$1,808.51	$1.84	$1,810.35	$1,876.03	$2.03	$1,878.06
CY2024		$1,295.19	$1.64	$1,296.83	$1,343.55	$1.81	$1,345.36

2024 ULTIMATE ALLOWED CLAIMS, PMPM

Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Capitation	Prescription Drug before Drug Rebates	Prescription Drug Rebates (Negative $)	Non-EHBs	Total EHB Allowed	Total Allowed (EHB + non-EHB)	Check Total Allowed (should be $0)
$104.28	$315.18	$106.60	$10.43	$0.00	$357.78	($79.71)	$1.79	$814.56	$816.35	$79.71
$109.67	$331.49	$112.12	$10.97	$0.00	$376.30	($85.87)	$1.88	$854.68	$856.56	$85.87
$223.22	$674.70	$228.20	$22.33	$0.00	$765.90	($89.23)	$3.83	$1,825.11	$1,828.94	$89.23
$138.23	$417.82	$141.31	$13.83	$0.00	$474.29	($91.45)	$2.37	$1,094.04	$1,096.41	$91.45
$166.62	$503.62	$170.33	$16.67	$0.00	$571.69	($93.23)	$2.86	$1,335.69	$1,338.55	$93.23
$115.41	$348.83	$117.98	$11.54	$0.00	$395.98	($93.05)	$1.98	$896.70	$898.68	$93.05
$115.45	$348.95	$118.02	$11.55	$0.00	$396.12	($95.85)	$1.98	$894.25	$896.23	$95.85
$216.57	$654.62	$221.40	$21.66	$0.00	$743.09	($97.21)	$3.71	$1,760.13	$1,763.85	$97.21
$166.27	$502.57	$169.98	$16.63	$0.00	$570.50	($99.85)	$2.85	$1,326.10	$1,328.95	$99.85
$175.89	$531.65	$179.81	$17.59	$0.00	$603.51	($101.11)	$3.02	$1,407.35	$1,410.37	$101.11
$148.84	$449.88	$152.16	$14.89	$0.00	$510.69	($102.20)	$2.55	$1,174.26	$1,176.81	$102.20
$218.55	$660.59	$223.42	$21.86	$0.00	$749.88	($105.35)	$3.75	$1,768.96	$1,772.71	$105.35
$156.56	$473.22	$160.05	$15.66	$0.00	$537.18	($93.96)	$2.69	$1,248.71	$1,251.39	$93.96

Comments

The formulas above do not allow for the proper treatment of rebates. In order for column T to be 0, column S would have to exclude rebates. We have left the original formulas in tact.

WA Exhibit 2: Overall Actual to Expected Experience Reporting and Analysis

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Actual-to-Expected Experience

		2024, TOTAL				2024, PMPM			2024, % of PREMIUM		
Line Item	Description	ACTUAL EXPERIENCE (A)	PROJECTED (i.e., Expected; E)	A:E - 1	A - E	ACTUAL EXPERIENCE (A)	PROJECTED (i.e., Expected; E)	A:E - 1	ACTUAL EXPERIENCE (A)	PROJECTED (i.e., Expected; E)	A - E
a	Member Months (MM)	6,108	13,104	-53.4%							
b	Premium	$4,524,562	$9,618,561	-53.0%		$740.76	$734.02	0.9%			
c	Allowed Claims	$8,217,439	$10,251,541	-19.8%		$1,345.36	$782.32	72.0%	181.6%	106.6%	75.0%
d	Incurred Claims	$7,347,110	$8,825,282	-16.7%		$1,202.87	$673.48	78.6%	162.4%	91.8%	70.6%
e	Cost Sharing Reduction (CSR) Amounts	$136,681	$193,796	-29.5%		$22.38	$14.79	51.3%	3.0%	2.0%	1.0%
f	Risk Adjustment Transfer Amounts	$2,120,570	$473,252	348.1%		$347.18	$36.12	861.3%	46.9%	4.9%	41.9%
g	Administrative Expense	$390,156	$678,109	-42.5%		$63.88	$51.75	23.4%	8.6%	7.1%	1.6%
h	Taxes and Fees	$101,395	$211,608	-52.1%		$16.60	$16.15	2.8%	2.2%	2.2%	0.0%
i	Profit Margin (a.k.a. Profit & Risk Load)	($1,193,528)	$336,650	-454.5%		($195.40)	$25.69	-860.6%	-26.4%	3.5%	-29.9%
j	Paid-to-Allowed Ratios	89.4%	86.1%	3.9%	3.3%						

Profit Reconciliation

Calculate profit using PMPMs from the table above	($195.40)	$28.76
Difference (should be close to $0)	$0.00	$3.07

Loss Ratios

Simple Loss Ratio (=Incurred Claims / Premium)	162.4%	91.8%	70.6%
Indicated Rate Change Required, if only based on A:E simple loss ratio	77.0%		
Risk Adjusted Loss Ratio (=Incurred Claims / (Premium + Risk Adjustment Transfer))	110.6%	87.4%	23.1%
Indicated Rate Change Required, if only based on A:E risk adjusted loss ratio	26.4%		

Comments

Line Item	Comments

WA Exhibit 3: Essential Health Benefit (EHB) Trend Reporting and Analysis by Benefit Category, Frequency and Unit Cost

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

DATA -- EHB Allowed Claims

EXPERIENCE -- 2022

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	188.85	$6,361.63	$100.11
Outpatient Hospital	Services	6,787.01	$426.74	$241.36
Professional	Services	14,181.18	$105.92	$125.17
Prescription Drug	Days Filled	406,427.60	$4.63	$156.91
Total				$623.56

EXPERIENCE -- 2023

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	408.57	$5,697.37	$193.98
Outpatient Hospital	Services	9,905.41	$520.48	$429.63
Professional	Services	16,030.42	$121.21	$161.93
Prescription Drug	Days Filled	452,426.87	$5.87	$221.48
Total				$1,007.02

EXPERIENCE -- 2024

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	276.34	$6,798.56	$156.56
Outpatient Hospital	Services	8,812.02	$644.42	$473.22
Professional	Services	17,475.58	$109.90	$160.05
Prescription Drug	Days Filled	554,261.01	$11.63	$537.18
Total				$1,327.01

PROJECTED (i.e., EXPECTED) -- 2026

URRT w1 Benefit Category	Frequency Units	Units per 1,000	Unit Cost	EHB Cost PMPM
Inpatient Hospital	Days	293.86	$7,495.42	$183.55
Outpatient Hospital	Services	9,370.65	$710.47	$554.80
Professional	Services	18,583.42	$121.17	$187.64
Prescription Drug	Days Filled	589,397.87	$12.82	$629.79
Total				$1,555.78

TRENDS -- EHB Allowed Claims

EXPERIENCE TREND -- 2022 to 2023

				Unit Cost Components			
Service	Total EHB Cost	Utilization	Unit Cost	Service Mix / Intensity	Reimbursement	Unit Cost	Check
Inpatient Hospital	93.76%	116.35%	-10.44%	-13.61%	3.67%	-10.44%	TRUE
Outpatient Hospital	78.00%	45.95%	21.97%	17.96%	3.40%	21.97%	TRUE
Professional	29.36%	13.04%	14.44%	12.38%	1.83%	14.44%	TRUE
Prescription Drug	41.15%	11.32%	26.80%	11.78%	13.44%	26.80%	TRUE
Total	**61.496%**						

EXPERIENCE TREND -- 2023 to 2024

				Unit Cost Components			
Service	Total EHB Cost	Utilization	Unit Cost	Service Mix / Intensity	Reimbursement	Unit Cost	Check
Inpatient Hospital	-19.29%	-32.36%	19.33%	10.09%	8.39%	19.33%	TRUE
Outpatient Hospital	10.15%	-11.04%	23.81%	15.24%	7.44%	23.81%	TRUE
Professional	-1.16%	9.02%	-9.33%	-12.27%	3.35%	-9.33%	TRUE
Prescription Drug	142.54%	22.51%	97.97%	78.47%	10.93%	97.97%	TRUE
Total	**31.775%**						

ANNUALIZED PROJECTED TREND -- 2024 to 2026

				Unit Cost Components			
Service	Total EHB Cost	Utilization	Unit Cost	Service Mix / Intensity	Reimbursement	Unit Cost	Check
Inpatient Hospital	8.28%	3.12%	5.00%	-0.40%	5.42%	5.00%	TRUE
Outpatient Hospital	8.28%	3.12%	5.00%	-0.40%	5.43%	5.00%	TRUE
Professional	8.28%	3.12%	5.00%	1.72%	3.23%	5.00%	TRUE
Prescription Drug	8.28%	3.12%	5.00%	0.00%	5.00%	5.00%	TRUE
Total	**8.277%**						

Comments

There is no "Other" category, so this won't match up to the URRT PMPMs. For our development of the URRT, we have historically usedifferent frequency units.

WA Exhibit 4: Normalized Allowed Claims Analysis

Carrier Name:	**BridgeSpan Health Company**
Market:	**Individual**
Rate Filing Plan Year:	**2026**
Experience Period Year:	**2024**

Table 3.1

										Allowable Rating Adjustments									
Incurred Date (YYYYMM)	Member Months	Allowed Claims (as of 3/31/2025)	Allowed Claims Completion factor (based on IBNP estimates)	Ultimate Allowed Claims	One-Time Adjustment for High Claims (Non-Predictive Claims)	One-Time Adjustment for HCRP Receipts	Non-EHB Allowed Claims	Predictive Ultimate Allowed EHB Claims	Predictive Ultimate Allowed EHB Claims PMPM	Morbidity Adjustment	Demographic Shift	Plan Design Changes	Other Adjustments	Combined Adjustment	Accumulated Adjustments	Allowable Rating Adjustment Normalization Factor	Normalized Allowed Claims PMPM (to Experience Period)	Unadjusted 12-Month Rolling Allowed Claims Trend	Normalized 12-Month Rolling Allowed Claims Trend
202201	1,795	$1,294,777	1.0000	$1,294,777	$62,569		$2,584	$1,229,623	$685.03	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$848.25		
202202	1,844	$1,327,345	1.0000	$1,327,345	$177,822		$2,649	$1,146,874	$621.95	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$770.15		
202203	1,826	$1,776,350	1.0000	$1,776,350	-		$3,546	$1,772,805	$970.87	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$1,202.20		
202204	1,807	$1,149,373	1.0000	$1,149,373	-		$2,294	$1,147,079	$634.80	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$786.06		
202205	1,774	$1,102,582	1.0000	$1,102,582	-		$2,201	$1,100,381	$620.28	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$768.08		
202206	1,748	$1,125,012	1.0000	$1,125,012	-		$2,246	$1,122,766	$642.31	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$795.36		
202207	1,723	$1,133,236	1.0000	$1,133,236	-		$2,262	$1,130,974	$656.40	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$812.80		
202208	1,729	$1,132,306	1.0000	$1,132,306	-		$2,260	$1,130,046	$653.58	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$809.32		
202209	1,743	$822,708	1.0000	$822,708	-		$1,642	$821,066	$471.06	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$583.31		
202210	1,751	$1,087,070	1.0000	$1,087,070	-		$2,170	$1,084,900	$619.59	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$767.22		
202211	1,736	$1,138,512	1.0000	$1,138,512	-		$2,272	$1,136,239	$654.52	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$810.47		
202212	1,676	$1,276,518	1.0000	$1,276,518	-		$2,548	$1,273,970	$760.13	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.2383	$941.25		
202301	1,181	$1,080,880	1.0000	$1,080,880	-		$2,157	$1,078,722	$913.40	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$990.89		
202302	1,087	$845,130	1.0000	$845,130	-		$1,687	$843,443	$775.94	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$841.77		
202303	1,066	$1,292,377	1.0000	$1,292,377	-		$2,580	$1,289,797	$1,209.94	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,312.60		
202304	1,033	$932,341	1.0000	$932,341	-		$1,861	$930,480	$900.75	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$977.18		
202305	998	$1,214,084	1.0000	$1,214,084	-		$2,423	$1,211,660	$1,214.09	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,317.10		
202306	973	$923,861	1.0000	$923,861	-		$1,844	$922,017	$947.60	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,028.00		
202307	946	$1,629,043	1.0000	$1,629,043	$271,260		$3,252	$1,354,531	$1,431.85	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,553.34		
202308	933	$1,169,050	1.0000	$1,169,050	$87,201		$2,333	$1,079,515	$1,157.04	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,255.21		
202309	911	$840,478	1.0000	$840,478	-		$1,678	$838,800	$920.75	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$998.87		
202310	884	$951,663	1.0000	$951,663	-		$1,900	$949,764	$1,074.39	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,165.55		
202311	859	$881,690	1.0000	$881,690	-		$1,760	$879,930	$1,024.37	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,111.28		
202312	820	$940,101	1.0000	$940,101	-		$1,876	$938,224	$1,144.18	1.1300	1.0016	1.0000	1.0084	1.1414	1.1414	1.0848	$1,241.25	58.08%	38.49%
202401	600	$673,840	1.0000	$673,840	-		$1,345	$672,495	$1,120.82	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,120.82	57.88%	39.04%
202402	557	$575,725	1.0000	$575,725	-		$1,149	$574,576	$1,031.55	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,031.55	59.55%	41.07%
202403	536	$1,078,880	1.0000	$1,078,880	$245,726		$2,153	$831,001	$1,550.37	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,550.37	60.84%	43.19%
202404	523	$683,338	1.0000	$683,338	-		$1,364	$681,974	$1,303.97	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,303.97	61.59%	44.50%
202405	513	$785,474	1.0000	$785,474	-		$1,568	$783,906	$1,528.08	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,528.08	55.29%	39.55%
202406	514	$545,504	1.0000	$545,504	-		$1,089	$544,415	$1,059.17	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,059.17	53.06%	38.23%
202407	499	$550,893	1.0000	$550,893	-		$1,100	$549,794	$1,101.79	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,101.79	39.29%	26.43%
202408	492	$965,946	0.9988	$967,145	$85,780		$1,930	$879,435	$1,787.47	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,787.47	37.43%	25.07%
202409	479	$707,811	0.9984	$708,946	-		$1,415	$707,531	$1,477.10	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,477.10	35.41%	23.41%
202410	473	$729,514	0.9970	$731,720	-		$1,461	$730,260	$1,543.89	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,543.89	32.90%	21.45%
202411	468	$634,923	0.9963	$637,260	-		$1,272	$635,988	$1,358.95	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,358.95	30.65%	19.85%
202412	454	$848,484	0.9951	$852,624	-		$1,702	$850,922	$1,874.28	1.0878	0.9946	1.0000	1.0027	1.0848	1.2383	1.0000	$1,874.28	31.19%	20.93%

Table 3.2

Plan Year	Total Member Months	Total Allowed Claims (as of 3/31/2025)	-	Total Ultimate Allowed Claims	Total One-Time Adjustment for High Claims (Non-Predictive Claims)	Total One-Time Adjustment for HCRP Receipts	Total Non-EHB Allowed Claims	Total Predictive Ultimate Allowed EHB Claims	Total Predictive Ultimate Allowed EHB Claims PMPM
2022	21,152	$14,365,789		$14,365,789	$240,392	-	$28,674	$14,096,723	$666.45
2023	11,691	$12,700,697		$12,700,697	$358,461	-	$25,351	$12,316,885	$1,053.54
2024	6,108	$8,780,332		$8,791,350	$331,506	-	$17,548	$8,442,296	$1,382.17

Comments

Allowed claims in this exhibit are before adjustments for rx rebates. This will not match Exhibit 1 or the URRT as a result.
Large Claims adjusts for individuals with more than 200k in claims within a single month. Allowed claims are before cost sharing is applied, so no plan design adjustments are applied.
Other adjustmenst consists of Network normalizations.

WA Exhibit 5: URRT Worksheet 1 (w1) EHB Pool-Level Adjustment Factors

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table 1

Component	ACTUAL EXPERIENCE (A)		PROJECTED (i.e., EXPECTED; E)				A:E	
	2021 to 2023	2022 to 2024	2021 to 2023	2022 to 2024	2023 to 2025	2024 to 2026	2021 to 2023	2022 to 2024
	(2)	(3)	(4)	(5)	(6)	(7)	(8) (2) vs. (4)	(9) (3) vs. (5)
URRT Worksheet 1								
Annualized Cost Trend Factor	1.200	1.329	1.036	1.040	1.059	1.050	1.158	1.278
Annualized Utilization Trend Factor	1.067	1.097	1.017	1.023	1.029	1.031	1.049	1.072
Morbidity Adjustment	1.180	1.560	1.075	1.052	1.080	0.751	1.097	1.483
Demographic Shift	1.015	0.996	0.991	1.016	0.988	0.997	1.024	0.981
Plan Design Changes	1.030	1.013	1.007	0.993	1.024	1.073	1.023	1.020
Other	0.970	0.966	0.907	1.028	0.995	1.002	1.070	0.940

[1] Ratios for factors. Subtraction for percents.

Comments

WA Exhibit 6: URRT Worksheet 2 (w2) Actuarial Values by Plan

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table 8.1

HIOS Plan ID	Metal Level	AV Metal Value 2024	AV Metal Value 2025	AV Metal Value 2026	Projections: AV Pricing Value 2024	Projections: AV Pricing Value 2025	Projections: AV Pricing Value 2026	Difference of Pricing Value and Metal Value: 2024	Difference of Pricing Value and Metal Value: 2025	Difference of Pricing Value and Metal Value: 2026
53732WA0790024	Gold	0.8189	0.8139	0.8181	0.8911	0.8848	0.8367	0.0722	0.0709	0.0186
53732WA0790030	Gold			0.7806			0.7833	#VALUE!	#VALUE!	0.0027
53732WA0790025	Silver	0.7179	0.7075	0.7184	0.7090	0.7070	0.7185	-0.0089	-0.0005	0.0001
53732WA0790026	Bronze	0.6455	0.6364	0.6497	0.6329	0.6317	0.6306	-0.0126	-0.0047	-0.0191

Overall AV Metal Value			Overall AV Pricing Value			Difference of Pricing Value and Metal Value		
2024	2025	2026	2024	2025	2026	2024	2025	2026
0.6825	0.6890	0.7000	0.6757	0.6984	0.6933	-0.0068	0.0095	-0.0066

Comments

The AV Pricing Values shown in this exhibit are net of the Induced Demand Factor and Above EHB Factor and therefore will not match the AV Pricing Values shown in other exhibits such as Exhibit E2.
AV Pricing Values for years 2024-2025 have been re-scaled to align with scale used for 2026 filing.

WA Exhibit 7: URRT Worksheet 2 (w2) Plan Adjustment Factors, in Aggregate

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table

Component	ACTUAL EXPERIENCE (A) 2022	2023	2024	PROJECTED (i.e., EXPECTED; E) 2022	2023	2024	2025	2026	YEAR-TO-YEAR CHANGE in PROJECTED AMOUNTS 2022 to 2023	2023 to 2024	2024 to 2025	2025 to 2026	2024 EXPERIENCE to 2026 PROJECTED	A:E 2022	2023	2024
Paid-to-Allowed Ratio (All, Unadjusted)	0.8265	0.8746	0.8941	0.7307	0.8337	0.8609	0.8766	0.9010	1.141	1.033	1.018	1.028	1.008	1.131	1.049	1.039
Paid-to-Allowed Ratio (Catastrophic, Unadjusted)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Paid-to-Allowed Ratio (Bronze, Unadjusted)	0.7818	0.8253	0.8384	0.7218	0.8305	0.8488	0.8717	0.8841	1.151	1.022	1.027	1.014	1.055	1.083	0.994	0.988
Paid-to-Allowed Ratio (Silver, Unadjusted)	0.8828	0.9219	0.9271	0.7609	0.8341	0.8824	0.8811	0.9437	1.096	1.058	0.999	1.071	1.018	1.160	1.105	1.051
Paid-to-Allowed Ratio (Gold, Unadjusted)	0.8836	0.9212	0.9232	0.8141	0.8645	0.9043	0.8879	0.8723	1.062	1.046	0.982	0.983	0.945	1.085	1.066	1.021
Paid-to-Allowed Ratio (Platinum, Unadjusted)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV and Cost Sharing Design of Plan Development Components																
AV Pricing Value	0.5318	0.6250	0.5453	0.5261	0.5293	0.5345	0.5558	0.8229	1.006	1.010	1.040	1.481	1.509	1.011	1.181	1.020
Induced Demand Factor (IDF)	1.3958	1.2759	1.4690	1.3549	1.5427	1.5717	1.5503	0.9611	1.139	1.019	0.986	0.620	0.654	1.030	0.827	0.935
CSR Silver Load	1.0259	1.0266	1.0260	1.0214	1.0196	1.0231	1.0171	1.1377	0.998	1.003	0.994	1.119	1.109	1.004	1.007	1.003
Factor for cost of abortion services for which public funding is prohibited	1.0020	1.0020	1.0020	1.0020	1.0020	1.0020	1.0020	1.0020	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
AV and Cost Sharing Design of Plan	0.7630	0.8203	0.8236	0.7295	0.8342	0.8612	0.8781	0.9016	1.143	1.032	1.020	1.027	1.095	1.046	0.983	0.956
Benefits in Addition to EHB	1.0030	1.0020	1.0020	1.0030	1.0020	1.0020	1.0020	1.0020	0.999	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Catastrophic Adjustment	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Comments

Pricing AVs were re-scaled for 2026 to accommodate the requirements of emergency rule CR-103E, hence the change in the AV Pricing Value and Induced Demand Factor from 2025 to 2026.

WA Exhibit 8: CSR Related Experience

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Table

					Plan Year 2024 Actual Experience							
HIOS Plan ID	Metal Level	CSR Plan Variant	2026 Plan Category (New, Renewing, Terminated)	CSR Silver Load (Projected)	Member Months	Allowed Claims	Paid Claims	Paid-to-Allowed Ratio	CSR Paid Claims	CSR-Adjusted Paid-to-Allowed Ratio	APTC Payments	Net CSR Funds
53732WA0790007	Bronze	NA	Terminated	1.0000	2,330	$1,203,813	$913,789	0.759078696	$0	0.759078696	$588,107	
53732WA0790007	Bronze	Zero Cost-Share	Terminated	1.0000	84	$190,523	$190,372	0.999204658	$55,402	0.708415903	$49,520	-$5,882
53732WA0790007	Bronze	Limited Cost-Share	Terminated	1.0000	1	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790024	Gold	NA	Renewing	1.0000	837	$1,606,635	$1,483,283	0.923223708	$0	0.923223708	$172,254	
53732WA0790024	Gold	Zero Cost-Share	Renewing	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790024	Gold	Limited Cost-Share	Renewing	1.0000	12	$62	$48	0.764628783	$0	0.764628783	$0	
53732WA0790025	Silver	NA	Renewing	1.0980	727	$1,160,335	$1,018,873	0.878085128	$0	0.878085128	$135,081	
53732WA0790025	Silver	Zero Cost-Share	Renewing	1.0980	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790025	Silver	Limited Cost-Share	Renewing	1.0980	12	$963	$0	0	$0	0	$1,212	
53732WA0790025	Silver	CSR 73%	Renewing	1.0980	262	$290,009	$235,383	0.811642074	$3,238	0.800478269	$157,577	$154,339
53732WA0790025	Silver	CSR 87%	Renewing	1.0980	438	$905,431	$846,968	0.935430595	$47,070	0.883444219	$225,989	$178,919
53732WA0790025	Silver	CSR 94%	Renewing	1.0980	184	$1,266,307	$1,257,594	0.993119647	$30,972	0.968661393	$101,944	$70,972
53732WA0790026	Bronze	NA	Renewing	1.0000	1,221	$1,593,360	$1,400,799	0.879147813	$0	0.879147813	$262,233	
53732WA0790026	Bronze	Zero Cost-Share	Renewing	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790026	Bronze	Limited Cost-Share	Renewing	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790030	Gold	NA	New	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790030	Gold	Zero Cost-Share	New	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	
53732WA0790030	Gold	Limited Cost-Share	New	1.0000	0	$0	$0	#DIV/0!	$0	#DIV/0!	$0	

Comments

WA Exhibit 9: URRT Worksheet 2 (w2) AV and Cost Sharing Design Factors

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

HIOS Plan ID	Metal Level	2026 Plan Category (New, Renewing, Terminated)	Exchange Plan?	Requesting Expanded AV Pricing Value Range	AV Metal Value	AV Pricing Value	Induced Demand Factor (IDF)	CSR Silver Load	Check AV Pricing Value within 2% (or 3%) of AV Metal Value	Check Expected Risk Adjustment IDF	Check CSR Silver Load
53732WA0790024	Gold	Renewing	Yes	No	0.8181	0.8367	1.1030	1.0000	1.86%	1.1030	
53732WA0790030	Gold	New	Yes	No	0.7806	0.7833	1.0700	1.0000	0.27%	1.0700	
53732WA0790025	Silver	Renewing	Yes	No	0.7184	0.7185	1.0380	1.4350	0.01%	1.0380	1.435
53732WA0790026	Bronze	Renewing	Yes	No	0.6497	0.6306	1.0070	1.0000	-1.91%	1.0070	

Comments

1. Induced demand factors and expected induced demand factors have both been rounded to three decimal places.

WA Exhibit 10: Summarized Risk Adjustment (RA)

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

ACTUAL EXPERIENCE, 2024

Description	Statewide Metal Plans	Carrier: Total for Metal + Catastrophic	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Catastrophic
Billable Member Months (MM)		6,183	6,183	-	864	1,645	3,674		-
Actuarial Value (AV)	0.686		0.654552522	0.900	0.800	0.700	0.600	0.570	0.570
Plan Liability Risk Score (PLRS)	1.292		2.091	0.000	4.604	3.401	0.914	0.000	0.000
Allowable Rating Factor (ARF)	1.711		1.776	0.000	1.538	1.754	1.842	0.000	0.000
Induced Demand Factor (IDF)	1.030		1.019	0.000	1.080	1.030	1.000	0.000	0.000
Geographic Cost Factor (GCF)	1.000		1.005	0.000	0.980	1.014	1.007	0.000	0.000
Final SWAP PMPM (before 86% adjustment is applied)	$590.07							$0.00	
Plan Liability Component approximation = PLRS * IDF * GCF	1.331		2.143	0.000	4.870	3.551	0.921	0.000	0.000
Normalized PLRS * IDF * GCF (N1)			1.610	0.000	3.659	2.668	0.692		TBD
Allowable Rating Component approximation = AV * ARF * IDF * GCF	1.210		1.191	0.000	1.302	1.282	1.114	0.000	0.000
Normalized AV * PLRS * IDF * GCF (N2)			0.985	0.000	1.076	1.060	0.920		TBD
Approximate Transfer PMPM (P * [N1 - N2] * 0.86)			**$317.36**	$0.00	$1,311.04	$816.27	($115.84)		TBD
Approximate Aggregate Transfer (Transfer PMPM * MM)			**$1,962,195**	$0	$1,132,644	$1,342,801	($425,565)		TBD
Aggregate Experience RA Transfer PMPM		331.542608	$331.54	$0.00	$1,311.04	$816.27	-$115.84		$0.00
Transfer PMPM Difference			$14.18	$0.00	$0.00	$0.00	$0.00		TBD
HCRP assessment PMPM (amounts should be negative)		-$2.60	-$2.60	$0.00	-$2.60	-$2.60	-$2.60		$0.00
HCRP receipts PMPM (amounts should be positive)		$14.04	$14.04	$0.00	$14.04	$14.04	$14.04		$0.00
RADV adjustment PMPM, if applicable		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
Final Risk Adjustment PMPM		$342.98	$342.98	$0.00	$1,322.47	$827.70	-$104.40		$0.00

PROJECTED (i.e., EXPECTED), 2026

Description	Statewide Metal Plans	Carrier: Total for Metal + catastrophic.	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Catastrophic
Billable Member Months (MM)		262,536	262,536	-	99,456	54,708	108,372		-
Actuarial Value (AV)	0.686		0.697	0.900	0.800	0.700	0.600	0.000	0.000
Plan Liability Risk Score (PLRS)	1.344		1.562	0.000	2.134	1.785	0.924	0.000	0.000
Allowable Rating Factor (ARF)	1.711		1.732	0.000	1.680	1.667	1.811	0.000	0.000
Induced Demand Factor (IDF)	1.030		1.037	0.000	1.080	1.030	1.000	0.000	0.000
Geographic Cost Factor (GCF)	1.000		1.002	0.000	1.001	1.002	1.004	0.000	0.000
Statewide Average Premium (SWAP) PMPM									
Starting SWAP PMPM	$590.07							$0.00	
Trend from 2024 to 2025	6.61%							0.00%	
Trend from 2025 to 2026	17.06%							0.00%	
Final SWAP PMPM (before 86% adjustment is applied)	$736.41							$0.00	
Plan Liability Component approximation = PLRS * IDF * GCF	1.384		1.623	0.000	2.307	1.843	0.928	0.000	0.000
Normalized PLRS * IDF * GCF (N1)			1.173	0.000	1.667	1.332	0.670		TBD
Allowable Rating Component approximation = AV * ARF * IDF * GCF	1.210		1.253	0.000	1.453	1.205	1.091	0.000	0.000
Normalized AV * PLRS * IDF * GCF (N2)			1.036	0.000	1.201	0.996	0.901		TBD
Approximate Transfer PMPM (P * [N1 - N2] * 0.86)			**$86.65**	$0.00	$294.99	$212.62	($146.37)		TBD
Approximate Aggregate Transfer (Transfer PMPM * MM)			**$22,747,580**	$0	$29,338,778	$11,632,156	($15,862,566)		TBD
Aggregate Projected (Rate Development) RA Transfer PMPM		95.63780935	$95.64	$0.00	$294.99	$212.62	-$146.37		$0.00
Transfer PMPM Difference			$8.99	$0.00	$0.00	$0.00	$0.00		TBD
HCRP assessment PMPM (amounts should be negative)		-$5.30	-$5.30	$0.00	-$5.30	-$5.30	-$5.30		$0.00
HCRP receipts PMPM (amounts should be positive)		$5.30	$5.30	$0.00	$5.30	$5.30	$5.30		$0.00
RADV adjustment PMPM, if applicable		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
Final Risk Adjustment PMPM		$95.64	$95.64	$0.00	$294.99	$212.62	-$146.37		$0.00

PROJECTED (i.e., EXPECTED), 2026 versus ACTUAL EXPERIENCE, 2024

Statewide Metal Plans	Carrier: Total for Metal + catastrophi	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Catastrophic
	42.462	42.462		115.121	33.256	29.498		
1.000		1.064	1.000	1.000	1.000	1.000	-	-
1.040		0.747		0.464	0.525	1.011		
1.000		0.975		1.093	0.951	0.983		
1.000		1.017		1.000	1.000	1.000		
1.000		0.997		1.022	0.989	0.996		
1.248								
1.040		0.757		0.474	0.519	1.007		
		0.728		0.455	0.499	0.968		
1.000		1.052		1.116	0.940	0.979		
		1.052		1.116	0.940	0.979		
		0.273		0.225	0.260	1.264		
		11.593		25.903	8.663	37.274		
	0.288	0.288		0.225	0.260	1.264		
		0.634		-	0.100	0.158		
	2.038	2.038		2.038	2.038	2.038		
	0.378	0.378		0.378	0.378	0.378		
	0.279	0.279		0.223	0.257	1.402		

PROJECTED (i.e., EXPECTED), 2024

Description	Statewide Metal Plans	Carrier: Total for Metal +	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Catastrophic
Billable Member Months (MM)		13,104	13,104	-	888	3,084	9,132		-
Actuarial Value (AV)	0.670		0.637	0.900	0.800	0.700	0.600	0.000	0.000
Plan Liability Risk Score (PLRS)	1.323		1.425	0.000	2.959	2.346	0.964	0.000	0.000
Allowable Rating Factor (ARF)	1.763		1.829	0.000	1.616	1.792	1.863	0.000	0.000
Induced Demand Factor (IDF)	1.024		1.012	0.000	1.080	1.030	1.000	0.000	0.000
Geographic Cost Factor (GCF)	1.000		1.011	0.000	1.007	1.016	1.010	0.000	0.000
Statewide Average Premium (SWAP) PMPM									
Starting SWAP PMPM	$537.44							$0.00	
Trend from 2022 to 2023	5.75%							0.00%	
Trend from 2023 to 2024	6.28%							0.00%	
Final SWAP PMPM (before 86% adjustment is applied)	$604.08							$0.00	
Plan Liability Component approximation = PLRS * IDF * GCF	1.355		1.458	0.000	3.218	2.455	0.974	0.000	0.000
Normalized PLRS * IDF * GCF (N1)			1.076	0.000	2.376	1.812	0.719		TBD
Allowable Rating Component approximation = AV * ARF * IDF * GCF	1.209		1.193	0.000	1.406	1.313	1.128	0.000	0.000
Normalized AV * PLRS * IDF * GCF (N2)			0.986	0.000	1.163	1.086	0.933		TBD
Approximate Transfer PMPM (P * [N1 - N2] * 0.86)			**$46.70**	$0.00	$630.18	$377.48	($111.40)		TBD
Approximate Aggregate Transfer (Transfer PMPM * MM)			**$612,009**	$0	$559,596	$1,164,143	($1,017,298)		TBD
Aggregate Projected (Rate Development) RA Transfer PMPM		TBD	TBD	$0.00	$597.26	$347.20	-$117.72		$0.00
Transfer PMPM Difference			TBD	$0.00	-$32.92	-$30.28	-$6.32		TBD
HCRP assessment PMPM (amounts should be negative)		TBD	TBD	$0.00	-$4.04	-$4.04	-$4.04		$0.00
HCRP receipts PMPM (amounts should be positive)		TBD	TBD	$0.00	$4.04	$4.04	$4.04		$0.00
RADV adjustment PMPM, if applicable		TBD	TBD	$0.00	$0.00	$0.00	$0.00		$0.00
Final Risk Adjustment PMPM		TBD	TBD	$0.00	$597.26	$347.20	-$117.72		$0.00

ACTUAL EXPERIENCE, 2024 versus PROJECTED (i.e., EXPECTED), 2024

Statewide Metal Plans	Carrier: Total for Metal +	Carrier: Total for Metal Plans	Carrier: Platinum	Carrier: Gold	Carrier: Silver	Carrier: Bronze	Statewide Catastrophic Plans	Carrier: Catastrophic
	0.472	0.472		0.973	0.533	0.402		
1.025		1.027	1.000	1.000	1.000	1.000		
0.977		1.468		1.556	1.450	0.948		
0.971		0.971		0.952	0.979	0.989		
1.006		1.007		1.000	1.000	1.000		
1.000		0.994		0.973	0.998	0.998		
0.977								
0.982		1.469		1.513	1.447	0.946		
		1.496		1.540	1.472	0.963		
1.001		0.999		0.926	0.977	0.987		
		0.998		0.925	0.976	0.986		
		6.795		2.080	2.162	1.040		
		3.206		2.024	1.153	0.418		
				2.195	2.351	0.984		
				0.000	0.000	0.000		
				0.645	0.645	0.645		
				3.477	3.477	3.477		
				2.214	2.384	0.887		

Comments

BridgeSpan is using Regence projected risk adjustment for 2026 for credibility see Actuarial Memorandum section 4.4.3.6(b)

WA Exhibit 11: Retention / Administrative Costs

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

	ACTUAL EXPERIENCE (A)						PROJECTED (i.e., EXPECTED; E)										YEAR-TO-YEAR SHIFTS in PROJECTED AMOUNTS								2024 EXPERIENCE to		A:E					
	2022		2023		2024		2022		2023		2024		2025		2026		2022 to 2023		2023 to 2024		2024 to 2025		2025 to 2026		2026 PROJECTED		2022		2023		2024	
Description	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM	% of Premium	PMPM
Administrative Expenses																																
Commissions	1.36%	$7.00	1.09%	$6.58	1.05%	$7.70	1.31%	$6.72	1.16%	$7.00	0.86%	$6.30	0.77%	$6.72	0.64%	$6.78	-0.15%	4.17%	-0.30%	-10.00%	-0.08%	6.67%	-0.13%	0.89%	-0.41%	-11.91%	-0.05%	-3.94%	0.07%	6.45%	-0.19%	-18.15%
Quality improvement	0.70%	$3.59	0.64%	$3.85	0.72%	$5.29	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	-0.72%	-100.00%	-0.70%	-100.00%	-0.64%	-100.00%	-0.72%	-100.00%
Investment income credit (enter as a negative number)	-0.01%	($0.03)	-0.12%	($0.75)	-0.13%	($0.92)	-0.01%	($0.03)	-0.12%	($0.75)	-0.13%	($0.92)	-0.17%	($1.50)	-0.16%	($1.70)	-0.12%	2400.00%	0.00%	22.67%	-0.05%	63.04%	0.01%	13.33%	-0.03%	84.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Commercial reinsurance premium	0.37%	$1.90	0.37%	$2.25	0.36%	$2.66	0.31%	$1.59	0.41%	$2.48	0.55%	$4.04	0.41%	$3.56	0.50%	$5.30	0.10%	55.68%	0.14%	63.05%	-0.14%	-11.75%	0.09%	48.87%	0.14%	99.04%	-0.06%	-16.40%	0.04%	9.91%	0.19%	51.50%
Other administrative expenses	8.49%	$43.55	7.41%	$44.78	6.39%	$46.90	7.78%	$39.89	7.32%	$44.20	6.32%	$46.41	6.84%	$59.46	6.14%	$65.13	-0.46%	10.80%	-1.00%	5.00%	0.52%	28.12%	-0.70%	9.54%	-0.25%	38.87%	-0.71%	-8.41%	-0.10%	-1.29%	-0.07%	-1.04%
Total administrative expenses	**10.92%**	**$56.01**	**9.39%**	**$56.70**	**8.40%**	**$61.63**	**9.39%**	**$48.17**	**8.76%**	**$52.93**	**7.61%**	**$55.83**	**7.85%**	**$68.24**	**7.12%**	**$75.51**	**-0.62%**	**9.87%**	**-1.16%**	**5.48%**	**0.25%**	**22.24%**	**-0.73%**	**10.65%**	**-1.28%**	**22.53%**	**-1.53%**	**-13.99%**	**-0.63%**	**-6.66%**	**-0.79%**	**-9.41%**
Taxes and Fees																																
Premium tax	2.00%	$10.26	2.00%	$12.08	2.00%	$14.68	2.00%	$10.26	2.00%	$12.08	2.00%	$14.68	2.00%	$17.38	2.00%	$21.21	0.00%	17.71%	0.00%	21.55%	0.00%	18.39%	0.00%	22.07%	0.00%	44.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Federal income tax	-2.43%	($12.47)	-5.37%	($32.42)	-4.86%	($35.64)	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	4.86%	-100.00%	2.43%	-100.00%	5.37%	-100.00%	4.86%	-100.00%
WA OIC regulatory surcharge	0.0723%	$0.37	0.0784%	$0.47	0.0778%	$0.57	0.0815%	$0.42	0.0759%	$0.46	0.0712%	$0.52	0.0766%	$0.67	0.0763%	$0.81	-0.01%	9.62%	0.00%	14.04%	0.01%	27.34%	0.00%	21.65%	0.00%	41.86%	0.01%	12.78%	0.00%	-3.24%	-0.01%	-8.42%
WA OIC fraud surcharge	0.0043%	$0.02	0.0047%	$0.03	0.0042%	$0.03	0.0052%	$0.03	0.0047%	$0.03	0.0042%	$0.03	0.0046%	$0.04	0.0041%	$0.04	0.00%	6.39%	0.00%	8.89%	0.00%	28.88%	0.00%	9.81%	0.00%	41.85%	0.00%	21.70%	0.00%	0.12%	0.00%	0.23%
Risk adjustment user fee	0.05%	$0.25	0.04%	$0.21	0.02%	$0.18	0.05%	$0.25	0.04%	$0.22	0.03%	$0.21	0.02%	$0.18	0.02%	$0.20	-0.01%	-12.00%	-0.01%	-4.55%	-0.01%	-14.29%	0.00%	11.11%	-0.01%	9.69%	0.00%	0.93%	0.00%	3.24%	0.00%	15.17%
PCORI fee	0.05%	$0.25	0.04%	$0.27	0.04%	$0.27	0.05%	$0.25	0.04%	$0.26	0.04%	$0.28	0.03%	$0.30	0.03%	$0.32	-0.01%	4.00%	0.00%	7.69%	0.00%	7.14%	0.00%	6.67%	-0.01%	17.96%	0.00%	-0.98%	0.00%	-2.88%	0.00%	3.21%
Mitigating inequity fee	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD	0.00%	TBD
WSHIP assessment	0.03%	$0.17	0.06%	$0.38	-0.02%	($0.16)	0.12%	$0.64	0.07%	$0.40	0.05%	$0.36	0.02%	$0.17	0.03%	$0.32	-0.06%	-37.50%	-0.02%	-10.00%	-0.03%	-52.78%	0.01%	88.24%	0.05%	-301.09%	0.09%	274.89%	0.00%	4.81%	0.07%	-326.22%
WAPAL assessment	0.01%	$0.07	0.01%	$0.08	0.01%	$0.08	0.01%	$0.04	0.01%	$0.07	0.01%	$0.06	0.01%	$0.07	0.01%	$0.07	0.00%	75.00%	0.00%	-14.29%	0.00%	16.67%	0.00%	0.00%	0.00%	-14.56%	-0.01%	-43.12%	0.00%	-9.19%	0.00%	-26.76%
Total administrative expenses	**-0.21%**	**($1.08)**	**-3.13%**	**($18.90)**	**-2.72%**	**($19.98)**	**2.32%**	**$11.89**	**2.24%**	**$13.51**	**2.20%**	**$16.14**	**2.16%**	**$18.80**	**2.17%**	**$22.98**	**-0.08%**	**13.70%**	**-0.04%**	**19.46%**	**-0.04%**	**16.48%**	**0.00%**	**22.19%**	**4.89%**	**-214.98%**	**2.53%**	**-1204.91%**	**5.37%**	**-171.51%**	**4.92%**	**-180.78%**
Profit & Risk Load	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	3.50%	$17.96	3.50%	$21.14	3.50%	$25.69	3.50%	$30.41	3.50%	$37.13	0.00%	17.71%	0.00%	21.55%	0.00%	18.39%	0.00%	22.07%	3.50%	TBD	3.50%	TBD	3.50%	TBD	3.50%	TBD
Total Retention (excluding Exchange Fee)	**10.71%**	**$54.93**	**6.26%**	**$37.80**	**5.67%**	**$41.64**	**15.21%**	**$78.01**	**14.50%**	**$87.58**	**13.31%**	**$97.66**	**13.52%**	**$117.46**	**12.79%**	**$135.62**	**-0.70%**	**12.26%**	**-1.20%**	**11.52%**	**0.21%**	**20.28%**	**-0.73%**	**15.46%**	**7.11%**	**225.66%**	**4.50%**	**42.01%**	**8.24%**	**131.65%**	**7.63%**	**134.51%**
Exchange User Fee *	0.60%	$3.06	0.50%	$3.00	0.41%	$2.98	0.58%	$3.00	0.50%	$3.00	0.41%	$3.00	0.59%	$5.11	0.48%	$5.11	-0.09%	0.00%	-0.09%	0.00%	0.18%	70.33%	-0.11%	0.00%	0.08%	71.37%	-0.01%	-2.12%	0.00%	0.02%	0.00%	0.61%
Total Retention (including Exchange Fee)	**11.30%**	**$58.00**	**6.76%**	**$40.80**	**6.08%**	**$44.63**	**15.79%**	**$81.01**	**15.00%**	**$90.58**	**13.71%**	**$100.66**	**14.11%**	**$122.57**	**13.27%**	**$140.73**	**-0.79%**	**11.81%**	**-1.29%**	**11.13%**	**0.39%**	**21.77%**	**-0.84%**	**14.81%**	**7.19%**	**215.35%**	**4.49%**	**39.68%**	**8.24%**	**121.98%**	**7.63%**	**125.57%**
Projected Required Premium PMPM		$513.03		$603.87		$733.99		$513.03		$603.87		$733.99		$868.96		$1,060.74		17.71%		21.55%		18.39%		22.07%		44.52%		0.00%		0.00%		0.00%

* Exchange User Fee on incurred claim basis (not on allowed claim basis like what is on URRT worksheet 1)

Comments

1. Actual investment income credit is assumed equal to projected investment income credit since actual investment income earned is not credited directly to a specific line of business.
2. Projected income tax is zero as this filing includes no explicit contribution to surplus, as indicated in Section 4.4.7(c) of the Actuarial Memorandum.
3. Quality Improvement expenses for the projected periods are embedded in Other Administrative Expenses.

WA Exhibit 12: URRT Worksheet 2 (w2) Projections, Reconciliation

Carrier Name:	BridgeSpan Health Company
Market:	Individual
Rate Filing Plan Year:	2026
Experience Period Year:	2024

Description	PROJECTED (i.e., EXPECTED), 2026 % of Premium	PROJECTED (i.e., EXPECTED), 2026 PMPM
Aggregate Projected Administrative Costs		
3.6 Administrative Expense	7.12%	$75.51
3.7 Taxes and Fees	2.17%	$22.98
3.8 Profit & Risk Load	3.50%	$37.13
Total Retention (excluding Exchange Fee)	12.79%	$135.62
Aggregate Projected Amounts PMPM		
Exchange user fee		$5.11
4.15 Incurred Claims		$1,015.65
4.16 Risk Adjustment Transfer Amount		$95.64
4.17 Premium		$1,060.74
A. (Premium) + (Risk Adjustment Transfer Amount)		$1,156.38
B. (Incurred Claims) + (Admin, Taxes & Fees) + (Profit & Risk Load) + (Exchange User Fee)		$1,156.38
C. Difference = A - B (should be $0)		$0.00

Comments

Factor Summary

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

Area Factor Summary		
Rating Area	Service Area	Factor
1	King	1.000
2	Kitsap	1.131
3	Clark, Klickitat	1.074
4	Spokane	0.988
5	Pierce, Thurston	1.037
6	Benton, Franklin, Yakima	1.045
7	N/A	N/A
8	Skagit, Snohomish	1.055
9	Columbia, Walla Walla	1.111
Only eligible portions of Rating Areas are listed under Service Area		

Tobacco Factor Summary		
Status	Description	Factor
Non-Tobacco	Does not use Tobacco	1.00
Tobacco	Uses Tobacco	1.00
Tobacco factors only apply to members aged 18 and over.		

Summary of Current and Prior Year Factors

Area Factor Changes

Rating Area	Service Area	2025 Factor	2026 Factor	% Change
1	King	1.000	1.000	0.0%
2	Kitsap	1.135	1.131	-0.4%
3	Clark, Klickitat	1.080	1.074	-0.6%
4	Spokane	0.999	0.988	-1.1%
5	Pierce, Thurston	1.045	1.037	-0.8%
6	Benton, Franklin, Yakima	1.046	1.045	-0.1%
7	N/A	N/A	N/A	N/A
8	Skagit, Snohomish	1.059	1.055	-0.4%
9	Columbia, Walla Walla	1.134	1.111	-2.0%

Tobacco Factor Changes

2025 Factor	2026 Factor	% Change
1.15	1.00	-13.0%

Plan Level Pricing AV and Base Rate Changes

HHS Plan ID	2025 Pricing AV	2026 Pricing AV	% Change	2025 Base Rate	2026 Base Rate	% Change
53732WA0790026	0.4950	0.6360	28.5%	$409.19	$440.02	7.5%
53732WA0790024	0.7830	0.9250	18.1%	$647.26	$639.96	-1.1%
53732WA0790025	0.6055	1.0719	77.0%	$500.53	$741.59	48.2%

Plan Summary

2026 Pool Base Rate	$691.85

Network	Metal	Plan Name	HHS Plan ID	Benefits	Base Rates	Exchange Status	Available in Rating Areas
Individual Value	Bronze	BridgeSpan Cascade Bronze	53732WA0790026	BASE	$440.02	Inside the Exchange	1 2 3 4 5 6 8 9
Individual Value	Gold	BridgeSpan Cascade Complete Gold	53732WA0790024	BASE	$639.96	Inside the Exchange	1 2 3 4 5 6 8 9
Individual Value	Gold	BridgeSpan Cascade Vital Gold	53732WA0790030	BASE	$581.15	Inside the Exchange	1 2 3 4 5 6 8 9
Individual Value	Silver	BridgeSpan Cascade Silver	53732WA0790025	CSR Silver	$741.59	Inside the Exchange	1 2 3 4 5 6 8 9

BridgeSpan Health Company - Individual
WAOIC# 500823
Supplementary Exhibits
Table of Contents

BridgeSpan Health Company - Individual
WAOIC# 500823
Rates Effective 1/1/2026
BHC Data Summary

	BSWA Individual ACA		
Month	**Membership**	**Earned Premium**	**Incurred Claims**
12/2024	454	$332,147	$825,062
11/2024	468	$341,913	$578,144
10/2024	473	$344,127	$690,312
9/2024	479	$348,229	$659,875
8/2024	492	$360,240	$882,798
7/2024	499	$367,323	$476,338
6/2024	514	$381,393	$490,512
5/2024	513	$383,593	$707,180
4/2024	523	$393,500	$598,001
3/2024	536	$402,893	$990,248
2/2024	557	$422,421	$505,153
1/2024	600	$446,770	$517,399
Total	**6,108**	**$4,524,551**	**$7,921,023**

- Incurred Claims reflect March 2025 UCL and do not reflect pharmacy rebates

BridgeSpan Health Company - Individual
WAOIC# 500823
Rates Effective 1/1/2026
Data Summary

	RBS Individual ACA		
Month	**Membership**	**Earned Premium**	**Incurred Claims**
12/2024	27,954	$18,653,472	$24,521,647
11/2024	28,343	$18,906,402	$22,926,592
10/2024	28,492	$19,026,608	$26,777,228
9/2024	28,499	$19,041,171	$22,662,317
8/2024	28,529	$19,054,820	$23,923,516
7/2024	28,474	$19,018,122	$24,057,797
6/2024	28,400	$18,993,220	$20,572,719
5/2024	28,253	$18,912,416	$23,849,007
4/2024	28,133	$18,873,563	$24,071,321
3/2024	27,937	$18,773,502	$20,412,260
2/2024	27,801	$18,705,483	$18,101,413
1/2024	26,536	$17,974,547	$18,912,597
Total	**337,351**	**$225,933,326**	**$270,788,415**

- Incurred Claims reflect March 2025 UCL and do not reflect pharmacy rebates

BridgeSpan Health Company - Individual
WAOIC# 500823
Rates Effective 1/1/2026
Medical and Rx Paid Claims Triangle

Medical

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	41,539	0	0	0	0	0	0	0	0	0	0	0
202402	191,691	29,902	0	0	0	0	0	0	0	0	0	0
202403	90,233	324,478	55,730	0	0	0	0	0	0	0	0	0
202404	11,157	20,717	326,646	70,804	0	0	0	0	0	0	0	0
202405	5,533	8,224	429,936	308,025	125,102	0	0	0	0	0	0	0
202406	283	-45,171	36,806	13,870	241,742	52,107	0	0	0	0	0	0
202407	152	45	1,070	4,603	110,617	200,990	24,203	0	0	0	0	0
202408	1,771	3,874	463	5,663	9,156	36,228	244,036	125,615	0	0	0	0
202409	-158	427	210	159	824	1,393	2,381	155,273	93,051	0	0	0
202410	3,770	2	0	432	2,763	148	3,020	40,099	142,499	67,181	0	0
202411	-1,766	-46	-634	1,466	336	588	5,236	18,405	35,638	124,934	70,822	0
202412	170	21,487	0	388	0	472	165	1,248	6,054	41,721	134,156	94,095
202501	0	175	0	175	268	0	447	501	224	2,361	30,312	139,640
202502	42	2,990	157	943	1,433	1,316	1,993	1,139	743	120	2,005	4,076
202503	0	0	-8,816	-534	-689	0	268	6,541	4,116	192	640	265,208

Rx

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	167,241	0	0	0	0	0	0	0	0	0	0	0
202402	5,742	152,079	0	0	0	0	0	0	0	0	0	0
202403	0	-14,031	156,835	0	0	0	0	0	0	0	0	0
202404	0	0	-8,156	184,710	0	0	0	0	0	0	0	0
202405	0	0	0	7,298	218,462	0	0	0	0	0	0	0
202406	0	0	0	0	-2,834	210,157	0	0	0	0	0	0
202407	0	0	0	0	0	-12,886	202,885	0	0	0	0	0
202408	0	0	0	0	0	0	-19,906	530,170	0	0	0	0
202409	0	0	0	0	0	0	11,610	2,807	393,010	0	0	0
202410	0	0	0	0	0	0	0	0	-16,664	462,470	0	0
202411	0	0	0	0	0	0	0	0	0	-10,667	337,725	0
202412	0	0	0	0	0	0	0	0	0	0	484	328,098
202501	0	0	0	0	0	0	0	0	0	0	0	-10,258
202502	0	0	0	0	0	0	0	0	0	0	0	0
202503	0	0	0	0	0	0	0	0	204	0	0	204

- Incurred Claims have not been adjusted for unpaid claims estimates or pharmacy rebates

BridgeSpan Health Company - Individual
WAOIC# 500823
Rates Effective 1/1/2026
Medical and Rx Allowed Claims Triangle

Medical

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	63,771	0	0	0	0	0	0	0	0	0	0	0
202402	264,149	36,042	0	0	0	0	0	0	0	0	0	0
202403	99,076	363,031	72,003	0	0	0	0	0	0	0	0	0
202404	13,007	20,603	376,341	84,513	0	0	0	0	0	0	0	0
202405	5,770	-34,701	440,073	343,502	141,758	0	0	0	0	0	0	0
202406	339	-44	37,045	18,199	271,564	66,707	0	0	0	0	0	0
202407	-3,029	596	671	7,077	121,721	222,016	36,505	0	0	0	0	0
202408	4,020	4,376	611	6,434	12,354	38,320	292,584	163,197	0	0	0	0
202409	108	-44	326	382	2,397	2,145	4,120	187,018	99,167	0	0	0
202410	5,353	59	7	581	2,801	645	3,369	41,470	169,905	71,678	0	0
202411	20	190	0	2,084	557	644	5,011	18,143	37,715	142,428	78,150	0
202412	210	21,487	-104	388	0	581	952	113	6,894	42,820	154,649	101,369
202501	-267	85	-20,742	-3,192	1,081	-634	557	-2,220	-431	3,520	40,873	153,272
202502	62	3,131	158	3,156	1,567	2,061	1,638	2,604	1,516	160	3,086	146
202503	0	0	0	0	-913	-465	438	8,238	5,505	287	1,266	265,892

Rx

	Incurred Month											
Paid Month	202401	202402	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412
202401	215,175	0	0	0	0	0	0	0	0	0	0	0
202402	6,077	177,168	0	0	0	0	0	0	0	0	0	0
202403	0	-16,250	186,434	0	0	0	0	0	0	0	0	0
202404	0	-4	-13,943	213,270	0	0	0	0	0	0	0	0
202405	0	0	0	6,945	232,595	0	0	0	0	0	0	0
202406	0	0	0	0	-2,007	226,181	0	0	0	0	0	0
202407	0	0	0	0	0	-12,695	217,693	0	0	0	0	0
202408	0	0	0	0	0	0	-23,849	547,090	0	0	0	0
202409	0	0	0	0	0	0	11,903	2,235	405,078	0	0	0
202410	0	0	0	0	0	0	-29	-1,944	-17,742	481,571	0	0
202411	0	0	0	0	0	0	0	0	0	-12,951	356,874	0
202412	0	0	0	0	0	0	0	0	0	0	25	337,829
202501	0	0	0	0	0	0	0	0	0	0	0	-10,228
202502	0	0	0	0	0	0	0	0	0	0	0	0
202503	0	0	0	0	0	0	0	0	204	0	0	204

- Incurred Claims have not been adjusted for unpaid claims estimates or pharmacy rebates

BridgeSpan Health Company - Individual
WAOIC# 500823
Rates Effective 1/1/2026
Months of Surplus

BridgeSpan Health Company	1/1/2026
Statutory Surplus*	$41,958,104
Statutory Claims Exp**	$8,803,036
Monthly Claims Exp	$733,586
Months of Surplus	57.20

Note: A contribution to surplus of 0.0% is proposed in this filing.
*Source: Annual Statement, Page 3, Column 3, Line 33
**Source: Annual Statement, Page 4, Column 2, Line 18

Checklist Item 25 b: Prescribed projection for 2026 Months of Surplus

Trend	10.20%
Risk and Contigency	3.50%
Loss Ratio	86.73%
Projected 2025 Claims	$9,700,946
Projected 2026 Claims	$10,690,442
Projected 2026 Monthly Claims	$890,870
Projected Change to Surplus	$822,869
Projected 2026 Surplus	$42,780,973
Projected 2026 Months of Surplus	48.02

- Projected Claims is the Statutory Claims Exp trended using the rate filing assumption of 10.2% annual trend.
- Projected Change to Surplus assumes 3.5% will be retained in 2024 and 2025 after applying the 86.7% loss ratio from the rate filing.

BridgeSpan Health Company - Individual
WAOIC# 500823
Rates Effective 1/1/2026
Financial Statements

This page left intentionally blank.
Balance Sheet from Annual Statement on next four pages.
Additional Data Statement Information on the following four pages.

ASSETS

		Current Year			Prior Year
		1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1.	Bonds (Schedule D)	37,683,931		37,683,931	36,892,564
2.	Stocks (Schedule D):				
	2.1 Preferred stocks			0	0
	2.2 Common stocks	11,524		11,524	11,241
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens			0	0
	3.2 Other than first liens			0	0
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
	4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
	4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5.	Cash ($ 25,688 , Schedule E - Part 1), cash equivalents ($ 2,736,701 , Schedule E - Part 2) and short-term investments ($ ..... , Schedule DA)	2,762,389		2,762,389	6,153,599
6.	Contract loans, (including $ ..... premium notes)			0	0
7.	Derivatives (Schedule DB)			0	0
8.	Other invested assets (Schedule BA)			0	0
9.	Receivables for securities	13		13	0
10.	Securities lending reinvested collateral assets (Schedule DL)			0	0
11.	Aggregate write-ins for invested assets	0	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	40,457,856	0	40,457,856	43,057,404
13.	Title plants less $ ..... charged off (for Title insurers only)			0	0
14.	Investment income due and accrued	241,057		241,057	191,952
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	10,284	581	9,703	0
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	0
	15.3 Accrued retrospective premiums ($ 0) and contracts subject to redetermination ($ 2,140,211)	2,140,211		2,140,211	2,026,373
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers	223,181		223,181	536,660
	16.2 Funds held by or deposited with reinsured companies			0	0
	16.3 Other amounts receivable under reinsurance contracts			0	0
17.	Amounts receivable relating to uninsured plans	1,385,488		1,385,488	0
18.1	Current federal and foreign income tax recoverable and interest thereon			0	0
18.2	Net deferred tax asset	155,197	616	154,581	83,309
19.	Guaranty funds receivable or on deposit			0	0
20.	Electronic data processing equipment and software	64,225	64,225	0	0
21.	Furniture and equipment, including health care delivery assets ($ .....)			0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23.	Receivables from parent, subsidiaries and affiliates	205,354		205,354	439,756
24.	Health care ($ 255,910) and other amounts receivable	317,234	61,324	255,910	347,370
25.	Aggregate write-ins for other-than-invested assets	380,689	346,030	34,659	34,747
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	45,580,776	472,776	45,108,000	46,717,571
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28.	Total (Lines 26 and 27)	45,580,776	472,776	45,108,000	46,717,571
	DETAILS OF WRITE-INS				
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199.	Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501.	Indirect Taxes Recoverable	34,659		34,659	34,747
2502.	Prepaid Assets	346,030	346,030	0	0
2503.					
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	380,689	346,030	34,659	34,747

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1	2	3	4
		Covered	Uncovered	Total	Total
1.	Claims unpaid (less $ 134,000 reinsurance ceded)	1,402,149	3,934	1,406,083	2,723,488
2.	Accrued medical incentive pool and bonus amounts	36,517		36,517	42,459
3.	Unpaid claims adjustment expenses	29,950		29,950	57,738
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act	629,575		629,575	860,666
5.	Aggregate life policy reserves			0	0
6.	Property/casualty unearned premium reserves			0	0
7.	Aggregate health claim reserves			0	0
8.	Premiums received in advance	133,150		133,150	128,621
9.	General expenses due or accrued	157,341		157,341	256,437
10.1	Current federal and foreign income tax payable and interest thereon (including $ (110,232) on realized capital gains (losses))	132,806		132,806	195,592
10.2	Net deferred tax liability			0	0
11.	Ceded reinsurance premiums payable	1,285		1,285	1,182
12.	Amounts withheld or retained for the account of others			0	0
13.	Remittances and items not allocated	324,420		324,420	323,122
14.	Borrowed money (including $ current) and interest thereon $ (including $ current)			0	0
15.	Amounts due to parent, subsidiaries and affiliates	199,844		199,844	389,697
16.	Derivatives			0	0
17.	Payable for securities	98,399		98,399	0
18.	Payable for securities lending			0	0
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)			0	0
20.	Reinsurance in unauthorized and certified ($) companies			0	0
21.	Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22.	Liability for amounts held under uninsured plans			0	0
23.	Aggregate write-ins for other liabilities (including $ 526 current)	526	0	526	526
24.	Total liabilities (Lines 1 to 23)	3,145,962	3,934	3,149,896	4,979,528
25.	Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26.	Common capital stock	XXX	XXX	53,062,640	53,062,640
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX		
29.	Surplus notes	XXX	XXX	0	
30.	Aggregate write-ins for other-than-special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	(11,104,536)	(11,324,597)
32.	Less treasury stock, at cost:				
	32.1 shares common (value included in Line 26 $)	XXX	XXX		
	32.2 shares preferred (value included in Line 27 $)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	41,958,104	41,738,043
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	45,108,000	46,717,571
	DETAILS OF WRITE-INS				
2301.	Unclaimed Property	526		526	526
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399.	Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	526	0	526	526
2501.		XXX	XXX		0
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	0	0
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year		Prior Year
		1 Uncovered	2 Total	3 Total
1.	Member Months	XXX	13,712	23,713
2.	Net premium income (including $ 0 non-health premium income)	XXX	9,714,377	15,586,915
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	0
4.	Fee-for-service (net of $ medical expenses)	XXX	0	0
5.	Risk revenue	XXX	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	9,714,377	15,586,915
	Hospital and Medical:			
9.	Hospital/medical benefits	13,586	4,657,460	9,628,100
10.	Other professional services	987	338,317	767,998
11.	Outside referrals	73	24,963	89,953
12.	Emergency room and out-of-area	2,607	893,769	1,599,020
13.	Prescription drugs	9,518	3,262,959	2,133,334
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		36,907	33,311
16.	Subtotal (Lines 9 to 15)	26,771	9,214,375	14,251,716
	Less:			
17.	Net reinsurance recoveries		411,339	499,506
18.	Total hospital and medical (Lines 16 minus 17)	26,771	8,803,036	13,752,210
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $ 143,439 cost containment expenses		236,251	651,513
21.	General administrative expenses		791,691	1,864,126
22.	Increase in reserves for life and accident and health contracts (including $ 0 increase in reserves for life only)		200,000	(700,000)
23.	Total underwriting deductions (Lines 18 through 22)	26,771	10,030,978	15,567,849
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(316,601)	19,066
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		1,365,069	1,073,554
26.	Net realized capital gains (losses) less capital gains tax of $ (110,232)		(414,682)	(237,509)
27.	Net investment gains (losses) (Lines 25 plus 26)	0	950,387	836,045
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ 0) (amount charged off $ 19,000)]		(19,000)	(32,092)
29.	Aggregate write-ins for other income or expenses	0	(10,000)	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	604,786	823,019
31.	Federal and foreign income taxes incurred	XXX	242,359	260,138
32.	Net income (loss) (Lines 30 minus 31)	XXX	362,427	562,881
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.		XXX		
0702.		XXX		
0703		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0
2901.	Other Expense		(10,000)	
2902.				
2903				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(10,000)	0

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	41,738,043	41,177,755
34.	Net income or (loss) from Line 32	362,427	562,881
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	236	355
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	71,017	(156,287)
39.	Change in nonadmitted assets	(213,618)	153,339
40	Change in unauthorized and certified reinsurance	0	0
41.	Change in treasury stock	0	0
42.	Change in surplus notes	0	0
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in	0	0
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders		
47.	Aggregate write-ins for gains or (losses) in surplus	0	0
48.	Net change in capital and surplus (Lines 34 to 47)	220,062	560,288
49.	Capital and surplus end of reporting period (Line 33 plus 48)	41,958,104	41,738,043
	DETAILS OF WRITE-INS		
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0

Additional Data Statement Form for the Year Ending December 31, 2024

Company: BridgeSpan Health Company NAIC Company Code: 95303

I. Analysis of Washington Operations by Lines of Business

See annual statement	1 Total	2 Comprehensive (Medical & Hospital) Individual	3 Comprehensive (Medical & Hospital) Group	4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVII Medicare	9 Title XIX Medicaid	10 Credit A&H	11 Disability Income	12 Long-term Care	13 Other Health	14 Other Non-Health
1. Net Premium Income	6,414,320	6,414,320												
7. Total Revenues (Lines 1 to 6)	6,414,320	6,414,320												
15. Subtotal (Lines 8 to 14)	6,812,508	6,812,508												XXX
16. Net Reinsurance Recoveries	0													XXX
17. Total hospital and medical (Lines 15 minus 16)	6,812,508	6,812,508	0	0	0	0	0	0	0	0	0	0	0	XXX
19. Claims adjustment expenses	109,838	109,838												
20. General administrative expenses	374,576	374,576												
21. Increase in reserves for accident and health contracts	200,000	200,000												XXX
23. Total underwriting deductions (Lines 17 to 22)	7,496,922	7,496,922	0	0	0	0	0	0	0	0	0	0	0	
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	(1,082,602)	(1,082,602)	0	0	0	0	0	0	0	0	0	0	0	0

Additional Data Statement Form for the Year Ending December 31, 2024

Company: BridgeSpan Health Company NAIC Company Code: 95303

II. Analysis of the Washington Comprehensive Line

	1 Total Comprehensive (Hospital & Medical)	2a Individual Contracts	2b Children's Health Insurance Program	3 Small Group Contracts	Large Group Contracts 4a Public Employees Benefits Board	 4b School Employees Benefits Board	 4c Pathway 1 Association Health Plans	 4d Large Group (what is not in columns 4a, 4b or 4c)	5 Other	6 List the full legal name of each Pathway 1 Association Health Plan included in column 4c
1. Net Premium Income	6,414,320	6,414,320								1
										2
7. Total Revenues (Lines 1 to 6)	6,414,320	6,414,320								3
										4
										5
15. Subtotal (Lines 8 to 14)	6,812,508	6,812,508								6
										7
16. Net Reinsurance Recoveries	0									8
										9
										10
17. Total hospital and medical (Lines 15 minus 16)	6,812,508	6,812,508	0	0	0	0	0	0	0	11
										12
19. Claims adjustment expenses	109,838	109,838								13
										14
										15
20. General administrative expenses	374,576	374,576								16
										17
21. Increase in reserves for accident and health contracts	200,000	200,000								18
										19
										20
23. Total underwriting deductions (Lines 17 to 22)	7,496,922	7,496,922	0	0	0	0	0	0	0	21
										22
										23
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	(1,082,602)	(1,082,602)	0	0	0	0	0	0	0	24
										25

Additional Data Statement Form for the Year Ending December 31, 2024

Company: BridgeSpan Health Company NAIC Company Code: 95303

III. Group Enrollment in Washington

Total Members at end of:	1 Total Comprehensive (Hospital & Medical)	2a Individual Contracts	2b Children's Health Insurance Program	3 Small Group Contracts	Large Group Contracts 4a Public Employees Benefits Board	 4b School Employees Benefits Board	 4c Pathway 1 Association Health Plans	 4d Large Group (what is not in columns 4a, 4b or 4c)	5 Other
1. Prior Year	841	841							
2. First Quarter	544	544							
3. Second Quarter	521	521							
4. Third Quarter	488	488							
5. Current Year	462	462							

6 List the full legal name of each Pathway 1 Association Health Plan included in column 4c (continued)	
26	
27	
28	
29	
30	
31	
32	
33	
34	
35	
36	
37	
38	
39	
40	
41	
42	
43	
44	
45	
46	
47	
48	
49	
50	

Additional Data Statement Form for the Year Ending December 31, 2024

Company: BridgeSpan Health Company NAIC Company Code: 95303

IV. Deposit or Funded Reserve or Underwriting of Indemnity Calculation

Mark the type of certificate the company holds and then fill in the data.

☐ Multiple Employer Welfare Organization (MEWA)

☐ Maintain a $200,000 restricted deposit held under a Depositary Agreement with the Commissioner.

☐ Health Maintenance Organization (HMO)

$150,000 Funded Reserve is maintained by:
☐ Cash or securities deposit
☐ Surety Bond
☐ Combination of the two

☑ Health Care Service Contractor (HCSC) **Complete both calculations**

Calculation of Deposit Requirements (WAC 284-44-320 and 284-44-330)

$6,186,263	A1. Premiums Collected
8.3%	A2. One-twelfth
$513,460	A3. Calculated Requirement (line A1 x line A2)
$150,000	A4. Minimum Indemnity
$513,460	A5. Indemnity Required (greater of line A3 or line A4)

Calculation of Indemnity Required (WAC 284-44-340)

	1 Incurred but Unpaid	2 Service Benefits	3 Non-Service (Indemnity)
B1. Line of Business Subtotal	$737,792	$735,728	$2,064
B2. Percentage of Claim Reserve and Claim Liability	100%	100%	0%
B3. Estimated Increase (Decrease) During Ensuing Year			($973)
B4. Adjusted Claim Reserve and Claim Liability (line B1 + line B3)			$1,092
B5. Policy Reserves	$216,275		$605
B6. Premiums Received in Advance	$87,905		$246
B7. Total Unearned Prepayments (line B5 + line B6)			$851
B8. Calculated Alternate Indemnity Requirement (line B4 + line B7)			$1,942
B9. Minimum Indemnity			$150,000
B10. Indemnity Required (greater of line B8 or line B9)			$150,000
B11. Total of Deposit Market Value, Surety Bond and Insurance Policy at December 31.			$150,861
B12. (Negative) means an Increase is Required; Positive means an Excess			$861

Indemnity is maintained by:
☑ Cash or securities deposit
☐ Surety Bond
☐ Insurance policy

☐ Limited Health Care Service Contractor (LHCSC)

☐ LHCSC certificate held three or MORE years

	C1. Uncovered Expenditures
	C2. Anticipated increase or (decrease) in the line above
$0	C3. Total (line C1 + line C2)
25%	C4. Twenty-five percent
$0	C5. Line C3 x line C4
	C6. Policy Reserves
	C7. Premiums Received in Advance
$0	C8. Indemnity Required (line C5 + line C6 + line C7)
	C9. Total of Deposit Market Value, Surety Bond and Insurance Policy at December 31
$0	C10. (Negative) means an Increase is Required; Positive means an Excess

Indemnity is maintained by:
☐ Cash or securities deposit
☐ Surety Bond
☐ Insurance policy

☐ LHCSC certificate held for LESS than three years

	D1. Projected net premiums earned for the next year
0.5%	D2. One-half of one percent
$0	D3. Indemnity Required (line D1 x D2)

D4. _____ insures or guarantees the LHCSC's Uncovered Expenditures and that insurer/guarantor's NAIC company code is _____

Question 1:

Part 1: Please provide issuer's name, market, and plan year information.
Part 2: Please provide a table with the following information:

1. In the first column, list all 2025 HIOS Plan IDs and all 2026 HIOS Plan IDs (one HIOS Plan ID per row; insert rows in the table as needed);
2. In the second column, state the 2025 plan name associated with the HIOS Plan ID (if the plan is new in 2026, state "N/A");
3. In the third column, state the 2026 plan name associated with the HIOS Plan ID (if the plan terminated in 2026, state "N/A");
4. In the fourth column, state if the plan is New (a new plan in 2026), Renewal (an existing plan from 2025), or Terminated (a 2025 plan that is not offered in 2026); and
5. In the fifth column provide the enrollment as of March 31, 2025.

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

Response:

Part 1

Issuer Name:	BridgeSpan Health Company
HIOS Issuer ID:	53732
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
53732WA0790007	Bronze Essential 8500	N/A	Terminated	0
53732WA0790024	BridgeSpan Cascade Gold	BridgeSpan Cascade Complete Gold	Renewal	64
53732WA0790025	BridgeSpan Cascade Silver	BridgeSpan Cascade Silver	Renewal	119
53732WA0790026	BridgeSpan Cascade Bronze	BridgeSpan Cascade Bronze	Renewal	193
53732WA0790030	N/A	BridgeSpan Cascade Vital Gold	New	0
Total				**376**

Question 2:

For each plan with a 2025 HIOS Plan ID that is included in the 2026 rate filing, justify and explain in detail that it is a renewal plan within a renewal product and meets all of the criteria listed in 45 CFR §147.106(e)(3).

Response:

All plans with a 2025 Plan ID included in the 2026 rate filing are considered renewal plans because:
i. They are offered by the same health insurance issuer.
ii. They are offered as the same product network type.
iii. Each product continues to cover at least a majority of the same service area.
iv. Each product has the same cost-sharing structure as before, except for changes related to cost and utilization of medical care or to maintain the same metal tier level. See Question 4a for detailed changes.
v. Each product covers essentially the same covered benefits, with cumulative benefit changes not exceeding +/- 2 percentage points.

2025 HIOS Plan ID	2026 Plan Name
53732WA0790024	BridgeSpan Cascade Complete Gold
53732WA0790025	BridgeSpan Cascade Silver
53732WA0790026	BridgeSpan Cascade Bronze

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?
53732WA0790030	BridgeSpan Cascade Vital Gold	This is a new plan design offered on exchange.

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)**
53732WA0790024	BridgeSpan Cascade Gold	BridgeSpan Cascade Complete Gold	RGWA-134490492	None	In-Network Deductible	$600	$1,000
53732WA0790024					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
53732WA0790024					Artificial Insemination	Not Covered	Deductible and Coinsurance
53732WA0790025	BridgeSpan Cascade Silver	N/A - Same as 2025	RGWA-134490492	None	In-Network Out-of-Pocket Maximum	$9,200	$9,750
53732WA0790025					Acupuncture / Spinal Manipulations	$30	$20
53732WA0790025					Mental Health / Substance Use Disorder Office Visit and Psychotherapy	$30 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for MHSUD)	$20 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for MHSUD)
53732WA0790025					Primary Care Office Visit	$30 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$20 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)
53732WA0790025					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
53732WA0790025					Artificial Insemination	Not Covered	Deductible and Coinsurance
53732WA0790025					Virtual Care (Store & Forward)	$30 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)
53732WA0790025					Virtual Care (Telehealth)	$30 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$20 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)
53732WA0790026	BridgeSpan Cascade Bronze	N/A - Same as 2025	RGWA-134490492	None	In-Network Out-of-Pocket Maximum	$9,200	$10,150
53732WA0790026					Acupuncture / Spinal Manipulations	$50	$40

					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)**
53732WA0790026					Mental Health / Substance Use Disorder Office Visit and Psychotherapy	$50 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for MHSUD)	$40 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for MHSUD)
53732WA0790026					Primary Care Office Visit	$50 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)	$40 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)
53732WA0790026					Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
53732WA0790026					Artificial Insemination	Not Covered	Deductible and Coinsurance
53732WA0790026					Virtual Care (Store & Forward)	$50 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)
53732WA0790026					Virtual Care (Telehealth)	$50 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)	$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)

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)**
53732WA0790007	Bronze Essential 8500	53732WA0790026	BridgeSpan Cascade Bronze	RGWA-134490492	None	In-Network Deductible	$8,500	$6,000
53732WA0790007		53732WA0790026				In-Network Out-of-Pocket Maximum	$9,200	$10,150
53732WA0790007		53732WA0790026				In-Network Coinsurance	10%	40%
53732WA0790007		53732WA0790026				Acupuncture / Spinal Manipulations	Deductible and Coinsurance	$40
53732WA0790007		53732WA0790026				Home Health	Deductible and Coinsurance	$50
53732WA0790007		53732WA0790026				Outpatient Hospice	Deductible and Coinsurance	$50
53732WA0790007		53732WA0790026				Mental Health / Substance Use Disorder Office Visit and Psychotherapy	Deductible and Coinsurance	$40 $1 copy for first 2-visits, then regular copay applies (combined with Virtual Care for MHSUD)
53732WA0790007		53732WA0790026				Primary Care Office Visit	$60 Deductible waived, 4 upfront visit limit shared for Primary Care, Specialist & Urgent Care, Deductible and Coinsurance after limit is met	$40 $1 copay for first 2-visits, then regular copay applies (combined with Virtual Care for PCP)
53732WA0790007		53732WA0790026				Hearing Instruments	Not Covered	Deductible Waived, Coinsurance Applies
53732WA0790007		53732WA0790026				Artificial Insemination	Not Covered	Deductible and Coinsurance
53732WA0790007		53732WA0790026				Specialist Office Visit	$60 Deductible waived, 4 upfront visit limit shared for Primary Care, Specialist & Urgent Care, Deductible and Coinsurance after limit is met	$100 Subject to Deductible
53732WA0790007		53732WA0790026				Urgent Care Facility Office Visit	$60 Deductible waived, 4 upfront visit limit shared for Primary Care, Specialist & Urgent Care, Deductible and Coinsurance after limit is met	$100

53732WA0790007		53732WA0790026				Virtual Care (Store & Forward)	Covered in Full	$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)
53732WA0790007		53732WA0790026				Virtual Care (Telehealth)	Covered in Full	$40 $1 copay for first 2-visits PCP and first 2-visits MHSUD, then regular copay applies (Combined with PCP / MHSUD)
53732WA0790007		53732WA0790026				Rx Tier 1 Retail	$20	$32
53732WA0790007		53732WA0790026				Rx Tier 1 Home Delivery	$60	$96
53732WA0790007		53732WA0790026				Rx Tier 2 Retail	30%	40%
53732WA0790007		53732WA0790026				Rx Tier 2 Home Delivery	30%	40%
53732WA0790007		53732WA0790026				Rx Tier 4 Retail	50%	40%
53732WA0790007		53732WA0790026				Rx Chemo	10%	40%

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):	376
Overall Average Rate Change (weighted by 03/31/2025 enrollment) 5(l):	18.38%

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
53732WA0790007	Bronze Essential 8500	Terminated	0	53732WA0790026	BridgeSpan Cascade Bronze	7.30%	0.00%	4.43%	12.06%
53732WA0790024	BridgeSpan Cascade Gold	Renewal	64	N/A	N/A	0.40%	0.00%	-1.90%	-1.51%
53732WA0790025	BridgeSpan Cascade Silver	Renewal	119	N/A	N/A	46.12%	0.00%	0.92%	47.46%
53732WA0790026	BridgeSpan Cascade Bronze	Renewal	193	N/A	N/A	7.86%	0.00%	-0.75%	7.05%

April 15, 2025

Christine Gibert
Policy Director
Washington Health Benefit Exchange
Via email: Christine.gibert@wahbexchange.org

RE: CERTIFICATION FOR WAHBE 2026 STANDARD PLAN DESIGNS

At the request of the Washington Health Benefit Exchange (WAHBE), Wakely is providing an actuarial value (AV) certification and unique plan justification for the 2026 standardized plan designs. The 2026 benefit designs were modestly adjusted to fit within the parameters of the revised final 2026 federal AV calculator's (AVC) constraints and to include special cost sharing for office visits for primary care and mental health/substance use disorder (MH/SUD). For 2026, Acumen modified the 2026 standardized plan designs to fit within the actuarial value requirements and made adjustments to the federal AVC for unique plan designs that did not fit into the AVC and could be considered material. Wakely completed a review of Acumen's methodology, conducted reasonability checks, and is certifying the unique plan adjustments and plan actuarial values.

While this memo discusses Acumen's methodology at a high level, it primarily focuses on review completed by Wakely to confirm the reasonability of Acumen's AV estimates. Wakely is providing an actuarial certification for the adjusted actuarial values allowed under 45 CFR §156.135(b) (3) in Appendices A and B. The documentation that Acumen provided on their methodology can be found in the Appendix C.

Our understanding is that WAHBE will use the final certification for plan year 2026. Use of this document for other purposes may not be appropriate. This document, and any accompanying files and correspondence, are intended for WAHBE internal use only and are not meant for broad distribution. The estimates presented here are based on emerging data and information available as of the date of this report.

This memo should only be utilized by qualified individuals with an understanding of the assumptions and limitations of the analysis described in the disclosures section of the memo. If disseminated, the memo should only be shared in its entirety. During the review of the memo, if you should have any questions or would like further clarification, please do not hesitate to contact us via email or phone (contact information available below), and we will be happy to provide assistance.

wakely.com

Washington Health Benefit Exchange

2026 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification

April 15, 2025

Prepared by:
Wakely Consulting Group, LLC

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
Darren Johnson, FSA, MAAA
Consulting Actuary

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
500 Airport Blvd., Ste 100
Burlingame, CA 94010
Main (650) 558-8882
Fax (650) 558-3981
http://www.acumenllc.com

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

(Begins on next page)

ACUMEN

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.

ACUMEN

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

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	BridgeSpan Health Company
Address	2890 E. Cottonwood Parkway
	Salt Lake City, Utah 84121
Carrier Identification Number	WAOIC# 500823

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

Proposed Rate Summary

Current community rate:	$896.05	per month
Proposed community rate:	$1,060.74	per month
Percentage change:	18.38%	%
Portion of carrier's total enrollment affected:	44.50	%
Portion of carrier's total premium revenue affected:	46.60	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims	$920.01	86.73%
b) Expenses	$105.30	9.93%
c) Contribution to surplus contingency charges, or risk charges	$37.13	3.50%
d) Investment earnings	$1.70	0.16%
e) Total (a + b + c - d)	$1,060.74	100.00%

Summary of Pooled Experience

	Experience Period	First Prior Period	Second Prior Period
	From 1/1/2024 To 12/31/2024	From 1/1/2023 To 12/31/2023	From 1/1/2022 To 12/31/2022
Member Months	6108	11690	21156
Earned Premium	$4,524,562.08	$7,311,510.50	$11,028,411.24
Paid Claims	$8,458,047.07	$9,959,728.10	$12,184,329.03
Beginning Claim Reserve	$1,706,389.48	$1,206,943.60	$2,303,661.62
Ending Claim Reserve	$595,452.13	$1,706,389.48	$1,206,943.60
Incurred Claims	$7,347,109.72	$10,459,173.98	$11,087,611.01
Expenses	$491,550.70	$917,162.43	$1,415,816.79
Gain/Loss	-$3,314,098.34	-$4,064,825.91	-$1,475,016.56
Loss Ratio Percentage	162.38%	143.05%	100.54%

General Information

1. Trend Factor Summary

Types of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	10.20%	46.91%
Professional	10.20%	11.92%
Prescription Drugs	10.20%	40.01%
Dental	N/A	N/A
Other	10.20%	1.17%

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

	1)	2)	3)
	1/1/2025	1/1/2024	1/1/2023
	14.92%	16.35%	15.68%
	Date %	Date %	Date %

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

		Yes	No
Geographic Area		X	
Family Size			X
Age			X
Wellness Activities			X
Other (specify)	Remove tobacco rating factor	X	

4. Attach a table showing the base rate for each plan affected by this filing.

Please see Rate Factors exhibit for base rates by plan. Please see Rate Schedule exhibit for detailed rate information.

5. Attach comments or additional Information

6. Preparer's Information

Name:	Daniel Boeder
Title:	Manager, Actuarial Pricing
Telephone Number:	(206) 332-5619

Unified Rate Review v6.1

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

Company Legal Name:	**BridgeSpan Health Company**		
HIOS Issuer ID:	**53732**	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	$8,217,438.64	$1,345.36
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$7,347,109.72	$1,202.87
Risk Adjustment	$2,120,570.07	$347.18
Experience Period Premium	$4,524,562.08	$740.76
Experience Period Member Months	6,108	

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	$156.56	1.050	1.024	1.050	1.024	$181.10
Outpatient Hospital	$473.22	1.050	1.024	1.050	1.024	$547.41
Professional	$160.05	1.050	1.024	1.050	1.024	$185.14
Other Medical	$15.66	1.050	1.024	1.050	1.024	$18.11
Capitation	$0.00	1.050	1.024	1.050	1.024	$0.00
Prescription Drug	$537.18	1.050	1.041	1.050	1.041	$642.37
Total	$1,342.67					**$1,574.14**

Morbidity Adjustment		0.736
Demographic Shift		0.997
Plan Design Changes		1.073
Other		1.001
Adjusted Trended EHB Allowed Claims PMPM for	**1/1/2026**	**$1,240.71**

Manual EHB Allowed Claims PMPM	$1,096.33
Applied Credibility %	2.00%

			Projected Period Totals
Projected Index Rate for	**1/1/2026**	**$1,099.22**	$4,959,680.64
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		$109.42	$493,710.53
Exchange User Fees		0.52%	$23,239.78
Market Adjusted Index Rate		**$994.95**	**$4,489,209.90**

Projected Member Months	**4,512**

Product-Plan Data Collection

Company Legal Name: **BridgeSpan Health Company**
HIOS Issuer ID: **53732** 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		BridgeSpan Exchange EPO No Ped Dental				
1.2	Product ID		53732WA079				
1.3	Plan Name		BridgeSpan	BridgeSpan	BridgeSpan	BridgeSpan	Bronze Essential
1.4	Plan ID (Standard Component ID)		53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
1.5	Metal		Gold	Gold	Silver	Bronze	Bronze
1.6	AV Metal Value		0.818	0.781	0.718	0.650	0.623
1.7	Plan Category		Renewing	New	Renewing	Renewing	Terminated
1.8	Plan Type		EPO	EPO	EPO	EPO	EPO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes	No
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		-4.93%	0.00%	42.34%	3.33%	0.00%
1.12	Product Rate Increase %		15.07%				
1.13	Submission Level Rate Increase %		15.07%				

Worksheet 1 Totals		**Section II: Experience Period and Current Plan Level Information**						
	2.1	Plan ID (Standard Component ID)	Total	53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
$8,217,439	2.2	Allowed Claims	$8,217,439	$1,606,697	$0	$3,623,045	$1,593,360	$1,394,336
$0	2.3	Reinsurance	$0	$0	$0	$0	$0	$0
	2.4	Member Cost Sharing	$870,329	$123,366	$0	$264,226	$192,561	$290,176
	2.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
$7,347,110	2.6	Incurred Claims	$7,347,110	$1,483,331	$0	$3,358,819	$1,400,799	$1,104,161
$2,120,570	2.7	Risk Adjustment Transfer Amount	$2,120,570	$1,142,521	$0	$1,361,609	-$128,803	-$254,757
$4,524,562	2.8	Premium	$4,524,562	$788,578	$0	$1,345,978	$889,100	$1,500,906
6,108	2.9	Experience Period Member Months	6,108	849	0	1,623	1,221	2,415
	2.10	Current Enrollment	376	64	0	119	193	0
	2.11	Current Premium PMPM	$883.89	$986.78	$0.00	$953.18	$807.04	$0.00
	2.12	Loss Ratio	110.56%	76.81%	#DIV/0!	124.05%	184.24%	88.61%
		Per Member Per Month						
	2.13	Allowed Claims	$1,345.36	$1,892.46	#DIV/0!	$2,232.31	$1,304.96	$577.36
	2.14	Reinsurance	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00
	2.15	Member Cost Sharing	$142.49	$145.31	#DIV/0!	$162.80	$157.71	$120.16
	2.16	Cost Sharing Reduction	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00
	2.17	Incurred Claims	$1,202.87	$1,747.15	#DIV/0!	$2,069.51	$1,147.26	$457.21
	2.18	Risk Adjustment Transfer Amount	$347.18	$1,345.73	#DIV/0!	$838.95	-$105.49	-$105.49
	2.19	Premium	$740.76	$928.83	#DIV/0!	$829.31	$728.17	$621.49

Section III: Plan Adjustment Factors

3.1	Plan ID (Standard Component ID)		53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
3.2	Market Adjusted Index Rate		$994.95				
3.3	AV and Cost Sharing Design of Plan		1.0098	0.9170	1.1701	0.6943	0.0000
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.5	Benefits in Addition to EHB		1.0020	1.0020	1.0020	1.0020	0.0000
	Administrative Costs						
3.6	Administrative Expense		6.85%	6.85%	6.85%	6.85%	0.00%
3.7	Taxes and Fees		2.17%	2.17%	2.17%	2.17%	0.00%
3.8	Profit & Risk Load		3.50%	3.50%	3.50%	3.50%	0.00%
3.9	Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	0.0000
3.10	**Plan Adjusted Index Rate**		$1,150.77	$1,045.01	$1,333.51	$791.22	$0.00
3.11	Age Calibration Factor	0.5562	0.5562				
3.12	Geographic Calibration Factor	0.965	0.9650				
3.13	Tobacco Calibration Factor	1	1.0000				
3.14	**Calibrated Plan Adjusted Index Rate**		$617.65	$560.89	$715.74	$424.68	$0.00

Section IV: Projected Plan Level Information

4.1	Plan ID (Standard Component ID)	Total	53732WA0790024	53732WA0790030	53732WA0790025	53732WA0790026	53732WA0790007
4.2	Allowed Claims	$4,969,574	$878,967	$13,952	$1,583,407	$2,493,249	$0
4.3	Reinsurance	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$508,289	$114,777	$2,042	$94,555	$296,914	$0
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$4,461,285	$764,190	$11,909	$1,488,851	$2,196,335	$0
4.7	Risk Adjustment Transfer Amount	$204,801	$223,675	$3,550	$304,157	-$326,582	$0
4.8	Premium	$4,619,236	$869,980	$12,540	$1,904,245	$1,832,470	$0
4.9	Projected Member Months	4,512	756	12	1,428	2,316	0
4.10	Loss Ratio	92.48%	69.87%	74.01%	67.42%	145.85%	#DIV/0!
	Per Member Per Month						
4.11	Allowed Claims	$1,101.41	$1,162.65	$1,162.65	$1,108.83	$1,076.53	#DIV/0!
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.13	Member Cost Sharing	$112.65	$151.82	$170.20	$66.22	$128.20	#DIV/0!
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
4.15	Incurred Claims	$988.76	$1,010.83	$992.45	$1,042.61	$948.33	#DIV/0!
4.16	Risk Adjustment Transfer Amount	$45.39	$295.87	$295.87	$212.99	-$141.01	#DIV/0!
4.17	Premium	$1,023.77	$1,150.77	$1,045.01	$1,333.51	$791.22	#DIV/0!

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 1	1.0000
Rating Area 2	1.1310
Rating Area 3	1.0740
Rating Area 4	0.9880
Rating Area 5	1.0370
Rating Area 6	1.0450
Rating Area 8	1.0550
Rating Area 9	1.1110

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Bronze
HIOS Plan ID: 53732WA0790026
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Bronze
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	324.91	367.47	348.95	321.01	336.93	339.53		342.78	360.98	324.91	367.47	348.95	321.01	336.93	339.53		342.78	360.98
15	353.79	400.14	379.97	349.54	366.88	369.71		373.25	393.06	353.79	400.14	379.97	349.54	366.88	369.71		373.25	393.06
16	364.83	412.62	391.83	360.45	378.33	381.25		384.90	405.33	364.83	412.62	391.83	360.45	378.33	381.25		384.90	405.33
17	375.88	425.12	403.70	371.37	389.79	392.79		396.55	417.60	375.88	425.12	403.70	371.37	389.79	392.79		396.55	417.60
18	387.77	438.57	416.46	383.12	402.12	405.22		409.10	430.81	387.77	438.57	416.46	383.12	402.12	405.22		409.10	430.81
19	399.66	452.02	429.23	394.86	414.45	417.64		421.64	444.02	399.66	452.02	429.23	394.86	414.45	417.64		421.64	444.02
20	411.98	465.95	442.47	407.04	427.22	430.52		434.64	457.71	411.98	465.95	442.47	407.04	427.22	430.52		434.64	457.71
21	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86
22	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86
23	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86
24	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86	424.72	480.36	456.15	419.62	440.43	443.83		448.08	471.86
25	426.42	482.28	457.98	421.30	442.20	445.61		449.87	473.75	426.42	482.28	457.98	421.30	442.20	445.61		449.87	473.75
26	434.91	491.88	467.09	429.69	451.00	454.48		458.83	483.19	434.91	491.88	467.09	429.69	451.00	454.48		458.83	483.19
27	445.11	503.42	478.05	439.77	461.58	465.14		469.59	494.52	445.11	503.42	478.05	439.77	461.58	465.14		469.59	494.52
28	461.67	522.15	495.83	456.13	478.75	482.45		487.06	512.92	461.67	522.15	495.83	456.13	478.75	482.45		487.06	512.92
29	475.26	537.52	510.43	469.56	492.84	496.65		501.40	528.01	475.26	537.52	510.43	469.56	492.84	496.65		501.40	528.01
30	482.06	545.21	517.73	476.28	499.90	503.75		508.57	535.57	482.06	545.21	517.73	476.28	499.90	503.75		508.57	535.57
31	492.25	556.73	528.68	486.34	510.46	514.40		519.32	546.89	492.25	556.73	528.68	486.34	510.46	514.40		519.32	546.89
32	502.44	568.26	539.62	496.41	521.03	525.05		530.07	558.21	502.44	568.26	539.62	496.41	521.03	525.05		530.07	558.21
33	508.81	575.46	546.46	502.70	527.64	531.71		536.79	565.29	508.81	575.46	546.46	502.70	527.64	531.71		536.79	565.29
34	515.61	583.15	553.77	509.42	534.69	538.81		543.97	572.84	515.61	583.15	553.77	509.42	534.69	538.81		543.97	572.84
35	519.01	587.00	557.42	512.78	538.21	542.37		547.56	576.62	519.01	587.00	557.42	512.78	538.21	542.37		547.56	576.62
36	522.41	590.85	561.07	516.14	541.74	545.92		551.14	580.40	522.41	590.85	561.07	516.14	541.74	545.92		551.14	580.40
37	525.80	594.68	564.71	519.49	545.25	549.46		554.72	584.16	525.80	594.68	564.71	519.49	545.25	549.46		554.72	584.16
38	529.20	598.53	568.36	522.85	548.78	553.01		558.31	587.94	529.20	598.53	568.36	522.85	548.78	553.01		558.31	587.94
39	536.00	606.22	575.66	529.57	555.83	560.12		565.48	595.50	536.00	606.22	575.66	529.57	555.83	560.12		565.48	595.50
40	542.79	613.90	582.96	536.28	562.87	567.22		572.64	603.04	542.79	613.90	582.96	536.28	562.87	567.22		572.64	603.04
41	552.99	625.43	593.91	546.35	573.45	577.87		583.40	614.37	552.99	625.43	593.91	546.35	573.45	577.87		583.40	614.37
42	562.75	636.47	604.39	556.00	583.57	588.07		593.70	625.22	562.75	636.47	604.39	556.00	583.57	588.07		593.70	625.22
43	576.35	651.85	619.00	569.43	597.67	602.29		608.05	640.32	576.35	651.85	619.00	569.43	597.67	602.29		608.05	640.32
44	593.33	671.06	637.24	586.21	615.28	620.03		625.96	659.19	593.33	671.06	637.24	586.21	615.28	620.03		625.96	659.19
45	613.30	693.64	658.68	605.94	635.99	640.90		647.03	681.38	613.30	693.64	658.68	605.94	635.99	640.90		647.03	681.38
46	637.08	720.54	684.22	629.44	660.65	665.75		672.12	707.80	637.08	720.54	684.22	629.44	660.65	665.75		672.12	707.80
47	663.84	750.80	712.96	655.87	688.40	693.71		700.35	737.53	663.84	750.80	712.96	655.87	688.40	693.71		700.35	737.53
48	694.42	785.39	745.81	686.09	720.11	725.67		732.61	771.50	694.42	785.39	745.81	686.09	720.11	725.67		732.61	771.50
49	724.57	819.49	778.19	715.88	751.38	757.18		764.42	805.00	724.57	819.49	778.19	715.88	751.38	757.18		764.42	805.00
50	758.55	857.92	814.68	749.45	786.62	792.68		800.27	842.75	758.55	857.92	814.68	749.45	786.62	792.68		800.27	842.75
51	792.10	895.87	850.72	782.59	821.41	827.74		835.67	880.02	792.10	895.87	850.72	782.59	821.41	827.74		835.67	880.02
52	829.05	937.66	890.40	819.10	859.72	866.36		874.65	921.07	829.05	937.66	890.40	819.10	859.72	866.36		874.65	921.07
53	866.43	979.93	930.55	856.03	898.49	905.42		914.08	962.60	866.43	979.93	930.55	856.03	898.49	905.42		914.08	962.60
54	906.78	1025.57	973.88	895.90	940.33	947.59		956.65	1007.43	906.78	1025.57	973.88	895.90	940.33	947.59		956.65	1007.43
55	947.13	1071.20	1017.22	935.76	982.17	989.75		999.22	1052.26	947.13	1071.20	1017.22	935.76	982.17	989.75		999.22	1052.26
56	990.87	1120.67	1064.19	978.98	1027.53	1035.46		1045.37	1100.86	990.87	1120.67	1064.19	978.98	1027.53	1035.46		1045.37	1100.86
57	1035.04	1170.63	1111.63	1022.62	1073.34	1081.62		1091.97	1149.93	1035.04	1170.63	1111.63	1022.62	1073.34	1081.62		1091.97	1149.93
58	1082.19	1223.96	1162.27	1069.20	1122.23	1130.89		1141.71	1202.31	1082.19	1223.96	1162.27	1069.20	1122.23	1130.89		1141.71	1202.31
59	1105.55	1250.38	1187.36	1092.28	1146.46	1155.30		1166.36	1228.27	1105.55	1250.38	1187.36	1092.28	1146.46	1155.30		1166.36	1228.27
60	1152.69	1303.69	1237.99	1138.86	1195.34	1204.56		1216.09	1280.64	1152.69	1303.69	1237.99	1138.86	1195.34	1204.56		1216.09	1280.64
61	1193.46	1349.80	1281.78	1179.14	1237.62	1247.17		1259.10	1325.93	1193.46	1349.80	1281.78	1179.14	1237.62	1247.17		1259.10	1325.93
62	1220.22	1380.07	1310.52	1205.58	1265.37	1275.13		1287.33	1355.66	1220.22	1380.07	1310.52	1205.58	1265.37	1275.13		1287.33	1355.66
63	1253.77	1418.01	1346.55	1238.72	1300.16	1310.19		1322.73	1392.94	1253.77	1418.01	1346.55	1238.72	1300.16	1310.19		1322.73	1392.94
64 and over	1274.16	1441.07	1368.45	1258.86	1321.29	1331.49		1344.24	1415.58	1274.16	1441.07	1368.45	1258.86	1321.29	1331.49		1344.24	1415.58

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Vital Gold
HIOS Plan ID: 53732WA0790030
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	429.13	485.35	460.89	423.98	445.01	448.44		452.73	476.76	429.13	485.35	460.89	423.98	445.01	448.44		452.73	476.76
15	467.27	528.48	501.85	461.66	484.56	488.30		492.97	519.14	467.27	528.48	501.85	461.66	484.56	488.30		492.97	519.14
16	481.86	544.98	517.52	476.08	499.69	503.54		508.36	535.35	481.86	544.98	517.52	476.08	499.69	503.54		508.36	535.35
17	496.44	561.47	533.18	490.48	514.81	518.78		523.74	551.54	496.44	561.47	533.18	490.48	514.81	518.78		523.74	551.54
18	512.15	579.24	550.05	506.00	531.10	535.20		540.32	569.00	512.15	579.24	550.05	506.00	531.10	535.20		540.32	569.00
19	527.85	597.00	566.91	521.52	547.38	551.60		556.88	586.44	527.85	597.00	566.91	521.52	547.38	551.60		556.88	586.44
20	544.12	615.40	584.38	537.59	564.25	568.61		574.05	604.52	544.12	615.40	584.38	537.59	564.25	568.61		574.05	604.52
21	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22
22	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22
23	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22
24	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22	560.95	634.43	602.46	554.22	581.71	586.19		591.80	623.22
25	563.19	636.97	604.87	556.43	584.03	588.53		594.17	625.70	563.19	636.97	604.87	556.43	584.03	588.53		594.17	625.70
26	574.41	649.66	616.92	567.52	595.66	600.26		606.00	638.17	574.41	649.66	616.92	567.52	595.66	600.26		606.00	638.17
27	587.88	664.89	631.38	580.83	609.63	614.33		620.21	653.13	587.88	664.89	631.38	580.83	609.63	614.33		620.21	653.13
28	609.75	689.63	654.87	602.43	632.31	637.19		643.29	677.43	609.75	689.63	654.87	602.43	632.31	637.19		643.29	677.43
29	627.70	709.93	674.15	620.17	650.92	655.95		662.22	697.37	627.70	709.93	674.15	620.17	650.92	655.95		662.22	697.37
30	636.68	720.09	683.79	629.04	660.24	665.33		671.70	707.35	636.68	720.09	683.79	629.04	660.24	665.33		671.70	707.35
31	650.14	735.31	698.25	642.34	674.20	679.40		685.90	722.31	650.14	735.31	698.25	642.34	674.20	679.40		685.90	722.31
32	663.60	750.53	712.71	655.64	688.15	693.46		700.10	737.26	663.60	750.53	712.71	655.64	688.15	693.46		700.10	737.26
33	672.02	760.05	721.75	663.96	696.88	702.26		708.98	746.61	672.02	760.05	721.75	663.96	696.88	702.26		708.98	746.61
34	680.99	770.20	731.38	672.82	706.19	711.63		718.44	756.58	680.99	770.20	731.38	672.82	706.19	711.63		718.44	756.58
35	685.48	775.28	736.21	677.25	710.84	716.33		723.18	761.57	685.48	775.28	736.21	677.25	710.84	716.33		723.18	761.57
36	689.97	780.36	741.03	681.69	715.50	721.02		727.92	766.56	689.97	780.36	741.03	681.69	715.50	721.02		727.92	766.56
37	694.46	785.43	745.85	686.13	720.16	725.71		732.66	771.55	694.46	785.43	745.85	686.13	720.16	725.71		732.66	771.55
38	698.94	790.50	750.66	690.55	724.80	730.39		737.38	776.52	698.94	790.50	750.66	690.55	724.80	730.39		737.38	776.52
39	707.92	800.66	760.31	699.42	734.11	739.78		746.86	786.50	707.92	800.66	760.31	699.42	734.11	739.78		746.86	786.50
40	716.89	810.80	769.94	708.29	743.41	749.15		756.32	796.46	716.89	810.80	769.94	708.29	743.41	749.15		756.32	796.46
41	730.36	826.04	784.41	721.60	757.38	763.23		770.53	811.43	730.36	826.04	784.41	721.60	757.38	763.23		770.53	811.43
42	743.26	840.63	798.26	734.34	770.76	776.71		784.14	825.76	743.26	840.63	798.26	734.34	770.76	776.71		784.14	825.76
43	761.21	860.93	817.54	752.08	789.37	795.46		803.08	845.70	761.21	860.93	817.54	752.08	789.37	795.46		803.08	845.70
44	783.65	886.31	841.64	774.25	812.65	818.91		826.75	870.64	783.65	886.31	841.64	774.25	812.65	818.91		826.75	870.64
45	810.01	916.12	869.95	800.29	839.98	846.46		854.56	899.92	810.01	916.12	869.95	800.29	839.98	846.46		854.56	899.92
46	841.43	951.66	903.70	831.33	872.56	879.29		887.71	934.83	841.43	951.66	903.70	831.33	872.56	879.29		887.71	934.83
47	876.76	991.62	941.64	866.24	909.20	916.21		924.98	974.08	876.76	991.62	941.64	866.24	909.20	916.21		924.98	974.08
48	917.15	1037.30	985.02	906.14	951.08	958.42		967.59	1018.95	917.15	1037.30	985.02	906.14	951.08	958.42		967.59	1018.95
49	956.98	1082.34	1027.80	945.50	992.39	1000.04		1009.61	1063.20	956.98	1082.34	1027.80	945.50	992.39	1000.04		1009.61	1063.20
50	1001.86	1133.10	1076.00	989.84	1038.93	1046.94		1056.96	1113.07	1001.86	1133.10	1076.00	989.84	1038.93	1046.94		1056.96	1113.07
51	1046.17	1183.22	1123.59	1033.62	1084.88	1093.25		1103.71	1162.29	1046.17	1183.22	1123.59	1033.62	1084.88	1093.25		1103.71	1162.29
52	1094.97	1238.41	1176.00	1081.83	1135.48	1144.24		1155.19	1216.51	1094.97	1238.41	1176.00	1081.83	1135.48	1144.24		1155.19	1216.51
53	1144.34	1294.25	1229.02	1130.61	1186.68	1195.84		1207.28	1271.36	1144.34	1294.25	1229.02	1130.61	1186.68	1195.84		1207.28	1271.36
54	1197.63	1354.52	1286.25	1183.26	1241.94	1251.52		1263.50	1330.57	1197.63	1354.52	1286.25	1183.26	1241.94	1251.52		1263.50	1330.57
55	1250.92	1414.79	1343.49	1235.91	1297.20	1307.21		1319.72	1389.77	1250.92	1414.79	1343.49	1235.91	1297.20	1307.21		1319.72	1389.77
56	1308.70	1480.14	1405.54	1293.00	1357.12	1367.59		1380.68	1453.97	1308.70	1480.14	1405.54	1293.00	1357.12	1367.59		1380.68	1453.97
57	1367.04	1546.12	1468.20	1350.64	1417.62	1428.56		1442.23	1518.78	1367.04	1546.12	1468.20	1350.64	1417.62	1428.56		1442.23	1518.78
58	1429.30	1616.54	1535.07	1412.15	1482.18	1493.62		1507.91	1587.95	1429.30	1616.54	1535.07	1412.15	1482.18	1493.62		1507.91	1587.95
59	1460.15	1651.43	1568.20	1442.63	1514.18	1525.86		1540.46	1622.23	1460.15	1651.43	1568.20	1442.63	1514.18	1525.86		1540.46	1622.23
60	1522.42	1721.86	1635.08	1504.15	1578.75	1590.93		1606.15	1691.41	1522.42	1721.86	1635.08	1504.15	1578.75	1590.93		1606.15	1691.41
61	1576.27	1782.76	1692.91	1557.35	1634.59	1647.20		1662.96	1751.24	1576.27	1782.76	1692.91	1557.35	1634.59	1647.20		1662.96	1751.24
62	1611.61	1822.73	1730.87	1592.27	1671.24	1684.13		1700.25	1790.50	1611.61	1822.73	1730.87	1592.27	1671.24	1684.13		1700.25	1790.50
63	1655.92	1872.85	1778.46	1636.05	1717.19	1730.44		1747.00	1839.73	1655.92	1872.85	1778.46	1636.05	1717.19	1730.44		1747.00	1839.73
64 and over	1682.85	1903.29	1807.38	1662.66	1745.12	1758.57		1775.40	1869.65	1682.85	1903.29	1807.38	1662.66	1745.12	1758.57		1775.40	1869.65

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Complete Gold
HIOS Plan ID: 53732WA0790024
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Gold
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	472.56	534.47	507.53	466.89	490.04	493.83		498.55	525.01	472.56	534.47	507.53	466.89	490.04	493.83		498.55	525.01
15	514.56	581.97	552.64	508.39	533.60	537.72		542.86	571.68	514.56	581.97	552.64	508.39	533.60	537.72		542.86	571.68
16	530.62	600.13	569.89	524.25	550.25	554.50		559.80	589.52	530.62	600.13	569.89	524.25	550.25	554.50		559.80	589.52
17	546.68	618.30	587.13	540.12	566.91	571.28		576.75	607.36	546.68	618.30	587.13	540.12	566.91	571.28		576.75	607.36
18	563.98	637.86	605.71	557.21	584.85	589.36		595.00	626.58	563.98	637.86	605.71	557.21	584.85	589.36		595.00	626.58
19	581.27	657.42	624.28	574.29	602.78	607.43		613.24	645.79	581.27	657.42	624.28	574.29	602.78	607.43		613.24	645.79
20	599.19	677.68	643.53	592.00	621.36	626.15		632.15	665.70	599.19	677.68	643.53	592.00	621.36	626.15		632.15	665.70
21	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29
22	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29
23	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29
24	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29	617.72	698.64	663.43	610.31	640.58	645.52		651.69	686.29
25	620.19	701.43	666.08	612.75	643.14	648.10		654.30	689.03	620.19	701.43	666.08	612.75	643.14	648.10		654.30	689.03
26	632.55	715.41	679.36	624.96	655.95	661.01		667.34	702.76	632.55	715.41	679.36	624.96	655.95	661.01		667.34	702.76
27	647.37	732.18	695.28	639.60	671.32	676.50		682.98	719.23	647.37	732.18	695.28	639.60	671.32	676.50		682.98	719.23
28	671.46	759.42	721.15	663.40	696.30	701.68		708.39	745.99	671.46	759.42	721.15	663.40	696.30	701.68		708.39	745.99
29	691.23	781.78	742.38	682.94	716.81	722.34		729.25	767.96	691.23	781.78	742.38	682.94	716.81	722.34		729.25	767.96
30	701.11	792.96	752.99	692.70	727.05	732.66		739.67	778.93	701.11	792.96	752.99	692.70	727.05	732.66		739.67	778.93
31	715.94	809.73	768.92	707.35	742.43	748.16		755.32	795.41	715.94	809.73	768.92	707.35	742.43	748.16		755.32	795.41
32	730.76	826.49	784.84	721.99	757.80	763.64		770.95	811.87	730.76	826.49	784.84	721.99	757.80	763.64		770.95	811.87
33	740.03	836.97	794.79	731.15	767.41	773.33		780.73	822.17	740.03	836.97	794.79	731.15	767.41	773.33		780.73	822.17
34	749.91	848.15	805.40	740.91	777.66	783.66		791.16	833.15	749.91	848.15	805.40	740.91	777.66	783.66		791.16	833.15
35	754.85	853.74	810.71	745.79	782.78	788.82		796.37	838.64	754.85	853.74	810.71	745.79	782.78	788.82		796.37	838.64
36	759.80	859.33	816.03	750.68	787.91	793.99		801.59	844.14	759.80	859.33	816.03	750.68	787.91	793.99		801.59	844.14
37	764.74	864.92	821.33	755.56	793.04	799.15		806.80	849.63	764.74	864.92	821.33	755.56	793.04	799.15		806.80	849.63
38	769.68	870.51	826.64	760.44	798.16	804.32		812.01	855.11	769.68	870.51	826.64	760.44	798.16	804.32		812.01	855.11
39	779.56	881.68	837.25	770.21	808.40	814.64		822.44	866.09	779.56	881.68	837.25	770.21	808.40	814.64		822.44	866.09
40	789.45	892.87	847.87	779.98	818.66	824.98		832.87	877.08	789.45	892.87	847.87	779.98	818.66	824.98		832.87	877.08
41	804.27	909.63	863.79	794.62	834.03	840.46		848.50	893.54	804.27	909.63	863.79	794.62	834.03	840.46		848.50	893.54
42	818.48	925.70	879.05	808.66	848.76	855.31		863.50	909.33	818.48	925.70	879.05	808.66	848.76	855.31		863.50	909.33
43	838.25	948.06	900.28	828.19	869.27	875.97		884.35	931.30	838.25	948.06	900.28	828.19	869.27	875.97		884.35	931.30
44	862.95	976.00	926.81	852.59	894.88	901.78		910.41	958.74	862.95	976.00	926.81	852.59	894.88	901.78		910.41	958.74
45	891.99	1008.84	958.00	881.29	924.99	932.13		941.05	991.00	891.99	1008.84	958.00	881.29	924.99	932.13		941.05	991.00
46	926.58	1047.96	995.15	915.46	960.86	968.28		977.54	1029.43	926.58	1047.96	995.15	915.46	960.86	968.28		977.54	1029.43
47	965.50	1091.98	1036.95	953.91	1001.22	1008.95		1018.60	1072.67	965.50	1091.98	1036.95	953.91	1001.22	1008.95		1018.60	1072.67
48	1009.97	1142.28	1084.71	997.85	1047.34	1055.42		1065.52	1122.08	1009.97	1142.28	1084.71	997.85	1047.34	1055.42		1065.52	1122.08
49	1053.83	1191.88	1131.81	1041.18	1092.82	1101.25		1111.79	1170.81	1053.83	1191.88	1131.81	1041.18	1092.82	1101.25		1111.79	1170.81
50	1103.25	1247.78	1184.89	1090.01	1144.07	1152.90		1163.93	1225.71	1103.25	1247.78	1184.89	1090.01	1144.07	1152.90		1163.93	1225.71
51	1152.05	1302.97	1237.30	1138.23	1194.68	1203.89		1215.41	1279.93	1152.05	1302.97	1237.30	1138.23	1194.68	1203.89		1215.41	1279.93
52	1205.79	1363.75	1295.02	1191.32	1250.40	1260.05		1272.11	1339.63	1205.79	1363.75	1295.02	1191.32	1250.40	1260.05		1272.11	1339.63
53	1260.15	1425.23	1353.40	1245.03	1306.78	1316.86		1329.46	1400.03	1260.15	1425.23	1353.40	1245.03	1306.78	1316.86		1329.46	1400.03
54	1318.83	1491.60	1416.42	1303.00	1367.63	1378.18		1391.37	1465.22	1318.83	1491.60	1416.42	1303.00	1367.63	1378.18		1391.37	1465.22
55	1377.52	1557.98	1479.46	1360.99	1428.49	1439.51		1453.28	1530.42	1377.52	1557.98	1479.46	1360.99	1428.49	1439.51		1453.28	1530.42
56	1441.14	1629.93	1547.78	1423.85	1494.46	1505.99		1520.40	1601.11	1441.14	1629.93	1547.78	1423.85	1494.46	1505.99		1520.40	1601.11
57	1505.38	1702.58	1616.78	1487.32	1561.08	1573.12		1588.18	1672.48	1505.38	1702.58	1616.78	1487.32	1561.08	1573.12		1588.18	1672.48
58	1573.95	1780.14	1690.42	1555.06	1632.19	1644.78		1660.52	1748.66	1573.95	1780.14	1690.42	1555.06	1632.19	1644.78		1660.52	1748.66
59	1607.93	1818.57	1726.92	1588.63	1667.42	1680.29		1696.37	1786.41	1607.93	1818.57	1726.92	1588.63	1667.42	1680.29		1696.37	1786.41
60	1676.49	1896.11	1800.55	1656.37	1738.52	1751.93		1768.70	1862.58	1676.49	1896.11	1800.55	1656.37	1738.52	1751.93		1768.70	1862.58
61	1735.79	1963.18	1864.24	1714.96	1800.01	1813.90		1831.26	1928.46	1735.79	1963.18	1864.24	1714.96	1800.01	1813.90		1831.26	1928.46
62	1774.71	2007.20	1906.04	1753.41	1840.37	1854.57		1872.32	1971.70	1774.71	2007.20	1906.04	1753.41	1840.37	1854.57		1872.32	1971.70
63	1823.51	2062.39	1958.45	1801.63	1890.98	1905.57		1923.80	2025.92	1823.51	2062.39	1958.45	1801.63	1890.98	1905.57		1923.80	2025.92
64 and over	1853.16	2095.92	1990.29	1830.92	1921.73	1936.55		1955.07	2058.86	1853.16	2095.92	1990.29	1830.92	1921.73	1936.55		1955.07	2058.86

BridgeSpan Health Company
RATE SCHEDULE

Plan Information

Plan Name: BridgeSpan Cascade Silver
HIOS Plan ID: 53732WA0790025
Effective Date: 1/1/2026
Market Type: Individual
Exchange Status: Inside the Exchange
Metal Level: Silver
Plan Type: Standardized Non-Public Option Plan

Plan Geographic Availability

Area Number	Available in area?	Counties where this plan is available
1	Yes	King
2	Yes	Kitsap
3	Yes	Clark, Klickitat
4	Yes	Spokane
5	Yes	Pierce, Thurston
6	Yes	Benton, Franklin, Yakima
7	N/A	
8	Yes	Skagit, Snohomish
9	Yes	Columbia, Walla Walla

Plan Rates

Age	Non-Smoker Rates									Smoker Rates								
Band	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	547.59	619.32	588.11	541.02	567.85	572.23		577.71	608.37	547.59	619.32	588.11	541.02	567.85	572.23		577.71	608.37
15	596.27	674.38	640.39	589.11	618.33	623.10		629.06	662.46	596.27	674.38	640.39	589.11	618.33	623.10		629.06	662.46
16	614.88	695.43	660.38	607.50	637.63	642.55		648.70	683.13	614.88	695.43	660.38	607.50	637.63	642.55		648.70	683.13
17	633.49	716.48	680.37	625.89	656.93	662.00		668.33	703.81	633.49	716.48	680.37	625.89	656.93	662.00		668.33	703.81
18	653.53	739.14	701.89	645.69	677.71	682.94		689.47	726.07	653.53	739.14	701.89	645.69	677.71	682.94		689.47	726.07
19	673.58	761.82	723.42	665.50	698.50	703.89		710.63	748.35	673.58	761.82	723.42	665.50	698.50	703.89		710.63	748.35
20	694.34	785.30	745.72	686.01	720.03	725.59		732.53	771.41	694.34	785.30	745.72	686.01	720.03	725.59		732.53	771.41
21	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26
22	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26
23	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26
24	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26	715.81	809.58	768.78	707.22	742.29	748.02		755.18	795.26
25	718.67	812.82	771.85	710.05	745.26	751.01		758.20	798.44	718.67	812.82	771.85	710.05	745.26	751.01		758.20	798.44
26	732.99	829.01	787.23	724.19	760.11	765.97		773.30	814.35	732.99	829.01	787.23	724.19	760.11	765.97		773.30	814.35
27	750.17	848.44	805.68	741.17	777.93	783.93		791.43	833.44	750.17	848.44	805.68	741.17	777.93	783.93		791.43	833.44
28	778.09	880.02	835.67	768.75	806.88	813.10		820.88	864.46	778.09	880.02	835.67	768.75	806.88	813.10		820.88	864.46
29	800.99	905.92	860.26	791.38	830.63	837.03		845.04	889.90	800.99	905.92	860.26	791.38	830.63	837.03		845.04	889.90
30	812.44	918.87	872.56	802.69	842.50	849.00		857.12	902.62	812.44	918.87	872.56	802.69	842.50	849.00		857.12	902.62
31	829.62	938.30	891.01	819.66	860.32	866.95		875.25	921.71	829.62	938.30	891.01	819.66	860.32	866.95		875.25	921.71
32	846.80	957.73	909.46	836.64	878.13	884.91		893.37	940.79	846.80	957.73	909.46	836.64	878.13	884.91		893.37	940.79
33	857.54	969.88	921.00	847.25	889.27	896.13		904.70	952.73	857.54	969.88	921.00	847.25	889.27	896.13		904.70	952.73
34	868.99	982.83	933.30	858.56	901.14	908.09		916.78	965.45	868.99	982.83	933.30	858.56	901.14	908.09		916.78	965.45
35	874.72	989.31	939.45	864.22	907.08	914.08		922.83	971.81	874.72	989.31	939.45	864.22	907.08	914.08		922.83	971.81
36	880.45	995.79	945.60	869.88	913.03	920.07		928.87	978.18	880.45	995.79	945.60	869.88	913.03	920.07		928.87	978.18
37	886.17	1002.26	951.75	875.54	918.96	926.05		934.91	984.53	886.17	1002.26	951.75	875.54	918.96	926.05		934.91	984.53
38	891.90	1008.74	957.90	881.20	924.90	932.04		940.95	990.90	891.90	1008.74	957.90	881.20	924.90	932.04		940.95	990.90
39	903.35	1021.69	970.20	892.51	936.77	944.00		953.03	1003.62	903.35	1021.69	970.20	892.51	936.77	944.00		953.03	1003.62
40	914.81	1034.65	982.51	903.83	948.66	955.98		965.12	1016.35	914.81	1034.65	982.51	903.83	948.66	955.98		965.12	1016.35
41	931.98	1054.07	1000.95	920.80	966.46	973.92		983.24	1035.43	931.98	1054.07	1000.95	920.80	966.46	973.92		983.24	1035.43
42	948.45	1072.70	1018.64	937.07	983.54	991.13		1000.61	1053.73	948.45	1072.70	1018.64	937.07	983.54	991.13		1000.61	1053.73
43	971.35	1098.60	1043.23	959.69	1007.29	1015.06		1024.77	1079.17	971.35	1098.60	1043.23	959.69	1007.29	1015.06		1024.77	1079.17
44	999.99	1130.99	1073.99	987.99	1036.99	1044.99		1054.99	1110.99	999.99	1130.99	1073.99	987.99	1036.99	1044.99		1054.99	1110.99
45	1033.63	1169.04	1110.12	1021.23	1071.87	1080.14		1090.48	1148.36	1033.63	1169.04	1110.12	1021.23	1071.87	1080.14		1090.48	1148.36
46	1073.72	1214.38	1153.18	1060.84	1113.45	1122.04		1132.77	1192.90	1073.72	1214.38	1153.18	1060.84	1113.45	1122.04		1132.77	1192.90
47	1118.81	1265.37	1201.60	1105.38	1160.21	1169.16		1180.34	1243.00	1118.81	1265.37	1201.60	1105.38	1160.21	1169.16		1180.34	1243.00
48	1170.35	1323.67	1256.96	1156.31	1213.65	1223.02		1234.72	1300.26	1170.35	1323.67	1256.96	1156.31	1213.65	1223.02		1234.72	1300.26
49	1221.17	1381.14	1311.54	1206.52	1266.35	1276.12		1288.33	1356.72	1221.17	1381.14	1311.54	1206.52	1266.35	1276.12		1288.33	1356.72
50	1278.44	1445.92	1373.04	1263.10	1325.74	1335.97		1348.75	1420.35	1278.44	1445.92	1373.04	1263.10	1325.74	1335.97		1348.75	1420.35
51	1334.99	1509.87	1433.78	1318.97	1384.38	1395.06		1408.41	1483.17	1334.99	1509.87	1433.78	1318.97	1384.38	1395.06		1408.41	1483.17
52	1397.26	1580.30	1500.66	1380.49	1448.96	1460.14		1474.11	1552.36	1397.26	1580.30	1500.66	1380.49	1448.96	1460.14		1474.11	1552.36
53	1460.25	1651.54	1568.31	1442.73	1514.28	1525.96		1540.56	1622.34	1460.25	1651.54	1568.31	1442.73	1514.28	1525.96		1540.56	1622.34
54	1528.25	1728.45	1641.34	1509.91	1584.80	1597.02		1612.30	1697.89	1528.25	1728.45	1641.34	1509.91	1584.80	1597.02		1612.30	1697.89
55	1596.26	1805.37	1714.38	1577.10	1655.32	1668.09		1684.05	1773.44	1596.26	1805.37	1714.38	1577.10	1655.32	1668.09		1684.05	1773.44
56	1669.98	1888.75	1793.56	1649.94	1731.77	1745.13		1761.83	1855.35	1669.98	1888.75	1793.56	1649.94	1731.77	1745.13		1761.83	1855.35
57	1744.43	1972.95	1873.52	1723.50	1808.97	1822.93		1840.37	1938.06	1744.43	1972.95	1873.52	1723.50	1808.97	1822.93		1840.37	1938.06
58	1823.88	2062.81	1958.85	1801.99	1891.36	1905.95		1924.19	2026.33	1823.88	2062.81	1958.85	1801.99	1891.36	1905.95		1924.19	2026.33
59	1863.25	2107.34	2001.13	1840.89	1932.19	1947.10		1965.73	2070.07	1863.25	2107.34	2001.13	1840.89	1932.19	1947.10		1965.73	2070.07
60	1942.71	2197.21	2086.47	1919.40	2014.59	2030.13		2049.56	2158.35	1942.71	2197.21	2086.47	1919.40	2014.59	2030.13		2049.56	2158.35
61	2011.43	2274.93	2160.28	1987.29	2085.85	2101.94		2122.06	2234.70	2011.43	2274.93	2160.28	1987.29	2085.85	2101.94		2122.06	2234.70
62	2056.52	2325.92	2208.70	2031.84	2132.61	2149.06		2169.63	2284.79	2056.52	2325.92	2208.70	2031.84	2132.61	2149.06		2169.63	2284.79
63	2113.07	2389.88	2269.44	2087.71	2191.25	2208.16		2229.29	2347.62	2113.07	2389.88	2269.44	2087.71	2191.25	2208.16		2229.29	2347.62
64 and over	2147.43	2428.74	2306.34	2121.66	2226.87	2244.06		2265.54	2385.78	2147.43	2428.74	2306.34	2121.66	2226.87	2244.06		2265.54	2385.78

BridgeSpan Health Company – Individual
Actuarial Memorandum and Certification
ARPA Extended

The purpose of this memorandum is to identify the key assumptions and material factors that differ from the default set of rates should Congress extend the Expanded Premium Tax Credits guaranteed under the American Rescue Plan Act (ARPA) and the Inflation Reduction Act (IRA).

If Congress extends the EPTC as currently constituted through 2026, BridgeSpan Health Company (BHC) expects the following interrelated assumptions to be impacted:

- Increase to market and carrier projected enrollment
- Decrease to market and carrier projected morbidity
- Decrease to the statewide average premium
- Smaller absolute value of transfer payment (reflecting the reduction to statewide average premium)

BHC's default rates assume that individuals no longer eligible for PTC, or who will receive less PTC, will drop out of Washington's individual market more readily than individuals with current or long-term health issues. The default rates assume a 4% increase to market morbidity. This increases the statewide average premium by a similar amount, which magnifies the anticipated transfer payment/receivable.

BHC's morbidity model is not sensitive to the total projected market membership, nor to the mix of EPTC membership among metal levels. While these underlying assumptions may change as a result of EPTC extension, their impact is muted by offsetting effects.

If EPTC as currently constituted is extended through 2026, BHC's 2026 rates would decrease by 4.1%.

The following table compares the key assumption changes under the default rates and ARPA extension:

Assumption	**Default Rates**	**ARPA Extension Rates**
Market morbidity change	4.0%	0.0%
BridgeSpan morbidity change	2.5%	0.0%
Projected statewide average premium	$736.41	$713.98
Transfer payment	$95.64	$103.38
Base rate	$691.85	$667.80
Consumer rate change	18.4%	14.3%

Please see the document, "Part III Rate Filing Documentation and Actuarial Memorandum" for all other actuarial assumptions related to the rates with ARPA extension.

BridgeSpan Health Company – Individual
Actuarial Memorandum and Certification
ARPA Extended

Please see the following files for the resulting full rate schedule and Unified Rate Review Template:

- *Rate Schedule with ARPA extension duplicate.xlsx*
- *Rate Schedule with ARPA extension.pdf*
- *Part I Unified Rate Review Template with ARPA extension duplicate.xlsx*
- *Part I Unified Rate Review Template with ARPA extension.pdf*

The rates and assumptions above assume a specific scenario in which EPTCs are extended into 2026 with their current structure and subsidy levels remaining unchanged. It should be emphasized that this represents only one possible legislative outcome. The more probable scenario is that Congress will implement modifications to both the amounts and structure of future PTCs rather than a simple extension of the current framework. Should Congress enact any alterations to the PTC structure— including eligibility thresholds, subsidy amounts, or calculation methodologies— BHC would need to comprehensively reevaluate our pricing assumptions and potentially recalculate rates to reflect the new market dynamics and consumer behavior patterns that would emerge under the revised subsidy environment. This current analysis should therefore be understood as conditional upon the specific extension scenario requested, rather than a prediction of the most likely outcome.

Actuarial Certification

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

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

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations
    - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
    - Reasonable in relation to the benefits provided and the population anticipated to be covered
    - Neither excessive nor deficient
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates
- The factor representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, was calculated in accordance with actuarial standards of practice
- Geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2. Unique plan designs were fit appropriately in accordance with generally accepted actuarial principles and methodologies, as detailed in a separate certification.

- This rate filing is consistent with internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures*
- ASOP No. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*
- Professional Code of Conduct

Daniel Boeder

Digitally signed by Daniel Boeder
Date: 2025.05.15 08:04:34 -07'00'

Daniel Boeder, FSA, MAAA
Manager, Actuarial Pricing
Cambia Health Solutions, on behalf of BridgeSpan Health Company