1. GENERAL INFORMATION

Insurance Company Name	CHLIC
NAIC Company Code	67369
HIOS Issuer ID	41921
State	Virginia
Market Type	Individual
Proposed Effective Date	01/01/2026
Primary Contact Person and Title	[redacted]
Primary Contact Telephone Number	[redacted]
Primary Contact Email	[redacted]

Scope and Purpose of Filing: CHLIC is filing rates for comprehensive major medical product 41921VA002 for individuals & families, to be effective January 1, 2026. The plans represented in this filing will be Guaranteed Issue & Guaranteed Renewable and are to be marketed through Marketplace.Virginiv.gov, brokers, general agents, and directly to consumers as described in the policy form. These plans are attached to the product that has been submitted under policy form filing CCGH-134477629. This policy form is not subject to medical underwriting. Please note that the content of this filing is intended to be reviewed by an actuary.

2. PROPOSED RATE CHANGES

The proposed weighted average annual rate change by product, without the impact of aging, is provided below. It was calculated using enrollment data as of 3/31/2025.

2026 HIOS Product ID	**41921VA002**
Proposed Rate Change	[redacted]

The following factors are the main drivers of the proposed rate change:

- [redacted] of APTC Subsidies: This rate filing assumes that APTC subsidies will [redacted] on 12/31/2025. [redacted]
- Medical inflation and unit cost changes of medical services year over year: The underlying claim costs are expected to increase from 2024 to 2026, which is reflective of anticipated changes in the prices of medical services, the frequency with which consumers utilize services, as well as any changes in network contracts or provider payment mechanisms. The recent increase in Consumer Price Index (CPI) inflation is adding additional inflationary pressure for network contracts and provider payment mechanisms.
- The non-grandfathered individual market has continued to evolve since the inception of the Patient Protection and Affordable Care Act (PPACA), such as the introduction of the guaranteed issue requirement, the elimination of the individual mandate tax penalty, modified community rating, subsidies, the risk adjustment program, the external competitive landscape, anticipated changes to regulations regarding Short Term Medical and Association Health Plans, and many other provisions. After consideration for expected risk adjustment transfers, the single risk pool experience for Cigna Health & Life Insurance Company in Virginia was more adverse than assumed in the current rates. As a result, Cigna Health & Life Insurance Company's best estimate of the average market-wide morbidity of the covered population has increased compared to 2025.
- Expense Margin: Reflects decreased efficiencies and scale achieved by Cigna Health & Life Insurance Company relative to 2025.
- Plan design changes and benefit modifications: Changes have been made to plans regarding the mandated restricted actuarial values for metal tiers that are resulting in an increase in expected cost share and therefore an increase to premium. All plan designs conform to actuarial value and essential health benefit requirements.

The requested rate change is not the same across all plans. The following factors drive different rate changes by plan:

- Plan design changes and benefit modifications
- Trend leveraging due to member cost sharing provisions

- Cigna Health & Life Insurance Company has made refinements to the manual rating methodology based on its most recent Individual experience and refreshed the claim probability distribution (CPD) used in the development of the cost sharing for its plans based on recent data for the Individual market, which leads to expected claim cost changes and different cost share among plans
- Cigna Health & Life Insurance Company has updated the data and methodology used to project changes to customer utilization patterns as a result of changes in cost sharing

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

a. **Paid Through Date:** March 31, 2025
b. **Premiums (Net of MLR Rebate) in Experience Period:** Premiums in experience period represent actual 2024 premiums received through 12/31/2024. Cigna Health & Life Insurance Company of VA anticipates a PPACA MLR lower than 80% in 2024 and therefore estimates to pay MLR rebates as shown below.
   i. Prior to MLR Rebates: [redacted]
   ii. Expected MLR Rebates: [redacted]
   iii. Net of MLR Rebates: [redacted]

c. **Allowed & Incurred Claims:**
All claims are processed through Cigna Health & Life Insurance Company's claim system. Allowed claims shown below represent the sum of payments made under the policy to healthcare providers.

IBNR claims are calculated using completion factors, which represent the known paid claims as a percent of the estimated total accrual as of a particular lag period after a service month. Completion factors for a given reporting period are developed based on historical run-out patterns for national Individual experience, adjusted for actuarial judgment regarding deviance from the average (within a reasonable range based on historical deviance). The methodology used to calculate IBNR does not differ for allowed claims versus incurred claims.

Allowed and incurred claims in the experience period are as follows:

Allowed Claims	
Paid Through 3/31/2025	[redacted]
IBNR	[redacted]
Completed Allowed Claims	[redacted]

Paid & Incurred Claims	
Paid Through 12/31/2024	[redacted]
IBNR	[redacted]
Incurred Claims	[redacted]

4. BENEFIT CATEGORIES

To determine benefit categories, Cigna Health & Life Insurance Company uses a combination of Procedure Code and Place of Service to categorize each claim under an appropriate Major Service Category. These categories are defined as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, & other professional services, except hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- Prescription Drug: Includes drugs dispensed by a pharmacy, net of rebates received from drug manufacturers.

5. TREND FACTORS

The expected all-in annual medical cost trend is [redacted]. This trend is calculated from the in-network trends by service category and then by adding pharmacy trend as shown in the tables provided below.

[redacted]

Our trend methodology is prospective and develops unit cost trends for specific geographic groupings of zip codes in Virginia based on known and planned reimbursement contracts. In order to set the prospective unit cost trend, historical experience is used to aggregate the facility level reimbursement contracts into the higher-level geographic groupings. In order to determine prospective utilization trends, we look at utilization trends retrospectively by major service category on a national basis. These retrospective utilization patterns are examined and coupled with other macroeconomic forces that are expected to change in the future at the market level in order to develop the prospective utilization trend.

6. ADJUSTMENTS TO TRENDED EHB ALLOWED CLAIMS PMPM

- Changes in the Morbidity of the Population Insured: Experience was adjusted to account for expected morbidity differences between the underlying experience population and the projected 2026 population. The morbidity adjustment factor accounts for morbidity drivers specific to Cigna Health & Life Insurance Company's single risk pool, including the membership distribution by metal tier, cost-share reduction subsidy status, and network type.

- Demographic Shift: An adjustment was made to account for the change in distribution by age and gender between the 2024 underlying experience and the expected 2026 membership. The adjustment factor was developed as the ratio of the membership-weighted average demographic factor using 2026 projected membership, and a similar factor computed using the 2024 actual membership. An area adjustment was also made to reflect differences between the distribution of membership across rating areas in our experience population and our 2026 projected population.

- Plan Design Changes: The experience underlying the Projected Index Rate development represents a different distribution amongst metal tiers and CSR variants than is projected for Cigna Health & Life Insurance Company in 2026. Utilization patterns differ between plan designs due to the differences in induced demand, which is an allowable rating factor under the ACA. Therefore, an adjustment is made to account for the induced demand differences between the underlying and the projected populations.

- Other Adjustments: An adjustment was made to reflect anticipated changes in provider contracts that differ from those underlying the experience used.

7. MANUAL RATE ADJUSTMENTS

As outlined in Section 8, the 2024 single risk pool experience was assigned 100% credibility. Therefore, no Manual EHB Allowed Claims are shown in Section II Worksheet 1 of the URRT.
There are no services provided under a capitation arrangement for plans included in this filing.

8. CREDIBILITY OF EXPERIENCE

Limited fluctuation credibility was used to determine the credibility assigned to the 2024 single risk pool experience. 2024 exposure of 100,000 member months was assigned 100% credibility. Therefore, the credibility assigned to 2024 single risk pool experience was [redacted].

9. ESTABLISHING THE INDEX RATE

The Index Rate of the Experience Period for this filing is [redacted]. The Index Rate of the Experience Period in Section I, Worksheet 1 of the URRT represents the total combined 2024 allowed claims experience PMPM attributable to Essential Health Benefits in the single risk pool.

The Index Rate for the Projection Period for this filing is [redacted] and was developed in accordance with 45 CFR Part 156.80(d). The Index Rate for the Projection Period identified in Section II, Worksheet 1 of the URRT is a representation of the Expected Allowed Claims for 2026 attributable to Essential Health Benefits, and incorporates the impact of trend, benefit, morbidity, and demographic adjustments as outlined in Sections 5, 6 and 8 of this document. Refer to Section 8 of this document for additional information regarding the credibility attributed to single risk pool experience in the development of the Index Rate for the Projection Period. There are no benefits in addition to EHBs that are being covered under the proposed plans in 2026. No consideration is granted to the expected impact of specific eligibility categories for catastrophic plans because these plans are not being proposed in this filing.

10. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The Market-wide Adjusted Index Rate for this filing is [redacted]. The Market-wide Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156.80 (d)(1). The following market-wide adjustments have been made to the Index Rate, as allowed under these rules:

a. Reinsurance

The reinsurance program ended with the 2016 benefit year. Consequently, no reinsurance recoveries have been applied to the Index Rate in the development of the Market-wide Adjusted Index Rate and the Plan Adjusted Index Rate.

b. Risk Adjustment Payment/Charge

A 2026 risk transfer [redacted] of [redacted] PMPM on an allowed basis is assumed. Equivalently, the projected risk transfer on a paid basis is [redacted] PMPM [redacted].

The risk transfer formula was used for the calculation of Cigna Health & Life Insurance Company's 2026 risk transfer. Components of the transfer formula were estimated at the product level, providing an estimate of the paid risk transfer PMPM at the product level.

The components of the transfer formula are outlined below with a description of the methodology used to estimate each component. [redacted]

Market-Average Risk Transfer Components

- Market average factor including risk (MAF including risk) – [redacted]
- Market average factor excluding risk (MAF excluding risk) – [redacted]
- Statewide average premium (SAP) – [redacted]

Cigna Health & Life Insurance Company Risk Transfer Components

- Induced Demand Factor (IDF) – Weighted average of HHS Risk Adjustment Model IDFs based on projected 2026 Cigna Health & Life Insurance Company membership by metal tier
- Geographic Cost Factor (GCF) – Weighted average of estimated 2024 GCFs provided by [redacted] based on projected 2026 Cigna Health & Life Insurance Company membership by rating area
- Actuarial Value (AV) – Weighted average of HHS Risk Adjustment Model AV factors based on projected 2026 Cigna Health & Life Insurance Company membership by metal tier
- Allowable Rating Factor (ARF) – Weighted average of HHS Risk Adjustment Model ARFs based on projected 2026 Cigna Health & Life Insurance Company membership by age
- Plan Liability Risk Score (PLRS) – The projected change in morbidity of Cigna Health & Life Insurance Company's single risk pool from 2024 to 2026 was estimated as outlined in Section 7 of this document. The projected change in morbidity was used to estimate a projected change in PLRS for Cigna Health & Life Insurance Company's single risk pool from 2024 to 2026. The PLRS was also adjusted for expected changes as a result of moving to the proposed 2026 risk adjustment model.

The projected 2026 net allowed risk transfer [redacted] of [redacted] PMPM was applied to the Index Rate in the development of the Market-wide Adjusted Index Rate. The impact of net risk adjustment is [redacted] of [redacted] of Cigna Health & Life Insurance Company's 2026 premiums.

Cigna Health & Life Insurance Company does not anticipate any fees or receipts from the risk corridor program in 2026 and has not included any pricing adjustments for risk corridor payments in rate development.

c. Exchange User Fees

Exchange User Fees are applied as an adjustment to the index rate at the market level. The [redacted] Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in an expected fee of [redacted].

[redacted]

The Market-wide Adjusted Index Rate reflects the average demographic characteristics of the single risk pool and is not calibrated.

11. PLAN ADJUSTED INDEX RATE

Only the following allowable modifiers (as specified in 45 CFR 156.80(d)) have been used to adjust the Market-Wide Adjusted Index Rate to arrive at the Plan Adjusted Index Rates:

- Plan-specific actuarial value and cost sharing adjustments
- Administrative costs, excluding the Exchange User Fees which are already accounted for in the Market-wide Adjusted Index Rate

The adjustment impact of specific eligibility categories for the catastrophic plan is not applicable since Cigna Health & Life Insurance Company does not plan to offer catastrophic plans in 2026.

Note that the AV and cost-sharing adjustment encompasses expected cost-sharing differences and utilization differences due to differences in cost-sharing.

The expected cost-sharing ratio for each benefit plan is calculated by using 2024 claims and enrollment data from the Individual market (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. Note that for each Silver HIOS Component ID the expected cost-sharing ratio was calculated separately for the Base benefit plan as well as the benefit plans for each of the three CSR variant levels. A weighted average of the respective four different plan variant levels was calculated for each Silver HIOS Component ID according to the projected membership distribution outlined in Section 17.

The actual CSRs paid for enrollees in 2024 totaled [redacted].
The expected revenue collected from CSRs provided to enrollees in 2026 is [redacted].

In addition to cost sharing differences, this adjustment also includes utilization differences due to differences in cost sharing. In evaluating adjustment for utilization changes, Cigna Health & Life Insurance Company has used 2024 data to develop a relationship between historical utilization and corresponding metal tier or CSR plan variant. This adjustment is consistent with the description on page 41 of the 2026 Unified Rate Review Instructions. There are no explicit and/or additional adjustments used in our rate development process that reflect expected differences in utilization due to health status.

12. CALIBRATION

Cigna Health & Life Insurance Company calibrates the Plan Adjusted Index Rates to apply the allowable rating factors (age, geography, and tobacco) in order to calculate Consumer Adjusted Premium Rates. The calibration for each allowable rating factor is described below.

a. Age Curve Calibration

The weighted average age factor for the projected membership was calculated using the updated Default Federal Standard Age Curve defined in the addendum to 45 CFR 147.102(d). The average age associated with this projected membership (rounded to the nearest whole number) is [redacted]. This single risk pool average age was determined using a blend of the current 2024 age distribution in the

single risk pool and 2024 industry-wide enrollment data released by CMS. The Plan Adjusted Index Rate was divided by the weighted average age factor mentioned above, to arrive at the calibrated Plan Adjusted Index Rate for a 21-year-old. A demonstration of how the Plan Adjusted Index Rate and the age curve were used to generate the calibrated Plan Adjusted Index Rate for each plan is provided below.

b. Geographic Factor Calibration

Rate variations among geographical areas vary only by the geographic rating regions defined by the federal government. Area factors reflect only differences in the cost of the delivery of medical services among rating areas for a standard population and fixed market basket of covered services. The following table shows the geographic factors for each defined area in Virginia:

[redacted]

An average geographic factor is developed based on the projected distribution of membership across all areas. Then the calibrated Plan Adjusted Index Rate is calculated as Plan Adjusted Index Rate divided by this weighted average geographic factor.

c. Tobacco Use Rating Factor Calibration

[redacted]

A demonstration of calibration for the Plan Adjusted Index Rate is provided in the table below.

[redacted]

* The Plan Adjusted Index Rate represents average premium for the projected single risk pool at the unrounded average age, weighted using the best-estimate Default Federal Standard Age Curve factors. Linear interpolation between integer Default Federal Standard Age Curve factors was used in the development of the Demographic Calibration factor.

13. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

Consumer Adjusted Premium Rate is developed by applying the following allowable adjustments to the calibrated Plan Adjusted Index Rate.

- Individual and family tier – applied by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account
- Rating area factor – applied by multiplying the area factors to the calibrated Plan Adjusted Index Rate
- Age factor – applied by multiplying the age factor to the calibrated Plan Adjusted Index Rate
- Tobacco status – applied by multiplying the tobacco factor to the calibrated Plan Adjusted Index Rate

14. PROJECTED LOSS RATIO

The projected 2026 PPACA MLR, without adjustment for credibility, for Cigna Health & Life Insurance Company's individual products is [redacted].

A demonstration of the projected MLR calculation is illustrated below:

[redacted]

* Quality Improvement Activities & Risk Adjustment
** Premium/State Taxes/Federal Income Tax and ACA Fee Adjustments

Figures in the PPACA MLR exhibit have been calculated as follows:

- Member Months – projections for member months are developed internally as best estimates generated by applying current market share percentages and additional adjustments to take into account the addressable market opportunity. This figure ties to Cell F48 in Worksheet 1 URRT.
- Incurred Claims – projections for incurred claims are consistent with Cell D70 in Worksheet 2 of the URRT.
- Claims Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2026 (Final Rule)
- Earned Premium – projections for earned premium are consistent with Cell D72 in Worksheet 2 of the URRT.
- Premium Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2026 (Final Rule)
- Credibility Adjustment – The credibility adjustment is calculated using the methodology specified in 45 CFR 158.232. This adjustment incorporates the impact of the base credibility factor and the average deductible factor.

15. AV METAL VALUES

The AV Metal Values shown in Worksheet 2 of the URRT for the plans listed below were based on the AV Calculator, with the exception of the following unique benefits:

- Cost Sharing for Pharmacy Generic Drugs
- Cost Sharing for Mental Health/Substance Abuse Outpatient Office Visit vs. Facility Visit Services (where OV are copay and Facility visits are ded/coins)
- Copays for Urgent Care Services
- Cost Sharing for certain medical services for the treatment of diabetes or COPD

These benefits were outside the scope of the AV Calculator and hence an alternate methodology was deemed necessary as per 45 CFR 156.135(b). The impacted plans, alternate methodologies, and the reason for their use is explained in the accompanying actuarial certification titled “41921_va_uniqueplandesign_5_23_2025”.

[redacted]

16. MEMBERSHIP PROJECTIONS

The membership projections for Cigna Health & Life Insurance Company’s benefit plans are developed internally as best estimates. They were derived from Cigna Health & Life Insurance Company’s 2025 open enrollment experience. Active membership splits were used to develop projections by exchange indicator and metal tiers, together with growth assumptions by channel. The projected distribution of member months represents our expectation of the industry average distribution of enrollment by age for the Individual Market for 2026. For Silver metal plans, the projected enrollment subject to cost-sharing reduction subsidies at each level is developed based on Cigna Health & Life Insurance Company’s most recent actual enrollment data.

[redacted]

17. TERMINATED PLANS AND PRODUCTS

The table below shows the plan mapping for terminating plans to new or existing plans going from 2024 to 2026. Blank cells indicate that plans were terminated and unmapped in 2025 or 2026.

[redacted]

18. CONDITION SPECIFIC PLAN EXEMPTION JUSTIFICATION

For 2026, the Gold plan offering exceeds the standard plus two non-standard plan count limit. However, the following plans are condition specific plans which comply with the exception process outlined in the 2026 CMS Payment Notice. The Enhanced Diabetes Care plans

and Heart Care plans help remove barriers for members to receive the care needed to manage their conditions. These plan designs feature enhanced benefits that cover many of the necessary supplies, equipment, education, medication, select labs and exams at no cost to the member. The table below outlines the condition specific plans offered in 2026 that exceed the plan count limit and the corresponding non-standard plans which they are compared to:

The following demonstrates that the cost sharing for benefits pertaining to the treatment of diabetes is at least 25% lower than the cost sharing for the same benefits offered in another non-standard plan within the same metal.

Assume the representative treatment scenario for the treatment of diabetes is as follows:

- diabetic supplies & equipment claim(s) under the Medical Benefit, each worth , for a total of .
- diabetes education & self management training session(s), each worth , for a total of .
- diabetic laboratory services, each worth , for a total of .
- diabetic routine foot care visit(s), each worth , for a total of .
- diabetes retinal eye exam(s), each worth , for a total of .
- nutrition counseling session(s), each worth , for a total of .
- month(s) supply of preferred insulin, each worth , for a total of .
- month(s) supply of diabetic supplies under the pharmacy benefit, each worth , for a total of .
- month(s) supply of metformin, each worth , for a total of .

The collective allowed amount for treatment under the above set of services amounts to .

Under the comparable gold non-standardized plan as the in-limit point of comparison, this member could have out-of-pocket cost share responsibilities of up to , with of deductible accumulation, and another of additional copay and coinsurance responsibility.

Under the cost sharing structure in the non-standardized plan which is being submitted for exception from the limit, all services in the representative treatment scenario for diabetics are available at no cost to the member, with deductibles waived.
As a result, total out-of-pocket costs for the member are for the relevant services, which creates a reduction in cost share responsibility to the member.
This is true of all scenarios, regardless of what the member's deductible accumulation is outside of these services, if the member's out of pocket maximum has not yet been met.

The reduced cost sharing for these services pertains to clinically indicated guidelines as follows:

- **Diabetes Equipment:** CGM (continuous glucose monitoring) or fingerstick testing is essential for accurate and timely detection of blood sugar changes, prevention of acute events leading to ER/IP visits, and improving self-management of the condition.
- **Diabetes Education & Self-Management Training**: Effective education engages the person with diabetes and their caregivers in informed, shared decision-making, self-care behaviors, and problem-solving. Clinicians and educators who also provide behavioral and psychosocial support are bolstering sustained behavior change and improving clinical outcomes.
- **Diabetes Lab:** A1C and nephropathy testing are important to ensure effective medication/lifestyle management over a longer period of time and to detect changes in kidney function testing levels, as people with diabetes are at risk for developing chronic kidney disease.
- **Diabetic Routine Foot Care:** The lifetime risk of a foot ulcer for patients with type 1 or 2 diabetes may be as high as 34%, and the worldwide incidence of diabetic foot ulcer is approximately 18.6 million people per year. Management of diabetic foot ulcers accounts for a large number of inpatient stays, has a high rate of hospital readmission, and is associated with a 2.5-fold risk of death compared with patients with diabetes without foot ulcers.
- **Diabetes Retinal Eye Exam:** The onset of diabetic retinal complications is typically insidious, and patients remain generally asymptomatic and unaware of the disease during the early stages when treatment and medical management are most effective.

The asymptomatic presentation of diabetic retinopathy emphasizes the importance of retinal examinations to detect and evaluate disease severity and identify patients at risk for vision loss.

- **Nutritional Counseling:** Strong evidence supports the effectiveness of Medical Nutritional Therapy (MNT) interventions provided by RDNs for improving A1C, with absolute decreases up to 2.0% (in type 2 diabetes) and up to 1.9% (in type 1 diabetes) at 3–6 months. Ongoing MNT support is helpful in maintaining glycemic improvements.
- **Formulary preferred insulin/Patient Assistance Program (PAP):** In people with Type 1 diabetes, the pancreas does not produce insulin. People with Type 2 diabetes produce insulin, but their bodies do not use it properly. Over time, people with Type 2 diabetes may also produce less insulin. Various types of insulin may be prescribed for both types of diabetes to help regulate blood glucose.
- **Formulary Diabetic Supplies:** Typical stainless-steel lancet has a diameter of 0.3–0.8 mm and penetrates 0.7–1.3 mm, with depth of penetration directly related to pain. Although the extent of tissue injury and pain are less from the puncture by a thinner and shorter needle, the puncture by the very small size needle yields less blood volume which may not be sufficient for the glucose measurement. The pain from the needle puncture discourages diabetic patients to monitor the blood glucose levels as frequently as recommended, which adversely affects the quality of their health. According to a survey of 6,600 type 1 diabetic patients, to which 1,895 replied, actual testing frequency was less than recommended, mainly because of soreness, pain and inconvenience. The difference between the reported recommended and actual frequency of testing was proportional to the number of hospitalizations over the prior two years, which indicated that poor compliance increased complications of diabetes.
- **Metformin, Formulary Diabetes Prescription Drugs**: Diabetes medications are used to control blood glucose levels. The goal for people with diabetes is to achieve a HbA1c level less than 7%. By keeping the blood glucose in the target range, it can prevent or delay long term, serious health problems such as heart disease, vision loss, nerve damage and kidney disease. Metformin is recommended by the ADA as the first line of treatment for newly diagnosed diabetics provided there are not any contradictions.

The following demonstrates that the cost sharing for benefits pertaining to the treatment of cardiac care is at least 25% lower than the cost sharing for the same benefits offered in another non-standard plan within the same metal.

Assume the representative treatment scenario for the treatment of heart health is as follows:

- [redacted] Electrocardiogram(s) [up to [redacted] routine and up to [redacted] rhythm] and interpretation(s) under the Medical Benefit, each worth [redacted], for a total of [redacted].
- [redacted] Lipid Panel, each worth [redacted], for a total of [redacted].
- [redacted] Comprehensive Metabolic Panel, each worth [redacted], for a total of [redacted].
- [redacted] Basic Metabolic Panel, each worth [redacted], for a total of [redacted].
- [redacted] Course of Cardiac Rehab, each worth [redacted], for a total of [redacted].
- [redacted] month(s) supply of Brand Name Drugs, each worth [redacted], for a total of [redacted].
- [redacted] month(s) supply of Generic Drugs, each worth [redacted], for a total of [redacted].

The collective allowed amount for treatment under the above set of services amounts to [redacted].

Under the comparable gold non-standardized plan as the in-limit point of comparison, this member could have out-of-pocket cost share responsibilities of up to [redacted], with no deductible accumulation, and [redacted] of copay and coinsurance responsibility.

Under the cost sharing structure in the non-standardized plan which is being submitted for exception from the limit, all services in the representative treatment scenario for cardiac care are available at no cost to the member, with deductibles waived.
As a result, total out-of-pocket costs for the member are [redacted] for the relevant services, which creates a [redacted] reduction in cost share responsibility to the member.
This is true of all scenarios, regardless of what the member's deductible accumulation is outside of these services, if the member's out of pocket maximum has not yet been met.

These analyses were prepared in accordance with appropriate Actuarial Standards of Practice and the profession's Code of Professional Conduct.

19. PLAN TYPE

The plan types as inputted in Section I, Worksheet 2 of the URRT accurately describe the plans in this filing.

20. EFFECTIVE RATE REVIEW INFORMATION

a. Financial Information

CHLIC (Cigna Health & Life Insurance Company)					
($ Millions)	2021	2022	2023	2024	2025 (Proj)
Stat Capital & Surplus	5,700	5,792	7,121	6,283	[redacted]
Authorized Control Level RBC	1,283	1,414	1,522	1,653	[redacted]

Cigna Health & Life Insurance Company is in strong financial condition. The proposed plans and rates will have an immaterial impact on the company's financial condition, even with significant membership growth.

b. Rating Information

To see the proposed rate manual by age, area and smoking status please reference the accompanying QHP Rates Table Template. For additional rating rules used in deriving the premium please refer to the accompanying Business Rules Template.

A description of the benefits for all plans proposed in this filing is shown in the accompanying Plans Benefits Template.

Please note that Cigna Health & Life Insurance Company shall satisfy the requirement to offer coverage for all essential health benefits off-exchange by providing all applicants both a medical policy that does not include a pediatric dental benefit, and a standalone exchange-certified pediatric dental policy.

c. Other

Cigna Health & Life Insurance Company's anticipated loss ratio (without ACA adjustments) for the proposed plans in this filing is [redacted]

21. RELIANCE

I have relied on data and analysis provided by [redacted], in developing the proposed premium rates and in preparing the Part 1 Unified Rate Review Template submission. I have also relied on claim, premium, enrollment, and risk score data supplied by [redacted], and [redacted]. The data have been reviewed for reasonableness but have not been audited. In addition, I have relied on other internal and external sources, including [redacted], to develop the underlying assumptions used in the pricing methodology.

22. ACTUARIAL CERTIFICATION

I, [redacted], am a [redacted]. I certify, to the best of my knowledge and judgment, that:

a) The rates proposed in the above noted rate filing are
- In compliance with all applicable State & Federal Statutes & Regulations (45 CFR 156.80(d)(1))
- Developed in compliance with applicable Actuarial Standards of Practice, including but not limited to the following:
  - ASOP #5, Incurred Health & Disability Claims
  - ASOP #8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
  - ASOP #12, Risk Classification (for All Practice Areas)
  - ASOP #23, Data Quality
  - ASOP #25, Credibility Procedures
  - ASOP #26, Compliance with Statutory & Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
  - ASOP #41, Actuarial Communications
  - ASOP #50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
- Reasonable in relation to the benefits provided and the population anticipated to be covered

b) The Projected Index Rate presented in this filing is:

   a. In compliance with all applicable state and Federal statutes and regulations in 45 CFR 156.80(d)(1)
   b. Developed in compliance with the applicable Actuarial Standards of Practice
   c. Reasonable in relation to the benefits provided and the population anticipated to be covered
   d. Neither excessive nor deficient

c) Plan level rates were generated using only the index rate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)
d) The geographic rating factors reflect only differences in the costs of delivery, including unit cost and provider practice pattern differences, and do not include differences for population morbidity by geographic area.
e) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans, save the exceptions shown in Section 16, which are further explained in the accompanying actuarial certification "41921_va_uniqueplandesign_5_23_2025".

The URRT does not demonstrate the process used to develop the rates presented in this filing. 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.