MILLIMAN ACTUARIAL MEMORANDUM

Sentara Health Plans

Part III Actuarial Memorandum Individual Rate Filing

Effective January 1, 2026

July 23, 2025

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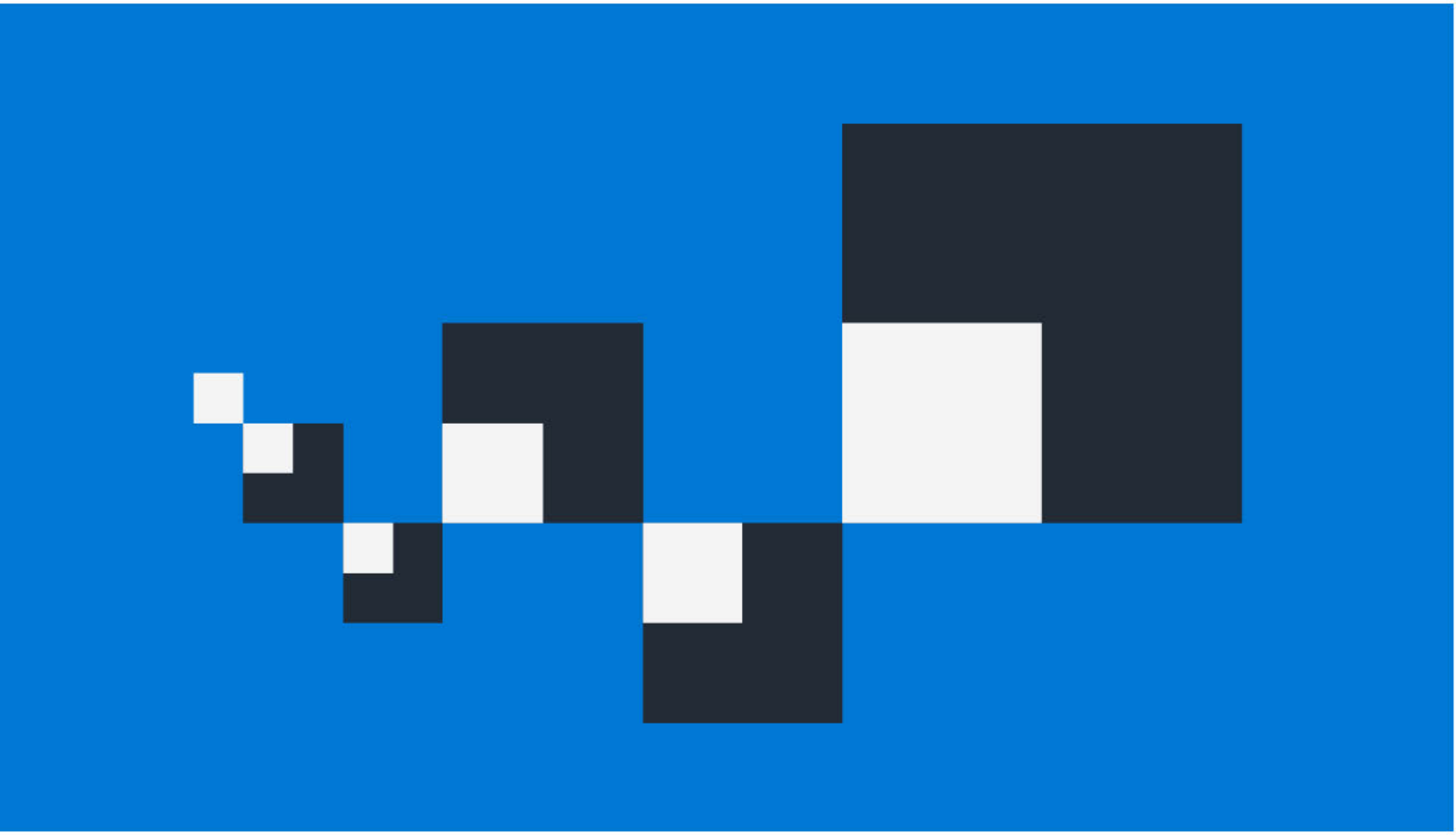
Principal and Consulting Actuary



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

Exhibit 1. General Information

DOCUMENT OVERVIEW

This document contains the Part III Actuarial Memorandum for Sentara Health Plans' (SHP) individual medical block of business, effective January 1, 2026. This Actuarial Memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of this Actuarial Memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This memorandum is also intended to fulfill specific requirements of the Commonwealth of Virginia Actuarial Memorandum. Virginia specific requirements may be found in Exhibits 1, 2, 3, and 13 of this memorandum, as well as Attachments A and D. This information may not be appropriate for other purposes.

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

The information in this Actuarial Memorandum was prepared in accordance with the Part III Actuarial Memorandum instructions, with considerations related to Actuarial communications in accordance with Actuarial Standards of Practice (ASOP) 41, Actuarial Communications, specifically Sections 3.1.1 (Form and Content) and 3.3 (Specific Circumstances), as well as Precept 8 from the Code of Professional Conduct, "Control of Work Product." Additional detail that may be needed to support the review of SHP's individual rate filing by the BOI, CCIIO, and their subcontractors can be made available upon request.

The premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded in 2026, as is consistent with current regulations and guidance. Per a "Note to Filer" dated June 29, 2019, the BOI recommends the impact of CSR subsidy non-payment to be a single factor applied across silver on-exchange plans only in the single risk pool. This filing assumes that the 1332 waiver reinsurance program will be funded in 2026 using the parameters provided in the BOI's April 23, 2025 email to carriers. At the time of this rate filing submission, we acknowledge there is uncertainty regarding whether the enhanced premium tax credit subsidies introduced through the American Rescue Plan Act (ARPA) will or will not be extended beyond 2025. As instructed by the BOI, we have prepared this set of rate filing materials assuming that these enhanced premium subsidies will expire at the end of 2025 and will not be applicable in 2026. The expiration versus extension of these subsidies could have a material impact on morbidity, enrollment, and other factors related to the Individual market. We have incorporated various premium rate adjustments to reflect the estimated financial impact of these subsidies expiring. A reasonable range of expected impacts, from which final assumptions were determined, are derived using Milliman internal research that incorporates data from CMS reports, proprietary Milliman datasets, and other publicly available information. The potential range of impact will evolve as new information becomes available and new actions are taken by the authorities and other stakeholders. Future modifications in legislation, regulation, sub-regulatory guidance, and / or court decisions regarding the funding of CSR payments, ARPA enhanced premium subsidies or other aspects of health insurance programs may affect the extent to which the premium rates are either excessive or deficient. SHP reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed.

BENEFIT DESCRIPTION

The individual plans included in this filing provide comprehensive medical expense benefits subject to insured cost-sharing provisions relating to deductible, coinsurance, and co-payments. Plan designs and member cost-sharing levels were designed to meet requirements for individual policies under federal and state laws and regulations related to the Patient Protection and Affordable Care Act (ACA). These plan offerings include federal standard plans for all metal levels in which SHP offers plans, as mandated for the 2026 plan year.

Please refer to the filed policy contract and schedule pages for additional details.

RENEWABILITY

These benefit plans are guaranteed renewable in accordance with applicable federal and state insurance regulations.

ISSUE AGE LIMITS

The policies are available for sale to eligible individuals of all ages. Dependent children are eligible for coverage up to and including age 25, subject to specified exceptions as required under requirements of state laws and regulations (e.g., disabled dependent children).

GENERAL MARKETING METHODS

These products will be marketed through direct marketing representatives, web-based marketing, and independent insurance brokers.

In addition, certain plans will be available through the Virginia State Based Exchange (SBE), subject to approval. The plans that SHP intends to sell through the SBE are indicated as such in the rate filing materials.

COMPANY IDENTIFYING INFORMATION

Company Legal Name:	Sentara Health Plans
State:	Virginia
HIOS Issuer ID:	20507
Market:	Individual
Effective Date:	January 1, 2026

COMPANY CONTACT INFORMATION

Primary Contact Name:	Robert Stegner, ASA, MAAA
Primary Contact Telephone Number:	[redacted]
Primary Contact Email Address:	[redacted]

Exhibit 2. Proposed Rate Changes

This submission is for the following rate revisions and new benefit plans, effective January 1, 2026:

- Rate revisions to existing SHP individual medical ACA-compliant products, as presented by HIOS Plan ID in the applicable line item of Worksheet 2 in the URRT. The average proposed rate change across all plans from the most recently approved rates effective January 1, 2025, is [redacted] The cumulative average rate change over the past 12 months is the same, since the most recently approved rates were effective January 1, 2025.
- Proposed premiums for new individual benefit plans to be available for sale effective January 1, 2026.

To the extent that current membership on terminating plans are proposed to be mapped into another plan, the applicable rate change is illustrated in the URRT and included in the previously noted average.

IMPACT OF ARPA ENHANCED PREMIUM SUBSIDIES

As instructed by the BOI, we prepared this set of rate filing materials assuming the ARPA enhanced premium subsidies will expire at the end of 2025 and not be available in 2026. As detailed in this actuarial memorandum, we apply adjustments to projected 2026 membership and to overall market morbidity due to the expected disenrollments resulting from expiration of the enhanced subsidies. The BOI also requested payers to provide the projected rate change if the enhanced subsidies were to continue, as well as a corresponding Virginia Rate Filing Template.

The overall rate change if the enhanced subsidies were to continue is [redacted] from the filed rates. This change reflects a combination of [redacted] Please see Exhibit 5 for additional discussion of expected changes due to the expiration of ARPA enhanced premium subsidies.

REASON FOR RATE CHANGES

The proposed rate changes reflect consideration for the impact of a number of factors, including:

- 2024 experience and emerging 2025 membership.
- Anticipated medical and pharmacy cost and utilization trends.
- Consideration for anticipated changes in the average morbidity of the SHP covered population and general marketplace, including any impact from expiration of the ARPA enhanced premium subsidies.
- Changes in demographic mix of business.
- Changes in negotiated provider reimbursement arrangements and PBM contracts.
- Benefit changes, including the impact of allowable changes due to the expanded actuarial value ranges under the Marketplace Integrity and Affordability Final Rule, which [redacted]
- Projected recoveries from Virginia's 1332 state reinsurance waiver program.
- Changes to projected non-benefit expenses and risk margin.
- Introduction of a premium rating factor for tobacco users.

Rate changes vary by benefit plan and / or rating area to reflect a combination of the following:

- Benefit changes.
- Changes in negotiated provider reimbursement arrangements.
- The anticipated impact of fixed cost-sharing parameters and deductible leveraging given increasing medical costs (i.e., paid to allowed).
- Changes in the rate adjustment to on-exchange Silver plans for the non-funding of CSR subsidies, reflecting historical experience and changes in member mix.
- Updates to rating area factors reflecting more recent experience and expected regional network impacts.
- The allocation of administrative expenses reflecting costs that vary on a per member basis.

COMPARISON OF CURRENT AND REVISED PREMIUM

Attachment A provides a comparison of current and revised average premium rates by benefit plan and rating area. The increase shown is the average increase for a member in a specific plan and rating area. Attachment A only includes rate changes for plan and rating area combinations existing in 2024, a full set of rates for all plans can be found in the Virginia Rate Filing Template.

ESTIMATED ANNUAL PREMIUM PER POLICY

Table 1 provides information regarding the current and proposed average annual premium per policy and per member for these plans.

TABLE 1
SENTARA HEALTH PLANS
AVERAGE ANNUAL PREMIUMS

MEASURE	CURRENT	PROPOSED
Per Policy	[redacted]	[redacted]
Per Member		

PREMIUM RATE CHANGE HISTORY AND IMPACTED MEMBERSHIP

These policies were first made available for sale on January 1, 2014. As of March 1, 2025, there were [redacted] members in SHP individual plans. Total 2025 annualized premium for these members is expected to be [redacted] Table 2 provides a summary of historical rate revisions for these policy forms.

TABLE 2
SENTARA HEALTH PLANS
ANNUAL AVERAGE RATE CHANGE

EFFECTIVE DATE	AVERAGE RATE CHANGE
January 1, 2015	5.4%
January 1, 2016	9.1%
January 1, 2017	24.3%
January 1, 2018	81.8%
January 1, 2019	-13.2%
January 1, 2020	-20.5%
January 1, 2021	7.7%
January 1, 2022	-3.8%
January 1, 2023	-21.4%
January 1, 2024	-3.1%
January 1, 2025	-1.9%

Exhibit 3. Experience and Current Period Premium, Claims, and Enrollment

PAID THROUGH DATE

Incurred claims presented in Worksheet 1, Section I of the URRT for the experience period from January 1, 2024 through December 31, 2024 are based on claims paid through March 31, 2025.

CURRENT DATE

The reported date for current enrollment and premium in URRT Worksheet 2, Section II is March 1, 2025.

EXPERIENCE PERIOD PREMIUM

Earned premiums presented in Worksheet 1, Section I of the URRT are calculated as follows:

- Collected premium – Change in Unearned Premium + Change in Due and Unpaid Premium

In accordance with the URRT instructions, the amounts included in Worksheet 1, Section I of the URRT do not reflect any MLR rebates. SHP does not anticipate the payment of any MLR rebates for calendar year 2024.

ALLOWED AND INCURRED CLAIMS DURING THE EXPERIENCE PERIOD

Table 3 provides a breakdown of the allowed and incurred claims during the experience period, as presented in Worksheet 1, Section I of the URRT.

TABLE 3
SENTARA HEALTH PLANS
SUMMARY OF ALLOWED AND INCURRED CLAIMS

ITEM	PROCESSOR	ALLOWED CLAIMS	INCURRED CLAIMS
Processed Claims (Fee-for-Service)	Issuer	[redacted]	[redacted]
	External		
Incurred but Not Paid Claims (Fee-for-Service)	N/A		
State Reinsurance			
Capitated Claims	N/A		
Total			

Processed fee-for-service (FFS) allowed and paid claims reflect the applicable values from SHP's claim payment system for claims incurred during the experience period and paid through March 31, 2025 for those services covered on an FFS basis (i.e., not capitated). These amounts are adjusted to reflect prescription drug rebates. The difference between incurred and allowed includes both member cost sharing and state reinsurance payments.

Total allowed claims were calculated as a combination of the following:

- [Allowed Claims Incurred and Processed (FFS) * Completion Factor] + [Capitation PMPM * Member Months]

Total incurred claims were calculated as a combination of the following:

- [Paid Claims Incurred and Processed (FFS) * Completion Factor] + [Capitation PMPM * Member Months] – [State Reinsurance]

Incurred but Not Paid Claims (FFS) are calculated as follows, for allowed and paid values, respectively:

- [Allowed Claims Incurred and Processed (FFS) * Completion Factor] – Allowed Claims Incurred and Processed (FFS)
- [Paid Claims Incurred and Processed (FFS) * Completion Factor] – Paid Claims Incurred and Processed (FFS)

Completion factors are developed by SHP using generally accepted actuarial development methods for estimating claim liabilities. Consideration is given for liabilities calculated using a claim cost, or loss ratio method for recent incurral months prior to the valuation date that have less data available (e.g., one to three months).

HISTORICAL EXPERIENCE – FORM 130A

Form 130A is included in the Virginia Rate Filing Template to be submitted with rate filings. This form provides a summary of historical and projected loss ratio experience. The development of proposed rates is done using an Annual Renewable Term (ART) methodology. As such, premium rates are projected for the proposed plan year only, and do not include the impact of persistency or interest.

SHP only sells business in Virginia. As such, projected experience, and the basis for the determination of proposed premiums are based on Virginia experience only. To some extent, nationwide industry data, studies, etc., on various assumptions are used in the development of rates, as indicated in reference to those particular items in this memorandum.

Exhibit 4. Benefit Categories

Each claim processed on a fee-for-service basis during the experience period is assigned to the applicable benefit category in Worksheet 1, Section II of the URRT. The categorization methodology looks at detailed claims records and assigns the applicable category based on the combination of a number of items including specialty codes, place of service, form types, facility type, DRG codes, provider types, and types of service indicators. Core drivers for assignment in each service category are as follows:

- Inpatient – DRG
- Outpatient – Procedure and revenue codes
- Professional – Procedure code
- Prescription Drugs – NDC code

The Inpatient and Outpatient categories contain only facility costs with no related professional fees. The Professional category reflects non-facility provider costs (i.e., Primary and Assistant Surgeons, Anesthesia, etc.). Prescription drug costs are net of rebates.

The capitation line item reflects the negotiated capitation rates for applicable services.

Exhibit 5. Projection Factors

TREND FACTORS (COST / UTILIZATION)

This section includes a description of trend factors used to project the experience period allowed claims to the projection period, and supporting information related to the development of those factors.

The utilization and cost trend factors shown in Worksheet 1, Section II reflect an annual allowed claim trend of [redacted] Trends were developed based on a combination of SHP small group experience, the Milliman *Health Cost Guidelines*™ *(HCGs)*, and general industry knowledge regarding recent trends in medical and prescription drug inflation. Annual trends are projected to be comparable in Year 1 and Year 2, as illustrated in the URRT.

With historical patterns of significant population turnover and growth in SHP's individual book of business, we use small group experience to develop trend assumptions, as the population has been much more stable. Form 130B in the Virginia Rate Filing Template includes a demonstration of historical SHP small group trend, which was used as the basis for trend development.

ADJUSTMENTS TO TRENDED EHB ALLOWED CLAIMS PMPM

This section includes a description of adjustment factors (other than trend) that are applied to the experience period claims in order to develop projected essential health benefit (EHB) allowed claims, and supporting information related to the development of those factors.

MORBIDITY ADJUSTMENT

Assuming the ARPA enhanced premium subsidies are allowed to expire at the end of 2025, SHP anticipates a reduction in membership for SHPs population and the overall market relative to emerging 2025 experience, along with an overall market morbidity impact. The following provides additional background on the expected morbidity impact relative to 2024 experience.

SHP experience period membership is approximately 807,000 member months, with emerging 2025 membership [redacted]

For purposes of projecting 2026 costs, we calculate an adjustment to 2024 allowed claims reflecting expected population changes and costs given changes over the two-year period, as described above. We calculate the adjustment by looking at the risk profiles of projected 2026 membership in two cohorts:

- 2024 members continuing into 2025 and 2026
- New members in 2025 and 2026

Each cohort reflects assumed disenrollments resulting from expiration of ARPA enhanced premium subsidies.

For purposes of evaluating the relative morbidity of 2024 members continuing into 2025 and 2026, we use SHP estimate of 2024 risk scores based on each identifiable member's 2024 risk score information. With respect to the new members in 2025 and 2026, we assume they will reflect a morbidity level consistent with statewide averages based on statewide average risk scores developed from the CMS 2024 risk adjustment transfer report dated June 30, 2025.

We determine the expected morbidity of each cohort based on the 2024 risk score data provided by SHP and combine them to arrive at an aggregate factor. The aggregate factor is compared to the factor underlying 2024 experience to arrive at the projected impact of [redacted] on costs. Please note, the risk score values used in this calculation reflect changes in the volume and mix of business but were not adjusted for expected overall market morbidity changes. We assume the impact to SHP and statewide factors will be comparable and apply this adjustment separately as described below.

The expiration of the ARPA enhanced premium subsidies at the end of 2025 is expected to result in increased average statewide morbidity in 2026 as consumers either lose access to subsidies (for those at or above 400% of the Federal Poverty Level) or face higher net premiums due to less generous subsidies. We anticipate the remaining risk pool in 2026 to have greater healthcare needs, on average, as healthier consumers are more likely to lapse coverage. We expect the SHP population to be impacted similarly and apply a morbidity adjustment of [redacted] to reflect anticipated changes in statewide average morbidity.

This adjustment is applied to the aggregate cohort based factor resulting in an overall morbidity factor of [redacted] relative to SHP's 2024 experience.

DEMOGRAPHIC SHIFT

The Demographic Shift factor in Worksheet 1, Section II of the URRT includes the impact of expected changes in age, gender, and geographic mix between 2024 and 2026. The following outline the expected impact of each change:

- Adjustments to reflect the difference in geographic mix between 2024 and that expected in 2026. The impact of the geographic mix change based on allowed cost relationships results in a cost [redacted] (factor of [redacted]).
- Adjustments to reflect the difference in age / gender mix between 2024 and that expected in 2026. The 2026 expected distribution is based on emerging 2025 membership, adjusted to reflect assumed disenrollments resulting from expiration of ARPA enhanced premium subsidies. The impact of the age / gender mix change results in a cost [redacted] (factor of [redacted]).

The resulting factor of [redacted] shown in the URRT is the composite result of the factors listed above [redacted]).

PLAN DESIGN CHANGES

The "Plan Design Changes" factor in Worksheet 1, Section II of the URRT includes a [redacted] in expected allowed costs due to the impact of benefit changes and membership mix by plan on the average cost of services between the experience and projection periods

OTHER ADJUSTMENTS

The "Other" factor in Worksheet 1, Section II of the URRT includes the following adjustments for changes between 2024 and 2026:

- Changes in negotiated provider reimbursement arrangements.
- Expected savings due to care and utilization management initiatives.
- Changes to prescription drug costs as a result of a new PBM contract.
- The mix of members with CSR plans.
- Small adjustments to reflect the final expected 2026 capitation rate in projected costs, additional PMPM costs related to breast cancer screenings and diagnostic exams covered at no cost share, and removing benefits from the index rate that are considered non-EHBs in the projection period.

We confirm coverage of EHB benefits related to oral enteral nutrition and prosthetic devices but make no additive adjustment as we estimate the actual impact to costs to be negligible. We make no explicit additive adjustment for the addition of special enrollment periods for pregnancy and the mental health medical necessity definition, but we confirm SHP's intended compliance with these requirements. No costs have been added for PANDAS and PANS coverage, we confirm that the EHB portion of these requirements is already covered by Sentara benefits and the non-EHB portion is expected to result in no additional cost to SHP QHP plans since they are defrayed by the Commonwealth.

Table 4 provides a summary of the build-up of these components into the "Other" factor in Worksheet 1, Section II of the URRT.

TABLE 4
SENTARA HEALTH PLANS
OTHER ALLOWED ADJUSTMENTS BUILDUP

COMPONENT	FACTOR
Network Impacts	[redacted]
Care Management	
PBM Contract Change	
CSR Induced Utilization Adjustment	
Capitation / Additive Cost and Non-EHB Adjustment	
Total	

Exhibit 6. Manual Rate Adjustments

SHP's individual experience is considered to be fully credible for purposes of rate development, as discussed in Exhibit 7. As such, a manual rate was not developed and zeroes have been entered into the credibility manual rate section of the URRT, in accordance with URRT instructions.

Exhibit 7. Credibility of Experience

SHP's individual experience in aggregate is considered to be fully credible for purposes of rate development. As shown in Section 1 of the URRT, there are [redacted] As such, a 100% credibility factor to the projected experience is assigned.

Exhibit 8. Establishing the Index Rate

The index rate is developed based on the single risk pool for SHP Virginia individual plans, established in accordance with the requirements in 45 CFR part 156, §156.80(d). The single risk pool reflects covered lives in all non-grandfathered products sold in the Virginia individual market by SHP. There are no transitional members in the SHP individual risk pool for 2024 as SHP did not sell individual business prior to 2014.

EXPERIENCE PERIOD INDEX RATE PMPM

The index rate for the experience period is equal to the Allowed Claims PMPM for the experience period, as shown in Worksheet 1, Section I of the URRT, as SHP included only EHB benefits in its 2024 plans.

The segmentation of the index rate into cost by service category is illustrated in Worksheet 1, Section II of the URRT.

PROJECTED INDEX RATE

The projected index rate is developed by applying projection factors to the experience period index rate. These projection factors and their development are described in Exhibit 5. Table 5 illustrates the projected index rate development.

TABLE 5
SENTARA HEALTH PLANS
PROJECTED INDEX RATE DEVELOPMENT

ANNOTATION	COMPONENT	AMOUNT PMPM
(1)	2024 EHB Allowed Claims PMPM	[redacted]
(2)	Trend (two years)	
(3) = (1) * (2)	Trended EHB Allowed Claims PMPM	
(4)	Morbidity Adjustment	
(5)	Demographic Shift	
(6)	Plan Design Changes	
(7)	Other	
(8) = (3) * (4) * (5) * (6) * (7)	**Projection Period Index Rate PMPM**	

Worksheet 1, Section II of the URRT includes a similar illustration to that shown in Table 5.

Exhibit 9. Development of the Market-Wide Adjusted Index Rate

The Market-wide Adjusted Index Rate (MAIR) is calculated as the Index Rate adjusted for all allowable market-wide modifiers as defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). Table 6 illustrates the MAIR development.

TABLE 6 SENTARA HEALTH PLANS MARKET-WIDE ADJUSTED INDEX RATE DEVELOPMENT	
2026 Index Rate PMPM	[redacted]
Market Adjustments (Paid Basis)	
+ Net Reinsurance	
+ Net Risk Adjustment Payment	
+ Exchange User Fees	
Paid-to-Allowed Ratio	
Market Adjustments (Allowed Basis)	
+ Net Reinsurance	
+ Net Risk Adjustment Payment	
+ Exchange User Fees	
Market Adjusted Index Rate PMPM	

Worksheet 1, Section II of the URRT includes a similar illustration to that shown in Table 6.

The adjustments applied to the Index Rate in developing the MAIR and their development are described below.

REINSURANCE

There are no federal reinsurance programs expected to impact SHP expected costs in 2026 at the time of this filing.

Virginia introduced a state reinsurance program under a 1332 Waiver. Per the guidance sent by the BOI on April 23, 2025, Virginia plans to continue the 1332 program into 2026 with a $45,000 attachment point, 65% coinsurance, and $170,000 cap. To estimate expected reinsurance recoveries from the 1332 Waiver program, we reviewed several years of historical experience, trended to 2026, and applied the proposed attachment point, cap, and coinsurance parameters to determine an expected reduction to paid claims under the reinsurance program. This results in a [redacted] PMPM reduction to paid claims, as shown in Table 6.

For purposes of developing the MAIR, we restate the expected reinsurance recoveries transfer to an allowed basis by dividing by the paid to allowed ratio of [redacted], for a final projected allowed-basis estimate of [redacted], as illustrated in Table 6.

RISK ADJUSTMENT PAYMENT / CHARGE

SHP's 2026 risk adjustment estimate is based on anticipated variances in SHP's risk profile relative to the statewide average and projected changes in statewide average premiums.

As discussed in Exhibit 5, with the shift in emerging 2025 membership and 2026 expectations, we evaluated SHP's expected 2026 risk profile based on a review of two population cohorts:

- 2024 members continuing into 2025 and 2026
- New emerging members in 2025 and 2026

Each cohort reflects assumed disenrollments resulting from expiration of ARPA enhanced premium subsidies.

The approach to calculating the expected risk adjustment transfer for this population is comparable to the process used to develop an expected morbidity impact for projecting claim costs, as described in Exhibit 5. We determine the expected risk adjustment formula components for each cohort based on the CMS 2024 risk adjustment transfer report dated June 30, 2025 and combine them to arrive at an aggregate factor. We develop these components consistent with the expected member mix and morbidity assumptions underlying each cohort. We then adjusted the 2024 based

components to reflect anticipated changes between 2024 and 2026 in the average statewide premium and the anticipated impact of risk adjustment model changes to arrive at a projected 2026 risk transfer [redacted] of [redacted].

For purposes of developing the MAIR, we restate the expected risk adjustment [redacted] to an allowed basis by dividing it by the paid to allowed ratio of [redacted], for a final projected allowed-basis estimate of [redacted], as illustrated in Table 6.

The estimates of relative risk and risk transfer amounts are highly dependent on the population that enrolls with SHP, as well as with other insurers in the state.

EXCHANGE USER FEES

The exchange user fee is applied as an adjustment to the projected index rate for calculating the MAIR. Specifically, exchange business premium is assumed to be about [redacted] of SHP's projected 2026 individual premium, as determined based on emerging 2025 in-force membership and assumed disenrollments resulting from expiration of ARPA enhanced premium subsidies. The resulting percent of premium value of 2.40% reflects an allocation of anticipated exchange fees of 2.50% of exchange premium across all projected individual enrollment. This results in an expected cost of [redacted] PMPM.

For purposes of developing the MAIR, we restate the expected exchange user fees to an allowed basis by dividing it by the paid to allowed ratio of [redacted], for a final projected allowed-basis estimate of [redacted], as illustrated in Table 6.

PAID TO ALLOWED RATIO

Table 7 provides an illustration of the development of the average paid to allowed ratio.

TABLE 7
SENTARA HEALTH PLANS
PAID TO ALLOWED RATIO DEVELOPMENT

COMPONENT	AMOUNT
Projected Weighted Average Paid Claim PMPM by Plan*	[redacted]
Projected Weighted Average Allowed Claim PMPM by Plan	
Paid to Allowed Ratio	

* Paid claims prior to the impact of the state reinsurance program.

The weighted average in both the numerator and denominator was developed based on projected member months by plan, as presented in Worksheet 2, Section IV of the URRT.

Exhibit 10. Plan Adjusted Index Rate

Plan adjusted index rates reflect the MAIR adjusted for allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). This is summarized as follows:

Market Adjusted Index Rate

x (1) Plan actuarial value and cost sharing value factor

x (2) Plan provider network, delivery system characteristics, and utilization management practices factor

x (3) Benefits provided by the plan that are in addition to EHB

x (4) Distribution and administrative costs, excluding user exchange fees

x (5) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans

The applicable adjustment factors for each plan, and the calculation of the plan adjusted index rates, are illustrated in Worksheet II, Section III of the URRT. Attachment B provides an illustration of the plan adjusted index rate calculations underlying final premium rates.

The following provides additional detail regarding the development of the MAIR adjustment factors.

ACTUARIAL VALUE AND COST SHARING DESIGN OF THE PLAN

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. In other words, these adjustments are based only on utilization expectations related to the comparative richness of each benefit plan and not on the people who select such a plan. The *HCGs* were used to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan, thereby excluding expected differences in the morbidity of members assumed to select the plan.

The *HCGs* provide a flexible, but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience, and establish interrelationships between different health coverages.

The *HCGs* are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The *HCGs* are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

The AV and cost sharing design values reflect full plan liability for CSR plans. Note, for purposes of developing final premium rate relativities, we use induced utilization factors from the HHS risk adjustment transfer model, as required by the BOI.

SUPPLEMENTAL INFORMATION FROM THE INSURANCE STANDARDS BULLETIN SERIES MEMO

The following provides supplemental information related to CSR funding, as requested in the Insurance Standards Bulletin Series dated May 2, 2025: The BOI prescribes that the impact of CSR subsidy non-payment should be spread across on-exchange silver plans only in the single risk pool.

- SHP estimates CSR payments of [redacted] in 2024. As is the case for many payers, SHP does not explicitly adjudicate its CSR claims separately from standard metallic cost sharing, so we use a reasonable and practicable approach to estimate the CSR payments based on a comparison of actual payments for CSR variants to that expected for a standard Silver plan.

- Based on the assumption that CSR subsidies will not be funded, we apply an adjustment of [redacted] across on-exchange silver plans to cover the expected CSR costs. We estimate the CSR payment impact adjustment by evaluating the expected AVs including CSR variants compared to the expected AVs for standard plan designs only (i.e., the portion of claims SHP would be responsible for if CSR subsidies were still in effect). The differential between these AVs is the assumed CSR shortfall adjustment.
- We anticipate the additional revenue collected from the CSR premium adjustment will be comparable to projected 2026 CSR payments.

Attachment C illustrates the calculation of estimated 2024 CSR payments and the 2026 CSR rate adjustment.

PROVIDER NETWORK, DELIVERY SYSTEM CHARACTERISTICS AND UTILIZATION MANAGEMENT PRACTICES

The value of each provider network was determined based on the anticipated cost impact for the network of a given plan as compared to other network options. There are no applicable adjustments for plans in 2026.

BENEFITS IN ADDITION TO EHBS

SHP includes hearing aids for minors as a state mandated non-EHB benefit, however since this benefit is defrayed we include no additional costs in developing premium rates. SHP received reimbursements totaling [redacted] in 2024 for hearing aids for minors.

We confirm that the non-EHB portion of PANDAS and PANS coverage are added covered benefits in 2026, but they are expected to result in no cost to SHP on qualified health plans since they are also defrayed by the Commonwealth.

SHP plans offered off-exchange only include coverage for the non-EHB portion of PANDAS and PANS and all plans include coverage for SSTMPs, which will be considered non-EHBs as of 2026, resulting in the benefits in addition to EHB reported in Worksheet 2, Section III of the URRT.

ADMINISTRATIVE COSTS, EXCLUDING EXCHANGE USER FEES AND REINSURANCE FEES

Overall administrative expenses are expected to [redacted] used in 2025 pricing, to [redacted]. Administrative expenses vary as a percent of revenue by benefit plan due to the allocation of expenses on a PMPM basis.

TAXES AND FEES

Table 8 provides a breakdown of projected taxes and fees that are used to modify the MAIR in developing a plan-adjusted index rate.

TABLE 8
SENTARA HEALTH PLANS
PROJECTED TAXES AND FEES

ITEM	% PREMIUM
Premium Tax	[redacted]
Health Insurer Fee	
Risk Adjustment Fee	
PCORI Fee	
Total	

Under current regulations, the health insurer fee (HIF) sunset in 2021, thus, we assume no HIF for SHP in 2026. We assume a Patient Centered Outcomes Research Institute (PCORI) fee of $0.31 PMPM and a risk adjustment fee of $0.20 PMPM, consistent with the final 2026 Benefit and Payment Parameter notice.

PROFIT AND RISK MARGIN

The projected Profit and Risk Margin is [redacted] in aggregate assuming the proposed rate increase of [redacted] is implemented. A higher rate increase was indicated by the projected experience, but a business decision was made by SHP to accept a lower margin and minimize the impact to members, with consideration for the company's capital position and financial viability. The lower rate increase will also provide more stability of membership and allow Sentara to continue to drive improvements to profitability.

CATASTROPHIC ADJUSTMENT

SHP will not offer a catastrophic plan in 2026. As such, there are no adjustment factors for catastrophic plans.

Exhibit 11. Calibration

AGE CURVE CALIBRATION

To develop the age calibration factor, we premium-weighted the CMS federal age curve factors on a projected premium basis. The age curve calibration is applied to all plans. The weighted average age curve calibration factor is [redacted]. The calibration to the age curve complies with the rating rules specified in 45 CFR Part 147, §147.102.

Attachment D provides an illustration for the development of the age calibration factor. The aggregate age factor is approximately equal to the age [redacted] adult factor, as shown in Attachment D. Note, SHP applies a 0.000 age factor for children ages 0 to 20 that are beyond the three oldest children on the plan under 21, consistent with the applicable rating rules.

GEOGRAPHIC FACTOR CALIBRATION

SHP applies geographic rating area factors to its plans as shown in Worksheet 3 of the URRT. Attachment D provides an illustration for the development of the geographic calibration factor.

Geographic rating area factors are developed based on a combination of the following:

- Historical risk adjusted loss ratio experience by geographic rating area for SHP's individual business.
- Manual geographic rating area factors developed using a combination of SHP risk-adjusted group experience and the Milliman *HCGs* adjusted for anticipated provider network contracts.

As is consistent with prior years, SHP elects to create a regional rate across selected Virginia ACA rating areas. The area factor for a given multi-area region reflects the weighted average of factors for each ACA rating area developed using the analysis described above. SHP includes Rating Areas 1, 3, 4, 5, 8, 11 and 12 in its 2026 regional grouping.

Changes in rating area factors are capped at [redacted] relative to the prior year analysis in order to reduce volatility.

The applicable rates in any one area do not exceed the thresholds described in 14VAC5-130-50, as shown in the VA rate template.

TOBACCO FACTOR CALIBRATION

Proposed SHP premiums include a tobacco surcharge of 1.200 for tobacco users ages 21 and older. The Plan Adjusted Index Rate does not include the expected premiums to be collected through the tobacco surcharge, resulting in a tobacco calibration factor of [redacted], as shown in Attachment D.

Exhibit 12. Consumer Adjusted Premium Rate Development

Attachment E provides an illustration for the development of consumer adjusted premium rates for sample insured members.

Exhibit 13. Projected Loss Ratios

The projected federal loss ratio is [redacted] for 2026. This loss ratio is calculated consistently with the Federal MLR methodology, according to the National Association of Insurance Commissioners, as prescribed by 211 CMR 147.00. Table 9 illustrates this calculation.

TABLE 9 SENTARA HEALTH PLANS MEDICAL LOSS RATIO – FEDERAL CALCULATION		
COMPONENT	**AMOUNT PMPM**	**ANNOTATION**
Incurred Claims	[redacted]	(1)
Risk Adjustment Paid (Received)		(2)
Quality Improvement / Health IT		(3)
Reinsurance Recoveries		(4)
MLR Numerator		**(5) = (1) + (2) + (3) + (4)**
Premium		(6)
Taxes and Fees		(7)
MLR Denominator		**(8) = (6) - (7)**
Federal MLR		**(9) = (5) / (8)**

ANTICIPATED LOSS RATIO OF NEW BUSINESS

The anticipated loss ratio for this business is [redacted] for 2026. Premium rates were developed using ART methodology, which projects an expected loss ratio for the proposed rating period of one calendar year. As such, the anticipated loss ratio does not include adjustments for interest or the impact of persistency. The projected loss ratio is calculated as the ratio of expected incurred claims to expected earned premiums during the rating period for all individual plans combined. Expected incurred claims include the risk adjustment program transfer, but not the fees related to these programs.

ANTICIPATED LOSS RATIO OF INFORCE BUSINESS

The anticipated loss ratio for inforce business is [redacted] for 2026. It is determined to be the same as that for new business, as is consistent with single risk pool requirements under state and federal regulations. The cumulative loss ratio combining historical and anticipated future experience is [redacted], as illustrated in Form 130A of the Virginia Rate Template.

ORIGINAL ANTICIPATED LOSS RATIO

These benefit plans are priced using ART methodology, so the anticipated loss ratio is reset on an annual basis. For comparison, the anticipated loss ratio for these policy forms was [redacted] and [redacted] in 2024 and 2025, respectively. Note, this loss ratio is calculated by including the risk adjustment transfer receipt in the numerator (as an offset to claims). The minimum standard for reasonability for individual benefit plans in Virginia is 75%. Anticipated loss ratios are expected to meet minimum requirements.

Exhibit 14. AV Metal Values

The AV Metal Values included in Worksheet 2, Section I of the URRT for renewing plans were developed using the 2026 CMS Actuarial Value (AV) calculator. Terminated plans included in the 2024 experience period illustrate their historical AV.

The AV calculator only has one entry field for Mental Health Outpatient services and associated cost sharing. For plans where the benefit cost sharing type (e.g., copay, coinsurance) for Mental Health Outpatient services differentiates between office visits and other sites of care, SHP developed an estimated effective cost sharing amount for entry into the AV calculator based on claims utilization and cost experience. Given this unique plan design, the actuarial certifications related to use of an alternate approach, as required by 45 CFR 156.135, are included with this filing.

Exhibit 15. Membership Projections

Membership projections, as presented in Worksheet 2, Section IV of the URRT were developed by SHP based on consideration for the following:

- Emerging 2025 membership
- Projected new sales activity and procurement of membership in existing and new areas
- Adjustments to reflect assumed disenrollments resulting from expiration of ARPA enhanced premium subsidies

The portion of projected enrollment that will be eligible for CSR subsidies is estimated to be approximately [redacted] of individuals purchasing on-exchange Silver coverage. This assumption and the distribution of members by CSR plan were developed based on emerging 2025 membership and assumed disenrollments resulting from expiration of ARPA enhanced premium subsidies.

Attachment F provides a summary of projected membership for Silver on-exchange plans by CSR subsidy level.

Exhibit 16. Plan Type

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT. They are all consistent with the available options in the drop-down box in Worksheet 2.

Exhibit 17. Terminated Plans and Products

There are no terminated plans from those offered in the experience period.

Exhibit 18. Effective Rate Review

Not applicable.

Exhibit 19. Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the management of Sentara Health Plans and its affiliates. If the underlying data or information is inaccurate or incomplete, the contents of the URRT and Part III Actuarial Memorandum along with many of our conclusions may likewise be inaccurate or incomplete.

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

A data reliance letter is included in this memorandum.

Exhibit 20. Actuarial Certification

This memorandum may be considered a statement of actuarial opinion. I, Margaret A. Chance, Principal and Consulting Actuary with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of Sentara Health Plans.

I certify to the best of my knowledge and judgment:

1. The projected index rate is:
    - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102).
    - Developed in compliance with the applicable Actuarial Standards of Practice.
    - Reasonable in relation to the benefits provided and the population anticipated to be covered.
    - Neither excessive, nor deficient based on my best estimates of the 2026 individual market.
2. The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
3. The geographic rating factors 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.
4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the Part I Unified Rate Review Template for all plans.

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

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

Milliman has developed certain models to estimate the values included in this filing. The intent of the models was to estimate 2026 rates for individual policies offered in the ACA market. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

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

This filing assumes that the 1332 waiver reinsurance program will be funded in 2025 using the parameters provided in the BOI's April 23, 2025 email to carriers. The premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded in 2026, as is consistent with current regulations and guidance. With the discontinuance of CSR funding, full liability for these costs will be SHP's responsibility. The additional premium needed to fund these additional CSR benefits has been reflected in only silver plan premiums offered through the exchange. This approach to rate setting is consistent with the BOI's "Note to Filer" dated June 29, 2019, recommending the impact of CSR subsidy non-payment to be a single factor applied across silver on-exchange plans only in the single risk pool. If these provisions materially change, then these rates may no longer be appropriate and will need to be withdrawn and refiled.

At the time of this rate filing submission, we acknowledge there is uncertainty regarding whether the ARPA enhanced premium tax credit subsidies will or will not be extended beyond 2025. As instructed by the BOI, we have prepared this set of rate filing materials assuming that these enhanced premium tax credits will expire at the end of 2025 and will not be applicable in 2026. The expiration versus extension of these subsidies could have a material impact on morbidity, enrollment, and other factors related to the Individual market. We have incorporated various premium rate adjustments to reflect the estimated financial impact of these subsidies expiring. A reasonable range of expected impacts, from which final assumptions were determined, are derived using Milliman internal research that includes data from CMS

reports, proprietary Milliman datasets, and other publicly available information. The potential range of impact will evolve as new information becomes available and new actions are taken by the authorities and other stakeholders. If subsequent information becomes available that would materially affect this rate filing submission, we would likely pursue opportunities to revise our pricing assumptions and resubmit this rate filing. Milliman expresses no opinion with regard to the future status of these programs.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Name:	Margaret A. Chance, FSA, MAAA
Title:	Principal and Consulting Actuary
Date:	July 23, 2025

RELIANCE LETTER

Sentara® Health Plans

PO Box 66189
Virginia Beach, VA 23466

May 21, 2025

Margaret Chance, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
71 South Wacker Drive, 31st floor
Chicago, IL 60606

Re: 2026 Individual Pricing - Sentara Health Plans and Sentara Health Insurance Company

Dear Margaret:

I, Eric Johnson, Chief Actuary for Sentara Health Plans (SHP) and Sentara Health Insurance Company (SHIC) (collectively "Sentara"), am a member of the American Academy of Actuaries. I hereby affirm the data sources, assumptions, and information identified below and provided to Milliman, Inc. were prepared under my direction, and that, to the best of my knowledge, are accurate and complete. I also affirm that all relevant information that affects the actuarial items examined has been provided to you, and I have disclosed all items of which I am aware that would have a material impact on the rate projections and premium rate development process for 2026.

The information provided includes:

1. Benefit plan designs for individual that SHP and SHIC intend to offer in 2026.
2. Product name, product ID, and plan name, as will be submitted into SERFF for each benefit plan.
3. Projected membership for 2026 and guidance regarding plan, geographic and demographic mix relative to current values.
4. Historical claim experience, premium and membership for existing products, including membership information for early 2025.
5. Information regarding anticipated administrative expenses.
6. Assumptions and background for Sentara's target profit and risk margins, including business decisions regarding the lowering of risk margin for SHP to minimize the impact of rate changes to members, while also considering the company's capital position and financial viability.
7. Information regarding the calculations and assumptions used in the development of geographic rating area factors to be used for 2026 pricing.
8. The Virginia rating regions in which SHP and SHIC intend to offer individual products in 2026.
9. Historical trend analyses and guidance on appropriate trend factors.
10. Information regarding provider network arrangements by region and reimbursement changes between 2024 and 2026.
11. Information regarding expected savings from care management initiatives and pharmacy benefit manager (PBM) contracting changes between 2024 and 2026.
12. Information regarding capitation arrangements and PMPM amounts for pediatric dental, pediatric vision care

and transplants.

13. Estimated 2024 SHP risk adjustment components and transfer payment / receipts by member and in aggregate, estimated statewide average components, along with guidance on setting SHP projected 2026 values.

14. Confirmation that SHP expects there are no Federal Medical Loss Ratio rebates to be paid for plan year 2024.

15. Confirmation of no expected reimbursements from HHS for individual Cost Sharing Reduction plan members in 2024.

16. Federal Actuarial Values as calculated by the 2026 Federal AV calculator. Confirmation of alternate approach methodology used related to mental health cost sharing in the AV calculator.

17. Guidance and information regarding the 1332 state reinsurance waiver funding and parameters, including rate filing instructions from the Virginia Bureau of Insurance (BOI) related to the program.

18. Confirmation that SHP would like to apply the additional premium amounts needed to cover the discontinuance of CSR funding to on-exchange Silver plans only, consistent with guidance from the BOI.

19. Expectations around the impact to Sentara and the overall individual marketplace, from the expiration of ARPA enhanced premium subsidies at the end of 2025. Confirmation of the final assumptions to be used within a reasonable range of potential impact estimates.

20. Other information provided by Sentara Health in various phone calls, emails, and other correspondence.

Signature

Eric D. Johnson
Print Name

Sentara Health
Company

May 21, 2025
Date