

AvMed, Inc.

Part III Actuarial Memorandum Individual Rate Filing Effective January 1, 2027

June 8, 2026

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Exhibit 1. General Information

DOCUMENT OVERVIEW

This document contains the Part III Actuarial Memorandum for AvMed, Inc.'s (AvMed) individual medical block of business, effective January 1, 2027. 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 information is intended for use by the Florida Office of Insurance Regulation (OIR), the Center for Consumer Information and Insurance Oversight (CCIO), and their subcontractors to assist in the review of AvMed'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 AvMed's individual rate filing by OIR, CCIO, 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 2027, as is consistent with current regulations and guidance. We apply the impact of CSR subsidy non-payment to be a single factor applied across silver on-exchange plans only in the single risk pool using the premium adjustment prescribed by the OIR in its April 13, 2026 email to carriers.

We have prepared this set of rate filing materials reflecting the expiration of enhanced premium tax credit subsidies introduced through the American Rescue Plan Act (ARPA) at the end of 2025. The expiration of these subsidies could have a material impact on morbidity, enrollment, and other factors related to the Individual market. While some initial emerging experience is available, uncertainty remains as to the ultimate impact on 2026 experience and beyond. We have incorporated various rating 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, changes in premium subsidies or other aspects of health insurance programs may affect the extent to which the premium rates are either excessive or deficient. AvMed reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed.

COMPANY IDENTIFYING INFORMATION

Company Legal Name:	AvMed, Inc.
State:	Florida
HIOS Issuer ID:	19898
Market:	Individual
Effective Date:	January 1, 2027

COMPANY CONTACT INFORMATION

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

Exhibit 2. Proposed Rate Changes

This submission is for the following rate revisions and new benefit plans, effective January 1, 2027:

- Rate revisions to existing AvMed 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, 2026, 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, 2026.
- Proposed premiums for new individual benefit plans to be available for sale effective January 1, 2027.

To the extent that current membership in 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.

REASON FOR RATE CHANGES

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

- 2025 experience and emerging 2026 membership.
- Anticipated medical and pharmacy cost and utilization trends.
- Consideration for anticipated changes in the average morbidity of the AvMed covered population and general marketplace, including any impact from expiration of the ARPA enhanced premium subsidies.
- Changes in demographic mix of business.
- Changes to projected non-benefit expenses and risk margin.

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

- Benefit changes.
- The anticipated impact of fixed cost-sharing parameters and deductible leveraging given increasing medical costs (i.e., paid to allowed).
- Changes related to the non-funding of CSR subsidies, including reflecting historical experience, changes in member mix, and changes to the premium rate adjustment applicable to on-exchange silver plans to account for CSR funding, as prescribed by OIR.
- Updates to rating area factors reflecting considerations for recent experience and a review of other marketplace area relativities to help further evaluate costs in the delivery of care.

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, 2025 through December 31, 2025 are based on claims paid through March 31, 2026.

CURRENT DATE

The reported date for current enrollment and premium in URRT Worksheet 2, Section II is March 1, 2026.

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. AvMed does not anticipate the payment of any MLR rebates for calendar year 2025.

ALLOWED AND INCURRED CLAIMS DURING THE EXPERIENCE PERIOD

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

TABLE 1 AVMED, INC. SUMMARY OF ALLOWED AND INCURRED CLAIMS			
ITEM	PROCESSOR	ALLOWED CLAIMS	INCURRED CLAIMS
Processed Claims (Fee-for-Service)	Issuer		
	External		
Incurred but Not Paid Claims (Fee-for-Service)	N/A		
Capitated Claims	N/A		
Total			

Processed fee-for-service (FFS) allowed and paid claims reflect the applicable values from AvMed's claim payment system for claims incurred during the experience period and paid through March 31, 2026 for those services covered on an FFS basis (i.e., not capitated). These amounts are adjusted to reflect prescription drug rebates.

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 AvMed 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).

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 annual allowed claim trends of [REDACTED]. Trends were developed based on a combination of historical experience, the Milliman *Health Cost Guidelines*TM (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.

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

The expiration of the ARPA enhanced premium subsidies at the end of 2025 is expected to result in increased average statewide morbidity in 2026 and beyond, as consumers either lost access to subsidies (for those at or above 400% of the Federal Poverty Level) or faced higher net premiums due to less generous subsidies. We anticipate the risk pool in 2026 and beyond to have greater healthcare needs compared to 2025, on average, as healthier consumers are more likely to lapse coverage. [REDACTED]

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 2025 and 2027. The following outline the expected impact of each change:

- Adjustments to reflect the difference in geographic mix between 2025 and that expected in 2027. 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 2025 and that expected in 2027. The 2027 expected distribution is based on emerging 2026 membership. 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 reflects [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 2025 and 2027:

- Changes in the impact of negotiated provider reimbursement arrangements and mix of business.
- The mix of members with CSR plans.
- Adjustments to reflect expected 2027 capitation rates in projected costs.

Table 2 provides a summary of the build-up of these components into the “Other” factor in Worksheet 1, Section II of the URRT.

TABLE 2 AVMED, INC. OTHER ALLOWED ADJUSTMENTS BUILDUP	
COMPONENT	FACTOR
Network Impacts	
CSR Induced Utilization Adjustment	
Capitation Adjustment	
Total	

Exhibit 6. Manual Rate Adjustments

AvMed'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

AvMed'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 over [REDACTED] member months included in the experience data, which supports [REDACTED] for the purposes of rate development. As such, [REDACTED] 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 AvMed Florida 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 Florida individual market by AvMed. There are no grandfathered or transitional members in the AvMed individual risk pool for 2025.

EXPERIENCE PERIOD INDEX RATE PMPM

The experience period Index Rate is equal to the experience period total allowed claims PMPM minus the total non-EHB allowed claims PMPM as illustrated in Table 3.

TABLE 3 AVMED, INC. EXPERIENCE INDEX RATE DEVELOPMENT		
ANNOTATION	COMPONENT	AMOUNT
(1)	Allowed Claims – Worksheet 1, Section 1	
(2)	Non-EHB Allowed Claims	
(3) = (1) - (2)	Allowed EHB Claims	
(4)	Member Months	
(5) = (3) / (4)	Index Rate (round to nearest cent)	

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 4 illustrates the projected index rate development.

TABLE 4 AVMED, INC. PROJECTED INDEX RATE DEVELOPMENT		
ANNOTATION	COMPONENT	AMOUNT PMPM
(1)	2025 EHB Allowed Claims PMPM	
(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 4.

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 5 illustrates the MAIR development.

TABLE 5 AVMED, INC. MARKET-WIDE ADJUSTED INDEX RATE DEVELOPMENT	
2027 Index Rate PMPM	
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 5.

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

REINSURANCE

There are no federal or state reinsurance programs expected to impact AvMed expected costs in 2027 at the time of this filing.

RISK ADJUSTMENT PAYMENT / CHARGE

AvMed estimates it will [REDACTED] developed based on a review of historical risk adjustment patterns for both AvMed and the Florida statewide individual ACA market. The composite expected risk adjustment transfer payment is allocated proportionally to all plans as a percent of premium.

For purposes of developing the MAIR, we restate the expected risk adjustment transfer 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 5.

The estimates of relative risk and risk transfer amounts are highly dependent on the population that enrolls with AvMed, as well as with other insurers in the state. Based on current regulatory guidance, we assume that the high-cost enrollee risk pooling program will be cost neutral for AvMed, and as such, do not make an explicit adjustment for this program in the 2027 risk adjustment transfer estimate.

EXCHANGE USER FEES

The exchange user fee is applied as an adjustment to the projected index rate for calculating the MAIR. Specifically, exchange business is projected to be about [REDACTED] of AvMed's 2027 individual membership, as determined based on emerging 2026 membership. The resulting percent of premium value of [REDACTED] reflects an allocation of anticipated exchange fees of 1.9% 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 5.

PAID TO ALLOWED RATIO

Table 6 provides an illustration of the development of the average paid to allowed ratio.

TABLE 6 AVMED, INC. 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	

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) CSR load factor, to account for CSR amounts provided to eligible enrollees if permitted by the applicable State authority, provided the issuer does not otherwise receive reimbursement for such amounts
- x (3) Plan provider network, delivery system characteristics, and utilization management practices factor
- x (4) Benefits provided by the plan that are in addition to EHB
- x (5) Distribution and administrative costs, excluding user exchange fees
- x (6) 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.

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. Please note, for purposes of developing final premium rate relativities, we use the OIR prescribed CSR load, applied to on-exchange silver plans only.

CSR LOAD FACTOR

Based on the assumption that CSR subsidies will not be funded in 2027, we apply a premium adjustment of [REDACTED] to all on-exchange silver plans to cover the expected lost CSR reimbursements, as prescribed by the OIR in its April 13, 2026 email to carriers.

AvMed continues to actively pursue evaluating 2025 CSR payments using the standard CMS methodology, as indicated in the final 2027 Notice of Benefit and Payment Parameters, published on May 15, 2026. While the required evaluation methodology is finalized, to comply with the required rate filing submission timeline, we include an estimate using a reasonable and practicable approach based on a comparison of the richness of CSR variants to that expected for a standard variant silver plan. We use a comparable approach to determine projected 2027 CSR payments. AvMed

intends to submit revised rate filing materials, including the URRT, reflecting updated reporting of base period CSR payments evaluated with the standard methodology, as outlined in 45 CFR 156.430(c)(2), once available.

We include estimated AvMed recoveries from the 2027 CSR load in URRT Worksheet 2, Section IV using the prescribed formulas in the plan year 2027 Unified Rate Review instructions (i.e., $\text{Premiums} - \text{Premiums} / (1 + \text{CSR Load})$). Note, this formula does not align with values produced using the premiums developed with and without recovery of CSR payments as it does not accurately capture the interaction of claims, reinsurance, risk adjustment, and non-benefit expenses in premium development. For the same reasons, this value also does not align with estimates of unreimbursed CSRs provided to eligible members.

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.

BENEFITS IN ADDITION TO EHBS

HIOS Product IDs 19898FL022, 19898FL023, 19898FL032, 19898FL033, 19898FL034, 19898FL037, 19898FL039, 19898FL041, and 19898FL042 do not include additional non-EHB benefits. As such, the adjustment factor for these plans is 1.000.

HIOS Product IDs 19898FL035 19898FL038, and 19898FL043 include additional non-EHB benefits of adult dental preventive services and adult vision eye exams. These items are paid on a capitated basis, so the non-EHB adjustment factor varies slightly by plan.

ADMINISTRATIVE COSTS, EXCLUDING EXCHANGE USER FEES AND REINSURANCE FEES

Overall administrative expenses are expected to equal [REDACTED] of premium in 2027.

TAXES AND FEES

Table 7 provides a breakdown of projected taxes and fees that are used to modify the MAIR in developing a plan-adjusted index rate.

TABLE 7 AVMED, INC. PROJECTED TAXES AND FEES	
ITEM	% PREMIUM
Risk Adjustment Fee	[REDACTED]
PCORI Fee	
Total	

We assume a Patient Centered Outcomes Research Institute (PCORI) fee of \$0.35 PMPM and a risk adjustment fee of \$0.18 PMPM, consistent with the final 2027 Benefit and Payment Parameter notice.

PROFIT AND RISK MARGIN

The Profit and Risk Margin target of [REDACTED] of premium in was determined based on corporate targets and considerations around expected risks in the ACA market and federal and state MLR requirements.

CATASTROPHIC ADJUSTMENT

AvMed will not offer a catastrophic plan in 2027. 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 A 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 A. Note, AvMed 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

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

Geographic rating area factors are developed based on historical rating area factors with consideration for recent experience and a review of other marketplace area relativities to help further evaluate costs in the delivery of care. They do not include differences for population morbidity by geographic area.

TOBACCO FACTOR CALIBRATION

Proposed AvMed premiums include a tobacco surcharge of [REDACTED] 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 A.

Exhibit 12. Consumer Adjusted Premium Rate Development

Attachment B 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 2027. 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 8 illustrates this calculation.

TABLE 8 AVMED, INC. 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)

Exhibit 14. AV Metal Values

The AV Metal Values included in Worksheet 2, Section I of the URRT for new or renewing plans were developed using the 2027 CMS Actuarial Value (AV) calculator, except for benefits that deviate substantially from the parameters of the AV Calculator. An acceptable alternative method outlined in CFR 156.135(b)(2) was used to estimate plan design inputs that fit into the parameters of the AV Calculator. Actuarial certifications related to use of an alternate approach, as required by 45 CFR 156.135, are included with this filing.

Terminated plans included in the 2025 experience period illustrate their historical AV.

Exhibit 15. Membership Projections

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

- Emerging 2026 membership
- Projected new sales activity and procurement of membership in existing and new areas

The portion of projected enrollment that will be eligible for CSR subsidies is estimated to be approximately [REDACTED] of individuals purchasing silver coverage. This assumption and the distribution of members by CSR plan were developed based on emerging 2026 membership.

Attachment C provides a summary of projected membership for silver 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

Attachment D provides a listing of plans from the experience period that were terminated prior to January 1, 2027.

Note, to the extent a terminating plan was available during the experience period, but did not have any membership in the experience period, it is not included in Worksheet II of the URRT.

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 AvMed 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 attached to 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 AvMed, Inc.

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 2027 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 2027 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 2027 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 2027 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.

The premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded in 2027, as is consistent with current regulations and guidance. With the discontinuance of CSR funding, full liability for these costs will be AvMed's responsibility. The additional premium needed to fund these additional CSR benefits has been reflected in only silver plan premiums offered through the exchange using the premium load prescribed by the OIR in its April 13, 2026 email to carriers. If these provisions materially change, then these rates may no longer be appropriate and will need to be withdrawn and refiled.

We have prepared this set of rate filing materials reflecting the expiration of the enhanced premium tax credit subsidies introduced through the American Rescue Plan Act (ARPA) at the end of 2025. The expiration of these subsidies could have a material impact on morbidity, enrollment, and other factors related to the Individual market. While some initial emerging experience is available, uncertainty remains as to the ultimate impact on 2026 experience and beyond. We have incorporated various rating 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.

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 or state mandated premium changes.

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:	June 9, 2026

RELIANCE LETTER



June 5, 2026

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

Re: 2027 Individual Pricing – AvMed, Inc.

Dear Margaret:

I, Eric Johnson, Chief Actuary for AvMed, Inc., (AvMed) 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 2027.

The information provided includes:

1. Benefit plan designs for individual that AvMed intends to offer in 2027.
2. Product name, product ID, and plan name for each benefit plan.
3. Projected membership for 2027 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 2026.
5. Information regarding anticipated administrative expenses.
6. Assumptions and background for AvMed's target profit and risk margins.
7. Information regarding geographic rating area factors to be used for 2027 pricing.
8. The Florida rating regions in which AvMed intends to offer individual products in 2027.
9. Historical trend analyses and guidance on appropriate trend factors.
10. Information regarding provider network arrangements including 2025 network adjustments and projected 2027 network adjustments.
11. Information regarding capitation arrangements and PMPM amounts for capitated services.
12. Estimated 2025 AvMed risk adjustment transfer payment / receipts, along with background on development, and guidance on setting AvMed projected 2027 values.
13. Confirmation that AvMed expects there are no Federal Medical Loss Ratio rebates to be paid for plan year 2025.
14. Confirmation of no expected reimbursements from HHS for individual Cost Sharing Reduction plan members in 2025.

15. Federal Actuarial Values as calculated by the 2027 Federal AV calculator. Confirmation of alternate approach methodology used in the AV calculator, as needed.
16. Guidance and information, including rate filing instructions from the Florida Office of Insurance and Regulation (OIR).
17. AvMed understands CMS' position that "CSR loading is meant to recover lost CSR reimbursement and should not be seen as a premium adjustment factor to achieve a desired premium subsidy level. Specifically, silver-plan premiums should not be loaded in a way that purposefully collects more in premium than the expected amount of unreimbursed CSRs to increase subsidy amounts and lower premiums at other metal levels", as outlined in the final 2027 Notice of Benefit and Payment Parameters, published on May 15, 2026. AvMed is incorporating the prescribed CSR load of 33.5% to comply with OIR instructions requiring all carriers to apply this mandated premium adjustment to on-exchange Silver plans only.
18. AvMed understands CMS instructions for the determination of historical CSR Issuer Payments, as outlined in the final 2027 Notice of Benefit and Payment Parameters, published on May 15, 2026, but is currently unable to determine values using the outlined approach due limitations in operational capabilities. As such, the associated URRT field is populated using a reasonable and practical simplified method. AvMed continues to actively pursue evaluating 2025 CSR payments as outlined and will resubmit the filing if able to do so.
19. Expectations around the impact to AvMed 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. Assurance Sentara has accurately entered plan designs into the PBT and other Federal forms consistently with the benefits summaries and the Actuarial Value calculations.
21. Other information provided by AvMed in various phone calls, emails, and other correspondence.

