PY2024
ACA-Compliant
Health Insurance Form Filing Guidance

Pennsylvania Insurance Department

As of March 21, 2023

Guidance –PY 2024 Filing Instructions for
ACA-Compliant Individual and Small Group Products

This guidance provides instructions for on and off-exchange Affordable Care Act (ACA)-compliant individual and small group major medical health plans and stand-alone dental plans (SADPs).[1] The timeline for filing plans and rates for Plan Year 2024 is the same for qualified health plan issuers (QHP issuers) and issuers that have no QHPs (non-QHP issuers).

The Pennsylvania Insurance Department (PID) is the primary regulator for all health insurance products sold in Pennsylvania. In addition to reviewing and approving rates and forms, PID will continue to perform plan management functions required for insurers' participation on the State-based exchange (Pennie®) for Plan Year 2024. These functions complement our traditional review and approval of forms and rates. By conducting these plan management functions, our goal is to make health plan regulation as efficient and streamlined as possible for health insurers, thereby reducing costs and complications and supporting a robust insurance market in Pennsylvania.

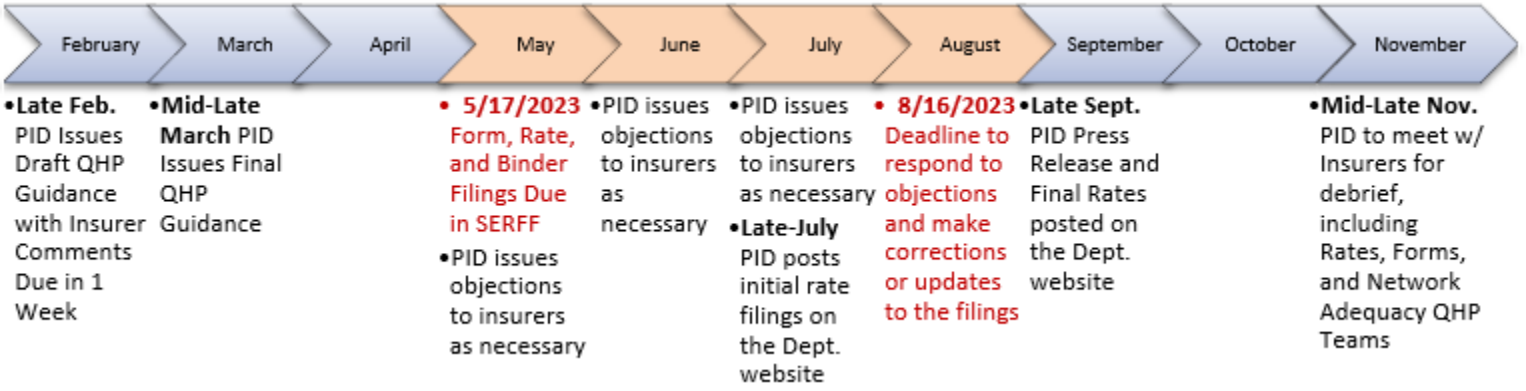
****For instructions for ACA-compliant individual and small group rate filings, see separate rate filing guidance at http://www.insurance.pa.gov/Companies/ProductAndRateRequire/.****

Are you new to Pennsylvania or considering moving into the individual or small group market for the first time? Reach out to linswartz@pa.gov as soon as possible to ensure a smooth set up.

Timeline for Form and Binder Filings

All health issuers that wish to issue or renew ACA-compliant individual or small group health insurance coverage on or after January 1, 2024, must file their forms (including all required documents for policies, certificates, or membership contracts) and plan binders containing all required templates beginning May 8, 2023, but no later than **May 17, 2023**. Late filings will not be accepted. A complete filing is required even if a policy form that will be used in 2024 has no changes from the approved form for 2023.

Forms, rates, and binder filings updates and/or corrections should be submitted to the Department by August 16, 2023. No exceptions will be permitted. A timeline* of key dates and activities is provided below. **Dates and Tasks are subject to change*



SERFF Submission and Required Documents

Please submit all filings through the System for Electronic Rate and Form Filings (SERFF) under the appropriate Type of Insurance (TOI).

Plan Validation Workspace in HIOS

Please do not submit QHP application data through HIOS, other than the pre-submission review Plan Validation Workspace in the HIOS Marketplace Plan Management System (MPMS) Module. Otherwise submitting QHP application data through HIOS will result in system malfunctions that could cause plan data to fail to display on Pennie®.

[1] By "ACA-compliant individual and small group plans," the Department means major medical (also known as comprehensive medical) plans that are fully compliantwith the 2014 ACA market reforms. This excludes grandfathered plans and possibly transitional (sometimes called grandmothered) plans. The federal government announced the indefinite continuation of its limited non-enforcement policy for transitional plans by letter on March 22, 2022. PID is following the federal government's guidance as of this writing. Starting in PY2025, the PID will discontinue the non-enforcement policy for individual transitional plans only; the non-enforcement policy for small group transitional plans will continue until further notice, or until the federal government discontinues its non-enforcement policy. Affected insurers may continue to offer renewal of the individual transitional plans for a policy year starting before October 1, 2024, but the coverage would have to come into compliance with all ACA requirements by January 1, 2025.

Major medical plans should be submitted under the appropriate TOI and corresponding sub-TOI.	**Stand-Alone dental plans** should be submitted using the proper TOI.
• H16G: Group Health – Major Medical • H16I: Individual Health – Major Medical • HOrg02G: Group Health Organizations - Health Maintenance (HMO) • HOrg02I: Individual Health Organizations –Health Maintenance (HMO)	• H10I: Individual Health – Dental • H10G: Group Health – Dental

All major medical health insurance forms should be filed through SERFF, even if those health plans are offered only in the market outside the State-based exchange. General instructions to filers in Pennsylvania will be provided on Pennsylvania's state page in SERFF, including any updates to these instructions. Please check SERFF on a regular basis for important general information, as well as specific information about your company's filings.

Please check the SERFF website for information and instructions about using SERFF. As was the case last year, issuers will work directly with PID to submit all QHP application data in accordance with federal and state guidelines. SERFF will be used by issuers to transmit information to PID, and PID will use SERFF to transmit information to Pennie®.

Applications and Enrollment forms must be included at the time of submission for the Small Group Market.

Guidance to Issuers

All issuers should carefully review all Pennie® PY 2024 certification guidance. The Pennie® certification guidance document contains important guidance regarding QHP certification, including details on the process for meeting expectations regarding QHP benefit design, review for non-discrimination, annual maximum out-of-pocket limits, and other topics. PID will review health plans that will be sold on Pennie® (and outside Pennie®, as applicable) according to the guidance issued and the requirements of Pennsylvania law and federal law. PID seeks to promote a level playing field inside and outside the exchange to the greatest extent possible.

PID will conduct the preliminary review for QHP certification and make a recommendation to Pennie®. Pennie® will send all substantive corrections to PID before sending those requested corrections to the issuer. Please do not make corrections without first seeking permission and receiving approval from PID to make those corrections through SERFF.

Content of Form Filings

A separate submission letter (as required by 31 Pa. Code § 89b.5) is required; reference to the filing description or General Information tab in SERFF does not satisfy this requirement. The submission may be rejected as incomplete if the submission letter is not included.

Please submit small group and individual health plans in separate SERFF filings. Please attach all forms submitted for review and approval to the Form Schedule tab in SERFF. Any form appearing on the Form Schedule tab should be submitted in clean final print, as intended for use. Copies of the forms with redlines, drafting notes, and other tracked changes are encouraged and should be uploaded on the Supporting Documentation tab.

Applications and Outline of Coverage (OOC) documents must be filed at the same time as the policy forms for products sold in the Individual Market. Additionally, Applications and Enrollment forms must be included at the time of submission for the Small Group Market.

Materials to be uploaded under the Supporting Documentation include:

- Completed Compliance Checklist, Worksheet, and Certification. These documents can be found on the Department's website at http://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages.
- Summary of Benefits and Coverage (SBC) per issuer for PPO/POS/EPO products and one per issuer for HMO products, if the issuer offers both PPO/POS/EPO and HMO products. For products that include plans designed to comply with metal level actuarial value requirements, please submit a Silver level plan SBC.
- Forms with Redlines, drafting notes, and other tracked changes.
- Completed Mental Health Parity Attestation, Nonquantitative treatment limitation parity analyses, and

Quantitative treatment limitation parity analyses.
- Sample insurance ID Card.

The filing may be rejected as incomplete if required documents are not provided within the timeframes identified by PID. Please note that separate Compliance Checklists are provided for major medical and stand-alone dental.

Variability within an ACA-compliant product filing is limited to cost-sharing; benefits may not be variable. Also, all benefits must be embedded in a plan, as explained in the URR Instructions. For example, suppose a company desires to add extraterritorial benefits for employees that live outside of Pennsylvania. In that case, it may amend the policy form to include those benefits, but it may not treat those benefits as optional. Such an amendment should contain language that has been approved by the other jurisdiction. Please also include in the filing a certification stating that the language has been approved by the other jurisdiction, identifying the jurisdiction, and confirming that the extraterritorial benefit does not diminish the benefits provided to an employee pursuant to Pennsylvania law.

Mental Health Parity Guidance

Section 203 of Consolidated Appropriations Act of 2021 (Pub. L. 116-260), codified at 42 U.S.C. § 300gg-26(a)(8), which became effective on February 10, 2021, and Acts 89 and 92 of 2020, codified at 40 Pa. C.S. §§ 4301-4304 and 40 P.S. § 908-14a-b, which are applicable for health insurance policies beginning on January 1, 2022, impose specific requirements on health insurers. These laws require plans subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended (MHPAEA), to document and make available parity analyses that identify limitations, describe the process used to develop, select, or continue those limitations, and define the factors used to determine whether a limitation is applicable to an MH/SUD service. To demonstrate compliance with these requirements, the PID requires specific reporting related to quantitative and non-quantitative treatment limitations (QTL/NQTLs) for health insurance policies subject to MHPAEA. More information about MHPAEA compliance is available at https://www.insurance.pa.gov/Coverage/Pages/Parity.aspx and the parity analysis templates and product filing instructions are available at https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages/default.aspx

Requirements include:
- Annual Attestations under Acts 89 and 92
- Quantitative Treatment Limitation (QTL) and Financial Requirement (FR) Parity Analysis Submission
- Non-Quantitative Treatment Limitation (NQTL) Parity Analysis Submission

QTL/FR Testing

To demonstrate compliance with these requirements, for each filing for a health insurance policy offered, issued, or renewed in the Commonwealth to which MHPAEA applies, PID expects that each form filing will include quantitative treatment limitations (QTLs) and Financial Requirements (FR) analyses for all metal levels in each plan design. For PY24, the Department is expecting each filing to include an analysis for one HMO plan design from each metal level, one PPO plan design from each metal level, and one EPO plan design from each metal level, as applicable. An insurer may choose to use the QTL compliance template available on the Department's website. For purposes of these analyses, QTLs/FRs include, but are not limited to, financial requirements like co-pays and coinsurance, as well as office visit limitations or other limits on how many times a treatment may be covered. The analyses must provide classifications and limitations for ALL covered benefits listed in the analyzed plan; please identify the form number and/or product/plan identification for certificates of coverage and schedules of benefits to which the analysis is being applied.

Expected claims dollar amounts must be provided for medical/surgical benefits.

If a health insurer does not use the template provided on the Department's website, the analysis should clearly identify all elements of the analysis as outlined in federal regulations. Such documentation may include a crosswalk or narrative comparison to the Department's template or to each element outlined in 45 C.F.R. § 146.136.

NQTL Analysis

Additionally, for each filing for a health insurance policy offered, issued, or renewed in the Commonwealth to which MHPAEA applies, please provide one example of non-quantitative treatment limitations (NQTLs) that may apply to medical/surgical (Med/Surg) services and mental health or substance use disorder (MH/SUD) services under the policy.

The example should illustrate and reference the baseline parity analysis performed for each limitation while demonstrating how the limitations are compliant with MHPAEA. An insurer may choose to use the NQTL compliance template available on the Department's website. NQTLs include, but are not limited to, medical management standards limiting or excluding benefits based on medical necessity, prior authorization processes, and step therapy; recognizing the importance and prevalence of prior authorization processes, you may wish to include prior authorization as the submitted example. If the NQTL analysis is the same for multiple products/plans, a company should submit the single analysis and reference the products/plans to which it applies.

The goal of these QTL/FR analyses and NQTL examples is to facilitate the Department's responsibility to gauge, at the point of policy form review, compliance "as written" with the above-cited provisions. As noted above, an insurer may choose to use the QTL and NQTL compliance templates available on the Department's website. Alternate means of demonstrating compliance are permitted but may delay the form review process.

Network Adequacy

As required in federal law and regulation, a QHP issuer that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. To promote efficiency across network types, PID will review all networks based on the same standards, generally referencing the requirements in Act 68 of 1998, 28 Pa. Code Ch. 9, and 45 C.F.R. § 156.230 as amended by the final 2024 Notice of Benefit and Payment Parameters. PID will use an updated version of the network adequacy template introduced during PY2022.

NOTE: network adequacy templates required as part of the QHP certification application must still be filed. While PID continues to explore options to reduce the number of templates required, PID has not yet been able to confirm removal of any templates.

Submit PID network adequacy templates via company-specific SFTP sites provided by Bureau of Managed Care staff. If your company has not received an SFTP link, please send a request for SFTP access to: RA-INBURMNGDCAREPRDR@pa.gov. Final network reports and additional justification will be uploaded to SERFF by PID staff.

Network Identification Filing Form

In addition to submitting the QHP network templates, starting in PY24, the Department is requesting insurers complete the Network Identification Filing Form available on the Department's website. This Form should be submitted within SERFF as Supporting Documentation in the Binder Filing. Please submit a separate form for each Network ID.

No Surprises Act

The No Surprises Act (NSA) applies to all QHPs. Under the NSA, emergency services, including air ambulance, must be covered without prior authorization and regardless of whether the provider or facility is in-network. Emergency services also include any post-stabilization services, unless certain conditions are met. Further, the NSA protections apply if a health plan covers any benefits for non-emergency services related to a visit in an in-network facility. In particular, the NSA seeks to protect patients who have little or no control over who provides their care, which means specified ancillary providers, such as labs, anesthesiologists, radiologists or doctors involved in a surgery that the patient does not select, and certain diagnostic services that the patient does not select, may not balance bill under any circumstance. In addition, cost-sharing for care by those ancillary providers or services is treated as in-network.

The NSA also protects patients who receive services from an out-of-network provider, other than those specified, in connection with a visit to a facility unless that out-of-network provider gives notice and receives consent in accordance with the Act.

Protections included in the No Surprises Act apply to the following facilities and services: emergency air ambulance, emergency facility and provider services, hospitals, hospital outpatient departments, ambulatory surgical centers, and non-emergency services in connection to a visit at a covered facility. The NSA does not currently apply to Ground Ambulance Services, but please note that when an individual requires medical transportation to travel to another facility, whether by air or ground, and the individual is not in a condition to receive notice or provide consent, the NSA protections continue to apply for services connected to the emergency visit even when the patient is post-stabilization.

PID expects form language and internal policies and procedures to accurately represent and implement these protections.

For more information about the No Surprises Act, please visit www.insurance.pa.gov/nosurprises.

Non-discrimination Provisions

The Department recognizes that plans include broad non-discrimination provisions. The Department encourages issuers to explicitly identify its non-discrimination protections for sexual orientation, sex, disability, gender identity, pre-existing conditions, health status, and marital status in addition to the language already included.

Formulary and Prescription Drug Coverage

Prescription Drug Template

As part of the filing, the Department is requesting additional information about coverage of prescription drugs, including those drugs covered under the medical benefit. If an issuer offers drugs under the medical benefit and needs those drugs in order to satisfy the state benchmark drug count or to demonstrate appropriate coverage of services required to be covered under the plan to satisfy federal and state regulations, and the issuer is unable to utilize the seven-tier formulary template to report this information, please complete a Combined Prescription Drug Supporting Documentation and Justification form and include it in the filing as Supporting Documentation in SERFF. For additional guidance, the Centers for Medicare & Medicaid Services (CMS) released the following Prescription Drug FAQ[2].

Q1: How would an issuer who is already using all of the available seven (7) tier types within the Prescription Drug Template incorporate the drug tier type of Medical Service Drugs?

- The Prescription Drug Template cannot fully accommodate a formulary design that includes more than seven (7) formulary tiers. If the plans associated with the formulary cannot meet the essential health benefit (EHB) count unless medical drugs are included in the drug list, CMS recommends taking the following steps to submit the Qualified Health Plan (QHP) Application:
  - Enter all RXCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template,for each of the issuer's drug lists.
  - Use the Combined Prescription Drug Supporting Documentation and Justification to identify how thedrug list meets the requirement and submit the RXCUIs associated with the medical drugs for each drug list

Note, drugs without associated RXCUIs should not be included in the Prescription Drug Template, because these drugs are not used in evaluating EHB benchmark or non-discrimination compliance[3]. However, the Department is requesting issuers include a supplemental justification as Supporting Documentation within the filing for those drugs that may be covered by the plan but do not have a RXCUI. Please use the PID QHP Prescription Drug Supplemental Template available on the Department's website for reporting this information.

Prescription Drug Coverage Changes

The Department is monitoring year over year prescription drug coverage changes to be better informed about any potential consumer impact for the upcoming plan year. As Supporting Documentation and as applicable, please provide a list of all drugs that were previously covered under the plan (in PY23) but will no longer be covered in PY24, and all drugs that were added as new covered drugs this year (not previously covered by the issuer). Please use the PID QHP Prescription Drug Supplemental Template available on the Department's website for reporting this information.

Category and Class Drug Count Tool

For the Category and Class Drug Count Tool Results, some issuers indicated certain RXCUIs are "Not on Template", while other issuers listed those same RXCUIs as covered or not covered. To ensure consistency, when the template results in any RXCUI being designated "Not on Template", please submit a supplementary justification as Supporting Documentation in SERFF explaining whether that RXCUI would be covered or not covered by the plan. When submitting this supplementary justification, please use the federal form for combined prescription drug Supporting Documentation and justification[4].

[2] https://www.qhpcertification.cms.gov/s/Prescription%20Drug%20FAQs

[3] https://www.qhpcertification.cms.gov/s/Prescription%20Drugs

[4] PY2023 Combined Prescription Drug Supporting Documentation and Justification for the following formulary reviews: Clinical Appropriateness Review, Formulary Outlier, Category/Class Benchmark Count

Essential Drugs (EHBs) versus Non-Essential Drugs (non- EHBs)
The Department is aware that some issuers may be treating certain covered specialty medications as non-essential health benefits, meaning the cost of the medications do not apply towards satisfying the member's out-of-pocket limits. The Department requests that each issuer provide the following information as Supporting Documentation within the Binder filing. Please use the PID QHP Prescription Drug Supplemental Template available on the Department's website for reporting this information.

1. Identify all drugs currently **covered** under the plan that are considered non-essential drugs (i.e., not considered essential health benefits), if applicable.
2. If the plan is changing a previously essential drug to a non-essential drug, please identify those changes.
3. Please explain how the issuer designated drugs as being or not being essential, if applicable.

If all covered prescription drugs are considered EHB by the issuer, meaning the member's out-of-pocket cost-sharing for prescription drugs always counts towards satisfying the member's maximum-out-of-pocket, a supplemental form is not necessary.

Content of Binder Filings
A binder is required for each market type (individual or small group). "On-exchange" plans and "off-exchange only" plans should appear within the same binder; do not file separate binders based on exchange intentions. Correspondence related to the binder must be attached to the binder filing.

As in past years, the QHP data templates must be completed for all individual and small group health plans, regardless of whether plans are being submitted for QHP certification. New templates for 2024 must be filed even if no changes were made to the underlying policy forms. Issuers offering plans in both the individual and small group markets need to complete only one Business Rules Template; it will include both individual and small group plans. However, the Business Rules Template must be submitted in both the individual and small group SERFF filings and binders.

It came to PID's attention during plan year 2018 that the Plan and Benefits template does not include entries for Inherited Metabolic Disorder (PKU), Diabetes Care Management and Dental Anesthesia. As this problem has not been corrected for PY 2024, please add these as line items to the template as additional EHBs. This will allow the review tools to run properly. NOTE: PID network adequacy templates do not connect to CMS templates or checkers.

For the Formulary - Inadequate Category/Class Count Supporting Documentation and Justification: Provide a detailed explanation at the time of binder submission of any inadequate Category/Class Count. The detailed explanation should provide a more in-depth explanation of the associated Justification Code.

If an issuer needs to update information that results in a change to any template, the associated QHP Application Review tools must be run and results submitted each time there is a template revision.

All QHP issuers must run all applicable CMS tools, including the Master Review Tool, Data Integrity Tool, Cost Sharing Tool, Plan ID Crosswalk Tool, Essential Community Providers (ECP) Tool, SADP ECP Tool, Non-Discrimination Cost Sharing Review Tool, Category & Class Drug Count Tool, Non-Discrimination Formulary Outlier Review Tool, and the Non-Discrimination Clinical Appropriateness Review Tool. Submit the results as Supporting Documentation in SERFF. If the tool identifies deficiencies, the issuer must submit the appropriate justification addressing the identified deficiencies.

Submit the Quality Implementation Plan and Progress Report forms through SERFF since Pennsylvania performs plan management.

NOTE: Binders, like form filings, must be submitted no later than May 17, 2023 as described in the timeline.

Plan Validation Workspace in the HIOS Marketplace Plan Management System Module
Beginning in PY2024, issuers in all states will be required to validate their QHP Application data for compliance with a number of federal standards—including data integrity—prior to submitting this data to their state (via SERFF). The Department strongly encourages insurers utilize the new Plan Validation Workspace in the HIOS Marketplace Plan Management System (MPMS) Module.

From CMS's guidance on February 23rd, 2023:

- All issuers will also have access to a new Plan Validation Workspace in this module.
- States and issuers will need to request access to the new MPMS Module in HIOS; additional instructions are forthcoming.
- Validating application data or cross validating an application within the Plan Validation Workspace will allow issuers to access their pre-submission review results.
- Pre-submission review results ("validation results") display as:
    - Validation errors: issuers must correct prior to submitting an application
    - Validation warnings: issuers should review to determine whether a correction needs to be made to an application prior to submitting
- Issuers will not be able to submit their applications to CMS via HIOS or to their state via SERFF until all validation errors are resolved.
- As in previous years, issuers must pass validations within SERFF Validate & Transform in order to submit their QHP Applications to their states.
    - For PY2024, SERFF Validate & Transform has been enhanced to include several new validations, including validations related to data integrity and standardized plan options.
    - SERFF issuers must use the new Plan Validation Workspace in MPMS prior to Validate & Transform.

Stand-Alone Dental Plans and Vision Plans

Qualified stand-alone dental plan (QDP) issuers must file their rates, forms, and plan binders according to the same timelines and instructions that apply to all QHP issuers as outlined above. Pennsylvania's PPO network adequacy requirements also apply to dental plans and vision plans. The benefits template will be modified for dental plans as described in the 2024 Letter to Issuers in the Federally-facilitated Marketplaces. Each QDP issuer must specify whether the rates contained in the templates are guaranteed to consumers or will be subject to change (underwriting).

QDP forms, rates, and binders must be filed separately from QHP filings. Dental binders/filings should include all QDPs sold on and off the exchange.

Note: Off-exchange non-certified stand-alone dental plans are not required to be submitted during the same timeframe as for QDPs. An exception to this is a stand-alone dental plan that an issuer wishes to certify but only offer off-exchange. Refer to the Content of Binder Filings section above for details on certifying "off-exchange only" plans.

REMINDER: SADP issuers that wish to certify non-exchange dental plans with CMS must provide a table in the Binder Transmittal Letter or a separate document under Supporting Documentation in the binder that identifies the plans that the issuer would like to certify. This helps facilitate the transfer of those plans to HIOS. It is imperative that SADP issuers provide this information so that all plans can be properly transferred to CMS.

CONCLUSION

The Department reminds filing entities that all forms and rates used in Pennsylvania remain subject to, and must comply in all respects with, Pennsylvania's insurance laws and regulations. The Department retains its ability to take after-use enforcement action and seek any available remedy for non-compliant forms or rates. An issuer will be responsible for assuring that all of its insureds are provided the full benefits provided by state and federal law, including the ACA, MHPAEA, and the NSA. PID continues to review templates and documentation to try to reduce the number of required documents for any given submission and will accept comment on efficiencies and processes that will help reduce the overall filing burden for all concerned.

Please send any questions on this guidance that cannot be answered through the SERFF process to Lars Thorne at rlthorne@pa.gov. As appropriate, we may compile them and post responses as FAQs on the Department's website.

APPENDIX

Overview of Binder Submission, Rate Filing Submission and Form Filing Supporting Documents Submission, As Applicable.

Please note: For QHP application materials, CMS templates should be used unless a separate template is provided by the Department or Pennie®.

Qualified Health Plan (QHP) or Plan Certification Criteria	**Submission**
Plan Certification	Memo of Attestation to Pennie®
Accreditation Questions	SERFF – RATE FILING
Federal Actuarial Memorandum RRG.2	SERFF – RATE FILING
Category and Class Drug Count Tool Results	SERFF – Supporting Documentation
Combined Prescription Drug Supporting Documentation and Justification	SERFF – Supporting Documentation
Compliance Certification (signature)	SERFF – Supporting Documentation
Compliance Checklist	SERFF – Supporting Documentation
Compliance Worksheet	SERFF – Supporting Documentation
Consumer Friendly Justification	SERFF – RATE FILING
Cost Share Tool Results	SERFF – Supporting Documentation
Essential Community Providers Tools Results	SERFF – Supporting Documentation
Essential Community Providers Write-in Worksheet (when applicable)	SERFF – Supporting Documentation
Essential Community Providers/Network Adequacy Attestation	SERFF – Supporting Documentation
Essential Community Providers/Network Adequacy Template	SERFF- BINDER TEMPLATE
Essential Health Benefits-Substituted Benefit	SERFF – Supporting Documentation
Formulary Review Suite Tool Results	SERFF – Supporting Documentation
Insurer Marketplace Information Administrative Data	SERFF – Supporting Documentation
Master Review Tool Results	SERFF – Supporting Documentation
Mental Health Parity Attestation in compliance with Acts 89 & 92	SERFF – Supporting Documentation
Network Adequacy Template- PID/QUEST	To Quest with Company Specific SFTP
Network Identification Filing Form	SERFF – Supporting Documentation
Network Template (Network IDs)	SERFF – BINDER TEMPLATE
Non-Discrimination Clinical Appropriateness Review Tool Results	SERFF – Supporting Documentation
Non-Discrimination Formulary Outlier Review Tool Results	SERFF – Supporting Documentation
PA Actuarial Memorandum	SERFF – RATE FILING
Plan ID Crosswalk Justification	SERFF – Supporting Documentation
Plan ID Crosswalk State Authorization	SERFF – Supporting Documentation
Plan ID Crosswalk Template	SERFF – Supporting Documentation
Plans & Benefits Template	SERFF- BINDER TEMPLATE
Prescription Drug Template	SERFF- BINDER TEMPLATE
Quality Improvement Strategy Form	SERFF – Supporting Documentation
QTL/NQTL Templates	SERFF – Supporting Documentation
Rates Table Template	SERFF- BINDER TEMPLATE
Rate Exhibits	SERFF – RATE FILING
Rating Business Rules Template	SERFF- BINDER TEMPLATE
Redacted Justification Checklist (reasons companies can redact criteria)	SERFF – RATE FILING
SADP AV Supporting Documentation	SERFF – RATE FILING
SADP Description of EHB Allocation	SERFF – RATE FILING
Summary of Benefits and Coverage (SBC) Schedule Benefit	SERFF- BINDER/FORM FILING
Service Area Template	SERFF- BINDER TEMPLATE
Service Area Map	SERFF – Supporting Documentation
Stand-alone AVC screenshot	SERFF – Supporting Documentation
Stand-alone Dental Plan AV Supporting documentation and justification	SERFF – Supporting Documentation
State Partnership Exchange Issuer Program Attestation Response Forms	SERFF – Supporting Documentation
Transparency in Coverage Template	SERFF – BINDER TEMPLATE
Unique Plan Design Supporting Documentation	SERFF – Supporting Documentation