

Washington State SERFF

Health and Disability Form Filing

General Instructions

These instructions apply to filing of forms for all major medical plans (including higher education student health plans), stand-alone dental and stand-alone vision plans, and provider agreements.

Please see the Washington State SERFF Life and Disability Rate and Form Filing General Instructions for filing of any of the following: life insurance, annuities, Medicare supplement plans, long term care insurance, credit life insurance, life settlements, accidental death and dismemberment, and disability income insurance.

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I. Filing Requirements for ALL Health and Disability Filers

A. All health and disability policy forms must be filed in SERFF.

1. Please see the NAIC Uniform Life, Accident & Health, Annuity and Credit Coding Matrix for the list of these products.
 - a. The matrix can be found on the OIC's website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab and choose "SERFF Filing Guidelines" under Filing Instructions.
 - b. The matrix is also available on the Filing Rules tab, General Instructions section of SERFF.
2. NAIC Uniform Transmittal Forms are not required when submitting SERFF filings.
3. If you are a new issuer in Washington or are filing a product that uses a provider network you have not previously used, you must file all required provider network materials and provider contracting materials prior to or concurrent with filing rates and forms. WAC 284-170-280; WAC 284-170-401 *et seq.*
4. Network Access reports may not be filed in SERFF. For instructions on filing these reports, please see "Network Access Report Submission Instructions" located on the OIC website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab, then under "Filing Instructions", choose "Network Access".

B. Instructions for filing all forms:

1. All forms that are part of the health plan contract must be filed.¹ This includes the application, enrollment form, policy form, certificate of coverage/benefit booklet, riders, and disclosures.
 - a. Form and rate filings must be filed separately, but concurrently.
 - b. Forms translated from English to another language must be filed according to the requirements of WAC 284-44A-120 (HCSCs), WAC 284-46A-120 (HMOs), or WAC 284-58-066 (disability companies). You must include the two required certifications and identify the approved English version(s) of the form(s).

¹ RCW 48.18.100, RCW 48.43.730, RCW 48.44.040, RCW 48.46.060, and WAC 284-43-6560. "Form" is defined for HCSCs in WAC 284-44A-010(4), and for HMOs in WAC 284-46A-010(4).

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- c. You may attach supporting documentation for a specific form under the Supporting Documentation tab.
 - d. You may not encrypt or otherwise electronically protect any document filed with OIC for review. We must be able to make a PDF copy of each of your forms.
2. Individual and small group filings, including health plans, dental-only and vision-only filings, must contain no bracketing or variability (with the exception of variability for administrative purposes only, such as signature blocks and contact information). No benefits (such as adult dental or contraception) may be bracketed in Individual or Small Group plans. Plans with different benefits are separate products. Short Term medical plans may include variability (see Section II.B.). Limited variability used for administrative purposes only does not require a formal variability statement.
3. **Grandfathered** health plans must include a certification, signed by an officer of the company, under the Supporting Documentation tab verifying that the **Grandfathered** plan(s) meets all the criteria under WAC 284-43-0250.
4. Short Term medical plans, both individual and group, must include a completed Short Term Plans Analyst Checklist under the Supporting Documentation tab.
5. Forms that include a Table of Contents must list page numbers. The page numbers may be bracketed as a variable, but must be an accurate representation of the document attached on the SERFF Form Schedule tab.
6. If a plan uses a provider network, the network name must be clearly identified in the certificate of coverage/benefit booklet and match the network name filed with the OIC exactly (for example: "Your Provider Network is: _____").
7. All web-based application and enrollment forms must include a completed and signed "Custom Enrollment/Application Certification" on the Supporting Documentation tab.
8. In your initial submission, all forms that comprise your filing must be in final format and attached on the Form Schedule tab. (If your initial submission includes previously approved forms, see Section I.B.9. below.)
- a. You must list all filed forms in separate lines on the Form Schedule tab, and enter form numbers correctly. Each form listed on the Form Schedule tab must have only one form number.
 - b. Each form filed must contain a unique form number in the lower left hand corner of the document.
 - i. A form must retain the same form number, with no changes, throughout the review process. This means that, even when a form is revised as a result of objections or allowed amendments during the review process, it must retain the same form number.

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- ii. A form which has undergone any revision outside the review process is a new form. This means you may not file a revised version of a previously-approved form using the same form number.
 - iii. Forms that will be used for multiple lines of coverage (medical, dental, vision, etc.) need to be filed under each applicable TOI. For example, an enrollment form that will be used for both medical and vision plans will need to be filed separately using a medical TOI (i.e. H16G) on one filing and a vision TOI (H20G) on the second filing. The form can, however, have the same form number under each TOI as long as the form is identical under each TOI.
 - iv. If an identical form is used in the same market but for different carriers who share the same parent company, the form must contain a unique form number for each carrier using that form. **This provision does not apply to custom application and enrollment forms that are identical, or to filings made under TOI NA01.**
9. With the exception of Standard Master Contract filings, if your initial submission includes **previously approved** forms, or the filed form (i.e. application, rider, endorsement, etc.) will be used in conjunction with a previously approved form(s), you must associate the forms. To do this, you must:
- a. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) to which the notice applies on the Form Schedule tab. **DO NOT** attach the previously-approved forms;
 - b. All forms associated must be from a filing with the same TOI.
 - c. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed - State Tracking #[XXXXXX]" See the screenshot in section I.D.5. of these Instructions.
 - d. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside of this retention schedule, the form may not be associated and must be attached to the filing for review.
10. Standard Master filings must include all forms that comprise the filing. Forms may not be associated, as described in Section I.B.9. In instances when a Standard Master incorporates a previously approved form:
- a. Create a separate line item for each previously approved form, attach the PDF and list the previous Filing Tracking Number under the "Action Specific Data" column, and note "No Changes."
11. "Corresponding Filing Tracking Number" Field in SERFF:
- a. You must complete the "Corresponding Filing Tracking Number" field if there is

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a required corresponding filing. (Note that this field can be changed via post-submission update if necessary.)

- i. A "Corresponding Filing Tracking Number" is the number for a filing that is required to be filed in relation to the current filing. (For example, a corresponding rate filing for a form filing, a "for-public" rate for a fully negotiated filing).
 - ii. A corresponding filing tracking number must be a SERFF tracking number. It cannot be a state tracking number, company tracking number, or form number.
 - iii. If there are too many corresponding filing tracking numbers to be placed in the "Corresponding Filing Tracking Number" field (for example, a proprietary rate filing for a specific group that has multiple products), you may list the corresponding filing tracking numbers in a separate document attached on the Supporting Documentation tab, and indicate this in the "Corresponding Filing Tracking Number" field.
12. A form filing accepted for review generally cannot be changed. **DO NOT** file amendments or Post-Submission Updates to a filing currently under review. The only exception is where (a), (b), or (c) below, is true:
- a. Changes to the forms are required to be made in response to a form objection in the filing; or
 - b. Changes to the forms are required to be made in response to a rate objection:
 - i. You must send a Note to Reviewer in the form filing requesting to amend the filing in response to a rate objection. The Note to Reviewer must be sent in the filing you are requesting to change, and include specific details of the change requested, including the SERFF Tracking Number for the corresponding rate filing.
 - ii. Your analyst will notify you in a Note to Filer whether your request is accepted or denied; or
 - c. You have requested and been granted authorization to amend or submit a change through a Post-Submission Update on your filing via Note to Filer in SERFF. To request to make a change to a form filing after it has been accepted for review:
 - i. You must send a Note to Reviewer requesting to make a change to any SERFF field or to replace, modify, add, amend, or withdraw a form after it has been accepted for review. The Note to Reviewer must be sent in the filing you are requesting to change, and include specific details of the change requested, as well as the reason for the change.
 - ii. Your analyst will notify you in a Note to Filer whether your request is

accepted or denied.

- iii. If your request is denied you may not modify the filing. You may request that the filing be withdrawn.
 - iv. If your request is accepted you may update your filing as directed in the Note to Filer.
 - v. Do not make any modifications other than as specifically authorized in the Note to Filer. You will be required to remove any unauthorized modifications.
- d. Filings modified without proper authorization will be disapproved.
13. A carrier's request to have a filing re-opened will not be considered unless there are extraordinary circumstances, a change must be made for consumer protection, AND there is no other way to accomplish this. To request to re-open a filing:
- a. Submit a Note to Reviewer clearly identifying the exact change(s) proposed; and
 - b. A detailed explanation of why extraordinary circumstances exist requiring re-opening, why the change must be made for consumer protection, and why there is no other way to accomplish this.
 - c. If your request is accepted, the filing will be re-opened and approval will be verified in a Note to Filer.
 - d. Do not make any modifications other than as specifically authorized in the Note to Filer approval. You will be required to remove any unauthorized modifications.

C. SERFF amendment process vs. contract endorsements:

- 1. Form filings generally cannot be changed once accepted by the SERFF Intake Desk, other than changes required to be made in response to objections. Where a filing has been accepted for review, and you need to make a change to one or more of the forms in your filing, you will either need to request permission to amend the form(s) - see section I.B.12 - or file an endorsement to that form. A filing of an endorsement is a separate SERFF submission.
- 2. The terms "amendment" and "endorsement" tend to be used interchangeably, but they are not the same.
 - a. An amendment changes the terms of the plan starting on the effective date of the plan. Generally, an amendment is a change to a filing upon which final action has not yet been taken. (In other words, the forms are pending review or are under active review.)
 - b. An endorsement is a legal document that changes the terms of a plan mid-plan year, not from the effective date of the plan. Endorsements are documents that change the terms of a contract, and must be issued to all current enrollees on the plan(s) to which the endorsed form pertains, as well as any future enrollees

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under the plan(s). Generally, an endorsement is a change to a contract upon which final action has been taken, and where the plan is currently in effect for at least one enrollee. See section XI, below.

- c. There are situations where the “general” rules would lead to undesirable results such as unnecessary filings, additional unnecessary work, or consumer confusion. If you are unsure which process to use, or you believe that there is a reason that one process or the other is necessary, contact your analyst.
3. If you want to change a form, and the change dates back to the effective date of the plan(s) with which the form is associated, you must request permission to amend the form by submitting a Note to Reviewer.
 - a. Example 1: A large group Fully-Negotiated major medical plan has current enrollees and you wish to extend the contract period for that plan. The filing for that plan is pending review. You would need to request to extend the contract period through an amendment because the proposed change dates back to the effective date of the plan.
 - b. Example 2: You filed an individual major medical plan to be sold both on and off the Exchange for the upcoming plan year. The filing is under active review. You realize you have inadvertently included an error or typo that you would like to change. You would need to request to make this change through an amendment because the change will be in place from the plan’s effective date.
 - c. Example 3: The same facts as Example 2, except that final action has been taken on your filing. The plan has not yet been issued. This is a situation where the “general rules” can lead to confusion and undesirable results. The general rule is that a change to a plan upon which final action has been taken may only be made by filing an endorsement. See section XI, below. However, in this case, the change would date back to the effective date of the plan, which means the change should be made by an amendment. Endorsement would lead to undesirable results because there would already be an endorsement to your new plan before it had even been issued to any enrollees. In this case, you would need to call your analyst to discuss the situation. (Note that, per section XI below, a filing upon which final action has been taken cannot be changed. Thus, amending a plan upon which final action has been taken will not be allowed absent extraordinary circumstances.)
 - d. Example 4: You realize there is a typo in one of your large group benefit booklets. You want to make a change to correct it. Final action has been taken on the forms and plans have been issued. You should request permission to amend your benefit booklet, because this change would date back to the effective date of the plan. Note: In this particular situation, you may also want to contact your analyst, because this is likely to be a situation where the “general” rules lead to undesirable results. In this situation, it may be appropriate to file an endorsement to be issued to existing enrollees (rather than re-issuing complete

booklets for a small correction), and a corrected booklet to be issued to new enrollees going forward.

4. You will file an endorsement to the form if the change is to take place mid-plan year.
 - a. Example 1: A large group Fully-Negotiated major medical filing has current enrollees and the group wishes to add a new benefit. That benefit change would not date back to the effective date of the plan, but would have a later effective date. Therefore, you could not amend the forms initially filed, because this new benefit was not a benefit under the plan for part of the plan year. You would make this change by filing an endorsement.
 - b. Example 2: A large group stand-alone employee-only dental plan has current enrollees, and the employer policyholder wishes to drop coverage of orthodontia. This benefit change would not date back to the effective date of the plan, but would have a later effective date. For the same reason as in Example 1, above, you would make this change by filing an endorsement.

D. Filing Endorsements

1. Note: Fully Negotiated filings may only use the endorsement process if the changes to be endorsed do not result in a change in rates. If changes result in updated rates, a new Fully Negotiated filing must be submitted (see Section II.C.4.).
2. Endorsements filed for review must be listed and attached, in final form, on the Form Schedule tab.
3. Endorsement filings must populate the Product Name field using the standard: "END [Product Name]".
4. An endorsement must be filed under the same TOI as the plan it is endorsing.
5. Endorsements must be associated with the form(s) they endorse. To do this, you must:
 - a. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) to which the endorsement applies on the Form Schedule tab. **DO NOT** attach the policy forms being endorsed;
 - b. All forms associated must be from a filing with the same TOI.
 - c. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See "Diagram: Filing Endorsements", below.
 - d. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form

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received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.

Diagram: Filing Endorsements

The screenshot displays the Washington SERFF filing system interface. At the top, a message states "This Filing has been marked as public access." The header includes the Washington logo and a "View Filing Log" link. The main section is divided into two columns of information. The left column contains: Filing Company: Acme Insurance Co., TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO), Sub-TOI: HOrg02G.003B Large Group Only - POS, Filing Type: Form, Assigned To: .., Date Submitted: 02/15/2017, and State Filing Description:. The right column contains: SERFF Tr Num: Acme-123456789, SERFF Status: Assigned, State Tr Num:, State Status: Review Pending, Co Tr Num: LARGE GROUP ENDORSEMENT, and Disposition Date:. Below this is a tabbed interface with tabs for General Information, Form Schedule, Rate/Rule Schedule, Supporting Documentation, State Specific, Companies and Contact, Filing Fees, and Filing Correspondence. The "Form Count" is 4. A "Lead Form Number:" field is present. The main table lists four items, each with a form number, type, action, and attachments. Red arrows point to the "OTH" form type and the "Other" action for items 2, 3, and 4. Item 1 is a "Large group contract endorsement" (Form 4163, OTH, Initial) with attachment "Contract endorse.pdf". Item 2 is a "Large group benefits booklet endorsement" (Form 4159, OTH, Initial) with attachment "Booklet endorse.pdf". Item 3 is a "Benefits booklet" (Form .8881, OTH, Other) with attachment "Other Filed - state tracking Explanation #3103...". Item 4 is a "Benefits booklet" (Form 6217, OTH, Other) with attachment "Other filed - state tracking Explanation #3103...". All items were submitted on 02/15/2017.

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Action	Action Specific Data	Readability Score	Attachments	Submitted
1		Large group contract endorsement	4163	OTH	Initial			Contract endorse.pdf	Date Submitted: 02/15/2017
2		Large group benefits booklet endorsement	4159	OTH	Initial			Booklet endorse.pdf	Date Submitted: 02/15/2017
3		Benefits booklet	.8881	OTH	Other	Other Filed - state tracking Explanation #3103...			Date Submitted: 02/15/2017
4		Benefits booklet	6217	OTH	Other	Other filed - state tracking Explanation #3103...			Date Submitted: 02/15/2017

6. Endorsements may not be used with the Short Form filing process.
 - a. If a group whose plan has been filed using the Short Form process negotiates a new contract provision during the contract or plan year, the issuer must make this change by submitting a Fully Negotiated contract according to the instructions set forth in section II.C.4 of these instructions, below.

E. Renewal, discontinuation, and termination notices

1. Major medical plans must file these notices as a separate filing.
2. Notices filed for review must be listed and attached, in final form, on the Form Schedule tab.
3. These notices must be associated with the forms to which they apply. To do this, you must:
 - a. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) to which the notice applies on the Form Schedule tab. **DO NOT** attach the previously-approved forms;
 - b. All forms associated must be from a filing with the same TOI.
 - c. When you list a previously-approved form on the Form Schedule tab, you must

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populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed - State Tracking #[XXXXXX]" See the screenshot in section I.D.5. of these Instructions.

- d. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
4. For plans in the individual market (both inside and outside the Exchange, including catastrophic plans), you must use the state-specific notices published by OIC. No deviations from these templates will be allowed, including the form number. For plans in the small group market, you may, but are not required to, use the state-specific notices published by OIC.
 - a. These notices may be found on OIC's website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab and choose "Health Care and Disability Filings" under Filing Instructions.
5. For notices in both the individual and small group markets, you must conform to the following naming conventions:
 - a. Renewal notices must populate the Product Name field using the following standard (as appropriate):
 - i. "Renewal Notice - Exchange Market"; or
 - ii. "Renewal Notice - Outside Market"; or
 - iii. "Renewal Notice – Both Inside and Outside Exchange".
 - b. Discontinuation notices must populate the Product Name field using the following standard (as appropriate):
 - i. "Discontinuation Notice - Exchange Market"; or
 - ii. "Discontinuation Notice - Outside Market"; or
 - iii. "Discontinuation Notice – Both Inside and Outside Exchange".
 - c. Aging off catastrophic plan notices must populate the Product Name field using the following standard (as appropriate):
 - i. "Aging Off Catastrophic Plan Notice - Exchange Market"; or
 - ii. "Aging Off Catastrophic Plan Notice - Outside Market"; or
 - iii. "Aging Off Catastrophic Plan Notice – Both Inside and Outside Exchange".
6. For Notices in the Large Group market:
 - a. 90-day replacement notices must populate the Product Name field using the standard: "90 Day Replacement Notice."

- b. 180-day discontinuation notices must populate the Product Name field using the standard: "180 Day Discontinuation Notice."

F. Custom applications and enrollment forms (including web-based):

1. All web-based application and enrollment forms are considered "custom" and must follow the criteria listed under this section.
2. Custom applications and enrollment forms filed for review must be attached, in final form, on the Form Schedule tab.
3. You must complete the Product Name (when the custom application and enrollment form(s) is filed by itself) and Form Name fields using the following naming convention:
 - a. "Custom App/Enr [ABC Company]." "ABC Company" means the specific group, trust, association, etc.
 - b. "Custom App/Enr" for filings where no specific employer group, trust of association exists.
4. Custom forms must be associated with the form(s) with which they will be used. To do this, you must:
 - a. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) with which the custom application or enrollment form will be used on the Form Schedule tab, using the correct form numbers. **DO NOT** attach the previously-approved forms.
 - b. All forms associated must be from a filing with the same TOI.
 - c. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See the screenshot above in section I.D.5. of these Instructions.
 - d. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
5. For each custom application and enrollment form submitted, you must attach a completed and signed "Custom Enrollment/Application Certification" on the Supporting Documentation tab.

G. Health plan issued to an Association or Member-Governed Group:

1. **Grandfathered** Associations or Member-Governed Groups under WAC 284-43-0250 and WAC 284-43-0330.
 - a. You must state in the Filing Description field whether this is an in-state or out-

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of-state group filing. An out-of-state group filing is a filing of a group policy issued to a policyholder outside the state of Washington that provides coverage to residents of Washington.

- b. You must use the following in the Product Name field on the General Information tab "Grandfathered Association or Member-Governed Group– [Name of the Association]."
- c. Rates and forms for Grandfathered association or member-governed groups must be filed separately from rates and forms for Non-grandfathered association or member-governed groups. See Rate Filing General Instructions and WAC 284-43-0330.
- d. You must file all forms comprising the contract, including the group master application, enrollment form, policy, certificate of coverage(s), and other documents as appropriate. Each form submitted for review must be listed and attached on the Form Schedule tab. Each form must be in single case format. (Single case format means group-specific language with no bracketing or variability.)
- e. If a form has been previously approved, you must associate the form with the Fully Negotiated filing by:
 - i. Listing the previously-approved policy form number(s) and form name(s) on the Form Schedule tab, using the correct form numbers. **DO NOT** attach the previously- approved forms.
 - ii. All forms associated must be from a filing with the same TOI.
 - iii. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See the screenshot above in section I.D.5. of these Instructions.
 - iv. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
- f. Grandfathered association or member-governed group filings must include a certification, signed by an officer of the company, under the Supporting Documentation tab verifying that the Grandfathered plan(s) meets all the criteria under WAC 284-43-0250.
- g. The filing must include any applicable group-specific or unique application or enrollment forms. The forms must be listed and attached on the Form Schedule tab for review.

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- i. The forms must use the prescribed form name requirements, e.g., "Custom App/Enr [ABC Company]".
- ii. The filing must include a completed and signed "Custom Enrollment/Application Certification" for each unique application or custom enrollment form submitted for review. The certification(s) must be attached on the Supporting Documentation tab.

2. **Non-Grandfathered** Association Health Plans:

- a. **Pathway 1 Association:** Bona fide group or association of employers to whom the health plan is issued constitutes an employer under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act (ERISA) of 1974 and Department of Labor ("DOL") guidance issued prior to June 21, 2018 under WAC 284-43-0330(1) and (2).
 - i. The health plan must be filed as, and conform to the requirements for, a small group health plan if the number of participants is fifty or less. See Section I of these instructions.
 - ii. You must state in the Filing Description field whether this is an in-state or out-of-state group filing. An out-of-state group filing is a filing of a group policy issued to a policyholder outside the state of Washington that provides coverage to residents of Washington.
 - iii. Must use the following in the Product Name field on the General Information tab: "Pathway 1 Association or group under 29 U.S.C. Section 1002(5) of ERISA – [Name of the Association]".
 - iv. You must file all forms comprising the contract, including the group master application, enrollment form, policy, certificate of coverage(s), and other documents as appropriate. Each form submitted for review must be listed and attached on the Form Schedule tab. Each form must be in single case format. (Single case format means group-specific language with no bracketing or variability.)
 - v. If a form has been previously approved, you must associate the form with the Fully Negotiated filing by:
 - 1. Listing the previously-approved policy form number(s) and form name(s) on the Form Schedule tab, using the correct form numbers. **DO NOT** attach the previously- approved forms.
 - 2. All forms associated must be from a filing with the same TOI.

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3. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See the screenshot above in section I.D.5. of these Instructions.
 4. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
- vi. The filing must include any applicable group-specific or unique application or enrollment forms. The forms must be listed and attached on the Form Schedule tab for review.
1. The forms must use the prescribed form name requirements, e.g., "Custom App/Enr [ABC Company]".
 2. The filing must include a completed and signed "Custom Enrollment/Application Certification" for each unique application or custom enrollment form submitted for review. The certification(s) must be attached on the Supporting Documentation tab.
- vii. Your filing must include a certification from an officer of the company, attached on the Supporting Documentation tab.
1. The certification must state that the group health insurance coverage in connection with this large group health plan meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 29 CFR § 2590.702.
 2. The certification must include statements that the rules for the eligibility (including continued eligibility) of any individual to enroll under the terms of the large group health plan are not based on any of the following health status-related factors (prescribed in HIPAA) in relation to the individual or a dependent of the individual:
 - a. Health status;
 - b. Medical condition (including both physical and mental illnesses);
 - c. Claims experience;
 - d. Receipt of health care;
 - e. Medical history;
 - f. Genetic information;

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- g. Evidence of insurability (including conditions arising out of acts of domestic violence; or
 - h. Disability.
 - viii. Must attach a PDF document titled "Evidence as an Employer" on the Supporting Documentation tab. The document must include, at a minimum, the following information:
 - 1. A copy of the association bylaws; and
 - 2. A copy of the trust agreement or other organizational document which shows the purpose of the association and who governs the association; and
 - 3. A statement of the association's history; and
 - 4. A copy of the occupational categories/industry classifications comprising the employers in the association; and
 - 5. An advisory opinion from the Federal Department of Labor demonstrating that the group is qualified to purchase association coverage;
 - 6. In the absence of a United States Department of Labor opinion, an opinion from an attorney explaining how and why the association qualifies as an employer under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act (ERISA) of 1974 and DOL guidance issued prior to June 21, 2018.
- b. **Pathway 2 Association:** Bona fide employer group or association acting in the interest of an employer under section 3(5) of the Employee Retirement Income Security Act (29 U.S.C. 1002(5)) that meets the requirements set forth in paragraphs (b) through (e) of 29 C.F.R. 2510.3-5.
- i. Must meet the requirements under WAC 284-43-9010.
 - ii. You must state in the Filing Description field whether this is an in-state or out-of-state group filing. An out-of-state group filing is a filing of a group policy issued to a policyholder outside the state of Washington that provides coverage to residents of Washington.
 - iii. Must use the following in the Product Name field on the General Information tab: "Pathway 2 Association or group – [Name of the Association]".
 - iv. You must file all forms comprising the contract, including the group master application, enrollment form, policy, certificate of coverage(s), and other

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documents as appropriate. Each form submitted for review must be listed and attached on the Form Schedule tab. Each form must be in single case format. (Single case format means group-specific language with no bracketing or variability.)

- v. If a form has been previously approved, you must associate the form with the Fully Negotiated filing by:
 - 1. Listing the previously-approved policy form number(s) and form name(s) on the Form Schedule tab, using the correct form numbers. **DO NOT** attach the previously- approved forms.
 - 2. All forms associated must be from a filing with the same TOI.
 - 3. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See the screenshot above in section I.D.5. of these Instructions.
 - 4. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
- vi. The filing must include any applicable group-specific or unique application or enrollment forms. The forms must be listed and attached on the Form Schedule tab for review.
 - 1. The forms must use the prescribed form name requirements, e.g., "Custom App/Enr [ABC Company]".
 - 2. The filing must include a completed and signed "Custom Enrollment/Application Certification" for each unique application or custom enrollment form submitted for review. The certification(s) must be attached on the Supporting Documentation tab.

vii. Under the Supporting Documentation tab in SERFF, provide the required documentation under WAC 284-43-9010 (1), (2) and (3).

~~3. Submission requirements apply to both **Grandfathered** and **Non-grandfathered** filings, unless specifically noted:~~

~~a. You must state in the Filing Description field whether this is an in-state or out-~~

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of-state group filing. An out-of-state group filing is a filing of a group policy issued to a policyholder outside the state of Washington that provides coverage to residents of Washington.

- b. **Non-Grandfathered** associations or member-governed group filings must use the following product name convention: "Association or member-governed true employer group under 29 U.S.C. Section 1002(5) of ERISA— [Name of the Association]" in the Product Name field on the General Information tab.
 - c. **Grandfathered** associations or member-governed group filings must use the following product name convention: "Grandfathered Association or member-governed group— [Name of the Association]" in the Product Name field on the General Information tab.
 - d. Rates and forms for **Grandfathered** association or member-governed groups must be filed separately from rates and forms for **Non-grandfathered** association or member-governed groups. See Rate Filing General Instructions and WAC 284-43-0330.
4. A **Non-grandfathered** group to whom the health plan is issued must constitute a true employer group under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act (ERISA) of 1974. WAC 284-43-0330(1) and (2).
- a. The health plan must be filed as, and conform to the requirements for, a small group health plan if the number of participants is fifty or less. See section I of these instructions.
5. You must file all forms comprising the contract, including the group master application, enrollment form, policy, certificate of coverage(s), and other documents as appropriate. Each form submitted for review must be listed and attached on the Form Schedule tab. Each form must be in single case format. (Single case format means group-specific language with no bracketing or variability.)
- a. If a form has been previously approved, you must associate the form with the Fully Negotiated filing by:
 - i. Listing the previously-approved policy form number(s) and form name(s) on the Form Schedule tab, using the correct form numbers. **DO NOT** attach the previously-approved forms.
 - ii. All forms associated must be from a filing with the same TOI.
 - iii. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed— State Tracking #[XXXXXX]". See the screenshot above in section I.D.3.b of these Instructions.
 - iv. Associated forms must have received final action from the OIC within the

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State Government General Records Retention Schedule timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.

6. Your filing must include a certification from an officer of the company, attached on the Supporting Documentation tab.
 - a. The certification must state that the group health insurance coverage in connection with this large group health plan meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 29 CFR § 2590.702.
 - b. The certification must include statements that the rules for the eligibility (including continued eligibility) of any individual to enroll under the terms of the large group health plan are not based on any of the following health status-related factors (prescribed in HIPAA) in relation to the individual or a dependent of the individual:
 - i. Health status;
 - ii. Medical condition (including both physical and mental illnesses);
 - iii. Claims experience;
 - iv. Receipt of health care;
 - v. Medical history;
 - vi. Genetic information;
 - vii. Evidence of insurability (including conditions arising out of acts of domestic violence); or
 - viii. Disability.
7. **Non-grandfathered** major medical plan filings must attach a PDF document titled "Evidence as an Employer" on the Supporting Documentation tab. The document must include, at a minimum, the following information:
 - a. A copy of the association bylaws; and
 - b. A copy of the trust agreement or other organizational document which shows the purpose of the association and who governs the association; and
 - c. A statement of the association's history; and
 - d. A copy of the occupational categories/ industry classifications comprising the employers in the association; and
 - e. An advisory opinion from the Federal Department of Labor demonstrating that the group is qualified to purchase association coverage;
 - f. In the absence of a Federal Department of Labor opinion, an opinion from an attorney explaining how and why the association qualifies as a true employer

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~~under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act (ERISA) of 1974.~~

- ~~8. **Grandfathered** association or member-governed group filings must include a certification, signed by an officer of the company, under the Supporting Documentation tab verifying that the **Grandfathered** plan(s) meets all the criteria under WAC 284-43-0250.~~
- ~~9. A Large Group Analyst Checklist must be filed under the Supporting Documentation tab. A Checklist is not required for large group vision fully negotiated filings.~~
- ~~10. The filing must include any applicable group-specific or unique application or enrollment forms. The forms must be listed and attached on the Form Schedule tab for review.
 - ~~a. The forms must use the prescribed form name requirements, e.g., "Custom App/Enr [ABC Company]".~~
 - ~~b. The filing must include a completed and signed "Custom Enrollment/Application Certification" for each unique application or custom enrollment form submitted for review. The certification(s) must be attached on the Supporting Documentation tab.~~~~

H. Dental only or Vision only plans for Association or Member-Governed Groups:

1. Disability Out-of-State group dental and vision plans should follow Section III.A.
2. The requirements of Section G apply only to health plans; they do not apply to "excepted benefits," as those terms are defined in 29 CFR §2590.732.
3. Excepted benefits plans must use the following naming convention:
 - a. Product name must use "Association – [Group name];
 - b. Product name must **NOT** include the phrase "Association or member-governed true employer group under 29 U.S.C. Section 1002(5) of ERISA; and
 - c. Must file in compliance with Section II.A.1. through Section II.A.5., and Section II.C.4..
4. Form and rate filings (with the exception Large Group non-Association plans) must be filed separately, but concurrently.
5. Each form must be in single case format. (Single case format means group-specific language with no bracketing or variability.)
6. Expediting review of forms in an association filing:
 - a. Very similar filings may be reviewed as a group, which allows for quicker review and disposition on your filings, and prevents multiple objections to the same

language in different filings. See Section II.C.4.vii, below.

- b. If your filing would be considered an “off-the-shelf” filing if sold to a large group other than an association or member-governed group, please indicate that in the Filing Description or in your cover letter.

I. Taft-Hartley Plans:

1. Taft-Hartley plans are filed as large group employer plans, following the instructions in sections I.A and I.B., above, and section II.C.4, below.
2. You must state on the General Information tab that the filing is a Taft-Hartley plan.

II. General Requirements for Large Group Filings by ALL Carriers

A. General Requirements

1. Scope of Section by TOI in SERFF: H16G, HOrg02G, H10G, H15G, or H20G.
2. **Grandfathered** large group filings must include a certification, signed by an officer of the company, under the Supporting Documentation tab verifying that the **Grandfathered** plan(s) meets all the criteria under WAC 284-43-0250.
3. Standard Master filings must include all forms that comprise the filing.
 - i. In instances when a Standard Master incorporates a previously approved form with no changes from the approved version, create a separate line item for each previously approved form, attach the PDF and list the previous Filing Tracking Number under the “Action Specific Data” column, and note “No Changes.”
 - ii. In instances when a Standard Master incorporates a previously approved form that is substantially similar to a previously approved form, you may expedite review of this form by attaching a strikeout/underline (redline) document showing the changes from that previously-approved form. On the General Information tab (Filing Description field) or in a cover letter, indicate that you have attached such a strikeout/underline (redline), and provide the Form Number and Tracker ID for the filing in which the substantially similar form was approved. This allows your analyst to review only the parts of the form(s) that are different from the previously-approved form, and prevents multiple objections to the same language in different filings.
4. You must submit a properly completed Large Group Analyst Checklist for every large group health care, dental, and large group Standard Master Contract filing. A checklist is not required for large group vision Standard Master Contract filings.

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You must use the appropriate Analyst Checklist for your license (HCSC, HMO, or Disability Company).

5. Forms will be reviewed using the applicable Analyst Checklist.
 - a. If the analyst is unable to find a particular provision by using the Analyst Checklist completed by the issuer (i.e., if the provision is not found in the location indicated on the issuer's completed Analyst Checklist), the analyst will attempt to locate the provision in the filing. If the analyst is unable to locate the provision, the analyst will send an objection indicating that the provision cannot be found.
 - b. If the analyst is unable to find three separate provisions by using the Analyst Checklist (e.g., there are three instances where the provision is not found in the location indicated on the issuer's completed Analyst Checklist), the analyst will cease review of the filing. The analyst will send an objection indicating that review has ceased and requesting a corrected Analyst Checklist.
 - c. After the Analyst Checklist has been received, review of the filing will recommence in the appropriate order of priority, as determined by the review team.
6. For each large group, issuers are required to make sure that the group's rate and form filings are filed utilizing one of the four procedures outlined in subsection C of this Section. Also, see the separate document, *Appendix A: Large Group Form and Rate Filing Flowchart*, located on the OIC website (www.insurance.wa.gov)

B. Variability:

1. Variability is allowed in large group Standard Master Contract filings and in Short Term medical plan filings only. Individual and small group filings, including health plans, dental-only and vision-only filings, must contain no bracketing or variability (with the exception of variability for administrative purposes only, such as signature blocks and contact information). No benefits (such as adult dental or contraception) may be bracketed in Individual or Small Group plans. Plans with different benefits are separate products. Limited variability used for administrative purposes only does not require a formal variability statement.
2. Plans that are intended for sale without variability to multiple large groups may contain limited variability for administrative purposes only, such as group name, signature blocks, and contact information.
3. Each variable must be separately and completely explained in an Explanation of Variability attached on the Supporting Documentation tab. You must use the following format for Explanations of Variability:
 - a. Begin with a clean copy of the form as filed, in Word format. On the Word toolbar, click the "Review" tab. Use the "New Comment" feature to provide a comment for each variable, indicating the exact variable provisions that may be

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included. See "Diagram: Format for Statement of Variability" on the following page. Once the document is completed in WORD, convert to a PDF before loading to the SERFF Supporting Documentation tab.

- b. Every variable must be explained fully.
 - c. Variables must be specific. If the group may choose benefit amounts within a range, the specific available amounts within that range must be stated. For example: [5% - 25%, in increments of 5%], [10 – 20 visits, in increments of 1], [\$0 - \$50, in \$5 increments], or [\$0, \$20, \$40, or \$80]. Avoid variables within variables whenever possible.
4. Variability must be readily understandable.
- a. If the analyst is unable to follow your Explanation of Variability to understand exactly what variables may be used, the analyst will cease review of your filing. The analyst will send an objection indicating that review has ceased and requesting a corrected Explanation of Variability and/or filing.

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Diagram: Format for Statement of Variability

Per Member: $\$(1,000 - 6,850 \text{ in increments of } \$50)$
Per Family: $\$(\text{groups choose, two or three times the per Member maximum not to exceed } \$13,700)$

Categories 1 and 2
Per Member: $\$(1,000 - 6,850 \text{ in increments of } \$50)$
Per Family: $\$(\text{groups choose, two or three times the per Member maximum amount not to exceed } \$13,700)$

Category 3
Per Member: $\$(1,000 - 15,000, \text{ in increments of } \$50)$
Per Family: $\$(\text{groups choose, two or three times the per Member maximum amount})$

COPAYMENTS AND COINSURANCE
Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES
(Not Applicable)
Per Member: $\$(50 - 6,850 \text{ in increments of } \$50)$
Per Family: $\$(\text{groups choose, two or three times the per Member deductible amount not to exceed } \$13,700)$

Categories 1 and 2
(Not Applicable)
Per Member: $\$(50 - 6,850 \text{ in increments of } \$50)$
Per Family: $\$(\text{groups choose, two or three times the per Member deductible amount not to exceed } \$13,700)$

Category 3
(Not Applicable)
Per Member: $\$(100 - 15,000, \text{ in increments of } \$50)$
Per Family: $\$(\text{groups choose, two or three times the per Member deductible amount})$

Comments:

- Comment []: Include if group elects the combined category out-of-pocket maximum option (there is one amount for Categories 1, 2 and 3 combined).
- Comment []: Group may choose out-of-pocket maximum amount within this range.
- Comment []: Include if group elects the split category out-of-pocket maximum option (there is one amount for Category 1 and 2 and a separate amount for Category 3).
- Comment []: Group may choose out-of-pocket maximum amount within this range.
- Comment []: Group may choose out-of-pocket maximum amount within this range.
- Comment []: Include if group does not choose a calendar year deductible.
- Comment []: Include if group elects the combined deductible option (there is one amount for Categories 1, 2 and 3 combined).
- Comment []: Group may choose deductible amount within this range.
- Comment []: Include if group elects the split category deductible option (there is one amount for Category 1 and 2 and a separate amount for Category 3).
- Comment []: Include if group does not choose a Category 1 and 2 calendar year deductible.
- Comment []: Group may choose deductible amount within this range.
- Comment []: Include if group does not choose a Category 3 calendar year deductible.
- Comment []: Group may choose deductible amount within this range.

C. Four paths to file non-Association large group rates and forms

For each non-association large group, issuers are required to make sure the group's rate and form filings are filed utilizing one of the following four procedures. Also see the separate document, *Appendix A: Large Group Form and Rate Filing Flowchart*, located on the OIC website (<https://www.insurance.wa.gov/>). Corresponding form and rate filings must follow the same filing path; you cannot mix and match filing paths when filing corresponding form and rate filings. For association form health plan filings, see Section I.G.

1. Filing forms using the standard master contract filing process and filing rates using the standard rate manual filing process:

- Form Filing:** A "Standard Master Contract" is a health plan, dental only, or vision

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only contract intended to be sold to multiple large groups by HCSCs, HMOs, or Disability issuers. Standard Master forms are filed according to Section I of these Instructions.

- i. Standard Master form filings must populate the Product Name field using the naming convention: "Large Group Std. Master [Product Name]".
- ii. Standard Master filings must include all forms that comprise the form filing. Forms may not be associated, as described in Section 1.B.9. In instances when a Standard Master incorporates a previously approved form, create a separate line item for each previously approved form, attach the PDF and list the previous Filing Tracking Number under the "Action Specific Data" column, and note "No Changes."
- iii. All Standard Master forms should be attached to the Form Schedule tab in final format, and a Large Group Analyst Checklist must be filed under the Supporting Documentation tab. A Checklist is not required for large group vision Standard Master Contract filings.
- iv. Expediting review of forms in a Standard Master filing (See Section II.C.4.a.vii, below).

b. Rate Filing:

- i. A large group rate manual filing must include a rate schedule and the description and methodology used to obtain the premium for a specific group, if given the necessary information such as the demographic data and the plan design of the group [WAC 284-43-6520(11)].
- ii. The rate manual must be filed before you use it to determine a group's rate.
- iii. Under the General Information tab:
 1. In the SERFF Product Name field,
 - 1.1 The product name should start with, "Standard Large Group Rate Manual".
 - 1.2 If the filing is a for-public filing, include "for-public"; otherwise, state "not-for-public".
 2. In the Submission Type Field, indicate the type of submission.
 3. In the Filing Description, indicate whether the rate filing includes rates for new plans only, existing plans only, or both new and existing plans. List the plan name for each new plan, and the plan name and average rate change for each renewal plan.
 4. In the Corresponding Filing Tracking Number field, indicate all applicable SERFF Tracking IDs for the corresponding form filings for new plans and for the most recent corresponding rate and form filing for existing plans.

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- iv. Under the Rate/Rule Schedule Tab:
 - 1. Attach the rating manual in PDF file format.
 - 2. You may attach an Excel version of the rating manual; however, it must be a duplicate of the PDF version and include "Duplicate.xlsx" at the end of the file name.
 - 3. List the rate action as "revised" for all renewal filings and "new" for all filings with no rate history.
 - 4. Attach an Exhibit as a separate file for the base rate of each plan.
- v. Under the Supporting Documentation tab:
 - 1. Complete and attach Filing Summary under WAC 284-43-6540.
 - 1.1. Use the *Format – Rates – WAC 284-43-6540 Summary Duplicate* document (provided on the WA OIC's website, www.insurance.wa.gov).
- vi. For rate manual guidance, see *Guidance-Rate-Large Group Rate Manual* in the Filing Rules tab, General Instructions section of SERFF.
- vii. If you request some rate information to be proprietary, you must follow the procedures in the Washington State SERFF Health and Disability Rate Filing General Instructions, Section II.A.4.

2. **Filing forms using the standard master contract filing process and filing rates without using the standard rate manual filing process:**

- a. **Form Filing:** A "Standard Master Contract" is a health plan, dental only, or vision only contract intended to be sold to multiple large groups by HCSCs, HMOs, or Disability issuers. Standard Master forms are filed according to Section I of these Instructions.
 - i. Standard Master form filings must populate the Product Name field using the naming convention: "Large Group Std. Master [Product Name]"
 - ii. All Standard Master forms should be attached to the Form Schedule tab in final format, and a Large Group Analyst Checklist must be filed under the Supporting Documentation tab. A Checklist is not required for large group vision Standard Master Contract filings.
- b. **Rate Filing:**
 - i. Under the General Information tab:
 - 1. In the SERFF Product Name field, the product name must start with, "Single Case Rate without Form deviation – [Group Name]".
 - 2. In the Corresponding Filing Tracking Number field, list tracking numbers for the corresponding filings.

- ii. Under the Rate/Rule Schedule tab":
 - 1. Submit a complete "RATE SCHEDULE ITEM" and rate schedule under a public rate filing.
 - 1.1. Use the *Rate Schedule Item* document (provided on the WA OIC's website, www.insurance.wa.gov).
 - 2. Filing group experience per WAC 284-43-6540.
 - 2.1 Use the *Format – Rates – WAC 284-43-6540 Summary Duplicate* document (provided on the WA OIC's website, www.insurance.wa.gov).
 - 2.2 Use one of the following methods to file a group's experience.
 - 2.2.1 You may submit a rate filing that includes a WAC-284-43-6540 form for the group concurrently with the corresponding public rate filing. To use this method:
 - 2.2.1.1 Indicate in the RATE SCHEDULE ITEM document that "a filing summary under WAC 284-43-6540 is filed concurrently" in the provided section.
 - 2.2.1.2 You may submit the WAC 284-43-6540 form in the public rate filing. If you request the WAC 284-43-6540 form to be proprietary, you must file it in a separate proprietary rate filing (see Section II.A.4) and use the prescribed product name convention ("Single Case Rate without Form deviation – [Group's Name] – Not-for-Public").
 - 2.2.2 You may submit a WAC 284-43-6540 **annually** for a pool of specific groups or for all large groups. Under this method, a large group's rates are negotiated (not determined by a rate manual) but the group's experience is filed with other large groups or all large groups. If you normally request the WAC 284-43-6540 form to be not-for-public information, we recommend using this method because it eliminates the need to file a separate not-for-public rate filing and WAC 284-43-6540 form for every negotiated group. To use this method:
 - 2.2.2.1 You must submit the WAC 284-43-6540 form concurrently with one of the public filings for a group in the pool.

2.2.2.2 The product name of the large group pooled experience filing must follow the following naming convention: "Single Case Rate without Form deviation – [Concurrent Filing's Group Name] with Pooled Large Group Experience."

2.2.2.3 If the pooled experience does not include all large group experience, list the names of all groups accounted for in the experience. Otherwise, the description under the "Group Pool Name" in WAC 284-43-6540 should state "All Large Groups."

2.2.2.4 In the provided section of the RATE SCHEDULE ITEM document, you must check the box "A filing summary under WAC 284-43-6540 is filed separately with an existing rate manual or with a pool of groups" and provide the corresponding submission date and SERFF tracking number of the rate filing.

3. **Filing Rate and Form filings using the Short Form filing process:**

To use the Short Form filing process, the Short Form must be based upon a standard master contract on file with an effective date within 12 months of the Short Form filing effective date. Association health plans may not be filed using the Short Form process:

a. **Short Form Filing:**

- i. Definition: The Short Form filing process is used for filing a negotiated large group contract that has 12 or fewer deviations from a filed Standard Master Contract. The process may not be used where a filing has more than 12 deviations from a filed Standard Master Contract. (Such deviations can include changing eligibility requirements, networks, the way a benefit is administered, cost sharing, or deleting a non-mandated benefit entirely. However, a deviation does not include adding a benefit. A Fully Negotiated contract must be submitted according to the instructions set forth in section II.C.4 of these instructions in order to add a benefit not already listed in the Standard Master.)
- ii. Under the General Information tab:
 1. In the SERFF Product Name field, the product name must start with, "Short Form – [Group's Name]".

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2. In the Corresponding Filing Tracking Number field, list tracking numbers for the corresponding filings.

iii. Under the Form Schedule Tab:

1. Attach a properly completed "Short Form" as set forth in form SHORT FORM ED.5, and as revised from time to time,
 - 1.1 SHORT FORM ED.5 is a form prescribed by and available from the Commissioner. It can be found on the OIC's website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab and choose "SERFF Filing Guidelines" under Filing Instructions.
 - 1.1.1. Provide the exact language to be added or changed. A general description of the change is not acceptable (for example, listing the exact language to be added on the SHORT FORM ED.5 form, or placing a redline showing the modified provision under the Supporting Documentation tab, etc.).
 - 1.1.2. Provide the form number and page or section number where each listed change will occur.
 - 1.2 The form number may not be modified or removed from SHORT FORM ED.5.
 - 1.3 A public rate schedule must be included in the SHORT FORM ED.5.
2. The filing must include any applicable group-specific or unique application or enrollment forms. The forms must be listed and attached on the Form Schedule tab for review.
 - 2.1 The forms must use the prescribed form name requirements, e.g., "Custom App/Enr [ABC Company]."
 - 2.2 The filing must include a completed and signed "Custom Enrollment/Application Certification" for each unique application or group enrollment form submitted for review. The certification(s) must be attached on the Supporting Documentation tab.

iv. You may not file an endorsement to a plan filed using the Short Form filing process.

1. If a group whose plan has been filed using the Short Form process negotiates a new contract provision during the contract or plan year, the issuer must make this change by submitting a Fully Negotiated contract according to the instructions set forth below.

b. **Rate Filing:** Under the Short Form filing process, the public rate schedule is

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filed in the form filing under the SHORT FORM ED.5 document and therefore, an additional rate filing is not required for the purpose of filing rates. However, a separate rate filing is required if you need to file a group's experience per WAC 284-43-6540.

- i. Under the General Information tab in SERFF:
 - 1. In the SERFF Product Name Field:
 - 1.1 The product name must start with "Short Form – [Group's Name]".
 - 1.2 If the filing is a public filing, include "public"; otherwise, state "not-for-public".
 - 2. In the Corresponding Filing Tracking Number field, list tracking numbers for the corresponding filings.
- ii. Filing group experience per WAC 284-43-6540.
 - 1. Use the *Format – Rates – WAC 284-43-6540 Summary Duplicate* document (provided on the WA OIC's website, www.insurance.wa.gov). See the Washington State SERFF Health and Disability Rate Filing General Instructions for more information.

4. Filing Rate and Form filings using the Fully Negotiated Contract filing process:

a. Fully Negotiated Form Filing

- i. Definition: A "Fully Negotiated Contract" is a complete large group contract sold to one large group. Issuers can file a Fully Negotiated form filing if there are no Standard Master Contracts on file or if the contract has 13 or more deviations from any filed Standard Master Contract.
- ii. Fully Negotiated contracts are filed according to Section I of these Instructions.
- iii. Under the General Information tab:
 - 1. In the SERFF Product Name field, the product name must start with, "Full Neg - [Group's Name]".
 - 2. In the Corresponding Filing Tracking Number field, list tracking numbers for the corresponding filings.
- iv. Under the Form Schedule tab:
 - 1. The filing must be complete; all forms to be used with the Fully Negotiated contract must be listed on the Form Schedule tab.
 - 1.1 Any previously-approved forms which are to be used with the Fully Negotiated form filing must be associated with the filing by creating a separate line item for each associated form, but not

attaching them.

1.2 To do this, you must:

- 1.2.1 Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) to be used with the Fully Negotiated filing on the Form Schedule tab. **DO NOT** attach the policy forms;
- 1.2.2 All forms associated must be from a filing with the same TOI.
- 1.2.3 Populate the Action field with "Other" and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See the screenshot above in section I.D.5. of these Instructions.
- 1.2.4 Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.

1.3 Any form not previously approved must be listed and attached on the Form Schedule tab for review.

2. The filing must include any applicable group-specific or unique application or enrollment forms. These forms must be listed and attached on the Form Schedule tab for review.

2.1 The forms must use the prescribed form name requirements, e.g., "Custom App/Enr [ABC Company]."

v. Under the Supporting Documentation tab:

- 1. The filing must include a completed and signed "Custom Enrollment/Application Certification" for each unique application or group enrollment form submitted for review. The certification(s) must be attached on the Supporting Documentation tab.
- 2. A Large Group Analyst Checklist must be filed under the Supporting Documentation tab. A Checklist is not required for large group vision fully negotiated filings.
- 3. The issuer must provide the following information in a separate document:

2.1 Whether the group is a new group or a renewal group.

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- 2.2 The number of employees in the group (see RCW 48.43.005(15) for definition of “employee”);
 - 2.3 The number of enrolled employees; and
 - 2.4 An explanation for any filing delay beyond the 30 day period in WAC 284-43- 6560(3).
- vi. A public rate schedule must be included in the Fully Negotiated form filing.
- vii. Expediting review of forms in a Fully Negotiated filing:
 - 1. Very similar filings may be reviewed as a group, which allows for quicker review and disposition on your filings, and prevents multiple objections to the same language in different filings. Your analyst may contact you to discuss whether a particular set of large group filings should be reviewed as a group. You are also encouraged to contact your analyst if you wish to suggest group review of a set of your large group filings.
 - 2. Filings that may be reviewed together include a group of Fully Negotiated filings or Standard Master filings which all use the same “base” forms so that they include much of the same language.
 - 3. You may indicate in your filing that you believe the filing should be reviewed together with some of your other filings. You can do that by creating a list of Tracker IDs for filings that can be reviewed as a group, and attaching it on the Supporting Documents tab. Please indicate on the General Information tab or in your cover letter that the filing is part of a group that may be reviewed together.
 - 4. Any time you make a Fully Negotiated form filing, and one or more of the forms are substantially similar to a Standard Master contract or a previously- approved form, so that they include much of the same language, provide the Form Number and Tracker ID for the applicable Standard Master in a cover letter or on the General Information tab. You may also attach a line out / strikeout (redline) document showing the changes from that Standard Master or previously-approved form. On the General Information tab or in a cover letter, indicate you have attached such a line out / strikeout (redline), and provide the Form Number and Tracker ID for the Standard Master or previously-approved form. This allows your analyst to review only the parts of the form(s) that are different from the “base” form, and prevents multiple objections to the same language in different filings.

b. **Rate Filing:**

- i. If the Fully Negotiated group is a new group, no rate filing is required. If the Fully Negotiated group is a renewal group, you must file a separate rate filing. The “RATE SCHEDULE ITEM,” rate schedule, and the Filing Summary

under WAC 284-43-6540 must be filed concurrently in your rate filing(s). (The Rate Schedule Item and WAC 284-43-6540 files can be found on the WA OIC's website, www.insurance.wa.gov). If you request the Filing Summary under WAC 284-43-6540 to be proprietary, you must follow the procedures in Washington State SERFF Health and Disability Rate Filing General Instructions, Section II.A.4.

ii. Under the General Information Tab:

1. If the rate filing is for a single group, in the SERFF Product Name field, the product name must start with, "Full Neg - [Group's Name]".
2. If you negotiate or rate multiple groups together:
 - 2.1 In the SERFF Product Name field, the product name must start with, "Full Neg – Multiple Groups".
 - 2.2 In the Filing Description Field, list the name of each group.
3. In the Corresponding Filing Tracking Number field, list tracking numbers for the corresponding filings.

iii. Under the Rate/Rule Schedule tab:

1. For each group, provide a completed RATE SCHEDULE ITEM document in the public rate filing.
 - 1.1 Use the Rate Schedule Item document (provided on the WA OIC's website, www.insurance.wa.gov).
 - 1.2 Enter information corresponding to the fully negotiated form filing on lines 3a and 3b of the Rate Schedule Item.
2. Provide one rate schedule in the public filing.
3. Provide one completed Filing Summary under WAC 284-43-6540 for all groups rated together.
 - 3.1 Use the Format – Rates – WAC 284-43-6540 Summary Duplicate document (provided on the WA OIC's website, www.insurance.wa.gov).

D. Endorsement of Fully Negotiated contracts mid-plan year:

1. Note: Fully Negotiated filings may only use the endorsement process described under Section I.D. if the changes to be endorsed do not result in a change in rates. If changes result in updated rates, a new Fully Negotiated filing must be submitted (see Section II.C.4.)
2. The endorsement must be listed and attached on the Form Schedule tab for review.
3. An endorsement must be filed under the same TOI as the plan it is endorsing.
4. Endorsements must be associated with the form(s) they endorse. To do this, you must:

- a. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) to which the endorsement applies on the Form Schedule tab. **DO NOT** attach the forms being endorsed.
- b. All forms associated must be from a filing with the same TOI.
- c. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other", and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]". See the screenshot above in section I.D.5.
- d. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.

E. "PPACA" field:

1. Individual and small group Major medical plan submissions must populate the "PPACA" field as "Non-grandfathered Immed Mkt Reform".
2. If you check other boxes in this field your filing will require modification.
3. For large group submissions, you will generally select "Not PPACA-Related". However, you must populate this field with the option that accurately describes the particular filing.
4. Information on this requirement is available by clicking on the "What is PPACA?" link in SERFF directly below this field.

F. "Include Exchange Intentions" field:

1. Major medical plan submissions must properly complete the "Include Exchange Intentions" field on the General Information tab when the "PPACA" field is populated with "Non- grandfathered Immed Mkt Reform".
2. You must populate this field with "Exchange Only", "Outside Market Only", or "Exchange and Outside Market."
3. For large group submissions, you will select "No" when the "PPACA" field is marked "Not PPACA-Related."

III. Requirements for Disability (Insurance) Company Form Filings for Out-Of-State groups [WAC 284-30-600] and Discretionary Groups [RCW 48.21.010(2)]

A. Out-of-State Groups

1. Each group requires a new submission.

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- a. Forms to be used to cover Washington residents under a plan issued to an out of state group must be filed as a new submission. You may not request to re-open a previously-approved form or rate filing to modify its contents or to have it apply to new groups.
2. Complete Filing Required.
 - a. You must file for approval all certificates providing coverage in the state of Washington. A complete submission must include a policy and certificate of coverage; along with any applications, riders, or endorsements. All forms filed for approval must be listed and attached on the Form Schedule tab.
 - b. Groups other than employer groups (e.g. associations) must file in a single case format. "Single case format" means group-specific language with no bracketing or variability.
 - c. Employer groups, as defined in RCW 48.24.020, need not file in single case format. For an employer group to be exempted from the single case filing requirement, you must specify "employer group" and only "employer group" in the "Group Market Type" field.
 - d. If previously-approved applications, riders, or endorsements are to be used with the new certificate, they must be associated with the new certificate. To do this, you must:
 - i. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) on the Form Schedule tab. DO NOT attach the previously-approved form(s);
 - ii. All forms associated must be from a filing with the same TOI.
 - iii. When you list a previously-approved form on the Form Schedule tab, you must populate the Action field with "Other," and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]." See the screenshot entitled "Diagram: Filing Endorsements" in section I.D.5. of these instructions.
 - iv. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
3. SERFF Requirements:
 - a. You must disclose in the Filing Description field that this is an Out-of-State Group filing.
 - b. In the SERFF Product Name field, the product name must start with, "Out of State Group – [Group Name]."

- c. If Producer solicitation of the product is allowed, you must file a disclosure statement for approval on the Form Schedule tab. WAC 284-30-610.

B. Discretionary Groups

1. Approval by Commissioner.
 - a. Discretionary groups must be approved by the Commissioner. RCW 48.21.010(2). Thus, you must attach on the Supporting Documentation tab a statement why the Commissioner should find that your filing meets the requirements of RCW 48.21.010(2)(a)(i through iii).
 - b. If your filing is for a previously-approved discretionary group, this statement must include the SERFF Tracker ID of the filing in which such approval was granted.
2. Complete filing required.
 - a. All forms filed for approval must be listed and attached on the Form Schedule tab.
 - b. Filings for discretionary groups must be made in a single case format. "Single case format" means group-specific language with no bracketing or variability.
 - c. If any previously-approved forms are to be used, they must be associated with the new certificate. To do this, you must:
 - i. Create a separate line item for each associated form that lists the previously-approved policy form number(s) and form name(s) on the Form Schedule tab. DO NOT attach the previously-approved form(s);
 - ii. All forms associated must be from a filing with the same TOI.
 - iii. When you list a previously –approved form on the Form Schedule tab, you must populate the Action filed with "Other," and the Action Specific Data field with "Other Explanation Filed – State Tracking #[XXXXXX]." See the screenshot entitled "Diagram: Filing Endorsements" in section I.D.5. of these instructions.
 - iv. Associated forms must have received final action from the OIC within the *State Government General Records Retention Schedule* timeline (8 years). If the form received final action from the OIC outside this retention schedule, the form may not be associated and must be attached to the filing for review.
3. SERFF Requirements:
 - a. You must disclose in the Filing Description field that this is a Discretionary Group filing.
 - b. In the SERFF Product Name field, the product name must start with, "Discretionary Group – [Group Name]."

IV. 2019 Individual and Small Group Non-Grandfathered Health and Pediatric Stand-Alone Dental Plan Filings by ALL Issuers

The Washington Health Benefit Exchange (WAHBE) has provided the following guidance for individual and small group filings intended for certification as qualified health plans (QHPs) or qualified dental plans (QDPs) for plan year 2019:

1. Individual Market:

- a. The WAHBE Board will certify both QHPs and QDPs for plan year 2019. Major medical plans intended to be certified as QHPs must **NOT** include the pediatric dental Essential Health Benefit.
- b. The pediatric dental Essential Health Benefit must be offered in a stand-alone dental plan for QDP certification. A stand-alone QDP that offers the pediatric dental Essential Health Benefit may be offered as a pediatric-only plan or as a family plan that includes adult dental benefits. The WAHBE board will certify stand-alone family and pediatric-only QDPs to be offered both on the Exchange and in the outside market for plan year 2019.

2. Small Group (SHOP) Market:

- a. The WAHBE Board may certify QHPs for availability in the SHOP market for plan year 2019. In the SHOP market, the pediatric dental Essential Health Benefit **must be embedded** in the major medical plan.
- b. The WAHBE Board may certify stand-alone QDPs for plan year 2019 to be offered in the off-Exchange small group market. These plans must include the pediatric dental Essential Health Benefit and must meet all certification criteria applicable to plans offered outside the Exchange.
- c. If WAHBE certifies QHPs for availability in the SHOP market, the SHOP will support list billing for rates for plan year 2019. Composite rating will not be supported in the SHOP for plan year 2019.

A. Filing of rates, forms, and binders:

1. Scope of Section by Type of Insurance (TOI) in SERFF: H10I, H16I, HOrg02I, H10G, H16G, H22, and HOrg02G.
 - a. Note that, under the Affordable Care Act, higher education student health plans

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for domestic and inbound students are considered individual coverage, and must be filed consistent with the requirements for all other individual health plans for the 2018-2019 school year.

- i. Student health plans (H22) can only be issued by disability issuers per RCW 48.21.040(1)(c).
 - ii. The Product Name in SERFF must have the following naming convention: "2018-2019 School Year Student Health Plan."
2. Forms for Exchange and outside market products will be filed separately but concurrently with the rates and network access reports. For Plan Year 2019, binders are subject to the same May 24, 2018 filing deadline as forms, rates, and network access reports.
 - a. The Product Name in SERFF must start with: 2019 non-grandfathered [individual or small group].
3. Forms must be filed according to Section I of these instructions.
4. For forms, you may not file multiple Products in one submission. You must submit one Product per filing.

B. "PPACA" field:

1. Individual and small group Major medical plan submissions must populate the "PPACA" field as "Non-grandfathered Immed Mkt Reform".
2. If you check other boxes in this field your filing will require modification.
3. For large group submissions, you will generally select "Not PPACA-Related". However, you must populate this field with the option that accurately describes the particular filing.
4. Information on this requirement is available by clicking on the "What is PPACA" link in SERFF directly below this field.

C. "Include Exchange Intentions" field:

1. Major medical plan submissions must properly complete the "Include Exchange Intentions" field on the General Information tab when the "PPACA" field is populated with "Non- grandfathered Immed Mkt Reform".
2. You must populate this field with "Exchange Only", "Outside Market Only", or "Exchange and Outside Market." Student health plans should be marked as "No" in this field.

D. If you are filing revised versions of previous year's forms:

1. If you are filing forms that are revised versions of the previous year's approved forms:

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- a. You must file the revised forms on the Form Schedule tab with unique form numbers.
- b. When you list the revised form on the Form Schedule tab, you must populate the "Action" field with "Revised". You will then be prompted to enter "Action Specific Data". In the Action Specific Data field, you must enter the form number of the previous year's form (the one you are replacing) and the SERFF Tracker ID under which the previous year's form was filed.

(See "Diagram: Filing Revised Versions of Previous Year's Forms" on following page. See "Action" and "Action Specific Data" columns.)

- c. You must attach a strikeout / underline (redline) of the changes from the previous year's forms on the Supporting Documents tab.

Diagram: Filing Revised Versions of Previous Year's Forms:

	Form Type *	Action *	Action Specific Data	Re So
-	POL	Revised	Previous Filing # ACME-012345678 Replaced Form # ACME Contract 6789876	
-	CER	Revised	Previous Filing # ACME - 012345678 Replaced Form # Awesome 1000 Booklet (01-2015)	
-	CERA	Revised	Previous Filing # ACME-012345678 Replaced Form # Awesome 500 Booklet (01-2015)	
	AEF	Revised	Previous Filing # ACME - 012345678 Replaced Form # ACME MGA (01-2015)	
	AEF	Revised	Previous Filing # ACME - 012345678 Replaced Form # Awesome Booklet Insert (01-2015)	
	AEF	Initial		

E. You must include all forms, in final format.

F. You may not use variability to define product design.

1. Language deviations must be filed as a separate product filing.
2. Limited variability will be accepted for administrative purposes only, such as but not limited to: necessary Exchange and Off-Exchange eligibility language, signature blocks, company name, and street address. Small Group filings for the SHOP may include variability for the employee-only and family coverage options. No benefits (such as adult dental or contraception) may be bracketed in Individual or Small Group plans. Plans with different benefits are separate products.
3. Limited variability used for administrative purposes only do not require a formal variability statement. However, Exchange and Off-Exchange eligibility language or employee-only and family coverage options under SHOP plans should include a statement of variability as described under Section II.B.

G. Requirement for Completed Analyst Checklist:

1. You must submit on the Supporting Documentation tab a properly completed Analyst Checklist to support your initial submission. (Student health plans should use the *2018-2019 School Year Higher Education Student Health Plan* checklist.)
2. You must complete one Analyst Checklist for each market you have filed to participate in, based on one product/plan.
 - a. Identify the product/plan upon which the checklist is based by including that information on the checklist itself.
 - b. Your completed Analyst Checklist must be based upon the product you have identified in your Issuer Snapshot (see Section IV.G. below) as the recommended primary product for review.
 - c. The completed Analyst Checklist must be submitted with each primary product filing.
 - d. If your recommended primary product for review is not accepted as the primary product for review, the analyst will request a completed Analyst Checklist for the product that will be used as the primary product for review.
3. Forms will be reviewed using the applicable Analyst Checklist.
 - a. If the analyst is unable to find a particular provision by using the Analyst Checklist completed by the issuer (i.e., if the provision is not found in the location indicated on the issuer's completed Analyst Checklist), the analyst will attempt to locate the provision in the filing. If the analyst is unable to locate the provision, the analyst will send an objection indicating that the provision cannot be found.

- b. If the analyst is unable to find three separate provisions by using the Analyst Checklist (i.e., there are three instances where the provision is not found in the location indicated on the issuer's completed Analyst Checklist), the analyst will cease review of the filing. The analyst will send an objection indicating that review has ceased and requesting a corrected Analyst Checklist.
- c. After the corrected Analyst Checklist has been received, review of the filing will recommence in the appropriate order of priority, as determined by the review team.

H. Issuer Snapshot

1. You must submit a properly completed Issuer Snapshot in your **binder** to support your initial submission. (This is not a requirement for student health plans.)
2. There will be only one Issuer Snapshot per issuer, per market. (In other words, the same group of products and plans included on one binder are also included together on one Issuer Snapshot.) A PDF and an Excel copy of the Issuer Snapshot should be attached to the Supporting Documentation tabs for the product's **binder** filing.
3. "Product" and "plan" is defined under 45 CFR § 144.103.
4. The snapshot form and instructions for completing it are available on OIC's website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab and choose "Health Care and Disability Filings" under Filing Instructions.
5. The snapshot form and instructions for completing it are also available on the Filing Rules tab, General Instructions Section of SERFF.
6. Updated Issuer Snapshots will only be required if specifically requested by the analyst during the review process.

I. Uniform Product Modification Justification (UPMJ)

1. You must submit your Uniform Product Modification Justification documentation in **both** your rate filing and recommended primary form filing. (This is not a requirement for student health plans.)
2. In your recommended primary **form filing**, attach the document in **PDF format only** on the Supporting Documentation tab. Name the PDF document "Uniform Product Modification Justification".
3. The Uniform Product Modification Justifications and the instructions for completing them are available on OIC's website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab and choose "Health Care and Disability Filings" under Filing Instructions. Click on "Checklists for Health Coverage Analysts". The checklists are called: "Checklist – R&F – 2019 Individual Medical Uniform Product Modification Justification" and "Checklist – R&F – 2019 Small Group Medical Uniform Product Modification Justification." The Uniform Product Modification

Justifications and the instructions for completing them are also available on the Filing Rules tab, General Instructions Section of SERFF.

J. Forms, rates, and binder must all be consistent with one another.

1. If the analyst determines that the information in the binder does not match the information in the Form, the analyst will send an objection indicating that there is an inconsistency and requesting that the issuer amend the binder to match the form.
2. If the analyst finds that there are five or more inconsistencies between the form and the binder, the analyst will cease review of the binder. The analyst will send an objection indicating that review has ceased and requesting a corrected binder.
3. After the corrected binder has been received, review of the binder will recommence in the appropriate order of priority, as determined by the review team.
4. Binders are not required for student health plans.

K. Pediatric stand-alone dental plan (with Pediatric Dental EHB) for 2019 plan year

1. Scope of Section by TOI in SERFF: H10I.001 or H10G.001
2. Submission Requirements:
 - a. Under the General Information Tab, the Product Name in SERFF must include one of the following (as appropriate):
 - i. Individual Pediatric Dental EHB both inside and outside Exchange (kids only without family coverage)
 - ii. Individual Pediatric Dental EHB inside Exchange only (kids only without family coverage)
 - iii. Individual Pediatric Dental EHB outside Exchange only (kids only without family coverage)
 - iv. Individual Pediatric Dental EHB inside Exchange only (with family coverage)
 - v. Individual Pediatric Dental EHB outside Exchange only (with family coverage)
 - vi. Individual Pediatric Dental EHB inside and outside Exchange (with family coverage)
 - vii. Small Group Pediatric Dental EHB outside Exchange only (kids only without family plan)
 - viii. Small Group Pediatric Dental EHB outside Exchange (with family coverage)
 - b. In the Corresponding Filing Tracking Number field, list the SERFF Tracking Number(s) of the corresponding rate filing(s) (public and separate not-for-public

rate filing, if requested).

- c. **DO NOT** file large and small group products combined.

V. Individual and Small Group (Non-Pediatric EHB) Vision-Only and Dental-Only Plans for HCSCs and Disability Carriers

A. Scope of Section by TOI in SERFF: H10I, H10G, H20I, and H20G.

1. This section applies to plans which are not intended to provide the Pediatric Essential Health Benefits for oral care or vision.

B. File and Use:

1. All rates and forms, and modifications of a contract form or rate, for individual and small group stand-alone dental and stand-alone vision plans issued or renewed on or after January 1, 2016 must be filed before the contract form is offered for sale and before the rate schedule is used. RCW 48.43.733

C. Plans may not be negotiated:

1. Carriers must not negotiate individual and small group stand-alone dental and stand-alone vision plans. RCW 48.43.733(2), WAC 284-43-6520(8) and WAC 284-43-6560(2).

D. Filing Instructions:

1. These plans must be filed according to the instructions in Section I, subsections A-F of these Instructions.
2. Individual and small group filings, including health plans, dental-only and vision-only filings, must contain no bracketing or variability (with the exception of variability for administrative purposes only, such as signature blocks and contact information). Limited variability used for administrative purposes only do not require a formal variability statement.
3. You must populate the Product Name field using the standard: "Outside Market [Product Name]"

VI. 2018 Quarterly Formulary Filings [WAC 284-43-5642(6)(e)(i)]

A. When to file:

1. The first quarter formulary filing is the one filed on the Prescription Drug Template in the binder for that plan year. **These instructions pertain to the 2nd, 3rd, and 4th quarter formulary filings.**

2. Note: Under the Affordable Care Act, higher education student health plans for domestic and inbound students are considered individual coverage and can only be issued by disability issuers per RCW 48.21.040(1)(c). Student health plans are not required to file a binder. Therefore, formulary filings for student health plans must be filed quarterly using a filing TOI of "H22," and following the instructions under this section for 1st, 2nd, 3rd, and 4th quarter formulary filings.
3. The formularies must be filed prior to the beginning of the quarter during which they will be in effect. Therefore, the 2nd quarter filings are due prior to April 1, the 3rd quarter filings are due prior to July 1, and the 4th quarter filings are due prior to October 1.

B. You must file each formulary on the Form Schedule tab.

C. Product Name for formularies

1. You must complete the Product Name field using the following naming convention: "X" Quarter Year Formulary.
 - a. Example: in plan year 2018, issuers will submit the following formulary filings: 2nd Quarter 2018 Formulary, 3rd Quarter 2018 Formulary, and 4th Quarter 2018 Formulary.

D. Separate filings for each market:

1. You must make a separate formulary submission for your small group and individual plans.
2. You may file all formularies for the market in one SERFF submission; e.g., all formularies for all plans in the small group market may be filed together.
3. You must file your formulary filings on the following Sub-TOI's as appropriate:
 - a. Disability and HCSC filers must use: "H16I.005C Individual – Other"
 - b. Disability and HCSC filers must use: "H16G.003G - Small Group Only – Other"
 - c. Disability filers Student Health Plans must use: "H22.000 Student Health Insurance"
 - d. HMO filers must use: "HOrg02I.005C Individual – Other"
 - e. HMO filers must use: "HOrg02G.004E Small Group Only – Other"

E. Strikeout / underline (redline) versions and certifications

1. If there are changes to the formulary, you must attach a complete list of the changes to each formulary on the Supporting Documentation tab. You may do this by either:
 - a. Attaching a redline version of changes, or
 - b. Attaching a formulary Change List which documents the specific drug changes that will be made to the formulary for the upcoming quarter.

2. **For the 2nd, 3rd, and 4th quarter filings**, whether or not modifications have been made to the formulary, you must submit a certification signed by an officer of the issuer confirming that modifications (if any) to the formulary, as approved for the first quarter of the plan year, continue to comply with the requirements WAC 284-43-5642(6). This certification should be attached on the Supporting Documentation tab.

VII. Beginning 2019: Student Health Plans (TOI H22) Formulary Filings [WAC 284-43-5642(6)(e)(i)]

A. Note: Carriers who file non-grandfathered individual and small group plans must file their formularies quarterly using the instructions found under Section IV of the *Washington State SERFF Health and Disability Binder Filing General Instructions*.

B. For Filers of Student Health Plans

1. Under the Affordable Care Act, higher education student health plans for domestic and inbound students are considered individual coverage and can only be issued by disability carriers per RCW 48.21.040(1)(c).
2. Student health plans are not required to file a Binder. Therefore, quarterly formularies for these plans may continue to use the SERFF Filings function to file the formularies in any format you choose. You will not be required to submit results of the Electronic Review Tools. All other requirements apply.
3. You must complete the Product Name field using the following naming convention: "X" Quarter [Year] Formulary.
 - a. Example: in plan year 2019, student health plan issuers will submit the following formulary filings: 2nd Quarter 2019 Formulary, 3rd Quarter 2019 Formulary, and 4th Quarter 2019 Formulary.
4. Strikeout/underline (redline) versions and certifications
 - a. If there are changes to the formulary, you must attach a complete list of the changes to each formulary on the Supporting Documentation tab. You may do this by either:
 - i. Attaching a redline version of the changes, or
 - ii. Attaching a formulary Change List which documents the specific drug changes that will be made to the formulary for the upcoming quarter.
5. **For the 2nd, 3rd and 4th quarter filings**, whether or not modifications have been made to the formulary, you must submit a certification signed by an officer of the issuer confirming that modifications (if any) to the formulary, as approved for the first quarter of the plan year, continue to comply with the requirements WAC 284-

43-5642(6). This certification should be attached on the Supporting Documentation tab.

VIII. Provider and Facility Agreement Filings

Under RCW 48.43.730 and WAC 284-170-480 participating provider and facility contract forms must be in writing and filed for prior approval for Health Care Service Contractors, Health Maintenance Organizations, and Disability Issuers.

A. Provider and Facility Filings – General Provisions

1. Health carriers must file provider and facility agreements on the type of insurance (TOI) – NA. Filings received after April 30, 2017 on TOIs. H21 and HOrg03 will be rejected. Health carriers must accurately update the sub-TOI category. Washington will be using the following sub-TOI's only:
 - a. NA01.000 – Network Access Provider Contract
 - b. NA01.003 – Provider Leasing Agreement
2. **Effective May 1, 2018: All “for-public” provider agreement filings must include a completed Provider and Facility Agreement Analyst Checklist on the Supporting Documentation tab.**
3. If you are contracting with a provider or facility using a template, but you negotiate compensation, this is considered a fully-negotiated contract and you must submit “for-public” and “not-for-public” filings as negotiated [RCW 48.43.730(2); WAC 284-170-480(1) and (2)(b)(i)].

You may not associate a negotiated compensation exhibit with a previously filed template. When you negotiate any part of a contract, you are required to submit the full contract as negotiated (which includes both a “for-public” and a “not-for-public” filing) even when you haven’t made any changes to the template language.

4. You must make a separate submission for each provider and facility agreement type. You may not file multiple agreements [i.e. provider, facility, ancillary, etc.] in one SERFF submission.
5. You must populate the Requested Filing Mode field with “Review and Approval.” You may not file provider or facility agreements as informational nor as file and use.
6. If you make any changes to an approved provider or facility agreement outside of the allowed bracketing and variability, you must assign a new form number to the contract and file it for prior approval [WAC 284-170-480(2)(a)(i)].

B. Contract Templates:

1. You must make a separate submission for each contract template.
2. You must properly identify the type of agreement being filed by following the Product Name field requirements set forth in the SERFF Submission Requirements.
3. You must clearly state whether the filing is "for public" or "not for public" in both the Filing Description and the Product Name fields.
4. "For public" Filings:
 - a. A Washington State specific template must include all forms, exhibits, and appendices [minus the rate compensation schedule] filed on the Form Schedule tab.
 - b. A National Template with a Washington State Regulatory Appendix must include all forms, exhibits, regulatory appendix [minus the rate compensation schedule], etc., filed on the Form Schedule tab.
 - c. If you are filing a "for public" document only, you must clearly identify in the General Information tab that a "not for public" filing is not required and a detailed explanation. For example, an issuer need not file a concurrent "not for public" filing when they are filing an amendment to only change contract provisions. Please note: new and revised contract templates must be filed with a concurrent "not for public" filing.
 - d. A contract addendum or amendment to the core agreement must be filed for approval and include a copy of the core agreement and all subsequent addenda or amendments [minus compensation exhibits] filed on the Form Schedule tab.
5. "Not for public" Filings:
 - a. A properly identified "not for public" filing [See VII.B.3] will be updated by the SERFF Intake desk to assure it is not available on-line for public review. The filing "Set the Public Access" function will be updated to "does NOT allow public access."
 - b. If you are filing to update compensation per WAC 284-170-480(2)(a)(iii), you do not need to refile the "for public" submission concurrently if there are no changes to the contract template agreement. The Filing Description field must clearly state no "for public" filing is required. You must provide a list of the agreement(s) with which the new compensation exhibit will be used on the Supporting Documentation tab.
 - c. The compensation schedule(s) must be filed on the Form Schedule tab.
6. Revised template agreements must have a unique form number and include a strikeout and/or underline version showing the changes to the documents [WAC

284-170-480(2)(a)(ii)]. This document must be filed on the Supporting Documentation tab.

7. Variability in provider and facility template contracts is permitted in five specific circumstances:
 - a. in a "not for public" filing, with regard to percentages, conversion factor or dollar amounts of provider or facility compensation;
 - b. in a "for public" filing, with regard to the amount of liability insurance a provider or facility must carry;
 - c. in a "for public" filing, the termination without cause provision may require a variable notification period of sixty (60) or more days per WAC 284-170-421(9);
 - d. the provider name; and
 - e. the effective and/or termination date of the agreement.
 - f. Variability must be submitted in brackets. A Statement of Variability must be attached to the Supporting Documentation tab if variability is used for compensation in the not for public filing and must indicate the increments in which the carrier will assign compensation to providers in dollars, percentages, or conversion factor only. For example:
 - i. Procedure A [\$60 - \$100] in increments of \$5
 - ii. Procedure B [100% - 150% of Medicaid] in increments of 2%

C. Negotiated Provider and Facility agreements:

1. You must make a separate submission for each negotiated agreement.
2. You must properly identify the type of agreement being filed by following the Product Name field requirements set forth in the SERFF Submission Requirements.
3. You must clearly state whether the filing is "for public" or "not for public" in both the Filing Description and the Product Name fields.
4. "For public" Filings:
 - a. The filing must include the provider specific agreement documents that will include but may not be limited to: core agreement, exhibits, and regulatory appendix (if applicable) filed on the Form Schedule. An issuer may not request to use a Variability Statement.
 - b. A contract addendum or amendment to the core agreement must be filed for approval and include a copy of the core agreement and all subsequent addenda or amendments [minus compensation exhibits] filed on the Form Schedule tab.
 - c. If you modify the negotiated agreement, you must refile the modified agreement for approval [WAC 284-170-480(2)(a)(i)]. You must also refile the corresponding

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"not for public" compensation filing regardless of whether there are changes to compensation or not.

5. "Not for public" Filings:
 - a. A properly identified "not for public" filing [See VII.C.3] will be updated by the SERFF Intake desk to assure it is not available on-line for public review. The filing "Set the Public Access" function will be updated to "does NOT allow public access."
 - b. If you are filing to update compensation per WAC 284-170-480(2)(a)(iii), you do not need to refile the "for public" submission concurrently if there are no changes to the core agreement. The Filing Description field must clearly state no "for public" filing is required.
 - c. The provider specific compensation schedule(s) must be filed on the Form Schedule tab. An issuer may not request to use a Variability Statement.
 - d. Global Outcome-based compensation schedules may be filed minus population of the variable annual percentage amount [upon request of the OIC, a carrier must produce the actual percentages per WAC 284-170-480(4)].
 - e. Variability is not permitted in negotiated agreements.
6. If the provider and issuer negotiate revised language during the contract term, a strikeout and/or underline version showing the negotiated language [WAC 284-170-480(2)(a)(ii)] must be filed on the Supporting Documentation tab. You may not file a strikeout/underline version when the parties negotiate a new agreement.

D. Intermediary Network Contracts with Providers and Facilities (leased networks and administrative service arrangements):

1. You must make a separate submission for each provider and facility agreement type. You may not file multiple agreements [i.e. provider, facility, ancillary, etc.] in one SERFF submission.
2. You must properly identify the type of agreement being filed by following the Product Name field requirements set forth in the SERFF Submission Requirements.
3. You must clearly state whether the filing is "for public" or "not for public" in both the Filing Description and the Product Name fields.
4. "For public" Filings:
 - a. A Washington State specific provider or facility agreement template must include all forms, exhibits, and appendices [minus the rate compensation schedule] filed on the Form Schedule tab.
 - b. A National Template with a Washington State Regulatory Appendix must include all forms, exhibits, regulatory appendix [minus the rate compensation schedule], etc., filed on the Form Schedule tab.

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- c. Negotiated contract filings must include the provider specific agreement that will include, but may not be limited to: core agreement, exhibits, and regulatory appendix (if applicable), filed on the Form Schedule tab.
 - d. You must file a copy of the intermediary (network leasing or administrative service) agreement between the parties on the Supporting Documentation tab for review.
 - i. An intermediary agreement means all contracts between the Issuer and other parties that, together, form the contract between the Issuer and the intermediary. For example, Issuer X delegates to an Interagency Arrangement Y to contract with ACME Network. The filing must include: (1) Issuer X's agreement with Interagency Y, and (2) Interagency Y's agreement with ACME Network.
 - e. If you are filing a "for public" document only, you must clearly identify in the General Information tab that a "not for public" filing is not required and a detailed explanation. For example, an issuer need not file a concurrent "not for public" filing when they are filing an amendment to only change contract provisions. Please note: new and revised contract templates must be filed with a concurrent "not for public" filing.
 - f. A contract addendum or amendment to the core agreement must be filed for approval and include a copy of the core agreement and all subsequent addenda or amendments [minus compensation exhibits] filed on the Form Schedule tab.
5. "Not for public" Filings:
- a. A properly identified "not for public" filing [See VII.D.3] will be updated by the SERFF Intake desk to assure it is not available on-line for public review. The filing "Set the Public Access" function will be updated to "does NOT allow public access."
 - b. If you are filing to update compensation per WAC 284-170-480(2)(a)(iii), you do not need to refile the "for public" submission concurrently if there are no changes to the contract template agreement or negotiated agreements. The Filing Description field must clearly state no "for public" filing is required. You must provide a list of the agreement(s) with which the new compensation exhibit will be used on the Supporting Documentation tab.
 - c. The provider or facility compensation schedule(s) must be filed on the Form Schedule tab.
 - d. If there is compensation associated with the intermediary agreement, it must be filed as Supporting Documentation.
 - e. A negotiated contract compensation exhibit may not be filed using a Variability Statement.

- f. You must file a copy of the intermediary payment arrangement/compensation (network leasing or administrative service) agreement between the parties on the Supporting Documentation tab. If you are only submitting a “not for public” filing, it must include a copy of the entire intermediary arrangement.
 - i. An intermediary agreement means all contracts between the Issuer and other parties that, together, form the contract between the Issuer and the intermediary. For example, Issuer X delegates to an Interagency Arrangement Y to contract with ACME Network. The filing must include: (1) Issuer X’s agreement with Interagency Y, and (2) Interagency Y’s agreement with ACME Network.
- 6. Revised templates, negotiated contracts and leasing agreements must include a strikeout and/or underline version showing the changes to the documents [WAC 284-170-480(2)(a)(ii)]. These documents must be filed on the Supporting Documentation tab.
- 7. Variability in provider and facility template contracts is permitted in five specific circumstances:
 - a. in a “not for public” filing, with regard to percentages, conversion factor or dollar amounts of provider or facility compensation;
 - b. in a “for public” filing, with regard to the amount of liability insurance a provider or facility must carry;
 - c. in a “for public” filing, the termination without cause provision may require a variable notification period of sixty (60) or more days per WAC 284-170-421(9);
 - d. the provider name; and
 - e. the effective and/or termination date of the agreement.
 - f. Variability must be submitted in brackets. A Statement of Variability must be attached to the Supporting Documentation tab if variability is used for compensation in the not for public filing and must indicate the increments in which the carrier will assign compensation to providers in dollars, percentages, or conversion factor only. For example:
 - i. Procedure A [\$60 - \$100] in increments of \$5
 - ii. Procedure B [100% - 150% of Medicaid] in increments of 2%

E. Provider Agreement “Implementation Date” field in SERFF:

Issuers have requested clarification about population of the “implementation date” field and how the OIC determines what date to use for “approval”.

- 1. Issuers must populate the “Implementation Date” field with either the option “Upon Approval” or a specific date.
 - a. A filing that requests “Upon Approval” will be approved on the date the OIC takes final action.

- b. A filing that requests a specific prospective date will be approved using that date.
 - c. A filing that requests a specific date that is now retrospective on the date the OIC takes final action will be approved as an "Upon Approval" action (see VII.E.1.a).
 - d. Changes to a previously filed and approved compensation exhibit that modify only the compensation amount or related terms that determine compensation is deemed approved upon filing. The "filing date" is the date the OIC Intake Desk accepts an issuer's submission and the filing is downloaded into the back office system. This type of filing is deemed approved per that date.
2. No provider agreement filing may be approved with a retrospective effective date.

IX. Your Filing Will Be Rejected If:

A. Your filing does not comply with Chapter 284-44A, 284-46A, or 284-58 WAC.

B. It is not timely filed.

1. Per WAC 284-43-0200, all 2019 filings listed under Section IV.A. (Individual health plans including higher education student health plans, small group health plans, and stand-alone dental plans that provide pediatric dental benefits as one of the essential health benefits) must be filed by May 24, 2018.
2. Issuers will be permitted to amend filings only at the direction of the Commissioner.
3. Filings not timely submitted will be rejected without review.

C. Your Short Form filing does not include the correct form, submitted correctly.

1. **Forms are filed using the Short Form Filing Summary, "SHORT FORM ED.5".**
Rates are filed using a different form – the Short Form Rate Schedule Item, "RATE SCHEDULE ITEM" document.
2. Your filing will be rejected if the SHORT FORM ED.5 is attached on a tab other than the Form Schedule tab.
3. Your filing will be rejected if a SHORT FORM ED.5 is filed for an Association or Trust group.

D. You have attempted to endorse a Short Form filing.

1. A Short Form filing may not be endorsed. See section II.C.3.a.iv, above.

E. You have attempted to use the Short Form process without a current Standard Master.

1. To use the Short Form filing process, the Short Form must be based upon a

standard master contract on file with an effective date within 12 months of the Short Form filing effective date. See Section II.C.3, above.

F. Missing certification:

1. Your filing will be rejected if it contains customized applications and/or enrollment forms for review, but does not include a signed and properly completed "Custom Enrollment/Application Certification".

G. Incorrect product name:

1. Your filing will be rejected if it does not use the correct Product Name format as set forth in these Instructions.

H. You have failed to identify a required corresponding filing.

1. See section I.B.11., above.

I. We cannot download your filing into our back office system.

1. There are a number of reasons why we cannot download filings into our back office system. The most common reasons include:
 - a. Attachments are not formatted using a Distiller in PDF format.
 - b. An incorrect CoCode number is entered in the Filing Company Information, under the Companies and Contact tab. This CoCode number is the same number as your company's 5-digit NAIC number.
 - c. Health Care Service Contractors and Health Maintenance Organizations do not populate the Company Tracking Number field.
 - d. You attach more than one form to a line in the Form Schedule tab.
 - e. You include an incorrect Type of Insurance (TOI) or Sub-TOI as listed on the NAIC Uniform Life, Accident & Health, Annuity and Credit Product Coding Matrix.
 - i. The matrix can be found on the OIC's website (www.insurance.wa.gov). Click on the "For Insurers and Regulated Entities" tab and choose "SERFF Filing Guidelines" under Filing Instructions.
 - ii. The matrix is also available on the Filing Rules tab, General Instructions section of SERFF.
 - f. You filed multiple policies in one submission (with the exception of individual and small group ACA filings where multiple policies represent one product).
 - g. You filed multiple provider agreements in one submission.

J. You filed a large and small group stand-alone dental or a large and small group stand-alone vision plan under a single filing.

1. RCW 48.43.733(1) and RCW 48.43.733(2) only allows negotiated plans (i.e. standard masters) for large, but not small, groups.

K. The Explanation of Variability does not follow the format described under Section II.B.

1. If the Explanation of Variability is not submitted in the correct format, the filing will be rejected if it is not corrected within one business day.

L. Rejected filings will not be re-opened.

1. If the OIC Technical Support Unit rejects your filing, you must submit a new filing following the procedures in our Rejection Notice and General Instructions.

M. Provider agreement

1. You filed for public provider agreement documents in a not for public filing.
2. You filed using H21 or HOrg03 types of insurance.

X. Requirements for Responses to SERFF Objection Letters

A. All attachments to responses must be in PDF format.

B. When responding to an objection letter, you must:

1. Amend your filing to respond to an objection. You must answer each objection individually, providing a detailed description of changes proposed to noncompliant forms.
2. Revise a Schedule Item on the Form Schedule tab to make changes to a form already submitted.
3. Add a Schedule Item on the Form Schedule tab to add additional forms not previously submitted.
4. Revise exhibits and supporting documentation on the Supporting Documentation tab.
5. Add exhibits and supporting documentation to the Supporting Documentation tab.
6. Respond to each objection using the SERFF response letter process.
 - a. Objection letter responses attached on the Supporting Documentation tab will not be reviewed.
 - b. If you have not responded to an objection letter using the response letter process, you have not responded to the objection letter, whether or not you have attached a response to the Supporting Documentation tab.
7. We must be able to determine which forms are "Approved," "Disapproved" or

"Withdrawn" when creating a Final Disposition Report.

8. If an objection letter indicates that your analyst has listed examples of an issue that exists throughout the filing, you must correct **ALL** instances where that issue occurs. Do not correct the issue only in the places listed in the examples. You must review the entire form(s), identify each place the issue occurs, and correct it in each place. Failure to do so delays review. Review of your filing may be stopped while another objection letter is sent asking you to complete the corrections.
9. The OIC will disapprove a filing if 30 days pass following the Objection Letter response date with no word from the carrier. **This provision does not apply to filings made under TOI NA01.**

C. Strikeout / Underline (redline) versions required:

1. For any form which is amended in response to an objection, you must attach a strikeout / underline (redline) version on the Supporting Documentation tab, showing all changes in response to the objection letter.
2. Please ensure that the copy of the form attached on the Form Schedule tab is the final, clean form.
3. Please ensure that the copy attached on the Supporting Documentation tab is the strikeout / underline (redline) version and shows all changes made in response to the objection letter.
4. The review process can involve more than one set of objections and responses, so that a form may undergo more than one set of changes. This can result in difficulty showing, and viewing, strikeout / underline (redline) changes. If you are unsure how best to strikeout / underline (redline) the changes to your form, contact your analyst. The goal is to create a clear record of the changes made from the original version of your form to the final version. Together you can determine how best to achieve this.

XI. After Final Disposition by OIC Analyst

After final disposition by an OIC analyst, you may not change or correct the filing. You must make a new filing in SERFF.

XII. For Questions Related to SERFF Filing Procedures, Contact:

Rates & Forms Help Desk

(360) 725-7111

rfhelpdesk@oic.wa.gov