

**PLAN YEAR 2025 CHECKLIST FOR NON-
 GRANDFATHERED INDIVIDUAL AND
 SMALL GROUP MARKET PRODUCT(S)
 OFF OF THE CALIFORNIA HEALTH
 BENEFIT EXCHANGE**

The Department of Managed Health Care (DMHC or Department) offers the following information to assist Individual and Small Group product filings outside of the California Health Benefit Exchange (Exchange) for the Plan Year 2025, for compliance with the Knox-Keene Act at California Health and Safety Code sections 1340 et seq. (the Act or KKA). References herein to “Section” are to sections of the Act. References to “Rule” are to the regulations promulgated by the Department at California Code of Regulations, title 28.

This checklist applies non-grandfathered Individual and Small Group Market benefit plan designs offered pursuant to Section 1366.6 subdivisions (c) and (e), and non-standard health benefit plans offered pursuant to Section 1366.6 subdivision (d). This checklist and attachments are not intended to be all-inclusive and represent only what issues, at a minimum, are required to be addressed by a health plan for compliance with the Act and Rules. Additional information as needed may be requested by the Department within the course of review of a health plan filing.

Filing Timeframes

Health plans amending benefit plan designs for the 2025 Plan Year must have Department approval of necessary filings, including, but not limited to, licensure, networks, product, benefit plan design, and rate filings. Complete filings are due as follows:

Plan Year 2025	New Licensee; Existing Licensee Proposing New: Rating Region, Line of Business, and/or Benefit Plan(s)	Existing Licensee proposing no changes to Rating Region or Line of Business
Benefit Plan Designs and All Other Exhibits Other Than Networks	No later than July 1	No later than July 31
Provider Network	No later than March 1	Within 30 days of any change requiring a network Change Amendment filing. ¹
Rates Individual	No later than July 12	No later than July 12
Rates Small Group (effective January 1, 2025)	No later than July 15	No later than July 15

¹ See Sections 1352, subdivision (a), 1367.27, subdivision (r); Rule 1300.52, subdivision (f).

Filing Checklist

- ❑ Prepare and submit an Amendment or Material Modification pursuant to Sections 1351 and 1352 to a health plan's license to address compliance with the Act, Rules, CA-ACA, and ACA laws and regulations.
- ❑ When submitting your filing in the e-Filing system, use the subject title "**Plan Year 2025 off-Exchange [Individual] or [Small Group] Products-[HMO], [PPO], [EPO], [POS]**". The health plan should utilize only the applicable variable language most accurately describing the content of its filing.
- ❑ Benefit plan design or product revisions that do not meet the federal Uniform Modification standards should be submitted as a Notice of Material Modification filing.² Health plans amending non-standard benefit plan designs or products must affirmatively demonstrate the proposed amendments qualify as a uniform modification by providing legal analysis.³
- ❑ Health plans participating on the Exchange are not required to submit each on-Exchange network for full review for the sole purpose of QHP recertification, unless certain network changes have or will occur (see below under "Provider Network").
- ❑ Complete and file the attached [Subcontractor Worksheet](#) as Exhibit E-1.
- ❑ For each formulary utilized in connection with product(s) required to comply with the 2025 Patient-Centered Benefit Plan Designs pursuant to Section 1366.6 subdivision (c), submit: (i) an Exhibit T-3 that contains a copy of the formulary, and (ii) an Exhibit T-5 that contains a signed [Prescription Drug Compliance Attestation](#).
- ❑ Changes and updates to previously approved exhibits should be indicated with clearly visible redlined changes.

Narrative: Exhibit E-1

At a minimum, the health plan must provide the following information in its Exhibit E-1:

- ❑ Whether the proposed benefit plan designs have been previously approved by the Department, including e-Filing numbers of previously approved benefit plan designs.
- ❑ An affirmation the health plan complied with the [Plan Year 2025 Networks Checklist and Worksheet for QHP and QDP Plans](#) filing requirements.
- ❑ To ensure the health plan has adequately considered State Law as well as confirmed the health plan's processes conform as such, provide an affirmation that the health plan's special enrollment period (SEP)

² 45 C.F.R. § 147.106(e).

³ *Id.*

triggering events are consistent with State law, as applicable, including, but not limited to, Sections 1357.503 and 1399.849.

- Identify the health plan’s documents that disclose SEP triggering events to the public and/or enrollees and whether said document(s) were previously filed for Department review. Note, the health plan is not required to file the documents described above unless requested by the Department.
- Identify the e-Filing number in which the health plan submitted the compliance filings associated with the Department’s All Plan Letter (APL) 22-031.
- Identify the page numbers of the Evidence of Coverage (EOC) or other policy and procedure that demonstrate compliance with newly enacted statutes or regulations(s) effective on or after January 1, 2024, including but not limited to:⁴
 - AB 118 (Committee On Budget, Ch. 42, Stats. 2023)—Budget Act of 2023: Health
 - AB 254 (Bauer-Kahan, Ch. 254, Stats. 2023)—Confidentiality of Medical Information Act: reproductive or sexual health application information
 - AB 659 (Aguiar-Curry, Ch. 809, Stats. 2023)—Cancer Prevention Act
 - AB 716 (Boerner, Ch. 454, Stats. 2023)—Ground Medical Transportation
 - AB 904 (Calderon, Ch. 349, Stats. 2023)—Health Care Coverage: Doulas
 - AB 948 (Berman, Ch. 820, Stats. 2023)—Prescription Drugs
 - SB 421 (Limón, Ch. 607, Stats. 2023)—Health Care Coverage: Cancer Treatment
 - SB 496 (Limón, Ch. 401, Stats. 2023)—Biomarker Testing
 - SB 621 (Caballero, Ch. 495, Stats. 2023)—Health Care Coverage: Biosimilar Drugs
 - Any other newly enacted statute(s) or regulation(s) for which the health plan deems revision is appropriate.
- For health plans that participate on the Exchange and product(s) offered off of the Exchange pursuant to Section 1366 subdivision (c), affirm the provision of Basic Health Care Service and Essential Health Benefits (health benefits) included in the applicable health plan documents are

⁴ For additional guidance see the Department’s All Plan Letter 23-025 regarding newly enacted statutes in 2023 impacting health plan license filings on or after January 1, 2024.

- identical to the health benefits approved by the Department in connection with the health plan's on-Exchange product(s) and provide the e-Filing number for the approved health benefits.
- For health plans that participate on the Exchange, benefit plan designs offered pursuant to Section 1366.6 subdivision (c) must identify the page numbers of the EOC revised for compliance with newly enacted or revised Endnotes in the 2025 Patient-Centered Benefit Plan Designs. If revision is not required, the health plan must provide a confirmatory declaration, which states no revisions are required.
 - For health plans that do not participate on the Exchange and/or for non-standard product(s),⁵ affirm the health plan's health benefits are identical to the Kaiser Foundation Health Plan Small Group HMO 30 plan, in the first quarter of 2014. Please ensure the health plan submits an EHB Filing Worksheet, if applicable. For further guidance, see the section entitled *Benefit Plan Designs* item *EHB Filing Worksheet* below.
 - Affirm the health plan discloses coverage of pediatric vision benefits without annual or lifetime limits on the dollar value of the covered benefits that are the same benefits as contained in the BCBS Association, 2014 FEP Blue Vision – High Option, including, but not limited to, low vision benefits, and that the health plan discloses coverage of the aphakia benefit without age limitations as required by Section 1367.005, subdivision (a)(2). Additionally, identify the page numbers of the EOC which disclose the pediatric vision and aphakia benefits.
 - For health plans that participate on the Exchange, affirm the pediatric dental benefits are identical to the pediatric dental benefits approved by the Department for its on-Exchange products and provide the e-Filing number for the approved dental benefits.
 - For health plans that do not participate on the Exchange, affirm the pediatric dental benefits are identical to the 2014 Medi-Cal dental program (Dental Benchmark Plan). Please note, the Dental Benchmark Plan utilizes outdated CDT codes. Covered California's 2025 Dental Standard Benefit Plan Design (Dental SOB) and Copay Schedule are based on the Dental Benchmark Plan and reflect the most recent CDT codes. Health plans should follow Covered California's Dental SOB when developing the pediatric dental benefits. Contact your assigned reviewer if you need assistance obtaining any of these documents.
 - Affirm any anticipated change in the plan's enrollment for its Covered California products is less than 5% of the plan's total enrollment and would not have a material impact on the plan's financial position. If the change in enrollment is greater than 5%, please describe the impact of the change to the plan's financial position.

⁵ Note, this provision is also applicable to health plans participating on the Exchange in connection with non-standard benefit plan designs.

For Small Group benefit plan designs only, affirm that for every contract it is offering coverage for:

- ❑ The treatment of infertility, as defined in Section 1374.55, except in vitro fertilization; and
- ❑ Orthotic and prosthetic and special footwear benefits, as set forth in Sections 1367.18 and 1367.19.

Contracts with Specialized Health Plans:

- ❑ Full service health plans that contract with specialized health plans for the provision of Essential Health Benefits⁶ (EHB), such as acupuncture, pediatric dental or vision benefits, should include in the Exhibit E-1 a brief explanation of each contractual relationship.
- ❑ Specialized health plans are required to submit a mirror filing in coordination with a contracted full service health plan for new or amended Plan-to-Plan contracts. Plan-to-Plan contracts, where the specialized health plan is at risk, should be filed as an Exhibit P-5. Plan-to-Plan contracts where the specialized health plan is not at risk (i.e. rental of network) should be filed as an Exhibit N-1.
- ❑ If the full service health plan is not providing its own specialized services list the entities providing specialized services on behalf of the full service health plan.
- ❑ Full service health plans should include the filing number for the specialized health plan's mirrored filing, if applicable. In addition, the full service health plan should ensure the Plan-to-Plan contract specifies the health plan that will be performing Utilization Management, and Grievance and Appeals functions. Ensure this information is set forth in the plan- to-plan contract.
- ❑ Specialized health plans are not required to provide eligibility information in connection with the Minimum Coverage benefit plan design within their Evidence of Coverage. Specialized health plans must file the Minimum Coverage Schedule of Benefits, if applicable.⁷ Note, full service health plans must also include the information regarding those benefit plan designs in the full service health plan's disclosure documents.

Contracts with Specialized Dental Plans:

- ❑ Dental Plan should identify whether it will be filing a mirrored filing or whether the pediatric dental information will be contained within the full service filing. If the dental plan is filing a mirrored filing, provide the filing number of the full service off-exchange filing in the Exhibit E-1.
- ❑ Dental benefits off-exchange must comply with the 2014 Medi-Cal Dental Program (Benchmark Plan). If your health plan does not provide dental

⁶ See Section 1367.005; Rule 1300.67.005.

⁷ See Section 1366.6 subdivisions (c)-(e).

benefit on Covered California, please reach out to your assigned reviewer for a copy of the Benchmark Plan.

- Dental Benefits off-exchange must follow the Covered California Standard Benefits Design for the benefits CDT codes, and the limitations and exclusions. Plan's may go to the Covered California website for a copy of the Standard Benefit Design or contact the assigned reviewer.
- Dental Plans must provide to the full service health plans 1) an EOC addendum containing the dental information or 2) identify by page and section numbers the dental portions of the full service EOC. The page and section numbers can be provided in the full service health plan's Exhibit E-1.

All Other Exhibits as Necessary

If the health plan will be relying on existing contracts, policies, or procedures previously approved by the Department, and there are no changes, the health plan should indicate this in the Exhibit E-1. The health plan is not required to submit these exhibits unless requested.

- **Quality of Care (Exhibit J).** Internal quality of care system(s) the health plan intends on implementing to serve Exchange enrollees, and address how it meets state and applicable federal requirements.
- **Provider and Administrative Services Contract(s) (Exhibits K and N).** New or revised provider or administrative service contract(s) related to Exchange product(s).
- **Plan Organization (Exhibit L).** New or revised organizational chart(s).
- **Plan-to-Plan Contracts (Exhibit P-5).** New or revised Plan-to-Plan contract(s) related to the delivery of services to Exchange enrollees.
- **Grievance & Appeals (Exhibit W).** New or revised Grievance and Appeal procedures.
- **Marketing (Exhibits V, Y, Z, AA, and BB).** Advertising and marketing materials related to Exchange product(s).

Benefit Plan Designs: Exhibits S, T, and U

- **Evidence of Coverage (EOC) or combined EOC and Disclosure Form (Exhibit T or U).** EOC(s) for each benefit plan design and/or product(s) proposed. Ensure all EHB are included in these exhibits, including those provided by a contracted specialized health plan.⁸
- **Schedule/Summary of Benefits (SOB) (Exhibit S, T, or U)**
 - For each proposed benefit plan design, submit a SOB.⁹
 - If the health plan prefers to submit a sample SOB, please use the Department's INDIVIDUAL AND SMALL GROUP MARKET

⁸ See the 2025 QDP Checklist for specific instructions for filing EHB dental benefits.

⁹ *Id.*

REPRESENTATIVE BENEFIT PLAN DESIGN WORKSHEET (Representative Worksheet). Health plans using this Representative Worksheet are not required to submit individualized SOBs for each benefit plan design offered in the Individual and/or Small Group markets. Health plans utilizing the Representative Worksheet or similar worksheet(s) must provide one representative SOB populated for use in connection with the California Health Benefit Exchange's 2025 Individual Silver 70 plan under the exhibit type(s) described above, together with the Representative Worksheet. For further instruction, see the [Representative Worksheet Instruction](#).

- **Federal Summary of Benefits and Coverage (SBC) (Exhibit S-3).** A federal SBC disclosure form in connection with the Exchange's Individual Silver benefit plan design only. This SBC will be reviewed as a representative sample for all benefit plan designs offered in the Individual and Small Group markets. Health plans are reminded to utilize the SBC instructions, materials and supporting documents authorized for use for any plan years that begin on or after January 1, 2021.¹⁰ If the health plan has already received approval of its representative SBC(s) pursuant to a separate filing, provide the e-Filing number in lieu of submitting the exhibit. If the health plan has not received approval of its representative SBC(s), submit in a separate filing the representative SBC(s) and provide the e-Filing number.
- **EHB Filing Worksheet (Exhibit T-2).** An EHB worksheet, as promulgated in Rule 1300.67.005 (effective as of June 27, 2017). Note, if the health plan has previously submitted a complete EHB worksheet, as described above, it is not required to submit a new EHB worksheet unless the previously approved EHB worksheet requires amendment.
- **Prescription Drug EHB Benchmark Plan Benefits Chart (Exhibit T-4).** A Prescription Drug EHB Chart, as promulgated in Rule 1300.67.005 (effective as of June, 27, 2017). If the health plan has previously submitted a complete Prescription Drug EHB Chart, as described above, it is not required to submit a new chart unless the previously submitted worksheet requires amendment.

As part of the submission of the chart disclose the following in the Exhibit E-1:

- If EHB Count Chart includes generics;
- A summary of any category/class variations from what is shown in the health plan's EHB Count Chart; and

¹⁰ Template instructions, materials and supporting documents authorized for use on and after January 1, 2021, may be located at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index>

- For each variation, a justification and basis for the health plan's determination of compliance with Rule 1300.67.005.

Renewal Notices: Exhibit I-9

- **Representative Renewal Notices (Exhibit I-9).** Renewal notices must comply with federal requirements including the Updated Federal Standard Renewal and Product Discontinuation Notices Bulletin (September 2, 2016; amended on July 31, 2020¹¹) issued by the Centers of Medicare & Medicaid Services (CMS), Form and Manner of Notices When Discontinuing a Product in the Group or Individual Market (September 2, 2014) issued by CMS, and Draft Standard Notices When Discontinuing or Renewing a Product in the Small Group or Individual Market (June 26, 2014) issued by CMS.

Provider Network

- Health plans are not required to file network exhibits for the sole purpose of QHP recertification, and nothing related to networks will be reviewed in this filing. Please refer to the Plan Year 2025 Networks Checklist and Worksheet for QHP and QDP Plans for filing guidance.

Actuarial Value Calculation: Exhibit FF-4

- Submit an actuarial certification that the benefit plan designs submitted do not vary by more than plus or minus two (2) percent.¹²
- Actuarial Value – Full service health plans proposing to offer 9.5 and/or 10.0 EHB should submit through the e-Filing portal the following supporting documentation under Exhibit FF-4:
 - If the benefit plan design is compatible with the federal AV calculator submit the following:
 - A screenshot of the AV calculator (Final Version) with inputs used for each benefit plan design.

¹¹ Updated guidance may be issued by CMS after the creation of this document. When completing the Plan's submission, the most current version of CMS guidance should be utilized. Contact the plan's assigned licensing reviewer if you have any questions regarding renewal notices.

¹² Actuarial value for nongrandfathered Individual and Small Group benefit plan designs shall not vary by more than plus or minus two (2) percent pursuant to Sections 1367.008, subdivision (b)(1) and 1367.009 subdivision (b)(1), respectively. The actuarial value for a nongrandfathered Bronze level health plan that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, as defined in United States Code, title 26, section 223, subdivision (c)(2), may range from plus five (5) percent to minus two (2) percent pursuant to Section 1367.0085. Pursuant to 45 CFR 156.200(b)(3), the allowable AV variation range for Individual Silver is between 0 and +2 percentage points. Pursuant to 45 CFR 156.400, the allowable AV variation for Silver Variant is between 0 and +1 percentage points. Additional guidance may be forthcoming.

- The Excel tab from the AV calculator entitled “User Inputs for Plan Parameters.”
- If the benefit plan design is not compatible with the AV calculator:
 - Submit an actuarial certification on the methodology chosen from the options specified in 45 CFR §156.135(b).
 - The certification must be prepared by a member of the American Academy of Actuaries.
 - Calculate the benefit plan designs’ AV by estimating a fit of the benefit plan design into the parameters of the AV calculator; or
 - Partial use of AV calculator for plan provisions that fit within the calculator parameters and with appropriate adjustments to the AV identified by the calculator for benefit plan design features that deviate substantially from the parameters of the AV calculator.

For either methodology, provide the following:

- A screenshot of the AV calculator with inputs used for each benefit plan design.
- A complete description of the data, assumptions, factors, rating models, and methods used to determine the adjustments.
- The actuarial certification must describe the methodology with sufficient clarity and detail to enable another qualified health actuary to make an appraisal of the reasonableness of the data, assumptions, factors, models, and methods.

Enrollment Projections: Exhibits CC, DD, and EE

- Enrollment projections and summary for all Individual and Small Group contracts. The first year of projections should be prepared on a monthly basis and the second year on a quarterly basis.

Financial Projections: Exhibit HH

- Financial projections may be requested by the Office of Financial Review, depending upon the financial position of the health plan. The projections should include a balance sheet, income statement, statement of cash flows, calculation of tangible net equity and calculation of administrative costs. If projections are requested, they should mirror the format of the enrollment projections noted above.

Rate Review

- 2025 SERFF rate filings deadlines are listed on Page 1 of this checklist.