

Standard Binder Questions for PY2026 Review (New Questions for PY2026 Review)

Please respond to all the following Standard Binder Questions for Plan Year 2026 and submit the responses as Supporting Documentation in the SERFF binder filing.

1. Are any benefits or services for this plan administered by a third-party administrator?

If so, please provide a list of those services or benefits:

Who is the TPA responsible for administration:

2. Which Pharmacy Benefit Manager (PBM) is utilized to administer pharmacy benefits for this plan?

3. Are any pharmacy benefits for this plan not handled by the PBM?

If so, which benefits (i.e., applicable prescription drugs), and who administers those benefits?

4. Based on the following federal guidance, which contraceptive coverage approach will be utilized by the issuer for PY2026?

“With respect to FDA-approved contraceptive drugs and drug-led devices, a plan or issuer could provide coverage consistent with the Departments’ prior guidance or, alternatively, consistent with the therapeutic equivalence approach outlined in these FAQs to comply with the requirements in PHS Act section 2713 and its implementing regulations.” ([FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 64 \(dol.gov\)](#))

5. How does the issuer plan to handle any drug shortages in the upcoming plan year should a covered drug become affected? Please explain.

6. Does the plan allow OB/GYNs to bundle prenatal visits, labor, delivery, and postpartum care together for purposes of consumer cost-sharing?

If yes, what are the bundled claim options?

If yes to bundling prenatal visits, labor, delivery, and postpartum care, does the issuer include anything within the provider contracts that prevents the OB/GYN from collecting all cost-sharing (copay, coinsurance, or deductible) for labor, delivery, and postpartum care during the first prenatal visit(s)?

7. It has come to the attention of PID that issuers may require a disabled dependent recertification to confirm that a dependent still meets the criteria for benefits due to their disability, and this recertification process may require submission of a form reaffirming the dependent's eligibility and providing updated medical information. PID is aware that there may be an *initial certification* which typically occurs once a child has reached the age limit for dependent coverage and needs to continue receiving benefits due to their disability or for an over-age disabled dependent of new enrollees. The questions below pertain specifically to any *recertification* requirement and process after initial certification.

Does the issuer require a disabled dependent recertification (after initial certification) to maintain eligibility?

If yes, the issuer requires a disabled dependent recertification, please provide a detailed explanation of the process (including how consumers are notified, what is required to be submitted, whether a medical provider must signoff, etc.) and the specific reason(s) for having the

recertification requirement.

If yes, the issuer requires a disabled dependent recertification, please provide a detailed explanation of the frequency of this requirement.

If yes, the issuer requires a disabled dependent recertification, please provide a copy of, or the URL for, the disabled dependent recertification form and the publicly accessible information on the process.

8. As applicable, please provide a list of all services/drugs specifically for chronic conditions that require prior authorization more than once per benefit year (after initial approval) and describe the required frequency for each.

Example: If the issuer requires a member with a chronic condition like Hemophilia A who is prescribed a specialty drug like Hemlibra to seek prior authorization every six months to continue coverage.

If the issuer does not require prior authorization for services/drugs for chronic conditions more than once per benefit year (after initial approval), please indicate that in the response.

The following standard binder questions are related to demonstrating compliance with the new requirements under PA Act 77 of 2024.

9. Are consumers required to fill prescriptions through mail order for a drug to be covered?

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If yes, explain under what circumstances that mail order would be required.

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If yes, what is the practice for consumers to get reimbursement for drug purchases outside of mail order service?

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If yes, provide consumer materials and specify the page number that explains to the consumer the option to opt out of auto enrollment through mail order pharmacy (except specialty pharmacy).

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10. Are consumers required to fill prescriptions through retail affiliate pharmacies in order for a drug to be covered?

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If yes, what is the practice for consumers to get reimbursement for drug purchases for retail non-affiliate pharmacies?

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If yes, provide consumer materials and specify the page number that explains to the consumer the reimbursement process for filling prescriptions through non-affiliate retail pharmacies.

Name of document:	
Page number(s):	
Document details:	

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11. Please provide consumer materials and specify the page number that explains to the consumer the process for utilizing a pharmacy that is out-of-network (except specialty pharmacy)?

Name of document:	
Page number(s):	
Document details:	

12. Please provide consumer materials and specify the page number that explains a prescription will not be transferred from an in-network pharmacy without the consumer's request/permission (except approved specialty pharmacy).

Name of document:	
Page number(s):	
Document details:	

13. Please provide consumer materials and specify the page number that explains to the consumer may be required to use an approved specialty pharmacy.

Name of document:	
Page number(s):	
Document details:	

14. Please provide consumer materials and specify the page number that explains to the consumer that the cost-sharing (e.g., copay, coinsurance, etc.) for a drug may not be higher than the actual cost of the drug without insurance.

Name of document:	
Page number(s):	

Document details:	
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