CERTIFICATIONS

_____(company name) _____, through the undersigned authorized representative, hereby certifies that:

☐ The Company is aware that accident and health rates and forms may be disapproved, or otherwise give rise to remedies or sanctions, if they fail to comply with applicable law or regulations. *See, e.g.,* 40 P.S. § 3801.304(b).

☐ The Company is aware that knowingly filing, or knowingly making any false material statement as to the financial condition of the Company, or knowingly making any false entry of material fact in any book, report or statement of the Company, or knowingly omitting to make a true entry of any material fact pertaining to the Company in a book, report or statement of the Company, to the Department is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. *See* 40 P.S. § 1171.5(a)(5).

AND further certifies, as to the below-referenced policy form, along with any related rate filing, that:

1. Rates and Forms Generally

☐ It is/they are drafted to be in compliance with the requirements of the Patient Protection and Affordable Care Act, P.L. 111-148,124 Stat. 119, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, 124 Stat. 1051, together and as modified referred to as the ACA, and the regulations and federal guidance promulgated thereunder.

☐ The Compliance Checklist submitted with the policy form is true, correct and complete.

I, _____(authorized representative's name)_____, hereby warrant that I have full, complete and final authority to certify the representations of the Company as set forth herein, that the certifications and representations set forth in this Certification Form (relative to statements above regarding Certifications and Rates and Forms General) are true, correct, and complete.

Policy Form # _____

_____ _____

Date Name and Title of Authorized Representative of the Company

_____

Signature of Authorized Representative of the Company

2. Mental Health and Substance Use Disorder Coverage Parity

☐ It is/they are drafted to be in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA, including the financial requirements (FR), quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) on Mental Health or Substance Use Disorder Coverage (MH/SUD).

☐ It is/they are drafted so that each FR, QTL, and NQTL applicable to MH/SUD benefits, as written and as to be applied, is in parity with medical/surgical benefits in the same classification, and that such parity is demonstrated by a documented and comprehensive analysis showing that:

- ☐ Each FR or QTL applied to MH/SUD benefits in any classification is not more restrictive than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification, where: an FR or QTL is considered to apply to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in the classification; and, if the FR or QTL applies to substantially all medical/surgical benefits in a classification, the predominant level of the FR or QTL is the level that applies to more than one- half of the medical/surgical benefits in the classification subject to the FR or QTL.

- ☐ As to each NQTL applied to MH/SUD benefits in any classification, under the terms of the policy as written and to be in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are intended to be applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.

I, _____(authorized representative's name)_____, hereby warrant that I have full, complete and final authority to certify the representations of the Company as set forth herein, that the certifications and representations set forth in this Certification Form (relative to Mental Health and Substance Use Disorder Coverage Parity) are true, correct, and complete.

Policy Form # _____

_____ _____

Date Name and Title of Authorized Representative of the Company

_____

Signature of Authorized Representative of the Company

3. Opioid Crisis Response

The Company provides coverage consistent with Act 146 of 2022 and the Department of Human Services' Bulletin Notices (as it relates to opioid use disorder treatment, MAB2024020601 (pa.gov)):

☐ Covers at least one of each type of Medication Assisted Treatment (MAT) for opioid addiction without pre-authorization, including coverage of:
- ☐ buprenorphine/naloxone prescription drug combination product;
- ☐ injectable and oral naltrexone;
- ☐ methadone; and
- ☐ buprenorphine.

☐ Covers certain MAT (buprenorphine/naloxone prescription drug combination product; injectable and oral naltrexone; and methadone) as a pharmacy benefit on the policy's lowest non-preventive cost tier, as applicable.

☐ Covers sublingual buprenorphine opioid use disorder treatment that exceeds a daily dose of 24 mg/day

☐ The supporting clinical review criteria adopted by the Company are based on applicable nationally recognized medical standards, are consistent with applicable governmental guidelines, provide for the delivery of a health care service in a clinically appropriate type, frequency and setting and for a clinically appropriate duration, and reflect the current medical and scientific evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature.

I, _____(authorized representative's name)_____, hereby warrant that I have full, complete and final authority to certify the representations of the Company as set forth herein, that the certifications and representations set forth in this Certification Form (relative to the Opioid Crisis Response) are true, correct, and complete.

Policy Form # _____

_____ Date

_____ Name and Title of Authorized Representative of the Company

_____ Signature of Authorized Representative of the Company