CONNECTICUT HEALTH INSURANCE EXCHANGE
d/b/a ACCESS HEALTH CT

PLAN YEAR 2026

SOLICITATION TO THE HEALTH PLAN ISSUERS FOR PARTICIPATION IN THE INDIVIDUAL AND/OR SMALL BUSINESS HEALTH OPTIONS PROGRAM MARKETPLACES

MARCH 10, 2025

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I. Overview

A. Purpose

The Connecticut Health Insurance Exchange (Exchange) dba Access Health CT is soliciting applications from eligible Health Insurance Issuers (Issuers) to market and sell Qualified Health Plans (QHPs) through the Access Health CT Individual and/or Small Group marketplaces for the 2026 plan year.

This document defines the QHP certification and data submission requirements an Issuer must comply with to participate on the Exchange. All requirements listed herein pertain to both the Individual and Small Group marketplaces, unless otherwise expressly noted.

To receive certification, the Issuer and its health plans must comply with all federal and state statutory requirements, as well as the standards set by Access Health CT. Access Health CT is responsible for certifying QHPs and ensuring that plans remain compliant with Access Health CT's QHP certification requirements. Federal regulations (45 C.F.R. 155.1000) allow the Exchange discretion to deny certification of plans that meet minimum certification standards but are not ultimately in the interest of consumers.

The QHP certification process and requirements for the 2026 plan year maintain many aspects of the processes and requirements carried out for previous plan years, including close coordination and collaboration with the Connecticut Insurance Department (CID).

The Patient Protection and Affordable Care Act of 2010 (ACA) and Connecticut General Statutes §38a-1080 et seq., provide the regulatory framework for defining the state's QHP certification requirements and grant authority to Access Health CT with respect to administering and managing exchange activity of the plans, certification of QHPs, compliance with federal and state laws and regulations that relate to exchange activities as well as this Solicitation, Application, and any related documents.

In setting the certification requirements, Access Health CT was guided by its mission to increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. This Solicitation reflects the criteria approved by the Access Health CT Board of Directors and that it deems are in the best interest of individuals and employers with a principal place of business in the State of Connecticut.

The Solicitation, Application and any related documents may be amended by addenda as necessary to assure compliance with state and federal laws as well as refinement of submission instructions or documents.

B. Why Access Health CT?

Access Health CT is Connecticut's trusted health and dental insurance marketplace, offering unmatched opportunities for issuers to expand their market presence, connect with consumers, and benefit from statewide promotion.

- **Easy to Shop and Compare:** Certified Issuers may offer plans on our statewide marketplace and our integrated platforms make it easier for individuals and small businesses and their employees to compare plans and buy health or dental insurance.
- **Enrollment Support:** Customers can enroll online, by phone or in person at one of the Access Health CT Enrollment Fairs or community partners throughout the state and have access to free help with their application.
- **Growth:** Health and dental plan enrollments increased from 2024 to 2025. In total, there was a 26.4% increase in dental and 17.2% increase in medical insurance enrollments with over 89.5% of the medical enrollees benefiting from financial assistance.
- **Development:** We continue to invest in technology. Access Health CT is launching a new platform in July 2025 to support Individual Health Reimbursement Arrangements (ICHRAs) for employers and employees, which will also help bolster enrollment on the Individual market.

- **Promotion Across Connecticut:** Issuers benefit directly from our multi-million-dollar mass media and advertising campaigns that boost awareness and engagement across the state.
- **Exclusive Offerings for Consumers and Employers:** Access Health CT is the only distributional channel in Connecticut through which individuals and small employers can qualify for certain affordability programs.

  Individual Marketplace programs:
  a. Premium tax credits and/or reduced cost-sharing for eligible residents.
  b. The Covered CT program, offering $0 cost coverage to eligible residents.
  c. Special plans for Alaska Native/American Indians.

  Small Group Marketplace programs:
  a. Tax credits are available for eligible employers providing coverage through Access Health CT.

C. Application Process

The application process shall consist of the following steps:

- Submission of a Non-Binding Notice of Intent
- Access Health CT Release of the Application and Appendixes
- Submission of Issuers responses
- Access Health CT Evaluation of Issuers responses
- Access Health CT Plan Certification

D. Non-Binding Notice of Intent (Pre-Requisite)

All Issuers interested in responding to this solicitation must submit the Non-Binding Notice of Intent (NBNOI) to apply**.** Only those Issuers acknowledging interest by submitting the NBNOI will receive Solicitation and/or Application-related correspondence, including the 2026 Access Health CT QHP Application and Appendix 1 and 2.

All questions to, and requests for, information from Access Health CT concerning this Solicitation by a prospective Issuer or a representative or agent of a prospective Issuer, should be directed to the following e-mail address: CTHIX-Issuers@ct.gov.

All answers to questions, and any Addenda, will be made available to all prospective Issuers.

E. Key Action Dates

The following schedule includes key dates and deliverables pertinent to Issuer and QHP certification. Dates are subject to change and any subsequent updates will be communicated directly to the individual identified in the Non-Binding Notice of Intent.

Action	Dates *(Dates are subject to change)*
Issuer Non-Binding Notice of Intent Due to Access Health CT	March 24, 2025
Access Health CT Releases Issuer Application and Appendixes	March 27, 2025
Rate and Form Filings Due to Connecticut Insurance Department	June 1, 2025
Completed Application, Templates and Supporting Documents Due to Access Health CT	June 1, 2025
Certification Process Commences	June 2 -September 19, 2025
Issuer Reviews and Approves Data in Staging System	September 22 – October 17, 2025
Access Health CT Certifies Submitted Plans	October 31, 2025

Action	Dates *(Dates are subject to change)*
Window Shopping Begins	One week prior to Open Enrollment
Commence Plan Year Open Enrollment Period	November 1, 2025 – January 15, 2026

F. Open Enrollment

Open enrollment for the Individual marketplace will begin on November 1, 2025, and continue through January 15, 2026. Access Health CT reserves the right to modify the dates of this open enrollment period. Open enrollment for the Small Group marketplace also begins on November 1, 2025, for plan year 2026 and continues on a rolling basis throughout the plan year.

Access Health CT plans to offer "Window Shopping" to allow individuals to begin reviewing plans prior to the beginning of the open enrollment period, typically about one week prior to the start of open enrollment.

II. QHP Application Components and Certification Requirements

A. General Overview

This section outlines the various components that Access Health CT will require for Plan Year 2026 QHP certification. The forthcoming QHP Application and Appendixes will be provided to the primary point of contact identified by the Issuer in the NBNOI. Appendix 1 will provide a comprehensive list of all required documents, Access Health CT specific templates, and all pertinent dates necessary for Issuer application submission and QHP certification. Reference materials that provide pertinent information relative to application requirements can be found within Appendix 2.

Issuers are required to adhere to all the certification standards and operational requirements set forth in 45 C.F.R. Parts 146, 147, 153, 155, and 156. Issuers must also adhere to state and Access Health CT requirements as well as maintain responsibility for the compliance and adherence of applicable requirements of their delegated and downstream vendor and contractor entities per 45 C.F.R. §156.340.

The QHP Application will collect Issuer information as well as plan-benefit and rate data, largely through standardized Federal data templates, Access Health CT specific templates and supporting documentation via the System for Electronic Rate and Form Filing (SERFF), in addition to submitting a signed Access Health CT QHP application. Issuers must also provide supporting documentation, such as plan documents, attestations, and applicable justifications through SERFF.

Access Health CT will coordinate with the National Association of Insurance (NAIC) SERFF team and facilitate the interchange of necessary information as required.

B. Non-Discrimination

Issuers must comply with the non-discrimination requirements outlined in Section 1557 of the ACA and 45 C.F.R. §156.

C. Licensure and Financial Condition

Consistent with 45 C.F.R. §156.200(b)(4), Access Health CT requires participating Issuers to be licensed by the CID as well as have a designation of good standing. The licensing and monitoring functions are the responsibility of the CID.

The following are some examples of a designation of good standing:

- CID has not restricted an Issuer's ability to underwrite new health plans.
- Issuer is not in hazardous financial condition.

- Issuer is not under administrative supervision.
- Issuer is not in receivership.

Issuers applying for QHP certification must be able to demonstrate state licensure and good standing prior to the beginning of the annual open enrollment period. Access Health CT will obtain information regarding an Issuer's state licensure as well as good standing designation directly from the CID.

D. Regulatory Filings

In accordance with Connecticut state law, all fully insured Individual and Small Group products must have forms and rates filed with and approved, where applicable, by the CID in advance of an Issuer presenting the product to the market for sale.

Determinations by Access Health CT to certify a health plan as "qualified" will be conditional upon the CID approving Issuer rate and form filings, as well as confirming certification of good standing, financial solvency, provider network and drug formulary adequacy. Access Health CT will work directly with the CID to obtain the appropriate documentation confirming compliance.

Issuers will be required to use the Connecticut Insurance Department (CID) prescribed Schedule of Benefits templates and instructions included in the Supporting Documentation of the "Filings" section of the SERFF. In conjunction with these CID materials, Access Health CT will provide guidance for completing Schedule of Benefits for standardized and non-standardized QHPs, "Access Health CT Supplemental Guidance for Completing Schedule of Benefits" in Appendix 2.

E. Accreditation

Access Health CT follows the standard regarding accreditation that is in place for the Federally Facilitated Marketplace (FFM). Issuers must provide information about their accreditation status to determine if the standard in 45 C.F.R. §155.1045(b) is met.

Certification documentation from the accrediting entity should be submitted to Access Health CT in conjunction with the signed Application and other required documents. An Issuer will not be considered accredited if the accreditation review is scheduled or in process.

Any information provided on accredited products must be the same for the same legal entity in the same state that submits the QHP Application.

Issuers will be required to authorize the accrediting entity to release to Access Health CT and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

Issuers will be required to provide Access Health CT with documentation of renewed certification if an Issuer's current accreditation status expires mid-plan year for which the Issuer is seeking QHP certification.

F. Office of Personnel Management (OPM) Certification of Multi-State Plan (MSP) Options

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan Program (MSP Program) as required under section 1334 of the Affordable Care Act. In accordance with section 1334(d) of the Affordable Care Act, Multi-State Plans (MSPs) offered by MSP Issuers under contract with OPM are deemed to be certified by Access Health CT.

Access Health CT requires MSP Issuers to comply with all the standards and requirements set forth in Access Health CT's QHP Issuer Application for Participation and all applicable Federal and Connecticut State laws that may apply to either health insurance or exchanges.

G. Applicant Company Information

The QHP Application will request the name and address of the legal entity that has obtained the Certificate of Authority to offer health insurance policies in the State of Connecticut. This information must match the information on file with the CID. The Issuer will also be asked to provide contact information for individuals with responsibility for the QHPs and benefit design. A list of vendors and third-party administrators that the Issuer contracts with for Exchange products will also need to be provided.

Contact information for the Issuer's Customer Service department will be requested, as well as clarifying information for billing and ID cards for both new and existing members. This information will be shared with Access Health CT's contact center to support consumer inquiries. Refer to the document titled "Applicant Company Information" in Appendix 1.

H. Compliance Plan and Organizational Chart

For new Issuers only, Access Health CT will request a compliance plan and an organizational chart as part of the QHP Application. The compliance plan is intended to document the Issuer's efforts to ensure that appropriate policies and procedures are in place to maintain adherence with Federal and State law as well as to prevent fraud, waste, and abuse. Access Health CT expects an Issuer's compliance program to include the following elements:

- Designation of a compliance officer and compliance committee.
- Written policies and procedures and documentation of proven adherence.
- Effective communication among all levels of the company ensuring a shared responsibility to compliance.
- A record retention policy, not less than 10 years; including any information related to CSR or APTC.
- Compliance education and an effective training program.
- Compliance metrics as part of an employee performance appraisal process and compliance standards enforced through well-publicized disciplinary guidelines.
- An internal audit process and the monitoring of such.
- Corrective action plan initiatives to monitor and respond to detected offenses.
- A statement of corporate philosophy and codes of conduct.

Further, the Issuer will be required to attest that its compliance plan adheres to all applicable laws, regulations, and guidance and that the compliance plan is implemented or ready to be implemented.

I. Performance Oversight

Access Health CT intends to monitor and evaluate an Issuer's performance using information received directly by Access Health CT from various entities including but not limited to, the CID, Office of Healthcare Advocate, consumers, and providers. Access Health CT will utilize complaint data, Issuer self-reported problems, information related to consumer service and satisfaction, health care quality and outcomes, Issuer operations, and network adequacy in its assessment of an Issuer's performance in the Access Health CT marketplace.

Access Health CT expects Issuers to thoroughly investigate and resolve consumer complaints received directly from members or forwarded to the Issuer by Access Health CT or any other individual or organization through the Issuer's internal customer service process and as required by state law. As part of compliance and performance monitoring, Access Health CT reserves the right to require the Issuers to provide information pertaining to complaints.

J. Market Participation

An Issuer may elect to participate in either the Access Health CT Individual marketplace or Small Group, or both. Access Health CT will grant QHP certification for one year, providing Issuer meets all requirements. Issuers interested in offering QHPs through Access Health CT marketplace in subsequent plan years must seek recertification on an annual basis.

If offering plans through the **Small Group** marketplace, the Issuer must agree to fully participate in each of Access Health CT's purchasing options. The three options are defined below:

- **Issuer Bundle (Vertical Choice)**: Allows an eligible employer to offer their eligible employees plan options from all available "metal tiers" from any one selected Issuer (i.e., any 'Issuer A' plan in any tier).
- **Metal Tier Bundle (Horizontal Choice)**: Allows an eligible employer to offer their eligible employees plan options from all participating Issuers, across any one selected "metal tier" (i.e., any silver plan from any of the Issuers).
- **Single Plan (Single Choice)**: Allows an eligible employer to offer their eligible employees one plan design in any one metal tier from any one Issuer.

K. Plan Options

The requirements regarding plan options for each marketplace are outlined below. Refer to the document titled "Number of QHPs to be Offered" in Appendix 1 and provide responses as appropriate.

Each QHP must comply with the benefit standards required by the ACA, federal regulations, the State of Connecticut, and Access Health CT, including:

- Cost sharing limits
- Actuarial value ("AV") requirements and de minimis ranges by metal tier for non-cost share variant plans
- Federally approved State-specific essential health benefits ("EHB") –
    - All QHPs offered, inside and outside of the exchange, Individual and Small Group, must include the Connecticut specific EHBs. No substitution of actuarially equivalent benefits will be allowed. To view these benefits, please refer to the Connecticut exhibits found at the following CMS URL: https://www.cms.gov/cciio/resources/data-resources/ehb.html#Connecticut.
- In all plan designs, Issuers are required to embed pediatric dental and vision benefits.

Issuers may offer tiered networks in their non-standard plans only. Issuers should refer to Connecticut PA 16-205 if offering tiered networks. Should an Issuer offer a non-standard plan that includes tiered networks, Access Health CT will require an Issuer to:

- Clearly explain and prominently display any tiered cost shares on their Summary of Benefits and Evidence of Coverage documents.
- Clearly identify preferred vs. non-preferred providers and display these provider designations within their Provider Network Directories and online search tools.
- Indicate within the Actuarial Value calculator, a Tiered Network Plan designation and expected utilization, as applicable.

a. Individual Plans

Standardized plan designs promote transparency, ease, and simplicity for comparison shopping by consumers. Access Health CT has developed standardized plan designs for certain Individual marketplace metal tiers for the 2026 plan year which defines deductible, co-payment and/or co-insurance cost sharing on an in-network and out-of-network basis. The Individual standardized plan designs can be found on Access Health CT's website: http://agency.accesshealthct.com/healthplaninformation#one.

To participate in the Access Health CT Individual marketplace, the following criteria must be met:

- One (1) standardized **Gold** plan must be offered.
- One (1) standardized **Silver** plan must be offered.
    - Three (3) cost-sharing reduction (CSR) variants for the one standardized Silver Plan offered by the Issuer to households with attested income between 100% and 250% of Federal Poverty Level (FPL) applicable at the start of the plan year. The variants must conform to the requirements of 45 C.F.R. §156.420 and any other applicable federal guidance or regulations.

- Two (2) standardized **Bronze** plans must be offered, of which, one must be HSA compatible and one that is not.
- Two (2) cost-sharing alternatives for each QHP in accordance with 45 C.F.R. §156.420 which shall be made available to members of federally recognized American Indian tribes or Alaskan-Natives.

Note: Zero and limited cost-sharing variant plans offered through the Individual Exchange do not meet federal requirements to be HSA-eligible. Access Health CT will include an indicator to this effect within the consumer shopping experience.

The Access Health CT Individual marketplace standardized plan designs are not "gatekeeper/referral" plans and were designed to provide enrollees with direct access to specialists. The Issuer may make this a requirement in its Individual marketplace non-standardized plans. If an Issuer does so, the "gatekeeper/referral" requirement must be described explicitly in the Issuer's Evidence of Coverage (EOC). Additionally, Access Health CT will require an Issuer to identify this requirement in the Schedule of Benefits and/or the Issuer's Plan Marketing Name(s).

Issuers are also encouraged to offer any of the following optional plans:

- Up to two (2) non-standardized **Platinum** plans.
- Up to three (3) non-standardized **Gold** plans.
- Up to three (3) non-standardized **Bronze** plans.
- The Issuer may opt to offer a **Catastrophic** coverage plan. Any Issuer offering the catastrophic coverage plan option must comply with federal law including section 1302 (e) of the ACA and 45 C.F.R. §156.155, and any applicable State law.

b. Small Group Plans

There are no requirements to offer standardized plans in Small Group. To participate in the Small Group marketplace, an Issuer is required to offer the following combination of plans:

- One (1) **Gold** plan must be offered.
- Two (2) **Silver** plans must be offered, of which, one must be HSA compatible and one that is not.
- Two (2) **Bronze** plans must be offered, of which, one must be HSA compatible and one that is not.

Issuers are also encouraged to offer any of the following optional plans:

- Up to four (4) **Platinum** plans.
- Up to five (5) **Gold** plans.
- Up to four (4) **Silver** plans.
- Up to two (2) **Bronze** plans.

Additionally, the required plans must comply with the following requirements:

- Include Out-of-Network (OON) coverage.
- Include Pediatric Dental and Vision EHB coverage.
- Not require a "gatekeeper".

c. Plan Submission

Issuers currently participating in the Access Health CT Individual and/or Small Group marketplaces must provide Access Health CT with information pertaining to the actions the Issuer intends to take with regard to each QHP to be offered through the Individual and/or Small Group marketplaces in 2026 by completing and submitting the applicable Plan ID Crosswalk template.

For **Individual** plans, Issuers must complete and submit the "Access Health CT Plan ID Crosswalk Template", provided by Access Health CT.

For **Small Group** plans, an Issuer must submit the "Federal Plan Crosswalk Template".

Access Health CT will consider a QHP to be "modified" in accordance with 45 C.F.R. §146.152 (f)(3), §147.106 (e)(3), and §148.122 (g)(3)). If a QHP has been modified in a manner by which it does not meet the criteria specified in the regulations, Access Health CT will consider it to be a new QHP.

As finalized in the 2024 Notice of Benefit and Payment Parameters Final Rule, Access Health CT will allow Issuers to crosswalk individuals who age out of a catastrophic plan to renew into a similar bronze plan. The plan should be the same product and have a similar network to the catastrophic plan.

HIOS Plan ID's and Plan Marketing Name's included in the Crosswalk Template must match those listed within the Federal Plans & Benefits Template (PBT).

L. Marketing Guidelines

All Issuer marketing materials for any QHP offered through Access Health CT must be reviewed and approved in advance. Issuers must allow up to fifteen (15) business days for Access Health CT's review and approval prior to the materials being published and/or released. Issuers will be required to submit all marketing materials to Access Health CT for review via the Plan Management section of the SERFF. Required materials include benefit comparison charts, renewal notices, and product brochures. Marketing materials should be submitted to Access Health CT as they become available to allow ample time for review and feedback. Materials can be submitted in draft format.

a. Co-Branding

Access Health CT does not permit co-branding. Issuers are not allowed to use Access Health CT's name or logo in any of their marketing materials without express written prior approval from Access Health CT. In addition, Issuers' marketing materials cannot include a reference to the "Exchange", "Marketplace", "Connecticut Exchange", or any other word or sequence of words used with the intent to express a connection with Access Health CT, or which may lead a consumer to reasonably assume a connection between Access Health CT and the issuer exists without express prior approval from Access Health CT.

b. Plan Marketing Names

Access Health CT requires the Issuer's Plan Marketing Names to be consumer friendly and in plain language. Specifically,

- Access Health CT prohibits inclusion of an Issuer's internal coding, numeric values, and/or special characters (e.g., "%", "#", "$", etc.) in the Plan Marketing Names.
- Issuers must include appropriate commonly known abbreviations in the plan name, e.g., "PPO", "HMO", "POS", "HSA", the metal level, e.g., Platinum, Gold, Silver, Bronze, as well as the term "Standard" for those Individual standardized plans required by Access Health CT.
- Access Health CT's Plan Marketing Name character limit is 75 characters.
- Plan Marketing Names must be consistent with those that appear on Issuer websites, marketing, and member materials.
- Zero and limited cost-sharing reduction plan variants offered through the Individual Exchange do not meet federal requirements to be HSA-eligible. Therefore, plan documents should not include a reference to "HSA" for these plans.
- Plans that fall within the 'Expanded Bronze' Actuarial Value range should indicate 'Bronze' as the metal level within the Plan Marketing Name.
- Issuers offering a Multi-State Plan (MSP) option through Access Health CT must be distinguished from any other participating Issuer(s) by Issuer HIOS Plan ID number(s) and plan marketing name(s); each MSP option must include 'a Multi-State Plan' in the Plan Marketing Name, e.g., 'Silver POS, a Multi-State Plan'.

c. Company Logo

Issuers applying to the Access Health CT Individual or Small Group marketplace for the first time, or existing Issuers with a change to their current logo must provide the company logo. An electronic image of the Issuer's

logo must be provided to differentiate the Issuer's products for display on the Access Health CT shopping screens. Access Health CT will require two distinct formats:

- Individual - JPEG, GIF, or BMP file and must be 140x50 pixels.
- Small Group - SVG format.

d. Issuer Subsidy Calculator

Issuers may display or make reference, verbally or otherwise, to an Issuer calculator for the purpose of estimating a consumer's eligibility for APTCs or other affordability programs in the Individual Market, but only if the Issuer informs Access Health CT of this intended reference and includes the Access Health CT required Subsidy Calculator Disclaimer language any time an Issuer's calculator is referenced and/or displayed, which is as follows:

*"The information from the (Issuer name) calculator is an **estimate** of your eligibility for a federal subsidy. Only Access Health CT can determine your eligibility to receive federal subsidies, and the amount of your subsidy. The (Issuer name) calculator may give you a different amount or eligibility result because it does not contain all of the information that Access Health CT uses to determine your **official** subsidy."*

Affordability program eligibility assessment and enrollment is the sole responsibility of Access Health CT.

M. Consumer Information

Access Health CT requests all URLs that will be utilized during open enrollment be provided before becoming functional. URLs will be populated into staging systems and tested once made functional by the Issuer. Access Health CT expects the provided URLs will not be changed after the initial submission.

For **Individual** plans, Issuers will provide Provider (Network), Summary of Benefits and Coverage (SBC) and Formulary URLs by completing the "URL Submission Template" provided by Access Health CT.

For **Small Group** plans, Issuers will provide Provider (Network), Summary of Benefits and Coverage (SBC), Formulary URLs, and Final Combined SOB/EOC URLs using the "Federal URL Template".

a. Enrollee Materials

Draft Schedule of Benefits (SOB)

For both Individual and Small Group plans, Issuers will be required to submit the draft Schedule of Benefits (SOB), as a portable document format (PDF), for each unique offering that depicts the cost sharing for each plan to Access Health CT in English.

The draft SOBs must be submitted in a zipped file. Within the zipped file, each plan document must reflect the following unique file naming convention: **HIOS Plan ID_Plan Variant_STD or NSTD_Metal_Product Type_Version#_Date_Language ('ENG or 'SP').**

Example: 11121CT1234567_01_STD_Silver_PPO_V1_07 08 19_ENG.

This unique file name must also appear within the footer of each SOB.

Issuers may opt to add "deductible does not apply" following the member cost share amount for the applicable services. This will ensure a more concise understanding of plan benefits for consumers. Issuers should review the "AHCT Supplemental Guidance for Completing Schedule of Benefits", which may be found in Appendix 2.

When both adult and pediatric dental coverage are offered in a plan, the SOB's must be structured so that they contain information for these coverages in a single document for each plan submitted for certification. Cost-sharing information for adults must follow the cost sharing information for the pediatric dental coverage.

NEW 2026: If updates are required to the draft SOBs, Issuers will be required to submit a "redlined" version outlining the changes from the prior version, in addition to an updated "clean" copy.

Final Combined Schedule of Benefits and Evidence of Coverage (SOB/EOC)
Following approval by the CID, Issuers must submit the final combined SOB/EOC documents within 7 business days. Each combined document must have the SOB appear at the beginning of the document with the EOC following and reflecting the file name convention as outlined above.

For **Individual plans**, each combined document must be saved as a portable document format (PDF) and submitted as a Supporting Document within the Plan Management section of the SERFF, in both English and Spanish.

For **Small Group plans**, combined documents are requested in English only and Access Health CT will access the documents using the URLs provided within the Federal URL Template.

Additional Requirements for EOC
The Evidence of Coverage (EOC) document must include each product the Issuer intends to offer on the Exchange for sale (e.g., PPO, HMO, POS) and must also include the following language:

Plans that exclude elective abortion coverage must include text such as the following within the covered services section of the EOC document:

> *"Abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which Federal funding is allowed)."*

Plans that exclude elective abortion coverage must also include text such as the following within the exclusions section of the EOC document:

> *"We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is not allowed. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed."*

Summary of Benefits and Coverage (SBC)
Issuers must prepare an SBC that includes each coverage example defined by Health and Human Services (HHS) for each plan design and plan variation to be offered through Access Health CT.

Access Health CT reserves the right to review Issuer SBC documents to ensure accuracy and regulatory compliance.

Issuers will be required to submit SBC URLs to Access Health CT. Access Health CT will display this information to consumers via a URL provided by the Issuer for each plan and variant in English and in Spanish. The URL must directly link consumers to the plan design and plan variation as selected from the Access Health CT consumer shopping portal.

In accordance with 45 C.F.R. §147.200 and 45 C.F.R. §147.136(e) Issuers must prepare the SBC in a culturally and linguistically appropriate manner. In addition, the Issuer must conform with 45 C.F.R.§155.205(c)(2)(i)(A) which requires all Issuers to provide telephonic interpreter services in at least 150 unique languages.

b. Provider Directory

Pursuant to 45 C.F.R.§156.230(b), Issuers must make their provider directories available to Access Health CT for publication online by providing the URL to the Issuer's network directory.

The URL submitted must link directly to the provider directory so that consumers do not have to log on, enter a policy number, or otherwise navigate the Issuer's website before locating the appropriate directory. Additionally, if a plan covers other services such as vision, dental, and pharmacy, a consumer should be able to search the directory by these service types.

If an Issuer maintains multiple provider networks, the consumer must be able to easily discern which providers participate in which plans and which provider networks apply to which QHP(s) at the point when a consumer could access the Access Health CT shopping portal to review plan design options for a plan year. Access Health CT will not certify any QHP unless the URL is a direct link to the provider directory search tool for the specific QHP.

For each provider and regardless of specialty, the directory must include location, contact information, specialty, medical group, any institutional affiliations, and whether the provider is accepting new patients. Access Health CT requires Issuers to include an option for consumers to search the directories by filtering those providers that are accepting new patients versus those that are not. The Issuer is expected to update its provider network directory at least once a month.

NEW 2026: Issuers are required to identify telehealth services in their provider information and allow consumers to search their provider directory by providers that offer telehealth services.

Access Health CT QHP Issuers are responsible for complying with the culturally and linguistically appropriate standards outlined at 45 C.F.R. §155.205(c) regarding oral interpretation, written translations, taglines, and website translations. Issuers are encouraged to include languages spoken, provider credentials, and whether the provider is an Indian Health Service provider. Directory information for Indian Health Service providers should describe the population served by each provider.

Upon request, Access Health CT may also require Issuers to submit up-to-date, accurate, and complete in-network provider directories to Access Health CT for each QHP in either hard copy, a searchable PDF, or in an unprotected excel format.

Provider Data Files

Access Health CT QHP Issuers must also make provider information available to Access Health CT in a machine-readable format using JavaScript Object Notation (JSON). The data must be updated, at minimum, on a monthly basis and will be imported by Access Health CT as updates are required. The files are not intended for direct consumer use, but to support the consumer's shopping experience within the Access Health CT shopping portal. More information is provided in "Access Health CT Provider Data Requirement Documentation", found in Appendix 2.

New Issuers must begin submitting recurring submissions to Access Health CT, at minimum, on a monthly basis beginning June 1, 2025. Existing issuers will need submit data to Access Health CT for plan years 2025 and 2026 starting in September. The final file must be received by mid-October for Open Enrollment.

c. Prescription Drug Formulary

Issuers must publish, in a document with a searchable format and with a direct URL, an up to date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, Access Health CT, HHS, the U.S. Office of Personnel Management, and the general public, pursuant to 45 C.F.R. §156.122(d).

The URL provided as part of the QHP Application should link directly to the formulary so that consumers do not have to log on, enter a policy number or otherwise navigate the Issuer's website before locating the drug list. If an Issuer has multiple formularies, it should be clear to consumers which formulary applies for the specific QHP under which the consumer has elected to search.

Issuers must follow CID guidance pertaining to drug formulary requirements and submissions.

Access Health CT reserves the right to require Issuers to provide formulary information if deemed necessary.

N. Eligibility and Enrollment

a. Individual Marketplace

Access Health CT is responsible for the enrollment process and all eligibility determinations of individuals and families. In addition, all eligibility changes must be made through Access Health CT and Access Health CT will perform primary verifications through the Federal Data Services Hub (FDSH).

Licensed certified brokers, as defined in 45 C.F.R. §155.20, may assist individuals and/or their authorized designees with QHP selection and Access Health CT may provide enrollment assistance.

Please refer to 45 C.F.R. §155 for eligibility requirements. All eligibility determinations, re-determinations and changes will be made in accordance with federal and state law and in accordance with the terms of the Issuer Agreement and any related transactions between the Issuer and Access Health CT, which serve to amend or clarify such documents or applications of law. Access Health CT will distribute an 834 Companion Guide to all new participating Issuers, which will include the specifics regarding transactions and the coding of transactions.

b. Small Group Marketplace

Licensed certified brokers, as defined in 45 C.F.R. §155.20, may assist employers, and the employees of those groups, with QHP selection and Access Health CT may provide enrollment assistance.

Access Health CT's Small Group vendor transfers data electronically between the vendor and Issuers. The vendor produces a single premium invoice to the employer for the total premium dollars due. The employer remits the premium due (both employee and employer contributions) to the vendor. The vendor processes the employer premium payments by disbursing the applicable amount to the appropriate Issuer. The vendor is also responsible for sending an aggregated broker commission payment to the individual brokers for all enrollees the broker has assisted.

O. Rate Specifications and Details

Issuers participating in the Access Health CT **Individual** marketplace must agree to offer QHPs to any eligible consumer seeking to purchase such coverage for a term of up to twelve (12) months for coverage beginning on January 1st of a given plan year, or a term that shall last for the remainder of the plan year when coverage starts on February 1st or later in a given plan year. Rates must be set for the entire plan year. For any instance of partial month's coverage in the case of birth/adoption/foster child or death, Access Health CT will prorate premium in its enrollment system. Issuers are required to adhere to the established process for proration of premiums to arrive at the same prorated amount in the Issuer's enrollment system as the Access Health CT enrollment system.

Issuers participating in the Access Health CT **Small Group** marketplace must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage as defined in 45 C.F.R. §155.726(b). Issuers offering QHPs through the Access Health CT Small Group marketplace must also charge the same contract rate for each month of the applicable small employer's policy year in accordance with 45 C.F.R. §156.286(a)(3).

Issuer will also agree to offer its QHPs during special enrollment periods to eligible enrollees, and their eligible enrolled co-beneficiaries, where applicable, who may experience a valid change in circumstances as defined in 45 C.F.R. §155.420 for the Individual marketplace and 45 C.F.R. §155.726(c) for the Small Group marketplace. Access Health CT also grants a SEP for individuals who have been certified as pregnant within the last 30 days per Connecticut PA 18-43.

For the Covered CT Program, consumers may enroll throughout the plan year once eligible for the program.

Issuers should refer to CID guidance for information regarding rating factors in Individual and Small Group marketplaces.

- ***Single Risk Pool***. An Issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by the Issuer both inside and outside of the Access Health CT marketplace to be members of a single risk pool encompassing either the individual market or small group market.
- ***Tobacco Use***. Issuers are prohibited from using tobacco use as a rating factor in the Small Group market in accordance with CGS§38a -567. Access Health CT will not permit tobacco use rating in the Individual market.
- ***Family Composition***. Federal regulations require Issuers to add up the premium rate of each family member to arrive at a family rate as described in 45 C.F.R. 147.102(c)(1). However, the rates applicable to no more than the three oldest covered child dependents who are under age 21 will be used in computing the family premium.
- ***Age***. Federal regulations require Issuers to use a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market.
- ***Dependent Age Limit*.** Access Health CT will require Issuers to cover eligible dependent children through the end of the plan year in which he or she attains the age of twenty-six.
- An Issuer must submit a justification for a rate increase prior to the implementation of the increase and prominently post the justification on its website. Access Health CT will request a URL to the Issuer's website where the rate increase justification has been posted prominently. To ensure consumer transparency, Access Health CT will provide access to such justification on the website.
- An Issuer must offer a child-only QHP option at the same level of coverage(s) as any QHP offered through the Access Health CT marketplace in accordance with 45 C.F.R. §156.200(c). A consumer seeking child-only coverage may obtain that coverage through the purchase of a single QHP with applicable rating for child-only coverage.
- Access Health CT will require Issuers to submit, as part of the QHP Application, information that supports the rating submission, such as the Actuarial Memorandum Part III, which is a narrative describing and supporting information submitted on the Unified Rate Review Template (URRT). CMS guidance outlines the minimum information that should be contained in this document, including requirements related to current enrollment. Information related to rating factors for age, area, plan relativity and in the case of Small Group, quarterly trend adjustments should be incorporated. CMS guidance on completing this Actuarial Memorandum Part III is available at: https://www.qhpcertification.cms.gov/s/Unified%20Rate%20Review
    - The 'as of' date for the current enrollment entry on Worksheet 2 within the URRT is a required element for this document.
    - Screen shots from the AV Calculator for each plan/plan variant must be included with the submission.

P. Grace Periods

1. Individual Marketplace

a. Enrollees Receiving Advance Premium Tax Credit

Issuers must adhere to the requirements in 45 C.F.R. §156.270 in determining grace period and termination procedures due to non-payment of the premium for enrollees receiving an Advanced Premium Tax Credit (APTC).

As finalized in the 2026 Notice of Benefit and Payment Parameters Final Rule, Issuers may implement a fixed-dollar premium payment threshold or one of two percentage-based premium payment thresholds. The fixed-dollar threshold is set by CMS at a cap of $10 or less. The percentage-based threshold includes a net premium threshold of 95% or higher or a gross premium threshold of 98% or higher.

b. Enrollees Not Receiving Advance Premium Tax Credit

Access Health CT will require Issuers to comply with a 30-day grace period for the enrollees not receiving APTCs. To account for months with less than 30 days, the grace period extends to the end of the month.

c. Guaranteed Availability of Coverage and Premium Collection Methods

Participating Issuers may require payment of past due premiums before effectuating coverage for a new coverage year but cannot do so without advance notification to Access Health CT and enrollees*.

** Outlined in the 'Guaranteed Availability of Coverage' section (§147.104) of the preamble to the 2017 Market Stabilization Rule (82 FR 18346) as finalized April 18, 2017.*

d. Renewals

A binder payment is not required for passive reenrollments that continue effectuated coverage. If the consumer is in a grace period at the beginning of the plan year, nonpayment of the January premium by the due date set by the Issuer will trigger the applicable grace period.

2. Small Group Marketplace

Access Health CT has established a 30-day grace period for small employers that do not pay the premium on time. To account for months with less than 30 days, the grace period extends to the end of the month.

Q. Separate Billing and Segregation of Funds for Abortion Services

Per 45 C.F.R. §156.280, QHP issuers offering coverage of abortion services for which federal funding is prohibited have flexibility in selecting a method to comply with the separate payment requirement under section 1303 of the Affordable Care Act (ACA).

R. Federal Data Templates and Supporting Materials

The Federal data templates listed below must be completed and submitted within the Plan Management tab of the System for Electronic Rate and Form Filing (SERFF). All templates must be completed as part of the application process to obtain QHP Certification for each plan design intended for sale on the 2026 Access Health CT Individual and/or Small Group marketplaces. Access Health CT will extract specific information from these templates to populate the consumer shopping portal.

Note: If changes are made to the original SERFF submission, an explanation detailing the changes within SERFF must be included.

Information and instructional guidance on the Federal data templates and related materials can be found at https://www.qhpcertification.cms.gov/s/Application%20Materials .

The Plan Management General Instructions (PMGI), as well as the Template and Supporting Documentation tabs within the Plan Management section of SERFF, also contain specific information and a description of each required component.

The following identifies the required Federal Data Templates for certification and outlines Access Health CT requirements or tips for completing each template.

a. Plan & Benefits Template

Collects plan, benefit, and cost-sharing information for each plan to be offered via the exchange. Required for both Individual and Small Group.

- The 'Plan Variant Marketing Name' field on the Cost Share Variances tab must match the 'Plan Marketing Name' field on the Benefits Package tab.
- Do not modify the name on the Cost Share Variances tab for any of the plan variants. The appropriate cost share CSR plan variant name extension will automatically display within the detailed plan view of the

Access Health CT Consumer Portal, e.g., 'Silver Standard POS 73% CSR', 'Silver Standard POS 87% CSR', 'Silver Standard POS 94% CSR', etc.

- The below table includes "Additional EHB's" that must be added in the PBT with EHB Variance Reason as "Additional EHB Benefit" for each plan:

Benefit	How to Add:
Accidental Ingestion of a Controlled Drug	Benefits Package Tab - "Add A Benefit" Drop Down List Box
Bone Marrow Testing	
Bones/Joints	
Developmental Needs of Children & Youth with Cancer	
Diabetes Care Management	
Early Intervention Services	
Inherited Metabolic Disorder – PKU	
Post-Mastectomy Care	
Treatment of Medical Complications of Alcoholism	
Wound Care for Individuals with Epidermolysis Bullosa	
Mammography Ultrasound	Benefits Package Tab - "Add A Benefit" 'Custom' Benefit Button

To learn how to add these benefits when developing the PBT, please refer to the CMS link: https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits

- If a benefit feature is not supported in the Cost Share Variances tab, include cost share(s)/clarifying text in the 'Benefits Explanation' field of the Benefits Package tab, e.g., separate benefit deductible, copay maximum, or multiple cost shares based on provider/provider setting, etc. The following are a few examples of when the 'Benefits Explanation' field should be populated:
  - **Prosthetic Devices:** Cost sharing for Artificial Limbs should be identified in the Benefit Explanation field under Prosthetic Devices to account for the requirements outlined in CGS sections 38a-492t and 38a-518t. PBT entry should reflect the broader cost sharing for Prosthetics within the Cost Share Variances tab.
  - **Home Health Care Services:** For plans with a separate deductible for Home Health Care Services, select 'no' to the question "Do you have deductible sub-groups" when completing the PBT. Indicate the cost sharing value not subject to a deductible in the Cost Share Variances tab, and in the 'Benefit Explanation' field, note the amount of the separate deductible.
  - **Outpatient Facility Fee:** Enter the higher enrollee cost sharing level within the Cost Share Variances tab of the PBT. The lower enrollee cost sharing level should be entered in the 'Benefit Explanation' field.
  - **Integrated Dental and/or Stand-alone dental plan (SADP)** - include a notation regarding a calendar year maximum and/or a waiting period that may apply for adult benefits.
    ***NOTE**: Pediatric dental is an Essential Health Benefit (EHB) and cannot be subject to either a calendar year maximum or a waiting period.*
- Each benefit category must have one cost share value for In-Network and one cost share value for Out-of-Network.
- "Not Applicable" is to be used to indicate that the entry should be ignored.
- $0 copay and/or 0% Coinsurance should be entered to represent that an enrollee does not have any cost sharing responsibility for the benefit. **Do not use "No Charge" to represent this, as this is not an option for Access Health CT submissions**.
- If a benefit is not covered "Out of Network", enter "100%" for that service in the Cost Share Variances tab. ZCSR plan variants follow this approach, so the default of 0% would need to be changed to 100% for "Out of Network". HMO/EPO plans should also follow this methodology.

- For Individual QHP HSA plans, enter “No” in the “HSA Eligible” field at both the ZCSR and the LCSR plan variant levels. This will trigger custom language to appear just below the plan marketing name on the Access Health CT consumer portal, (e.g., ‘ZCSR – This plan is not HSA compatible’, ‘LCSR – This plan is not HSA compatible’)
- For plans where the deductible is waived for a certain number of primary care visits, enter the appropriate value in the “AV Calculator Additional Benefit Design” section (e.g. Catastrophic plans). Then proceed by entering the appropriate cost share value based on your form filing.
- For non-standard plans with a multi-tiered network, enter “No” in the “Multiple Tier Network?” field. Then, enter the higher cost share value for each applicable benefit in the ‘In-Network (Tier 1) field’. Also, include clarifying text and/or multiple cost share values within the Benefit Explanation field on the Benefit Package Tab.

b. Prescription Drug Template

Collects prescription drug benefit and formulary information. Required for both Individual and Small Group.

Neither ‘Zero Cost Share Preventive Drugs’ nor ‘Medical Service Drugs’ should be included as separate tiers, despite recommendation from CMS. Access Health CT requires that preventive drugs be incorporated into one of the existing four tiers.

c. Network Template

Collects the provider network ID for each provider network. Required for both Individual and Small Group.

Do not include Network IDs on this template that are not associated with a plan included in a PBT submitted for either the Individual and/or Small Group marketplaces.

d. Service Area Template

Collects information on the Service Areas available for each plan to be offered via the exchange. Required for both Individual and Small Group.

The CID received approval from CMS to establish eight rating areas by county for both the Individual and Small Group markets. Access Health CT currently requires Issuers to offer QHPs in all counties identified below.

RATING AREA	COUNTY
Rating Area 1	Fairfield
Rating Area 2	Hartford
Rating Area 3	Litchfield
Rating Area 4	Middlesex
Rating Area 5	New Haven
Rating Area 6	New London
Rating Area 7	Tolland
Rating Area 8	Windham

e. Rate Data Template

Collects rate data by plan, by rating area, for each age band to be offered via the exchange. Required for both Individual and Small Group.

- When entering rates in the Rates Table template, select one rating area ID per each set of rates per plan, regardless of whether the same set of rates is offered in more than one rating area.
- Do not select multiple area IDs for a set of rates.

f. Rating Business Rules Template

Defines the rating business rules to calculate rates/determine if a consumer is eligible for coverage under a plan. Required for both Individual and Small Group.

The following table includes information required in the Rating Business Rules Template that Issuers must submit within the binder in the Plan Management section of SERFF.

Data Field	Expected Response
What is the maximum number of rated underage dependents on this policy?	3
Is there a maximum age for a dependent? ***Note**: CMS has clarified maximum age for a dependent for purposes of eligibility at policy issuance or renewal.*	Yes (age 25)
How is age determined for rating and eligibility purposes?	Age on effective date
How is tobacco status returned for subscribers and dependents?	'Not Applicable'
What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	Self Spouse Child Foster Child Stepson/Stepdaughter Life Partner Ward Other Relationship No – dependent is not required to live in the same household as the primary subscriber

g. Plan Crosswalk Template

Collects renewal activity for plans offered via the marketplace. Required for Small Group only.

A separate crosswalk template provided by Access Health CT is required for Individual only

h. URL Template

Collects Carrier specific URLs for display to a consumer within the shopping portal. URL template may be submitted prior to activation of the URL. Required for Small Group only.

A separate URL template provided by Access Health CT is required for Individual only.

i. Unified Rate Review Template (URRT)

Collects data for market-wide rate review. This template includes Issuer information to support rating development. Required for Individual and Small Group.

j. Supporting Documentation/Justifications

In addition to the submission of the required Federal data templates, CMS and Access Health CT specific supporting documentation, attestations and justifications are also required, as applicable, to complete the certification process. All documents requiring signature must be executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information. These documents must be completed and submitted through SERFF Plan Management within the Supporting Documentation tab. Refer to Appendix 1 for more information.

k. Issuer Accountability

Application Review Tool Results:

The Issuer will be required to utilize and provide results from the application review tools developed by CMS or by Access Health CT to demonstrate that all errors have been corrected prior to each data submission to Access Health CT. Tools and results sent to Access Health CT must be based on the template data sent to Access Health CT via SERFF. Workbook names within the CMS tools submitted to Access Health CT should match the name of the template submitted via SERFF so that Access Health CT can verify the correct workbook was used to run the tools during the review process. An explanation of remaining warnings or errors must be submitted to Access Health CT. Revised tools are expected when changes are made to any federal template, and Issuers should validate they are using the most current version of the tools.

All CMS developed tools are required to be completed and submitted as part of the certification process, except for the Essential Community Providers (ECP) tool, Adverse Tiering tool, and the Plan Crosswalk tool. Requirements for ECP compliance can be found in section T, "Network Adequacy". The values required to run the "Expanded Bronze Plan Review" within the Cost Sharing Tool can be found in the "Expanded Bronze Review Guidance", in Appendix 2. For information and instructions on the CMS developed tools, go to: https://www.qhpcertification.cms.gov/s/Review%20Tools.

Issuers will also be required to run and provide results of the Access Health CT SOB-PBT Plan Comparison Tool. Refer to Appendix 2 for the "Access Health CT SOB-PBT Plan Comparison Tool Templates" and tool instructions.

l. Program & Connecticut Attestations

Consistent with the ACA, the Issuer must agree to comply with the minimum certification standards with respect to each QHP on an ongoing basis. Attestation language will cover the minimum certification standards required by CMS, the State, and/or Access Health CT and will cover an Issuer's existing operations as well as any contractual commitments needed to meet Access Health CT requirements. Attestations can be found in Appendix 1.

S. Reporting Requirements

a. Quality Rating System (QRS)

Issuers are required to comply with standards and requirements related to data collection of quality rating information pursuant to 45 C.F.R. § 156.1120, and the QHP Enrollee Survey pursuant to 45 C.F.R. § 156.1125. Issuers are expected to follow the specific requirements related to data collection, validation, and submission, as well as minimum enrollment criteria, for the QRS and QHP Enrollee Survey as detailed in technical guidance issued by CMS.

b. Quality Improvement Strategy (QIS)

As required by the ACA, QHP Issuers must implement a QIS, which is a payment structure providing increased reimbursement or other incentives that will improve enrollee health outcomes, reduce hospital readmissions, improve patient safety, and reduce medical errors, implement wellness and health promotion activities and/or reduce health and health care disparities.

Access Health CT will follow CMS guidance pertaining to QIS requirements, including Issuer completion and submission of various forms, depending on the Issuer's QIS status.

The Technical Guidance and report forms will be available on the Marketplace Quality Initiatives (MQI) website located at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page

T. Network Adequacy

a. General Requirements

Pursuant to 45 C.F.R. § 156.230(a)(2), an Issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health

and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

Issuers will be required to submit the Access Health CT "Network Narrative" template, included in Appendix 1.

Issuers must also adhere to the CID guidance pertaining to Network Adequacy.

Access Health CT reserves the right to require Issuers to submit information on consumer complaints pertaining to access to network providers in a format and at a frequency specified by Access Health CT.

b. Essential Community Provider (ECP) Network Adequacy Standards

Issuers must also meet specific standards for the inclusion of Essential Community Providers (ECPs) within their QHP provider networks. The definition of an ECP is included in 45 C.F.R. §156.235. The ECP must provide services that are considered covered health services under the currently adopted definition of Essential Health Benefits to individuals at disparate risk for inadequate access to healthcare.

Access Health CT ECP Network Adequacy standards as approved by the Board of Directors follows:

- Issuers must contract with 50% of the Federally Qualified Health Centers (FQHCs) in Connecticut on the Access Health CT ECP list.
- Issuers must contract with 50% of the non-FQHC providers on the Access Health CT ECP list.

To determine whether an Issuer is meeting the ECP standards, Access Health CT will require the Issuer to complete the Access Health CT "ECP List" on a semi-annual basis. This list is subject to periodic updates by CMS and Access Health CT. Access Health CT will provide Issuers with the ECP list/template for ECP data submission. Access Health CT populates the list with designated ECPs within Connecticut. Issuers must provide an indicator for whether the provider's location and service are included in the QHP network.

If an Issuer does not meet the standard(s) at the time of semi-annual submission of ECP data to Access Health CT, the Issuer will be required to complete a "Supplementary Response: Inclusion of ECPs form" and provide Access Health CT with a narrative outlining demonstration of a good faith effort in contracting.

U. Wellness Incentives

Access Health CT may require Issuers intending to offer a wellness program(s) to provide a detailed proposal of such programs to assess potential discrimination based on health status. Access Health CT reserves the right to decide whether a wellness program(s) as described by an Issuer should be offered in Small Group.

V. User Fees/Market Assessment

The Issuer must attest commitment to pay user fees and/or Issuer assessments, as applicable.

Refer to the "Exchange Assessment and Fees" document found within Appendix 2. This procedure was adopted by the Access Health CT Board of Directors on May 28, 2015.

W. Broker Commissions

Access Health CT will require participating Issuers to pay a commission to an insurance producer or broker who assists an individual or small employer in enrolling in a health insurance plan through Access Health CT.

Commissions on the exchange must be "similar" to an Issuer's commission off exchange and will be deemed similar if the following conditions are met:

- A commission is payable on the exchange for a plan if the Issuer pays a commission for a comparable plan and service functions off exchange. A comparable plan is one at the same metal tier or a subset of that tier if commissions are limited to a specific type of offering such as a plan sold in conjunction with a tax qualified health spending account.

- If an Issuer does not offer plans off exchange, a commission shall be payable based upon a comparable plan of an affiliate. In the case where there is not an affiliate, a commission shall be payable based upon a comparable plan of other Issuers participating on the exchange.