

**MI Uniform Modification Justification Form**

**Guidance:**

Pursuant to federal regulations, if an issuer makes changes to a product on renewal, it will be considered the same product for the renewal plan year only if the product meets **all** the following criteria:

1. The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the Public Health Service Act);
2. The product is offered as the same network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);
3. Changes to the service area do not violate the anti-discrimination requirements set forth in 45 CFR 155.1055;
4. Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and
5. The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of +/- 2 percentage points (not including changes pursuant to applicable federal or state requirements).

**Instructions:**

All Issuers must submit the MI Uniform Modification Justification Form in the SERFF Form/Rate filing **and** Plan Management Binder. If NO renewing product/plan includes changes to any of the following, please mark the certification checkbox on page 2:

1. Cost-sharing – either type or amount
2. Non-mandated benefits
3. Service area
4. Product type (PPO versus POS, etc.):
	1. This requirement applies to any Individual or Small Group filing except grandfathered and transitional filings. Any filing which contains changes to cost-sharing and/or benefits must include an Actuarial Justification. If there are no changes to a product/plan in these categories, the product/plan need not be included. The required format for saving this document is: ***IssuerName*\_UMJustification\_Version *#***.
		1. The initial filing will be identified as Version 1.
		2. Any changes to the responses in this form must be re-filed and must include the updated version #.

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**HIOS Issuer ID:** Click to enter text.

**Issuer Name:** Click to enter text.

**Market:** Click to enter text.

[ ]  Issuer certifies that no changes have been made to any filed plan that meet the criteria under the uniform modification regulation by checking box.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Product LevelHIOS ID | HIOSPlan ID (*Standard Component)* | Cost SharingChange\**(include section/item/page number)* | % change*(plan adjusted rate)* | Non-Mandated Benefit Change*(include section/item/page number)* | % change*(For each benefit and total)* | Service Area Change*(Counties added or removed)* | Product Network Type Change |
| 2024 | 2025 |
| **Example** | [#####MI#######] | DeductibleSOB-pg.2Added co-paySOB-pg. 3 | + 4%+ 1% | + Acupuncture *Sect.2 item 5 page 3*- Fertility Treatment*Sect. 2 item 7 page 3* | +1%-2.5%-1.5% total | +Macomb-Clinton-Eaton | POS | PPO |
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\* Copayment, Coinsurance, and/or Deductible. Include specific information and section/item/page number for each change.

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