PSHB Program Carrier Letter
All PSHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

FEHB ☐ PSHB ☒

Letter Number 2025-06

Date: March 20, 2025

Fee-for-service [6] Experience-rated HMO [6] Community-rated HMO [6]

Subject: Technical Guidance and Instructions for 2026 Benefit Proposals

Enclosed are the Technical Guidance and Instructions for preparing your benefit proposals for the contract term January 1, 2026, through December 31, 2026. Guidance applicable to Postal Service Health Benefits (PSHB) Fee-For-Service (FFS) and Health Maintenance Organizations (HMOs): Community-Rated (CR), Experience-Rated (ER), Current HMO, and New HMO plans are noted throughout the document. Please read through the Technical Guidance carefully and contact your Health Insurance Specialist with questions.

OPM's annual policy and proposal guidance for PSHB Program health benefits proposals are issued in two documents:

1. The Call Letter (Carrier Letter 2025-01) dated January 15, 2025, and its Addendum (Carrier Letter 2025-01a) dated January 31, 2025, outlines policy goals and initiatives for the 2026 contract year; and
2. The Technical Guidance and Instructions for 2026 Benefit Proposals provides detailed requirements for items listed in the Call Letter that you must address in your benefit proposals.

The 2026 Rate Instructions are not included with these benefit instructions. Information regarding the 2026 Rate Instructions for Community-Rated HMO Carriers, Experience-Rated HMO Carriers, and Fee-For-Service Carriers will be sent via separate Carrier Letters.

OPM's primary emphasis for the upcoming plan year for Carriers is easing administrative burden on enrollees along with continued focus on prior year initiatives. Those initiatives include Medicare Employer Group Waiver Plans, Preventative Care, Fertility Benefits, Mental Health Parity and Network Adequacy, and Prevention and Treatment of Obesity. We continue to encourage all PSHB Carriers to thoroughly evaluate their health plan options with a focus on improving quality and affordability.

Each Carrier is responsible for ensuring that every benefit proposal complies with all applicable Federal laws and regulations. As a reminder, all Carriers must commit to the PSHB Program Guiding Principles, as applicable. For the 2026 proposal submissions, PSHB Carriers will submit their 2026 proposals via Carrier Connect.

We appreciate your efforts to submit benefit proposals timely. We look forward to working closely with you on these activities.

Sincerely,

Holly Schumann
Acting Associate Director
Healthcare and Insurance

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Schedule

We offer the following charts with deadlines that are part of the benefit and rate proposal negotiation process. Benefit proposals must be complete upon submission. The deadlines for concluding negotiations are firm and we cannot consider late proposals.

Benefit and Rate Proposal Important Dates

Dates	Activity
March 20	**Carrier Connect Training** Training for OPM's new web-based application for PSHB benefit and rate proposals.
April 1	**Carrier Connect Opens for 2026 PSHB Benefit and Rate Proposal Submissions** PSHB Carriers must use Carrier Connect to submit all benefit and rate proposal materials.
May 2	**Community Benefit Package for HMOs** The Community Benefit Package (Certificate of Coverage, Evidence of Coverage, Master Group Contract or Agreement) for the commercial health insurance coverage sold to the majority of non-Federal employees. This must be submitted in Carrier Connect.
May 31	**Benefit and Rate Proposals** As required by 5 CFR § 890.203, all PSHB Carriers must submit a complete proposal for each contract containing any proposed benefit changes and clarifications in Carrier Connect.
May 31	**2025 Drug Formularies** **All 2025 PSHB Carriers** must submit their 2025 drug formularies to Research and Oversight Repository (ROVR) using the 2025 Formulary Submission File Template found in Appendix IX.

Dates	Activity
May 31	**Proposed 2026 Drug Formularies** **PSHB Carriers** must submit proposed formularies in Carrier Connect using the 2026 Formulary Submission File Template found in Appendix IX for each of the following: • 2026 non-EGWP PSHB formulary • 2026 CMS Base formulary • 2026 PSHB PDP EGWP formulary • 2026 PSHB MA-PD EGWP formulary, if applicable. **PSHB Carriers** must also submit a 2026 Formulary Comparison for each EGWP product being offered using the 2026 Formulary Comparison Template found in Appendix IX.
October 15	**Final 2026 Drug Formularies** **PSHB Carriers** must submit finalized formularies in Carrier Connect using the 2026 Formulary Submission File Template found in Appendix IX for each of the following: • 2026 non-EGWP PSHB formulary • 2026 CMS Base formulary • 2026 PSHB PDP EGWP formulary • 2026 PSHB MA-PD EGWP formulary, if applicable. **PSHB Carriers** must also submit a 2026 Formulary Comparison for each EGWP product being offered using the 2026 Formulary Comparison Template found in Appendix IX.

Brochure Important Dates

Dates	Activity
June 2-13	**Brochure Creation Tool (BCT) Training** OPM hosts three (3) online training sessions for BCT during the timeframe listed; Carriers must attend one session. OPM will provide the 2026 BCT User Manual no later than June 13.
June 13	**BCT Open for Carrier Data Entry** Please contact BPBCT@opm.gov for password resets, technical questions or if you have suggestions on changes to the BCT.
June 30	**PSHB HMOs Submit State-Approved Benefit Packages to OPM** Last day to submit proof of state approval for newly proposed benefits or service area expansions.

Dates	Activity
July 26	**Brochure Templates** OPM will send the 2026 Brochure templates.
August 8	**Initial Carrier Submission** Carriers must complete initial update or submission of brochure language in BCT no later than August 8 or a date set by your Health Insurance Specialist, whichever is earliest.
August 31	**Access to Providers** If you are a new plan, proposing a new service area, or changing your service area, provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts.
September 2	**Brochure Finalization** Carriers must finalize brochures by this date. OPM sends brochure quantity forms, as well as other related Open Season instructions, to Carriers after Health Insurance Specialist approves brochure for printing. **Summary of Benefits and Coverage are due the same date as the final brochure.**
September 5	**Rate Import** Carriers must complete import of approved rate information into BCT.
October 10	**Brochure Shipment** Orders for Carrier brochures must be received by the Retirement Services vendor.

Note: Within five (5) business days following your receipt of the close-out letter or the date set by your Health Insurance Specialist, please send them an electronic version of your 2026 brochure.

Part I: 2026 Benefit Proposal Instructions

Carriers are required to submit all materials in Carrier Connect, OPM's web-based application for PSHB benefit and rate proposals unless instructed otherwise. Please note that guiding prompts will also be available within Carrier Connect during the submission process. Proposal instructions not found within Carrier Connect are annotated within each section below.

Enrollment Types

Enrollment Type	Enrollment Code "Identifier"	Description
Self Only	PSHB: Codes ending in A and D	Self Only enrollment provides benefits for only the enrollee.
Self Plus One	PSHB: Codes ending in C and F	Self Plus One Enrollment provides benefits for the enrollee and one designated eligible family member.
Self and Family	PSHB: Codes ending in B and E	Self and Family Enrollment provides benefits for the enrollee and all eligible family members.

Notes

- For Self Plus One, the catastrophic maximum, deductibles, and wellness incentives must be for dollar amounts that are less than or equal to corresponding amounts in the Self and Family enrollment.
- Benefits, including all member copays and coinsurance amounts, must be the same regardless of enrollment type of the same plan option.
- Carriers with High Deductible Health Plans (HDHPs) must be aware of 26 U.S.C. § 223, which requires that deductibles, catastrophic maximums, and premium pass-through contributions for Self Plus One or Self and Family coverage be twice the dollar amount of those for Self Only coverage. Note that family coverage is defined under 26 CFR § 54.4980G-1 as including the Self Plus One coverage category.

Federal Preemption Authority

The law governing the PSHB Program at 5 U.S.C. 8902(m) gives PSHB contract terms preemptive authority over state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits.

Community Benefit Package (All HMOs)

The Community Benefit Package is the commercial group health insurance coverage sold to the majority of non-Federal subscribers. Submit a copy of your fully executed Community Benefit Package (e.g., Certificate of Coverage or Evidence of Coverage) by May 2, 2025, including riders, copays, coinsurance, and deductible amounts (e.g., prescription drugs, durable medical equipment) for your plan with the largest number of non-Federal subscribers in 2025. If you offer a plan in multiple states, please send us your Community Benefit Package for each state that you intend to offer coverage.

Community-Rated HMOs

In a cover letter to your Contracting Officer accompanying your Community Benefit Package, describe your state's process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent to us along with a copy of the state's approval document.[1] OPM usually accepts proposed benefit changes for review if you submit changes to your state prior to May 31, 2025, and obtain approval and submit approval documentation to us by June 30, 2025. Please let us know if the state grants approval by default (i.e., it does not object to proposed changes within a certain period after it receives the proposal). The review period must have elapsed without objection by June 30, 2025.

[1] If necessary, provide a translation in English.

Please include the name and contact information (phone number, email) of the state official responsible for reviewing your plan's benefits. If your plan operates in more than one state, provide the information for each state. If applicable, please include which state you have designated as the situs state. We may contact states about benefits as necessary.

Notes

PSHB CR-HMO Carriers:

Your materials must show all proposed benefits for PSHB for the 2026 contract term, including those still under review by your state. We will accept the community benefit package for review that you project will be sold to the majority of your non-Federal subscribers in 2026.

Experience-Rated HMOs

You must file your proposed benefit package (e.g., *Certificate of Coverage or Evidence of Coverage*) and the associated rate with your state, if the state requires it.

Notes

PSHB ER-HMO Carriers:

Carriers that choose to use a Certificate of Coverage that varies from the one submitted with the application must submit the new Certificate and attach a chart with the following information:

- Benefits that are covered in one package, but not the other;
- Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other; and
- The number of subscribers/contract holders who currently purchase each package.

Proposal materials must be submitted in Carrier Connect.

Benefit and Rate Proposal Information for All Carriers

Your benefit and rate proposal must be complete. The timeframes for concluding benefit negotiations are firm and we will not consider late proposals. Your benefit proposal must include:

Benefit Proposal Information	Current PSHB HMO Carriers	New PSHB HMO Carriers	PSHB FFS Carriers
A Signed Contracting Officials Form	Yes	Yes	Yes
A comparison of your 2025 benefit package (adjusted for PSHB benefits) and your 2026 benefit package.	Yes	No	No
Benefit package documentation (See Benefit Changes below).	Yes	No	Yes
A plain language narrative description of each proposed Benefit Change and the revised language for your 2026 brochure.	Yes	No	Yes
A plain language narrative description of each proposed Benefit Clarification and the revised language for your 2026 brochure.	Yes	No	Yes
Benefits package documentation (e.g., complete proposed brochure template with all benefit information).	No	Yes	No
Benefit Difference Comparison Chart In-Network Benefits Spreadsheet	Yes	Yes	No
A copy of your rate proposal. Instructions regarding your rate proposal will be sent in a separate Carrier Letter.	Yes	Yes	Yes
PSHB Carrier Pharmacy Benefit Checklist (See Appendix VIII for instructions).	Yes	Yes	Yes
Drug Formularies. See Appendix IX for the 2026 Formulary Submission Templates	Yes	Yes	Yes
Draft communications to enrollees, including information on the opt out process	Yes	Yes	Yes

Benefit Changes (Current Fee-For-Service plans and HMOs)

Your proposal must include a narrative description of each proposed benefit change. Please use the Benefit Change Worksheets in Appendix III and Appendix IV as the template to submit benefit changes. You must show all

changes, however minor, that result in an increase or decrease in benefits, even if there is no rate change. This must be inclusive of process changes that would impact a member's benefits (e.g., state mandate imposing a limit on opioids due to regulation).

You must respond to each of the items in Information Required for Proposal in the Benefit Change Worksheet format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incomplete Benefit Change Worksheet submissions.

Cost Neutrality

When proposing an increase in benefits, Carriers must propose benefit reductions within the same plan option to offset any potential increase in premium, with limited exceptions as authorized by OPM. As indicated in Carrier Letter 2019-01, OPM will consider Carrier-generated proposals for exceptions to the cost neutrality requirement. For the 2026 Plan Year, these exceptions are as follows:

- **Exception 1:** A Carrier may propose benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:
    - Maintain a meaningful difference between plan options and describe the difference;
    - Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
    - Provide evidence to support that cost neutrality is met in Plan Year 2026.
- **Exception 2:** A Carrier may propose benefit enhancements that are not cost neutral in the current year within a single plan option, if the Carrier can show a strategy to achieve cost neutrality within that option, and eventual savings, in the near-term future (i.e., within three years).

- **Exception 3:** Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.
- **Exception 4:** Any prescription drug benefit changes PSHB Carriers need to make to continue to meet CMS Creditable Coverage requirements in 2026 do not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

PSHB Information Required for Proposal

If you anticipate changes to your benefit package, please discuss them with your Health Insurance Specialist before preparing your submission.

- Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2026" section in a plain language narrative, using active voice, and written from the member's perspective. Show clearly how the change will affect members and the complete range of the change. For instance, if you propose to add inpatient hospital copays, indicate whether the change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, show each change.
- Describe the rationale for the proposed benefit change.
- State the actuarial value in (a) the existing benefit and (b) your overall benefit package. If an increase, describe whether any other benefit change within that plan option offsets the increase. Include the cost impact of the change as a bi-weekly amount for the Self Only, Self Plus One, and Self and Family rates. Indicate whether this is no cost impact, or if the proposal involves a cost trade-off with another benefit and what benefit is being used as the offset. If you are proposing an exception to the cost neutrality requirement, note the exception category (1, 2, 3, or 4) and provide the information necessary to support that exception as described above.

Benefit Clarifications (Current Fee-For-Service plans and HMOs)

Clarifications help members understand how a benefit is covered. Clarifications are not benefit changes and have no premium impact. Please

use the Benefit Clarification Worksheet (Appendix V) as a template for submitting all benefit clarifications.

Information required for proposal:

- Provide the current and proposed language for each proposed clarification and reference all sections and page numbers of the brochure it affects. Prepare a separate Benefit Clarification Worksheet (Appendix V) for each proposed clarification. You may combine more than one clarification to the same benefit, but you must present each one clearly on the worksheet using plain language.
- Explain the reason for the proposed clarification.

> **Note**
>
> If you offered a 2025 PSHB plan benefit package and anticipate significant changes between that and your proposed 2026 PSHB plan benefit package, please discuss them with your Health Insurance Specialist before preparing your submission. Your proposed materials must be submitted in Carrier Connect.

Alternate Benefit Package (Community-Rated HMOs)

OPM will allow HMOs the opportunity to adjust their offering in response to local market conditions. If you choose to offer an alternate benefit package, you must clearly state your business case for the offering. We will accept an alternate benefit package only if it is in the best interest of the Government and PSHB enrollees.

- The alternative benefit package may include greater cost sharing for members to offset premiums.
- The alternative benefit package may not exclude benefits that are required of all PSHB plans.
- Proposals for alternative benefit changes that would fail to meet the minimum value will not be considered.

Please consult with your Health Insurance Specialist and your contact in the Office of the Actuaries regarding any questions about the alternate benefit package. Be sure you refer to the rate instructions to adjust your rate proposal to account for the alternate package.

PSHB rates must be consistent with the Community Benefit Package on which it is based. Benefit differences must be accounted for in your rate proposal, or you may end up with a defective community rate.

Proposed benefits change materials must be submitted in Carrier Connect.

PSHB Benefit Difference Comparison Chart (CR HMOs)

You must complete the PSHB Benefit Difference Comparison Chart (Appendix VI) with the following information:

- Differences in copays, coinsurance, deductibles (subject to/or not), coverage levels (including visit and/or day limits, etc.) between the community benefit and 2026 PSHB proposed packages. In-network benefits are entered on a separate tab than out-of-network benefits.
- Highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 31, 2025, or if they were not specifically addressed in previous negotiations. Remember, you must obtain state approval and submit the documentation to us by June 30, 2025.
- Include whether riders are required within your proposed 2026 PSHB benefit package. Indicate the name of the Community Benefit Package, including the entity noted as having the largest number of non-Federal employee subscribers/contract holders who purchased the 2025 package and who are expected to purchase the 2026 package.

Part II: 2026 Service Area Proposal Instructions for All HMOs

Carriers are required to submit all benefit proposal materials in Carrier Connect; proposal instructions not found within are annotated within each section below. PSHB Carriers must use materials and instructions from Carrier Connect.

Service Area Eligibility

Postal Service employees and Postal Service annuitants who live or work within the approved service area are eligible to enroll in your plan. If you enroll non-PSHB members from an additional geographic area that surrounds, is contiguous with or adjacent to your service area, you may propose to enroll Postal Service employees and Postal Service annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to serve enrollees who work but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your PSHB Program enrollees. OPM will provide model language for stating your policy in your brochure.

Limitations on the Number of Plan Options within a Service Area

A Carrier can offer up to three options, or two options and a high deductible health plan within a continuous service area, per OPM contract.

Although PSHB regulations do not specify a limit on the number of contracts a Carrier may have with OPM, OPM retains discretion to administer PSHB in the best interests of enrollees. OPM aims to minimize administrative burden and unneeded complexity that does not offer quality and valuable choice, including by limiting the number of contracts and options it allows with each Carrier.

We are not entertaining new proposals for more than three options by a Carrier in a service area in the PSHB Program for 2026.

PSHB Carriers with current permitted exceptions should review their contracts and options offered and their 2026 PSHB Proposal should include a consolidation of service areas or plan options and remove overlap or

redundancy to maintain greater overall PSHB Program value. OPM will determine during benefit negotiations if it would be in the PSHB enrollees' best interest to consolidate or terminate any Carrier's PSHB contracts, plans, or options.

Service Area Changes

Current HMO Carriers proposing service area changes and new HMO Carriers proposing changes in their service area since they submitted their application to the PSHB Program should refer to the guidance in this section.

All HMOs must inform OPM of proposed service area changes.

You must provide the following information:

- A description of the proposed expansion area to which you are approved to operate OR the proposed reduced service or enrollment area.
- The proposed service area changes by ZIP code, county, city, or town (whichever applies) and a map of the old and new service areas.
    - Reductions must include a justification for the reduction, an enrollment report for the proposed reduced service area and a report on the aggregate claims paid for the previous two years.
- Provide the exact wording/narrative of how the service area change will be described in the brochure.

Your service area(s) must remain in place for the 2026 contract term.

Healthcare Delivery Network

The information you provide about your provider network(s) must be based on executed contracts. We will not accept letters of intent. All provider contracts must have a "hold harmless" clause that precludes the provider from pursuing or "balance billing" a member for costs in excess of the allowed amount under the plan.

New Enrollment Codes (Community-Rated HMOs)

OPM will assign new enrollment codes as necessary. In some cases, rating area or service area changes require reenrollment by your PSHB members. We will advise you if this is necessary.

Service Area Expansion Criteria

There are areas where our members have more limited choice. Please consider expanding your PSHB service area to all areas in which you have authority to operate. Propose any service area expansion by May 31, 2025. OPM grants an extension for submitting state approval supporting documentation until June 30, 2025.

OPM will evaluate your proposal to expand your service area based on the following criteria:

- Legal authority to operate;
- Adequate choice of quality primary and specialty medical care throughout the service area;
- Your ability to provide contracted benefits; and
- Your proposed service area is geographically contiguous.

You must also provide the following information:

- Your authority to operate in the proposed area. Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and contact information of the person at the state agency who is familiar with your service area authority.
- Reasonable access to network providers. Please provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts. You must include the mental health/behavioral health providers in your reports and identify areas with limited access to those providers separately. You must also submit updated information to OPM by August 31, 2025. The update must reflect any changes (non-renewals, terminations, or additions) in the number of executed provider contracts that have occurred since the date of your initial submission.

New Rating Area (Current Community-Rated HMOs only)

OPM will evaluate your proposal to add a new rating area (or split a current service area) according to these criteria:

- Why the area has been added;
- How it relates to the previous service area (for example, the new rating area is a portion of an existing area that has been split into two or more sections); and
- How your current enrollment will be affected by the addition of this new rating area.

Service Area Reduction Criteria (Current HMOs only)

Reducing a service area to prevent adverse selection in a portion of a previously approved service area, such as a single ZIP code, will not be allowed. In addition, proposals for service areas leaving out a county or ZIP code within a larger covered area will not be allowed.

Please explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain.

OPM will evaluate your proposal to reduce your service area or enrollment area according to the following criteria:

- The reduction proposed eliminates an entire service area.
- The reduction is associated with the following:
    - Significant loss of network providers;
    - Poor market growth;
    - Applies to other employer groups;
    - Applies to consolidation of two or more rating areas (current Community-Rated HMOs only); and
- Splitting rating areas (current Community-Rated HMOs only).

You must also provide the following information:

- All state approvals that apply or are associated with the revised service area. We will not accept service area proposals for the service areas that are not contiguous or consistent with the residence of the Federal population or proposals that seek to provide services only to lower-cost enrollees.

Part III: 2026 New Benefits and Initiatives

Easing Administrative Burden on Enrollees

Online Claims Filing

Carrier Letter 2025-01 directed all Carriers to implement a secure online claim-filing tool that members can access through the Plan's website to:

- Complete and submit fillable claim forms directly;
- Submit supporting documentation for the claim; and
- Acknowledge receipt of filed claims and clearly articulate the timeframe for review and processing.

Carriers must include in their proposals their strategy and operational plan for coming into compliance with this online claim filing requirement no later than the end of Plan Year 2026, including a timeline and a description of the measures that the Carriers plan to utilize to allow secure online claims filing.

Please ensure that forms that require an individual's sex list two options, male and female, and do not make available third options or request "gender identity." This requirement applies to all Carrier forms and documents, not just those related to online claims filing.

Effective Provider Directory Tools

For the 2026 Plan Year, all Carriers should offer members an easy-to-use provider lookup tool accessed by a link displayed on the Carrier's Plan home webpage that can be accessed by both members and prospective enrollees. All Carriers must include in their proposals a URL to the lookup tool and describe any unique features of the tool. OPM will give latitude in tool design to Carriers but, at a minimum, the tool must allow members and prospective enrollees to search for and filter providers by the following criteria:

- Provider Name;
- Name of the practice or group;
- Location(s);
- Network status for each location;
- Sex;
- Specialty, including whether board certified or board eligible;

- Language(s) spoken;
- Whether the provider is accepting new patients; and
- Whether the provider offers telemedicine services.

Carriers must also include in their proposals a detailed description of how they maintain up-to-date information about providers in the lookup tool.

Disputed Claims Information on Carrier's Plan Website

All Carriers should provide easy-to-access information on their website fully explaining the disputed claims process for enrollees. A reference or link to the Plan brochure is insufficient. At a minimum, this web-based information should include a downloadable fact sheet that incorporates the information below:

- A complete description of the disputed claims process, for both post and pre-service medical and pharmacy claims, including the right of members to request reconsideration by the Carrier and to request review by OPM;
- The required deadlines for the member to request reconsideration and to file a disputed claim with OPM and for the Carrier to respond;
- A clear explanation of how and when the member can receive copies of all relevant material used by the Carrier to make its decision; and
- A link to all forms the Carrier provides for a member to use in filing an appeal (all forms should be fillable online).

All Carriers should offer members a variety of ways to file a disputed claim, including secure email, fax, or other secure method. In their 2026 proposals, all Carriers should provide a detailed description of the disputed claims process information that they provide and a URL to the website where enrollees access this information.

Part IV: Continued Focus from Previous Years

Employer Group Waiver Plans (EGWP) – "Equal or Better"

PSHB Employer Group Waiver Plans (EGWPs)
PSHB Carriers must provide documents and explanations to demonstrate how they are implementing EGWP requirements as outlined in 5 CFR § 890.1616 and how they do or will meet each element specified in the PSHB Carrier EGWP Checklist (see Appendix VIII) as a part of their proposals.

Preventive Care – HIV Preexposure Prophylaxis (PrEP)

Please describe in your proposal narrative how you make HIV PrEP medications, associated testing, and follow-up care available without cost-sharing for in-network providers, in accordance with Carrier Letter 2025-01. All formulary submissions should also reflect that HIV PrEP medications are covered with $0 cost-share.

Fertility Benefits

State Laws related to IVF Coverage
Health Maintenance Organizations (HMOs) with service areas in a state with any IVF coverage mandate must include benefits that would satisfy the requirements under state law in their proposals, to the extent permitted by OPM policies.

OPM will exercise discretion in negotiating these benefits to ensure consistency with PSHB Program requirements and policy objectives. To ensure consistency of coverage across a service area, if a plan's service area crosses multiple states, including the District of Columbia, and only one of the states has an IVF mandate, the Carrier must propose to offer the IVF benefit required under that state's law across the service area, even if the enrollee is domiciled in a state with no mandate. If a plan's service area crosses multiple states with different mandates, Carriers must propose a benefit that would satisfy the requirements under all state laws, to the extent that it is not inconsistent. The proposal should include an overview of each state IVF benefit mandate, including citations to and copies of state

statutes, regulations and implementing guidance, and an explanation of how the proposed benefit meets the requirements of all mandates. In all situations, OPM Health Insurance Specialists will work with the Carrier during negotiations to determine the benefit that is most suitable for PSHB enrollees.

Iatrogenic Infertility

As part of your proposals for Plan Year 2026, please include the following information in your proposal submission regarding your fertility benefits:

- An overview of fertility preservation benefits for iatrogenic infertility, including those that go beyond what OPM required for PY 2025;
- Any dollar limits, if applicable, that may impact or limit a member's ability to access the minimum coverage requirements outlined in Carrier Letter 2025-01;
- How your brochures and any other applicable member-facing materials will clearly outline coverage requirements for standard fertility preservation for iatrogenic infertility; and
- How you will ensure that all brochure language clearly distinguishes fertility preservation coverage for iatrogenic infertility from additional fertility benefit coverage available to individuals experiencing infertility for reasons other than iatrogenic causes.

Mental Health Parity and Network Adequacy

Carriers are expected to include in your benefit clarifications and benefit updates the specific changes to your behavioral health networks since your 2025 submission that have resulted in significantly changed member wait times, in-network utilization rates, access for new patients and any other applicable aspects required by the regulatory bodies in which Carriers operate. Additionally, in accordance with Carrier Letter 2021-16, OPM is requiring the following information with your network benefit updates to assure compliance by Carriers on network composition and access as part of any NQTLs for MH/SUD services:

Name and description of any NQTLs;

Any limits for MH/SUD services (include all information on treatment limits [such as limits on the number of days or visits covered] and on other limits such as scope or duration of treatment);

Network composition data for the NQTL, including:

In-network and out-of-network utilization rates

Network adequacy metrics; and

Provider reimbursement rates.

According to the Tri-Department final rule, network-related NQTLs are "standards related to network composition, including but not limited to standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage."

OPM notes that material differences in access related to network composition are a strong indicator of a MHPAEA violation and a possible area for further follow up between OPM and the Carrier.

Further submission information and the MHPAEA submission template will be forthcoming.

Carriers are encouraged to and may populate this template that will be included in the future communication using information from their existing comparative analyses and existing plan proposals required by state regulatory agencies, state departments of insurance or accrediting organizations. In addition, per Carrier Letter 2023-15, OPM reserves the right to request reviews of specific network adequacy or behavioral health modules by accrediting organizations, state departments of insurance, or similar reports by other entities.

Prevention and Treatment of Obesity – Intensive Behavioral Therapy (IBT)

In accordance with Carrier Letter 2025-01A, Carriers are permitted, but not required, to propose revisions or update components of their obesity

benefits. If proposing updates to their obesity benefits, OPM strongly encourages Carriers to emphasize strategies to control or save costs related to obesity prevention and treatment and thus provides the following considerations.

Nutritional and Physical Activity Support

Individuals who receive access to medical nutritional therapy as part of IBT have been shown to achieve greater weight reduction compared to those who did not have access to IBT. IBT for obesity management has shown cost savings related to physician time, medication use, and obesity related costs.[2] Case management as part of IBT that is led by a registered dietitian has been shown to have lower mean health plan costs than usual care, with decreases in obesity related medical costs.[3]

If the member's obesity management journey involves the use of anti-obesity medications, access to supervised physical activity (e.g. in-network certified physical therapist or health coach) to ensure compliance with resistance and strength training to maintain lean muscle mass[4] is strongly recommended.

Frequency of Contact for Intensive, Multicomponent Behavioral Therapy

Carriers are to include coverage for IBT that follows the frequency found in USPSTF B recommendations' evidence-based trials for adults, children, and adolescents. For adult populations, IBT has been shown to be cost saving when session costs align with current Medicare reimbursement rates.[5] IBT programs in the USPSTF recommendations typically last 1 to 2 years, with most featuring 12 or more sessions within the first year. AI chat technology

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[2] Bradley DW, Murphy G, Snetselaar LG, Myers EF, Qualls LG. The incremental value of medical nutrition therapy in weight management. Manag Care. 2013 Jan;22(1):40-5. PMID: 23373140.

[3] Wolf AM, Siadaty M, Yaeger B, Conaway MR, Crowther JQ, Nadler JL, Bovbjerg VE. Effects of lifestyle intervention on health care costs: Improving Control with Activity and Nutrition (ICAN). J Am Diet Assoc. 2007 Aug;107(8):1365-73. doi: 10.1016/j.jada.2007.05.015. PMID: 17659904.

[4] https://www.endocrinepractice.org/article/S1530-891X(20)39214-4/fulltext

[5] Hoerger TJ, Crouse WL, Zhuo X, Gregg EW, Albright AL, Zhang P. Medicare's intensive behavioral therapy for obesity: an exploratory cost-effectiveness analysis. Am J Prev Med. 2015 Apr;48(4):419-25. doi: 10.1016/j.amepre.2014.11.008. Epub 2015 Feb 20. PMID: 25703178.

or app programs can be used as supplemental support for IBT sessions but cannot be substituted for one-on-one nutritional counseling support and IBT.

IBT programs for children and adolescents are often called Family Healthy Weight Programs (FHWP)[6] and have been recognized by organizations such as the CDC and the American Academy of Pediatrics (AAP). Examples of these programs can be conducted at the primary care setting or conducted at community-centered organizations and provide the required 26 or more contact hours over 3 to 12 months.

An updated 2024 table of ICD-10 CM Diagnosis Codes for Adult and Childhood Obesity is in Appendix XI and includes options for services offered by non-physician providers. If third-party obesity management vendors are being included as options for Carriers' obesity benefit, Carriers are encouraged to ensure that the vendors' programming includes but is not limited to coverage for the frequencies of member-provider contact listed in this Technical Guidance.

Intervention Providers and Program Content

For evidence-based, real-world obesity IBT options that provide cost-savings, OPM suggests Carriers consider coverage of in-person or virtual IBT programs that follow curriculum content similar to the CDC National Diabetes Prevention Program (NDPP)[7][8] that can be provided by CDC-certified Lifestyle Coaches (either health professionals or non-licensed personnel).

Medically Necessary Access to Obesity Benefit

While the USPSTF B recommendation for obesity coverage is required only for those with a BMI of over 30, there may be cases where obesity complications can arise in those with a lower BMI.[9] Carriers are encouraged

[6] CDC-Recognized Family Healthy Weight Programs | Family Healthy Weight Programs | CDC
[7] Cost-Effectiveness of the National Diabetes Prevention Program: A Real-World, 2-Year Prospective Study - PubMed
[8] Sweet CC, Jasik CB, Diebold A, DuPuis A, Jendretzke B. Cost Savings and Reduced Health Care Utilization Associated with Participation in a Digital Diabetes Prevention Program in an Adult Workforce Population. J Health Econ Outcomes Res. 2020 Aug 18;7(2):139-147. doi: 10.36469/jheor.2020.14529. PMID: 32884964; PMCID: PMC7458495.
[9] final-appendix.pdf (aace.com)

to provide the same treatment coverage options for at-risk populations at lower BMIs when deemed medically necessary.

Treatment of Gender Dysphoria

As stated in Carrier Letter 2025-01A, Carriers are reminded that they are to account for any corresponding reductions in PSHB premiums that occur with the exclusion of coverage for pediatric transgender surgeries or hormone treatments for the purpose of gender transition. Such reductions should be identified and included in your benefit and rate proposals.

For individuals age 19 or above, Carriers may propose to cover, but are not required to cover, transgender surgeries or hormone treatments for the purpose of gender transition.

Organ/Tissue Transplants

Technology and clinical advancements are continually evolving. Carriers are encouraged to provide coverage during the contract year for transplant services recommended under clinical trials and transplant services that transition from experimental/investigational, consistent with standards of good medical practice in the U.S. for the diagnosed condition. As in past years, we are providing guidance on organ/tissue transplants for 2026. When Carriers determine that a transplant service is no longer experimental, but is medically necessary, they may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year to begin providing such benefits. The following sections are included in the Organ/Tissue Transplants and Diagnoses worksheet found in Appendix X:

- Section 1 – OPM's required list of covered organ/tissue transplants.
- Section 2 – OPM's recommended coverage of transplants under Clinical Trials. All Carriers are to complete and return the worksheet below.
- Section 3 – OPM's recommended list of covered rare organ/tissue transplants. All Carriers are to complete and return the worksheet below.

Summary of Benefits and Coverage

All Carriers must provide a Summary of Benefits and Coverage (SBC) for each plan based on standards developed by the Departments of Labor, Health and Human Services, and the Treasury.

Part V: Appendices

The information required in the following appendices must be completed and returned to OPM as part of your Plan Year 2026 proposal. PSHB Carriers will submit these worksheet appendices as part of their proposal. If you have questions, please contact your Health Insurance Specialist.

PSHB Carriers submit via Carrier Connect completed:

- Appendix II: Carrier Contracting Official;
- Appendix III: Benefit Change Worksheet for Community-Rated HMOs;
- Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs;
- Appendix V: Benefit Clarification Worksheet; and
- Appendix IX: Drug Formulary Templates (see attachments)

Additionally, questionnaires provided in Appendix VIII: Pharmacy Benefit Checklist will be available as prompts for PSHB Carriers in Carrier Connect.

Not all appendices are applicable to each PSHB Carrier. The list and table below organize the appendices by their applicability to Carrier types.

Worksheet Appendix	Applicable to:		
	FFS	Current HMO (ER & CR)	New HMO
Appendix I: Technical Guidance Submission Checklist	Yes	Yes	Yes
Appendix II: Carrier Contracting Official	Yes	Yes	Yes
Appendix III: Benefit Change Worksheet for Community-Rated HMOs	No	Yes, only CR	No
Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	Yes	Yes, only ER	No
Appendix V: Benefit Clarification Worksheet	Yes	Yes	Yes
Appendix VI: PSHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet	No	Yes	Yes
Appendix VII: PSHB Program Statement About Service Area Expansion	No	Yes	Yes

Worksheet Appendix	Applicable to:		
	FFS	Current HMO (ER & CR)	New HMO
Appendix VIII: PSHB Carrier Pharmacy Benefit Checklist.	Yes	Yes	Yes
Appendix IX: Drug Formulary Templates	Yes	Yes	Yes
Appendix X: 2026 Organ/Tissue Transplants and Diagnoses	Yes	Yes	Yes
Appendix XI: 2024 ICD-10-CM Diagnosis Codes for Adult and Childhood Obesity	Yes	Yes	Yes
Appendix XII: Introduction to Carrier Connect	Yes	Yes	Yes

Appendix I: PSHB Carrier Technical Guidance Submission Checklist

Please utilize this checklist for required submissions, to complete your 2026 Benefit and rate proposal.

Not all appendices are applicable to each Carrier. Please refer to the Appendices section and if you have further questions, please contact your Health Insurance Specialist.

Appendix	**Appendix completed and in the proposal?** **Yes/No/NA**
Appendix II: PSHB Carrier Contracting Official	
Appendix III: Benefit Change Worksheet for Community-Rated HMOs	
Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	
Appendix V: Benefit Clarification Worksheet	
Appendix VI: PSHB Benefit Difference Comparison Chart In-Network Benefits (HMOs only)	
Appendix VII: PSHB Program Statement About Service Area Expansion	
Appendix IX: PSHB Carrier Pharmacy Benefit Checklist	
Appendix X: Drug Formulary Templates	
• 2026 Formulary Submission File Template	
• 2026 Formulary Comparison and Cost-Share File Template	
• 2025 Formulary Submission File Template	
Appendix XI: 2026 Organ/Tissue Transplants and Diagnoses	
Appendix XII: 2024 ICD-10-CM Diagnosis Codes for Adult and Childhood Obesity	

*__Note__ that the FEHB Benefit Difference Comparison Chart In-Network Benefits, 2026 Formulary Submission File Template, 2026 Formulary Comparison and Cost-Share File Template, and 2025 Formulary Submission File Template is an Excel Document attached with the 2026 Technical Guidance.

Appendix II: Carrier Contracting Official

The Office of Personnel Management (OPM) will not accept any contractual action from _____ (Carrier), including those involving rates and benefits, unless it is signed by one of the persons named below (including the executor of this form), or on an amended form acceptable by OPM. This list of contracting officials will remain in effect until the Carrier amends or revises it. An updated worksheet should be submitted any time revisions are made.

Please submit this information, via Carrier Connect, containing the signature of the contracting official.

Verifiable digital signatures are acceptable.

The people named in Carrier Connect have the authority to sign a contract or otherwise to bind the Carrier for _____ (Plan).

Enrollment code(s): _____

Typed Name	Title	Signature	Date

Signature of Contracting Officer Date

Typed Name Title

Email Telephone

Appendix III: Benefit Change Worksheet for Community-Rated HMOs

[Insert Health Plan Name]

[Insert Subsection Name]

Please complete the information, via Carrier Connect, for each proposed benefit change.

Please refer to Benefit Changes section to complete the worksheet.

Benefit Change Description

List option(s) this Benefit Change applies to (for example, High or HDHP):

Item	Narrative Description
Current Benefit	
Proposed Benefit	

Item	Narrative Description
Proposed Brochure Language	
Reason	
Cost Impact/Actuarial Value (See Note 1)	
Exception to Cost Neutrality Requested (If applicable; see Note 2)	

Notes:

1. Actuarial Value:
    a. Is the change an increase or decrease in existing benefit package?

    _____

    b. If it is an increase, describe whether any other benefit is offset by your proposal.

    _____

    c. What is the cost impact of this change as a bi-weekly amount for Self Only, Self Plus One, and Self and Family rates?

    _____

If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero as appropriate.

_____

2. Exception to Cost Neutrality: Indicate which exception applies and provide the information as indicated.

Exception 1: A Carrier may propose benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

a. Maintain a meaningful difference between plan options and describe the difference;
b. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
c. Provide evidence to support that cost neutrality is met in Plan Year 2026.

Exception 2: A Carrier may propose benefit enhancements that are not cost neutral in the current year within a single plan option, if the Carrier can show a strategy to achieve cost neutrality within that option, and eventual savings, in the near-term future.

Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.

Exception 4: Any prescription drug benefit changes PSHB Carriers need to make to continue to meet CMS Creditable Coverage requirements in 2026 do

not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

3. Is the benefit change a part of the plan's proposed community benefits package?
    a. If yes, when?

    _____

    b. If approved, when? (Attach supporting documentation)

    _____

    c. How will the change be introduced to other employers?

    _____

    d. What percentage of the plan subscribers now have this benefit?

    _____

    e. What percentage of plan subscribers do you project with have this benefit by January 2026?

    _____

4. If change is not part of the proposed community benefits package, is the change a rider?

    _____

    a. If yes, is it a community rider (offered to all employers at the same rate)?

    _____

    b. What percentage of plan subscribers not have this benefit?

    _____

    c. What percentage of plan subscribers do you project will have this benefit by January 2026?

    _____

    d. What is the maximum percentage of all subscribers you expect to be covered by this rider?

    _____

    e. When will that occur?

    _____

5. Will this change require new providers?

    _____

    a. If yes, provide a copy of the directory that includes new providers.

Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs

[Insert Health Plan Name]

[Insert Subsection Name]

Please complete **a separate worksheet** for each proposed benefit change.

Please refer to the Benefit Changes to complete the worksheet.

Benefit Change Description

List option(s) this Benefit Change applies to (for example, High or HDHP):

Item	Narrative Description
Current Benefit	
Proposed Benefit	

Item	Narrative Description
Proposed Brochure Language	
Reason	
Cost Impact/Actuarial Value (See Note 1)	
Exception to Cost Neutrality Requested (If applicable; see Note 2)	

Notes:

1. Actuarial Value:
    a. Is the change an increase or decrease in existing benefit package?
    b. If it is an increase, describe whether any other benefit is offset by your proposal.
    c. What is the cost impact of this change as a bi-weekly amount for Self Only, Self Plus One, and Self and Family rates?

If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero as appropriate.

2. Exception to Cost Neutrality: Indicate which exception applies and provide the information as indicated.

Exception 1: A Carrier may propose benefit enhancements in one plan option that are offset by reduction in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

a. Maintain a meaningful difference between plan options and describe the difference.
b. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
c. Provide evidence to support that cost neutrality is met in Plan Year 2025.

Exception 2: A carrier may propose benefit enhancement that are not cost neutral in the current year within a single plan option, if the Carrier can show a strategy to achieve cost neutrality within that option, and eventual savings, in the near-term future.

Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.

Exception 4: Any prescription drug benefit changes PSHB carriers need to make to continue to meet CMS Creditable Coverage requirements in 2026 do not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

Appendix V: Benefit Clarification Worksheet

[Insert Health Plan Name]

[Insert Subsection Name]

Please refer to Benefit Clarification section to complete the worksheet.

Note: Clarification help members understand how a benefit is covered; it is not a benefit change. If a benefit is a clarification, there should not be a change in premium.

Benefit Change Description

List option(s) the Benefit Clarification applies to (for example, High or HDHP):

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Appendix VI: – PSHB Benefit Difference Comparison Change (All PSHB HMOs)

The PSHB Benefit Difference Comparison Change is an Excel Spreadsheet included with the Technical Guidance. Please refer to the PSHB Benefit Difference Comparison Chart section and follow the Excel Spreadsheet Template for instructions.

If you have questions, please contact your Health Insurance Specialist.

Appendix VII: PSHB Program Statement About Service Area Expansion

New HMOs and Current HMOs complete this form only if you are proposing a service area expansion. Please refer to the Service Area Expansion section of the 2026 Technical Guidance. If you have additional questions, please contact your Health Insurance Specialist.

We _____ (Plan Name) have prepared the attached service area expansion proposal according to the requirement found in the Technical Guidance for 2026 Benefits and Service Area Proposals. Specifically,

1. All provider Contracts include "hold harmless" provisions that preclude the provider from pursuing or "back billing" a member for fees in excess of the allowed amount under the plan.
2. All provider contracts are fully executed at the time of this submission. We understand that letters of intent are not considered contracts for purposes of this certification.
3. All the information provided is accurate as of the date of this statement.

Signature of Plan Contracting Official

Printed Name

Title

Date

Appendix VIII: PSHB Carrier Pharmacy Benefit Checklist

The following checklist includes a list of items that Carriers must submit via Carrier Connect for review of PSHB pharmacy benefits during proposal season for benefit year 2026.

Carriers must enhance the EGWP benefit such that in all instances the PSHB member receives an equal or better benefit than they would have received if they had the corresponding PSHB benefit alone (i.e., benefits covered, cost-sharing, etc.). This means that PSHB members enrolled in an EGWP must have formulary access to all drugs covered under the corresponding plan option's PSHB formulary and at the same or lower cost-share than they would have otherwise had access to if they were enrolled solely in the PSHB plan. Carriers are reminded that all OPM pharmacy benefit requirements such as coverage of USPSTF Grade A or B recommendations at zero cost share, and coverage of at least one GLP-1 for the treatment of obesity, apply to all PSHB plan options, including PDP and MA-PD EGWPs.

For all carriers, verification of meeting FEHB Program pharmacy benefit standards will be evaluated through a formulary review process. Carriers must provide formularies, documents, and additional descriptions to demonstrate that they will meet each element specified on the checklist. If carriers have questions, they may contact their Health Insurance Specialist and copy OPMPharmacy@opm.gov.

Item	PSHB Carrier's Task
General Information	
1.	Applicable OPM-Carrier arrangement a. Fee-For-Service (FFS) b. Experience-Rated (ER) c. Community-Rated (CR)
2.	Do you subcontract with a pharmacy benefit manager (PBM) to administer pharmacy benefits for EGWP and non-EGWP plan options? If 'yes', identify all subcontracted PBMs. If you subcontract with more than one PBM to administer the pharmacy benefit, identify which aspects of the pharmacy benefit each PBM manages.

Item	PSHB Carrier's Task
3.	Provide all Carrier-PBM contracts to administer pharmacy benefits, including EGWP and non-EGWP products. If you have multiple contracts, provide all contracts in a zip file.
4.	Provide URLs to your online formularies where current and prospective enrollees can easily retrieve such information as drug cost, tiering, formulary alternatives, pharmacy networks, etc. URLs may be submitted at a later date, not to exceed the publication of marketing materials or the start of Open Season, whichever is sooner.
5.	Will preferred and non-preferred network pharmacies be established? If so, describe these networks, including any variable cost-share between preferred and non-preferred in-network pharmacies.
EGWP General Information	
6.	Type of PSHB EGWP being offered a. PDP b. PDP and MA-PD
7.	Describe your arrangement with the EGWP sponsor. Examples may include, but are not limited to: • "xx PBM will administer the MA-PD/PDP plan on behalf of XX Carrier. XX PBM will perform all aspects of plan administration according to CMS and U.S. OPM guidance, including enrollments, claims processing, customer service, appeals, xxx." • "CMS Pays XX PBM per member per month for each member…" • "XX Carrier pays XX PBM per member per month as a subcontractor to administer the benefits.")
8.	CMS PDP and/or MA-PD EGWP sponsorship details a. Organization Legal Name b. Organization Marketing Name c. Organization Type d. Organization Address e. Plan Name f. Plan Geographic Name g. Plan Type h. Contract Number i. Plan Number

Item	PSHB Carrier's Task
EGWP Formularies	
9.	Provide a completed Formulary Comparison for **each** EGWP product being offered. This must be submitted twice for every EGWP offering: (1) By May 31, 2025 – Upon initial proposal. Submission includes the CMS-proposed base formulary and the proposed EGWP enhanced and PSHB non-EGWP (i.e., commercial) formularies. Note: This is required as part of your complete 2026 proposal material for each contract. To this end, only proposed 2026 formulary data can be included in this file. Submissions containing 2025 data will not be accepted. (2) By October 15, 2025 – Final formulary. Submission includes the CMS-approved base formulary, the final EGWP and PSHB commercial formularies. The following file naming convention must be used: ProgramID_AttachmentName_CY26_SourceID_PlanOptionName_EGWPType • Example: PSHB_AttF_CY26_ATOZ_Standard_MAPD • Example: PSHB_AttF_CY26_ATOZ_Standard_PDP You must upload an Excel file.
EGWP Oversight	
10.	Explain how Part D-excluded drugs are covered through the PSHB EGWP.
11.	Did the EGWP sponsor request from CMS any EGWP waivers beyond what CMS publicly offers all EGWP sponsors? If yes, provide documentation and explanations of all requested EGWP waivers, detailing how these waivers will be used.
12.	Explain the EGWP sponsor's policies on formulary management and formulary exceptions. This may include SOPs on the P&T process, inclusion and/or exclusion of drugs on a formulary, tiering determinations, UM edits, etc. Attach any needed documentation to support the response.
13.	For all returning EGWP offerings, describe all incidences of CMS compliance notices within the previous 12 months. Provide documentation of these incidences, including any corrective action plans. For all new EGWP offerings, describe all incidences of CMS compliance notices within the previous 5 years. Provide documentation of these incidences, including any corrective action plans.

Item	PSHB Carrier's Task
EGWP Member Experience	
14.	Describe how pharmacy claims will be adjudicated at the point of sale using a seamless process to the member and the pharmacy. For example, members should not have to use two different cards, and a single ID card can contain only one RxBIN or RxIIN. The explanation must also include any differences in adjudication between Part D-covered and Part D-excluded products covered through the EGWP benefit.
15.	Provide a draft of the letter notifying PSHB EGWP beneficiaries that you intend to enroll them in a PDP through a group enrollment process, that the individual may affirmatively opt out of such enrollment, how to accomplish that, and any consequences to group benefits opting out would bring. Note: The opt-out process must be simple and member friendly; for example, it cannot require wet signature, mailing via USPS, etc.
16.	For members who are enrolled in the PSHB EGWP, are all pharmacy benefits received through the EGWP benefit and formulary?
17.	Will members who are enrolled in the PSHB EGWP have access to and be covered by pharmacy benefits through the corresponding commercial PSHB plan that non-Medicare eligible members have access to and are covered by?
18.	Describe your process for Part B versus Part D coverage determinations.
19.	Describe how you coordinate benefits and adjudicate claims for Part B drugs and supplies that are covered by the EGWP benefit for (1) EGWP members with Part B coverage and (2) EGWP members with Part A only coverage.
20.	Describe the financial liability of a PSHB EGWP pharmacy benefit claim versus a non-EGWP (i.e., commercial) PSHB pharmacy benefit claim. Descriptions for the EGWP pharmacy benefit must include examples for Part-D covered and Part-D excluded claims, and for both the EGWP and non-EGWP pharmacy benefit, examples must include differentiations for each phase of the benefit. Descriptions must be provided for each financially responsible party, including but not limited to the member, carrier, EGWP sponsor, manufacturer, CMS, and OPM.
Attestations	
21.	I attest that the PSHB EGWP is unique and will not include non-PSHB members.

Item	PSHB Carrier's Task
22.	I attest that enrollment materials will provide member education on the potential impact of the income-related monthly adjustment amount (IRMAA) premium.
23.	I attest that we will comply with all Medicare requirements with the exception of benefits under EGWP waivers, in which case we will comply with all OPM requirements, including but not limited to the PBM Transparency standards.
24.	I attest that we will provide summary results of pre-implementation testing and an assurance that corrections have been made for any inconsistencies found. This will be submitted no later than 30 days prior to the beginning of the Contract Year, and any additional pre-implementation testing results will be provided as they are completed.
25.	I attest that every CMS compliance action, including but not limited to compliance letters, notices of non-compliance, warning letters, and corrective action plans, will be provided to OPM within 3 business days of the PDP or MA-PD Sponsor receiving such notice. This notice must be emailed to OPM Pharmacy at opmpharmacy@opm.gov, the OPM Contracting Officer and Health Insurance Specialist.
26.	For Part D-excluded drugs, I attest that we will pass through 100 percent of rebates, indirect and direct subsidies, remuneration, and other payments collected for all Medicare-eligible medical and pharmacy benefits to OPM. Note: This attestation is not applicable to carriers who have a capitated arrangement with OPM.
Additional Information	
27.	Upload any additional information, as necessary, to support your pharmacy benefits proposal.

Signature of Plan Contracting Officer Title

Printed Name Date

Plan Name

Appendix IX: Drug Formulary Template Instructions

Please read and follow the instructions below and the information in the Instructions tabs of 2026 Formulary Submission and Comparison Templates very carefully before providing the requested information to avoid validation rejections or upload difficulties in Carrier Connect. If you have any questions regarding formulary file submissions, please reach out to OPMPharmacy@opm.gov. For Carrier Connect technical issues, please reach out to CarrierConnect@opm.gov. Copy your Health Insurance Specialist. All formulary files must be received by the submission deadline. Considerations will not be given for late submissions due to technical difficulties unless technical assistance was sought before the deadline.

2026 Formulary Submission File Template (Attachment A)

2026 Proposed Formularies

On or before May 31, 2025, all Carriers must submit each of the following 2026 proposed formularies to OPM, using the formulary template included as "2026 Formulary Template.xlsx" with this Technical Guidance Document via Carrier Connect:

- Non-EGWP PSHB Formulary
- CMS Base Formulary
- PDP EGWP Formulary
- MA-PD EGWP Formulary

The proposed formulary files are required as part of your complete 2026 proposal material for each contract. As such, only proposed 2026 formulary data can be included on your proposed formulary files. Formulary files containing 2025 formulary data will not be accepted. Additionally, any proposed formulary changes for CY 2026 including those identified on the benefit change worksheet must be included in these formulary files.

2026 Final Formularies

On or before October 15, 2025, all Carriers must submit each of the following final formularies to OPM, using the formulary template included as "2026 Formulary Template.xlsx" with this Technical Guidance Document via Carrier Connect:

- CMS Base Formulary
- Non-EGWP Formulary
- PDP EGWP Formulary
- MA-PD EGWP Formulary

Carrier Connect Submission Instructions

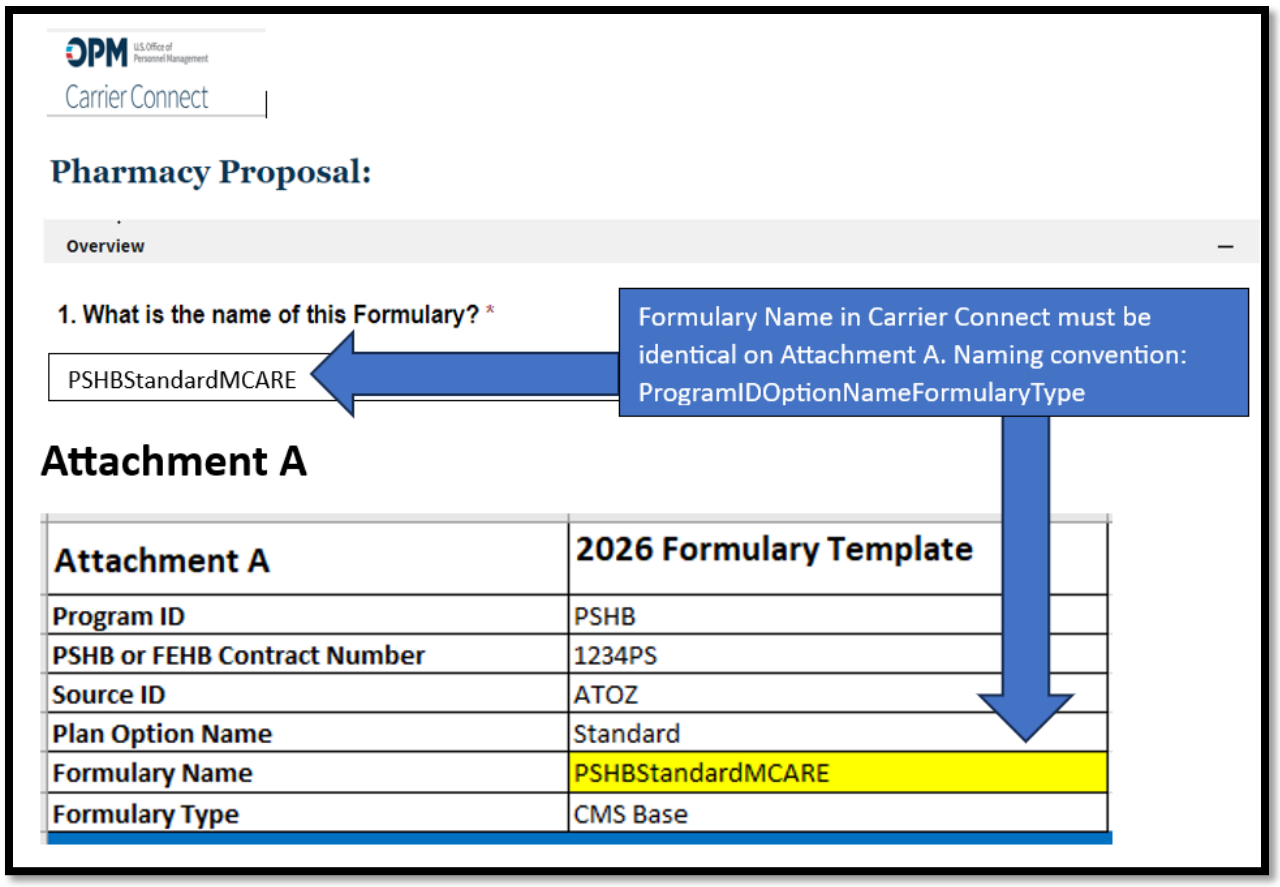
The 2026 Formulary Submission File Template must be used for submitting 2026 proposed and final formulary files in Carrier Connect. Similar to 2024, Carriers will enter formulary descriptors, formulary tiers and cost-shares for each proposed formulary file prior to uploading the 2026 Formulary Submission File in the Pharmacy Proposal Module within Carrier Connect. Generally, formulary descriptors, tiering and cost-shares do not have to be updated after the initial submission deadline in Carrier Connect, if there are no changes to this data between formulary file submissions.

The formulary name on Attachment A must be identical to the formulary name entered in Carrier Connect for each upload (Exhibit A). You must use the following naming convention: ProgramIDOptionNameFormularyType

- Examples:
    - PSHBStandardMCARE
    - PSHBHighMAPD

Do not include any special characters (e.g. ~`!#$%\^&*+=\-\[\]\\';,/{}|\\":<>\?) in the formulary name. Failure to follow these steps will result in the 2026 Formulary Submission File Template being rejected by Carrier Connect.

Exhibit A: Carrier Connect and the 2026 Formulary Submission File Template Formulary Name



The Formulary Type in Attachment A must correspond to the Formulary Type in Carrier Connect:

Attachment A Formulary Type	Carrier Connect **Formulary Type**
CMS Base	CMS – Proposed Base
Non-EGWP Formulary	Commercial
PDP EGWP Formulary	EGWP Enhanced
MA-PD EGWP Formulary	EGWP Enhanced

The following Excel file naming convention must be used when uploading the proposed and final formulary files using the 2026 Formulary Submission File Template in Carrier Connect:

ProgramID_AttachmentName_CY26_SourceID_PlanOptionName_FormularyType

- Examples
    - PSHB_AttA_CY26_ATOZ_Standard_PDP
    - PSHB_AttA_CY26_ATOZ_Standard_CMSBase

Additional submission instructions for the final formulary files will be provided in a separate Carrier communication prior to the October 15, 2025, deadline.

2026 Formulary Comparison and Cost-Share File Template (Attachment F)

2026 Proposed Formularies

On or before May 31, 2025, all Carriers must submit a formulary comparison between the 2026 proposed-CMS base, EGWP, and corresponding PSHB formularies with the relevant formulary tier definitions and cost shares assigned using the comparison template provided as "Formulary Comparison.xlsx" for each EGWP product being offered via Carrier Connect. The 2026 Formulary Comparison Template is required as part of your complete 2026 proposal material for each contract. Only proposed 2026 formulary data can be included in this file. Submissions containing 2025 data will not be accepted. Additionally, any proposed formulary changes for CY 2026 including those identified on the benefit change worksheet must be included in these formulary files.

2026 Final Formularies

On or before October 15, 2025, all Carriers must submit a final formulary comparison between the 2026 final-CMS base, EGWP, and corresponding PSHB formularies with the relevant formulary tier definitions and cost shares assigned using the comparison template provided as "Formulary Comparison.xlsx" for each EGWP product being offered via Carrier Connect.

Carrier Connect Submission Instructions

The proposed 2026 Formulary Comparison file must be uploaded when completing the Pharmacy Benefit Checklist, Item 9, EGWP Formularies on the Questionnaire page of the Pharmacy Module in Carrier Connect.

The following file naming convention must be used when uploading the proposed and final formulary comparison files using the 2026 Formulary Comparison Template in Carrier Connect:

ProgramID_AttachmentName_CY26_SourceID_PlanOptionName_EGWPType

- Examples
    - PSHB_AttF_CY26_ATOZ_Standard_PDP
    - PSHB_AttF_CY26_ATOZ_Standard_MAPD

Additional submission instructions for the final formulary comparison files will be provided in a separate Carrier communication prior to the October 15, 2025 deadline.

2025 Formulary Submission File Template (Attachment G)

All Carriers must provide their plans' full 2025 Non-EGWP, PDP EGWP and MA-PD EGWP formularies as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as "2025 Formulary Template.xlsx" with this Technical Guidance Document. The completed templates must be submitted to Research and Oversight Repository (ROVR) by May 31, 2025. If you have any questions regarding file submission, email OPMPharmacy@opm.gov and ROVRSupport@opm.gov. Copy your Health Insurance Specialists.

ROVR Submission Instructions

The submission process for ROVR is the same as previous years. See Appendix XII: Instructions for 2024 and 2025 FEHB Drug Formulary Information Completion from Carrier Letter 2024-06 for additional instructions. Formulary files will be processed automatically, and incorrect/incomplete files will be rejected. PSHB Carriers must use PSHB identifiers and use the naming conventions in the examples below:

<ProgramID>_<SourceID>_<AttachmentName>_<YearID>_<FormularyID>_<PlanOptionName>_<FormularyType>_<TransferDt>.<FileExtension>

- Examples:
    - PSHB_ATOZ_AttG_2025_ZZA_2025_Standard_PDP.xlsx.pgp
    - PSHB_ATOZ_AttG_2025_ZZA_2025_Standard_MAPD.xlsx.pgp
    - PSHB_ATOZ_AttG_2025_ZZA_2025_Standard_PSHB.xlsx.pgp

Appendix X: 2026 Organ/Tissue Transplants and Diagnoses

The information required in the following appendix must be completed and returned to OPM as part of your Plan Year 2026 proposal. If you have questions, please contact your Health Insurance Specialist.

Section 1: Required Coverage of Organ/Tissue Transplants

A. Solid Organ and Tissues Transplants: Subject to Medical Necessity

- Cornea
- Heart
- Heart – Lung
- Kidney
- Kidney – Pancreas
- Liver
- Pancreas
- Autologous Pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
- Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs such as the liver, stomach, and pancreas) or isolated small intestine
- Lung: Single/bilateral/lobar

B. Hematopoietic Stem Cell Transplant (HSCT)

Since the 2024 Plan Year, OPM has aligned the requirement for hematopoietic stem cell transplant (HSCT) coverage with those of the American Society for Transplantation and Cellular Therapy (ASTCT) as published in 2020[10]. ASTCT is the professional society for hematopoietic stem cell transplantation in the United States. Authors included both adult and pediatric clinicians, as well as payer representatives. ASTCT plans to update this publication on a 3–5-year basis. It is important to note that requirements for PSHB coverage taken from this manuscript are for HSCT

[10] Kanate AS, Majhail NS, Savani BN, et al. Indication for Hematopoietic Cell Transplantation and Immune Effector Cell Therapy: Guidelines from the American Society for Transplantation and Cellular Therapy. Biol Blood Marrow Transplant. 2020. 26 (7) 1247-1256. DOI: https://doi.org/10.1016/j.bbmt.2020.03.002.

only, and no recommendations are made regarding immune effector cell therapy. Since both OPM's previous guidance and ASTCT's manuscript reflect current standards of care and evidence, OPM believes that both documents align, without meaningful difference between them.

Table 1 from the manuscript defines the levels of evidence supporting various indications. OPM recommends that PSHB Carriers cover Standard of Care (S), Standard of Care, Clinical evidence available (C), and Standard of Care, Rare indication (R). Developmental (D) is also recommended for coverage within the context of a clinical trial, and Not generally recommended (N) is not recommended for coverage. **Table 4** from the manuscript lists pediatric indications for HSCT and **Table 5** from the manuscript lists adult (≥ 18 years) indications for HSCT.

Plans must clearly indicate coverage for Blood or Marrow Stem Cell Transplants in their plan brochures under required transplant coverage. Plans may link to the coverage criteria outlined in the manuscript.

Section 2: Recommended for Coverage: Transplants under Clinical Trials

Please return this worksheet with your proposal.

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2026? Yes/No
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	
Multiple myeloma	
Multiple sclerosis	
Sickle Cell Disease	
Beta Thalassemia Major	
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Hodgkin's lymphoma	

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2026? Yes/No
Non-Hodgkin's lymphoma	
Breast cancer	
Chronic lymphocytic leukemia	
Chronic myelogenous leukemia	
Colon cancer	
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease	
Myeloproliferative Disorders	
Myelodysplasia/Myelodysplastic Syndromes	
Non-small cell lung cancer	
Ovarian cancer	
Prostate cancer	
Renal cell carcinoma	
Sarcomas	
Small cell lung cancer	
Systemic lupus erythematosus	
Systemic sclerosis	
Scleroderma	
Scleroderma-SSc (severe, progressive)	

Section 3: Recommended for Coverage: Rare Organ/Tissue Transplants

Please return the worksheet below with your proposal.

Solid Organ Transplants	Does your plan cover this transplant for 2026? Yes/No
Allogenic islet transplantation	

Solid Organ Transplants	**Does your plan cover this transplant for 2026? Yes/No**
Blood or Marrow Stem Cell Transplants	
Allogeneic transplants for:	
Advanced neuroblastoma	
Infantile malignant osteopetrosis	
Kostmann’s syndrome	
Leukocyte adhesion deficiencies	
Mucolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy)	
Mucopolysaccharidosis (e.g., Hunters syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux Lamy syndrome variants)	
Myeloproliferative disorders	
Sickle cell anemia	
X-linked lymphoproliferative syndrome	
Ependymoblastoma	
Ewing’s sarcoma	
Medulloblastoma	
Pineoblastoma	
Waldenstrom’s macroglobulinemia	

Appendix XI: 2024 ICD-10-CM Diagnosis Codes for Adult and Childhood Obesity

Primary Weight-Related Diagnosis

International Classification of Diseases (ICD-10)	Description
E66.3	Overweight
E66.8	Obesity, other
E66.81	Obesity class*
E66.811	Obesity, class 1
E66.812	Obesity, class 2
E66.813	Obesity, class 3
E66.9	Obesity, unspecified
R63.6	Abnormal Weight Gain
Z68	Body mass index [BMI]
Z68.5	Body mass index [BMI] pediatric
Z68.53	Body mass index [BMI] pediatric 85th percentile to less than 95th percentile
Z68.541	Body mass index [BMI] pediatric 95th percentile to less than 120% of the 95th percentile
Z68.542	Body mass index [BMI] pediatric, greater than or equal to 120% of the 95th percentile to less than 140% of the 95th percentile
Z68.543	Body mass index [BMI] pediatric, greater than or equal to 140% of the 95th percentile
Z71.3	Dietary Counseling and Surveillance
Z71.89	Other Specified Counseling

Current Procedural Terminology (CPT)	Description
99078	Physician educational services rendered to patients in a group setting, delivered by a physician

Current Procedural Terminology (CPT)	Description
99202-99205	New patient office or other outpatient visit, 15-29 minutes; 30-44 minutes; 45-59 minutes; requiring high medical decision making
99212-99215	Established patient office or other outpatient visit, 10-19 minutes; 20-29 minutes; 30-39 minutes; 40-54 minutes
99381-99387	New Patient Preventive Medicine Services
99391-99395	Established Patient Preventive Medicine Services Periodic Comprehensive Preventive Medicine Reevaluation and Management
99401-99429	Established Patient Preventive Medicine Services Counseling Risk Factor Reduction and Behavior Change Intervention
99421-99429	Other Preventive Medicine Services

Non-Physician Provider Services

Current Procedural Terminology (CPT)	Description
96160	Administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument for the benefit of the patient, with scoring and documentation, per standardized instrument
97802	Medical nutrition therapy; initial assessment and intervention, individual, each 15 minutes
97803	Medical nutrition therapy; reassessment and intervention, individual, each 15 minutes
97804	Medical nutrition therapy group (2 or more individuals), each 30 minutes
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

Current Procedural Terminology (CPT)	Description
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month
+G0022	Each additional 30 minutes per calendar month
G0023	Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month
+G0024	Each additional 30 minutes per calendar month
G0136	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.
G0140	Principal illness navigation – peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month
+G0146	Each additional 30 minutes per calendar month
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 30 minutes

Current Procedural Terminology (CPT)	Description
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
S9470	Nutritional counseling
S9449	Weight management classes, per session
S9452	Nutrition classes
0591T-0593T	Health and Well-being Coaching face-to-face; individual assessment; individual follow-up, at least 30 minutes; group (two or more individuals), at least 30 minutes

Behavioral Counseling Services

Current Procedural Terminology (CPT)	Description of Service Type of Provider: Behavioral Health (PhD, PsyD, LCSW, LPC, LMFT, or LAC)
G0447	Face-to-face behavioral counseling for obesity, individual, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group, 30 minutes
90832, 34, 37, 47	Psychotherapy, 16-30 minutes; 31-45 min; 46-60 min; family psychotherapy
96127	Brief emotional/behavioral assessment with scoring and documentation, per standardized instrument.
96156	Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
Individual Intervention – Health and Behavior Codes	
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
+96159	Each additional 15 minutes (List separately in addition to code for primary procedure)

Group Intervention	
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
+96165	Each additional 15 minutes (List separately in addition to code for primary procedure)
Family Intervention WITH patient present	
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
+96168	Each additional 15 minutes (List separately in addition to code for primary procedure)
Family Intervention WITHOUT patient present	
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
+96171	Each additional 15 minutes (List separately in addition to code for primary procedure)
Caregiver Behavior Management Training	
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parents(s)/guardian(s)/caregiver(s); initial 60 minutes
+96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parents(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)

Appendix XII: Introduction to Carrier Connect

What is Carrier Connect?

Carrier Connect is OPM's web-based application for Carriers to forward PSHB applications and submit benefit and rate proposals and materials.

This Multi-factor Authenticated (MFA) system will only permit Plan contacts who are assigned as administrators, to submit information to OPM.

How existing Carrier administrators access Carrier Connect

OPM will register existing carriers in Carrier Connect. Carriers will receive account creation information and login instructions by email.

How is it used?

Carriers are to upload the following (in accordance with instructions provided within this Technical Guidance) for each contract:

- Carrier Contracting Officer designation
- Benefit Change Worksheet for Community-Rated HMOs
- Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs
- Benefit Clarification Worksheet
- Benefit Difference Comparison Chart
- Community Benefit Packages
- Proof of State-Approved Benefit Packages
- Alternate Benefit Package, if applicable
- CMS Medicare Part D Waivers
- Drug Formulary Templates & Comparison
- Service Area Changes

As screen prompts, Carriers will respond to:

- Proposed Service Area
- Pharmacy Benefit Checklist questions

Still in Benefits Plus

Carriers should continue to use Benefits Plus to enter contractually required data for the following:

- HEDIS/CAHPS
- Quality Assurance
- Fraud, Waste, and Abuse
- Member Enrollment

Item	Location
PSHB new carrier application	Carrier Connect
PSHB rate proposal submissions	Carrier Connect
PSHB benefit proposal submissions	Carrier Connect
Member Enrollment	Benefits Plus
PSHB brochures	Brochure Creation Tool

Help

General assistance may be found on OPMs Carrier Connect help page. Otherwise, contact CarrierConnect@opm.gov for assistance with:

- Creating a Carrier Connect account
- Using Carrier Connect
- Submitting a PSHB application

Contract concerns are to be addressed with their Health Insurance Specialist.