

# Qualified Health Plan Issuer Application Instructions

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2019

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Version 1

# Contents

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## Introduction: Qualified Health Plans for 2019

As defined in the Patient Protection and Affordable Care Act (PPACA), a qualified health plan (QHP) is an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits (EHBs), follows established limits on cost sharing, and meets several other requirements.

For an insurance plan to be certified as a QHP, issuers must complete and submit a QHP Application for each plan they intend to offer on the Federally-facilitated Exchange (FFE).

## Overview of the QHP Certification Process

Issuers must annually complete the application and certification process and comply with the PPACA and all applicable regulations. To facilitate this process, issuers are encouraged to read all applicable published guidance including the following- which can be found on the [CCIIO website](#):

- Each year, the Centers for Medicare & Medicaid Services (CMS) publishes a [Letter to Issuers](#) before the certification process. This letter provides guidance for issuers seeking to offer QHPs, including stand-alone dental plans (SADPs) in the FFEs or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). Issuers can find key dates for QHP certification, including application deadlines, in **Table 1** of the Letter to Issuers.
- CMS annually provides a [Notice of Benefit and Payment Parameters](#). The notice sets payment parameters that apply to the benefit year and proposes new standards to improve consumers' Exchange experience.
- CMS has also released other relevant guidance and regulations in the past, including the Market Stabilization Final Rule in 2017 and the Patient Protection and Affordable Care Act (PPACA) Exchange and Insurance Market Standards for 2015, and Beyond Final Rule in 2014.

CMS also provides a variety of other guidance on the [Health Insurance Market Reforms](#) and on the [Health Insurance Marketplaces](#) in general.

## QHP Application Submission Process

Issuers should submit their templates and supporting documentation and justifications for all plans they intend to have certified as part of their QHP Application. CMS requires issuers, including those offering SADPs, to submit a completed QHP Application by the initial submission deadline and to make necessary updates before the deadline for issuers to change QHP application.

New for PY2019, the QHP Application Rates Table template deadline is later than the other certification templates' initial submission deadline. Issuers will submit a complete QHP application except for the QHP Rates Table template by the initial submission deadline. Issuers will then submit a QHP Rates Table template by the initial deadline for QHP application Rates Table template to complete their initial QHP application.

CMS relies on a number of systems to automate the data collection and validation process. Issuers use different systems to submit their QHP Application materials, depending on the Exchange model to which their state belongs.

Issuers can reference a list of [Submission Systems](#) for information on the system in which issuers should file their QHP Applications and supporting data.

Issuers applying for QHP certification in FFEs, excluding those in States performing plan management functions, must submit their QHP Applications in the Health Insurance Oversight System (HIOS). Some FFE States use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) to collect plan data, which may include copies of the QHP templates. For issuers applying for QHP certification in FFEs where the State does not perform plan management functions, note that data must be submitted in HIOS, as it will not be transferred to CMS. Issuers in States performing plan management functions, however, should submit QHP Applications in SERFF in accordance with State and CMS review

deadlines. In FFEs where the State performs plan management functions, issuers should work directly with the State to submit all QHP issuer application data in accordance with State guidance. For all FFE states, issuers seeking to offer QHPs must also submit the Unified Rate Review Template (URRT) to CMS via the Unified Rate Review module in HIOS.

## HIOS

All issuers need to register in HIOS to obtain a HIOS Issuer ID and record issuer administrative contact information. Refer to the [HIOS Quick Reference Guide](#) and [HIOS Portal User Manual](#) for more information on registering and navigating through the portal.

The relevant HIOS modules are as follows:

- **Plan Finder Product Data Collection Module:** This is where all issuers submit, review and modify Issuer administrative data. Refer to the [Plan Finder Module User Guide](#) for detailed instructions.
- **QHP Issuer Module:** This is where FFE issuers submit, review, and modify QHP Application data pertaining to Attestations, Licensure and Good Standing, Accreditation, Essential Community Providers and Network Adequacy. The Issuer Module consists of sections that are accessible through tabs to submit the [templates and documentation](#). Refer to the [Issuer Module User Guide](#) for detailed instructions.
- **QHP Benefits and Service Area Module:** This is where FFE issuers submit, review, and modify QHP Application data pertaining to the Plans and Benefits, Service Area, and Formularies. The module allows issuers to submit all necessary information using a web-based user interface and Microsoft Excel templates. Refer to the [Benefits and Service Area Module User Guide](#) for detailed instructions.
- **QHP Rating Module:** This is where FFE issuers submit, review, and modify QHP Application data pertaining to plan rates and business rules. Refer to the [Rating Module User Guide](#) for detailed instructions.
- **Unified Rate Review System Module:** This is where all issuers submit the Unified Rate Review Template. Refer to the [Unified Rate Review System Module User Guide](#) for detailed instructions.
- **QHP Plan Preview Module:** QHP and on-exchange SADP issuers use Plan Preview to view plan data and issuer data similar to the way it will display in Plan Compare on HealthCare.gov. Issuers can refer to the [Plan Preview Module User Guide](#) for more information.

## SERFF

Issuers in states performing plan management functions and State-Based Exchanges (SBE) on the Federal Platform (SBE-FPs) submit their QHP Application through SERFF. Issuers need to contact their state for any additional application requirements.

Questions related to SERFF functionality should be directed to the SERFF Help Desk at [serffhelp@naic.org](mailto:serffhelp@naic.org). For information about state systems, issuers should contact the relevant state.

## QHP Application Sections and Associated Templates

Most sections of the QHP Application require the submission of Excel templates that contain issuer and plan data. **Table 1** lists all required templates according to where they appear in the QHP Application submission process.

Table 1. Required Templates

HIOS Module	Application Area	Template
	Administrative	No template—complete the <i>Issuer General Information</i> fields and the <i>Marketplace General Information</i> fields in the HIOS <a href="#">Plan Finder Module</a>

Table 1. Required Templates

HIOS Module	Application Area	Template
Issuer Module	Program Attestations	No template—FFE issuers respond to attestations in the HIOS Issuer Module Issuers in states performing plan management functions submit the State Partnership Exchange Issuer Program Attestation Response Form in SERFF
Issuer Module	State Licensure (optional)	No template—respond to attestations and upload state licensure documentation in the HIOS Issuer Module
Issuer Module	Good Standing (optional)	No template—respond to attestations and, if necessary, upload documentation in the HIOS Issuer Module
Issuer Module	Accreditation	No template—respond to Terms and Conditions (mandatory) and upload the Quality Improvement Strategy
Issuer Module	Essential Community Providers/Network Adequacy	Essential Community Providers/Network Adequacy Template. ECP data submission is mandatory for all issuers; Network Adequacy data submission is necessary for issuers in network breadth pilot states
Benefits and Service Area Module	Network ID	Network ID Template
Benefits and Service Area Module	Service Area	Service Area Template
Benefits and Service Area Module	Prescription Drugs	Prescription Drug Template
Benefits and Service Area Module	Plans & Benefits	Plans & Benefits Template Plans & Benefits Add-In Plans & Benefits Add-In Change Log
Rating Module	Rates Table	Rates Table Template
Rating Module	Business Rules	Business Rules Template
Unified Rate Review Module	Unified Rate Review	Unified Rate Review Template
	Plan ID Crosswalk	Plan ID Crosswalk Template
	Transparency	Transparency Template

## Supporting Documentation

Issuers may also be asked to submit supporting documentation and justifications as part of the QHP Application process. *Note:* Not all QHP Application sections require the submission of supporting documentation or justifications.

**Table 2** lists the supporting documentation and justifications in each application section; it also includes a description of the files, the submission criteria that determine whether an issuer must submit supporting documentation or a justification, the section to which the supporting documentation or justification applies, and the file-naming convention to be used by issuers when naming the supporting documentation or justification.

Table 2. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
SPE Issuer Program Attestation Response Form (only for issuers in states performing plan management functions)	Provides attestations for issuers in states performing plan management functions who are not able to respond to attestations via HIOS.	Required for all issuers in states performing plan management functions (see Section 1: Program Attestations).	Attestation	12345_SPEIssuer Attestations
Compliance Plan	Provides documentation that the issuer has a compliance plan that adheres to all applicable laws, regulations, and guidance; that the compliance plan is ready for implementation; and that the issuer agrees to reasonably adhere to the compliance plan provided.	Required if a <b>Yes</b> response is provided to the Optional Program Attestation (see Section 1: Program Attestations).	Attestation	12345_Compliance PlanandCoverSheet.pdf
Compliance Plan and Organizational Chart Cover Sheet	Accompanies issuer's compliance plan and identifies the page numbers where the required compliance plan elements are found.	Required if a <b>Yes</b> response is provided to the Optional Program Attestation (see Section 1: Program Attestations).	Attestation	12345_Compliance PlanandCoverSheet.pdf
Organizational Chart	Provides documentation that the issuer has an organizational chart.	Required if a <b>Yes</b> response is provided to the Attestations required of both Medical QHP and SADP issuers (see Section 1: Program Attestations).	Attestation	12345_Organizational Chart.doc
Program Attestation Justification for the Federally-facilitated Exchange	Describes why the issuer is not submitting a compliance plan.	Required if a <b>No</b> response is provided to the Optional Attestations (see Section 1: Program Attestations).	Attestation	12345_Compliance JustificationForm
Licensure Documentation	Provides documentation that the issuer is licensed.	Required if a <b>Yes</b> response is provided to Question 1 or 2 in the HIOS interface (see Section 1: State Licensure). <i>Note:</i> Required only if an issuer chooses to complete the Licensure section.	State Licensure	12345_Certificateof Compliance or 12345_COA or 12345_StateLicense

Table 2. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Good Standing Supplemental Response	Describes how the issuer intends to comply with state solvency standards and provides a justification for noncompliance that explains the conditions that caused the issuer to become financially insolvent.	Required if a <b>Yes</b> response is provided to Question 1 in the HIOS interface (see Section 1: Good Standing). <i>Note:</i> Required only if an issuer chooses to complete the Good Standing section.	Good Standing	12345_GoodStanding SupplementalResponse
Corrective Action Plan	Describes how the issuer intends to respond to corrective actions and provides a justification that explains how a corrective action plan or equivalent document will address the issues identified by the state.	Required if a <b>Yes</b> response is provided to Question 2 in the HIOS interface (see Section 1: Good Standing). <i>Note:</i> Required only if an issuer chooses to complete the Good Standing section.	Good Standing	12345_CorrectiveAction Plan
Accreditation Certificate	Demonstrates that the issuer is accredited.	Optional for all accredited issuers.	Accreditation	[HIOS Issuer ID]_[Name of Accrediting entity]
Quality Improvement Strategy (QIS)	Describes an implementation plan and progress of a payment structure that provides increased reimbursement or other market-based incentives to improve health outcomes of plan enrollees.	Required for QHP issuers that have participated in an Exchange for two or more consecutive years, offering family and/or adult-only medical coverage, and meet the QIS minimum enrollment threshold in the individual market or SHOP Exchange.	The technical guide may be found <a href="#">here</a>	[HIOS Issuer ID]-[Issuer Name]-QIS If submitting more than one QIS: [HIOS Issuer ID]-[Issuer Name]-QIS-[#]

Table 2. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Essential Community Providers Supplemental Response	Describes why the issuer cannot meet the ECP requirements. Justifications for medical ECPs and dental ECPs have different requirements.	For medical ECPs, issuers whose plan network does not include at least 20 percent of available ECPs in the service area, who do not offer a contract to all Indian healthcare providers in the service area, and who do not offer a contract to at least one ECP in each available ECP category in each county in the service area.  For dental ECPs, issuers whose plan network does not include at least 20 percent of available ECPs in the service area and who do not offer a contract to all Indian healthcare providers in the service area.	ECP/Network Adequacy	12345_ECP_supplemental_response  Dual-product issuers should submit two files with the following naming conventions: <ul style="list-style-type: none"> <li>◆ 12345_ECP_supplemental_response_QHP</li> <li>◆ 12345_ECP_supplemental_response_SADP</li> </ul>
Access Plan and Cover Sheet	Cover Sheet and Access Plan that address and reference the 11 areas in the Supporting Documentation table under Section 1E: Essential Community Providers/Network Adequacy. Recommend the Cover Sheet be inserted in front of the Access Plan (as opposed to being a separate document).	QHPs and SADPs that need to submit access plans will be notified directly by email.	ECP/Network Adequacy	12345_Access_Plan 12345_Access_Plan_Cover_Sheet (if Cover Sheet is submitted as a separate document)
Service Area Partial County Supplemental Response	Describes why the issuer cannot provide service to an entire county.	Required if the issuer is requesting a partial county service area.	Service Area	12345_XY_service_area_partial_county
Combined Prescription Drug Supporting Documentation and Justification	Identifies reasons why deficiency occurs in Clinical Appropriateness, Formulary Outlier or in Category/Class Benchmark Count and how they are not discriminatory.	Required if a deficiency occurs in Clinical Appropriateness, Formulary Outlier, or in Category/Class Benchmark Count.	Prescription Drug	12345_XY_combined_drug

Table 2. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Discrimination— Treatment Protocol Supporting Documentation and Justification	Identifies reasons why a drug list may be an outlier in terms of out-of-pocket cost but is not discriminatory.	Required if the out-of-pocket cost is determined to be an outlier.	Prescription Drug	12345_XY_treatment_protocol
Discrimination— Language Supporting Documentation and Justification	Identifies reasons why language identified as discriminatory is not.	Required if language is found to be discriminatory.	Plans & Benefits	12345_XY_discrimination_language
Discrimination— Cost-Sharing Outlier: Supporting Documentation and Justification	Identifies reasons why cost-sharing values found to be outliers should be allowed and are not discriminatory.	Issuers submit in HIOS when the cost-sharing values are identified as outliers at the national and state levels and remain uncorrected; SERFF submission requirements depend on the state.	Plans & Benefits	12345_XY_discrimination_cost_sharing
Unique Plan Design Supporting Documentation and Justification	Describes the reasons that a plan qualifies as unique (it is not compatible with the standard Actuarial Value Calculator) and the methods used to calculate actuarial value (AV).	Required if <i>Unique Plan Design?</i> is <b>Yes</b> .	Plans & Benefits	12345_XY_unique_plan_design
Silver/Gold Supporting Documentation and Justification	Identifies the reasons why the silver/gold plan requirement is not met.	Required for issuers who fail silver/gold plan review.	Plans & Benefits	12345_XY_silvergold
Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification	Describes the methods used to calculate AV and note the certified AV level of pediatric EHB.	Required for all SADP issuers.	Plans & Benefits	12345_XY_SADP_actuarial_value
Stand-Alone Dental Plan—Description of EHB Allocation	Details the methods and specific analysis used to determine the EHB apportionment for pediatric dental.	Required for all SADP issuers.	Plans & Benefits	12345_XY_description_EHB_allocation

### Saving Supporting Documents

Issuers should save supporting documentation and justifications using the file-naming conventions in the last column of the table above. When saving the file, do not include spaces in the file name. A period, a hyphen, and an underscore are the only special characters that can be used for a file name. The file name may include both lowercase and capital letters, and its full path length must not exceed 255 characters if the file is being uploaded to HIOS. The following document formats should be used when uploading supporting documentation and justifications: **.doc**, **.docx**, and **.pdf**.

## Uploading Supporting Documents

Issuers are encouraged, when possible, to upload one version of the supporting documentation and justifications. For example, when the supporting documentation or justification reasoning is the same for multiple products or plans for a particular application section, the products and plans can be listed in one document.

## Review Periods, Revision Process, and Certification

After the close of the initial QHP Application submission window, there will be a review period during which issuers' QHP Applications are checked for compliance with market-wide standards and other regulations.

Following the review period, CMS will send applicants notices summarizing any need for corrections identified during CMS's review. For issuers applying to offer one or more QHPs on-Exchange, these notices will also include critical data errors. The correction notice will provide detailed information regarding which section in the application the error has been found. Further, it will describe how the correction(s) should be addressed to eliminate the error.

During the QHP review period, issuers will be able to make necessary changes to their QHP Applications, including as a response to their notices, and upload revised QHP data templates. After the deadline for issuers to change their QHP Applications and the final review, CMS will conduct outreach to issuers who are required to enter the limited data correction window to correct critical data errors before Open Enrollment. However, CMS expects the data submitted by the deadline for issuers to change QHP applications to be accurate and complete, and any data changes for inaccurate application data will result in a notice of noncompliance. Errors and corrections must be addressed before the affected QHPs may be certified and/or displayed on HealthCare.gov.

New for PY2019, CMS will also offer an optional "early bird" review round. Issuers who submit prior to the early bird deadline will have their applications reviewed before initial submission deadline. For those issuers who participate, the early bird reviews will provide corrections earlier—allowing the opportunity to resubmit and correct errors prior to the initial submission deadline.

CMS's certification determination for the plans listed in the issuer's application is based on the information contained in the application. CMS reserves the right to revisit the certification status of any plan if there are any changes to the information an issuer supplied during the application process. Issuers must notify CMS of any changes to their QHP Application. Issuers' plans may be decertified during the plan year if CMS determines that any of the information contained in the issuer's application is inaccurate or incomplete or that it no longer meets all applicable certification standards, other program requirements, or both.

Please also be advised that CMS may contact issuers at any time as part of its routine monitoring of issuers to ensure ongoing compliance with certification standards and other program requirements. These standards and requirements remain in place throughout the entire plan year.

The determinations described above are based solely on CMS's review of the application for each plan's compliance with QHP certification standards, along with any information received by CMS from the applicable state regulator, including appropriate state approvals. Nothing in the determinations relieves issuers of QHPs or SADPs from the obligation to comply with all applicable state and federal requirements.

## Service Area Data Change Request Process

After the initial submission deadline, issuers cannot make changes to their service area, including as a response to a CMS- or state-identified correction, without CMS approval of a data change request prior to the issuer making the change.

Issuers should note that a change in service area is not always directly related to changes made to the Service Area Template. That is, a change to the Plans & Benefits Template may potentially affect the service area. For example, changing the service area ID associated with a plan from S001 to S002 constitutes a change to service area.

Requests from issuers must be submitted by the deadline listed in the Letter to Issuers, to allow sufficient time for review. All issuers must submit changes to their QHP Applications after the data change requests are approved and before the deadline for issuers to change QHP applications.

The required forms and instructions are located at <https://www.qhpcertification.cms.gov/s/Data%20Change%20Windows>.

## Data Integrity Tool and Review Tools

CMS provides issuers with a number of review tools to check their plans for errors in the QHP Application that would result in correction notices following submission. Issuers should run each of the following tools, as applicable to their issuer type (e.g., SADP, QHP), to identify and correct data errors before uploading materials to HIOS or SERFF. Given the limited review cycle, it is critical that issuers use the tools to ensure that all data submitted are free of errors so that their plans will be reviewed for certification on time. **Table 3** provides a high-level description of each tool's functionality.

Table 3. High-Level Description of Each Tool's Functionality

Tool	Purpose
Data Integrity Tool*	Identifies critical data errors within and across templates. Provides immediate feedback about data, reducing issuer resubmissions. Alerts issuers and state reviewers to irregularities in the template submissions. Imports QHP and SADP data from most application templates. Conducts validation checks beyond the standard HIOS and SERFF checks. Looks across templates for consistency in key fields. Produces error reports that describe the error and its location in the template.
Plan ID Crosswalk Tool*	Checks that the Plan ID Crosswalk Template has been completed accurately, by ensuring that all counties in all FFE plans that were offered in 2018 are included in the crosswalk, the plans are crosswalked to valid 2019 plans, the crosswalk reasons selected are consistent with plan offerings, and the crosswalk is compliant with the regulation in 45 Code of Federal Regulations (CFR) 155.335(j).
Master Review Tool*	Aggregates data from the Plans & Benefits, Service Area, ECP/Network Adequacy, and Prescription Drug templates and serves as a data input file to the other standalone tools.
Essential Community Providers Tool for QHPs	Calculates the total number of medical ECPs an issuer has in each plan's network and compares this to the number of available medical ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235.
Essential Community Providers Tool* for SADPs	Calculates the total number of dental ECPs an issuer has in each plan's network and compares this to the number of available dental ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235.
Non-Discrimination Tool	Performs an outlier analysis for "QHP Discriminatory Benefit Design" as discussed in the 2019 Letter to Issuers. This tool looks at all plans in the state, goes through a group of predetermined benefits, and determines whether any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.
Cost Sharing Tool*	Runs four different checks (when they are applicable to the plan) for cost-sharing standards. This includes Maximum Out-of-Pocket (MOOP) Review, Cost Sharing Reduction (CSR) Plan Variation Review, Expanded Bronze Plan Review, and Catastrophic Plan Review.
Category & Class Drug Count Tool	Compares the count of unique chemically distinct drugs in each USP v6 category and class for each drug list against a state's benchmark.

Table 3. High-Level Description of Each Tool's Functionality

Tool	Purpose
Formulary Review Suite: Non-Discrimination Formulary Outlier Review	Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in 27 USP classes.
Formulary Review Suite: Non-Discrimination Clinical Appropriateness Review	Analyzes the availability of covered drugs associated with certain conditions as recommended in clinical guidelines, to ensure that issuers are offering a sufficient type and number of drugs.

\* Indicates tools that apply for SADP issuers.

## Stand-Alone Dental Issuers

An issuer who participates solely in the dental market—a dental-only issuer—or one who participates in both the medical and dental markets—a dual-product issuer—may offer SADPs. SADP issuers are required to complete a subset of the entire QHP Application.

**Table 4** lists each of the application sections, templates, and supporting documentation that apply to SADP issuers, and in which section their instructions can be found.

Table 4. Instruction Location for Application Sections

Application Section	Instruction Section	Documents Required for SADP Issuers?
Administrative	HIOS Plan Finder Only (no section instructions)	Yes—Complete the <i>Issuer General Information Fields</i> and the <i>Marketplace General Information Fields</i> in the <a href="#">HIOS Plan Finder Module</a>
Program Attestation	Section 1: Program Attestations	Yes—Attestations in HIOS
State Licensure (optional)	Section 1: State Licensure	Yes—Supporting documentation
Good Standing (optional)	Section 1: Good Standing	Yes—Supporting documentation
Accreditation	Section 1: Accreditation	Not required
ECP/Network Adequacy	Section 1: ECP/Network Adequacy	Yes—Template
Network ID	Section 2: Network Identification	Yes—Template
Service Area	Section 2: Service Area	Yes—Template
Prescription Drug	Section 2: Prescription Drug	Not required
Plans & Benefits	Section 2: Plans & Benefits	Yes—Template
Rates Table	Section 3: Rates Table	Yes—Template
Business Rules	Section 3: Business Rules	Yes—Template
Actuarial Value Calculator	Appendix 1: Actuarial Value Calculator	Not required
Plan ID Crosswalk	Appendix 2: Plan ID Crosswalk	Yes—Template
Transparency	Appendix 3: Transparency in Coverage	Yes—Template

Pediatric dental is an EHB that must be offered by all issuers in the individual and small-group markets. If the pediatric dental benefits are covered by an SADP on the Exchange, QHPs in that state are not required to offer the pediatric dental EHBs on the Exchange.

Dental-only issuers and dual-product issuers should use either HIOS or SERFF, as applicable, to complete the relevant application sections and templates.

## Issuer Module

Users of the Issuer Module are assigned to one or both of the following roles: Issuer Submitter, an individual who submits the data necessary to complete the Issuer Module, and Issuer Validator, an individual who will verify that all sections of the Issuer Module are accurate.

This module is divided into various sections with tabs to navigate through the sections listed on the top of the page. There are three tabs to this module: the Data Submitter page, the Data Validator page, and the Final Submission page (see **Figure 1-1**).

Figure 1-1. Three Module Tabs



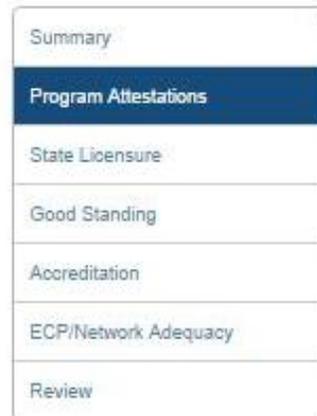
The Data Submitter page allows submitters to work on an existing application or view an already submitted application.

The Data Validator page allows validators to view a list of all the applications that have been submitted. This section also allows validators to upload supporting documentation and answer supplemental responses through HIOS.

The Final Submission page allows users to cross-validate data between modules and submit the QHP Application.

Each tab is broken down further with the information needed to create a new application or edit an existing application. For the Data Submitter page, the Program Attestations, Accreditation, and ECP/Network Adequacy sections must be completed before moving on to the Data Validator page (see **Figure 1-2**). The Licensure and Good Standing sections are optional; Data Submitters are not required to submit these sections to complete the module.

Figure 1-2. Data Submitter Page Selection List



Users can navigate to the Review page at any time using the left navigation links during the submission process. The Review page shows a table listing all sections of the application, the last modified date, and the name of the user who last modified the section (see **Figure 1-3**). The same applies to the Validator page (**Figure 1-4**).

Figure 1-3. Review Page Snapshot

Data Submitter Final Submission

 You have successfully submitted this application

All sections must be completed to the best of your knowledge before being submitted.

**Submitter Sections Table**

Application Sections	Modified Date	Modified By	Status
Program Attestations	01/25/2017 10:36:37 PM	FUNC02	Submission Completed
State Licensure	01/25/2017 10:36:42 PM	FUNC02	Submission Completed
Good Standing	01/25/2017 10:36:47 PM	FUNC02	Submission Completed
Accreditation	01/25/2017 10:36:52 PM	FUNC02	Submission Completed
ECP/Network Adequacy	01/25/2017 10:36:58 PM	FUNC02	Submission Completed

Figure 1-4. Validator Sections Table

Data Validator Final Submission

All sections must be completed to the best of your knowledge before being submitted.

**Validator Sections Table**

Application Sections	Modified Date	Modified By	Status
Program Attestations	01/25/2017 10:36:37 PM	FUNC02	Validation Passed
State Licensure	01/25/2017 10:36:42 PM	FUNC02	Validation Passed
Good Standing	01/25/2017 10:36:47 PM	FUNC02	Validation Passed
Accreditation	01/25/2017 10:36:52 PM	FUNC02	Validation Passed
ECP/Network Adequacy	01/25/2017 10:36:58 PM	FUNC02	Validation Passed

Return to Submitter Previous **Submit Application**

## Section 1A: Program Attestations

### 1. Introduction

In the Program Attestations section, issuers must respond to attestations regarding the intent to comply with FFE requirements. The Program Attestations section of the Issuer Module includes the following four subsections of attestations (in order):

- Attestations required of both Medical QHP and SADP issuers
- Attestations required of Medical QHP issuers only
- Attestations required of SADP issuers only
- Optional Attestations.

These instructions only apply to FFE issuers filing through HIOS. Issuers in states performing plan management functions need to complete and submit the State Partnership Exchange Issuer Program Attestation Response Form through SERFF. The 2019 State Partnership Exchange Issuer Program Attestation Response Form is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations>.

### 2. Data Requirements

To complete this section, issuers need the following information:

1. Company organizational chart: Save the organizational chart using the following naming convention: [HIOS Issuer ID]\_[Title of Document]. For example: "12345\_OrganizationalChart.doc."
2. Company compliance plan.
3. Compliance Plan and Organizational Chart Cover Sheet: The 2019 Compliance Plan and Organizational Chart Cover Sheet is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations>.
  - a. To add the Compliance Plan and Organizational Chart Cover Sheet PDF into an existing compliance plan PDF file, use the Document/Insert Pages function in Adobe Acrobat.
  - b. Merge the Compliance Plan and the Compliance Plan Cover Sheet into a single PDF file and save the document using the following naming convention: [HIOS Issuer ID]\_[Title of Document]. For example: "12345\_CompliancePlanandCoverSheet.PDF."
4. Justification Form, applicable only to those issuers attesting **No** to the optional compliance plan attestation. A blank justification form is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations>. Save the justification form using the following naming convention: [HIOS Issuer ID]\_[Title of Document]. For example: "12345\_ComplianceJustificationForm.PDF."
5. State Partnership Exchange Issuer Program Attestation Response Form, applicable only to issuers in states performing plan management functions submitting in SERFF. The 2019 State Partnership Exchange Issuer Program Attestation Response Form is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations>. Save the form using the following naming convention: [HIOS Issuer ID]\_[SPEissuerAttestations]. For example: "12345\_SPEissuerAttestations.PDF."

### 3. Quick Reference

Key Changes for 2019
<ul style="list-style-type: none"> <li>◆ The attestation language for the “Attestations required of Medical QHP issuers only” subsection has been updated to incorporate the segregation of funds requirement.</li> <li>◆ Issuers are strongly encouraged to submit a compliance plan.</li> <li>◆ Issuers responding <b>No</b> to the optional compliance plan attestation are required to upload a justification form.</li> </ul>

Tips for the Program Attestations Section
<ul style="list-style-type: none"> <li>◆ Issuers must respond to <b>all</b> attestation subsections.</li> <li>◆ Medical QHP-only issuers may respond <b>Not Applicable</b> to the Attestations required of SADP issuers only subsection.</li> <li>◆ SADP-only issuers may respond <b>Not Applicable</b> to the Attestations required of Medical QHP issuers only subsection.</li> <li>◆ All issuers, including those submitting only medical QHPs, only SADPs, or both, are strongly encouraged to respond <b>Yes</b> to the optional compliance plan attestation and upload a compliance plan and the Compliance Plan and Organizational Chart Cover Sheet.</li> <li>◆ All issuers are required to upload supporting documents depending on responses to the attestations.</li> <li>◆ The justification form is <b>only</b> for FFE issuers using HIOS.</li> <li>◆ The State Partnership Exchange Issuer Program Attestation Response Form is only for issuers in states performing plan management functions.</li> </ul>

### 4. Detailed Section Instructions

All issuers and their affiliates seeking to participate in the FFE, including SADP issuers, must complete all program attestations subsections of the application. To complete this section, issuers must respond to all program attestations subsections and, as applicable, upload supporting documentation or justifications.

Attestation Area	Steps
Attestations required of both Medical QHP and SADP issuers	<p>Choose from the following to attest to the attestations in this section:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the issuer agrees to the listed issuer attestation. If <b>Yes</b> is selected, issuers are required to submit the Organizational Chart. Use the document upload feature in the Attestations required of both Medical QHP and SADP issuers subsection and select “Organizational Chart” as the document type.</li> <li>◆ <b>No</b>—if the issuer does not agree to the listed issuer attestation. If <b>No</b> is selected, issuers may still submit an Organizational Chart or “Other” document.</li> </ul> <p><i>Note:</i> All issuers who wish to offer either certified QHPs or SADPs are required to respond <b>Yes</b>.</p>
Attestations required of Medical QHP issuers only	<p>Choose from the following to attest to the attestations in this section:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the issuer agrees to the listed issuer attestation.</li> <li>◆ <b>No</b>—if the issuer does not agree to the listed issuer attestation.</li> <li>◆ <b>Not Applicable</b>—if the issuer is not submitting for Medical QHP certification.</li> </ul> <p><i>Note:</i> Applicants applying to offer medical QHPs are required to respond <b>Yes</b> with regard to those medical QHPs. All applicants not applying to offer medical QHPs should select <b>Not Applicable</b>.</p>
Attestations required of SADP issuers only	<p>Choose from the following to attest to the attestations in this section:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the issuer agrees to the listed issuer attestation.</li> <li>◆ <b>No</b>—if the issuer does not agree to the listed issuer attestation.</li> <li>◆ <b>Not Applicable</b>—if the issuer is not submitting for SADP certification.</li> </ul> <p><i>Note:</i> Applicants applying to offer SADPs are required to respond <b>Yes</b> with regard to those SADPs. All applicants not applying to offer SADPs should select <b>Not Applicable</b>.</p>

Attestation Area	
Optional Attestations	<p>Choose from the following to attest to the attestations in this section:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the issuer agrees to the listed compliance plan attestation. If <b>Yes</b> is selected, submit the Compliance Plan and the Compliance Plan and Organizational Chart Cover Sheet. Use the document upload feature in the Optional Attestations subsection and select “Compliance Plan” as the document type.</li> <li>◆ <b>No</b>—if the issuer does not agree to the listed compliance plan attestation. If <b>No</b> is selected, complete and submit the justification form. Use the document upload feature in the Optional Attestations subsection and select “Other” as the document type. Issuers may still submit a Compliance Plan.</li> </ul> <p><i>Note:</i> CMS strongly encourages all applicants, including those submitting medical QHPs, SADPs, or both, to respond <b>Yes</b> and upload a Compliance Plan and the Compliance Plan Cover Sheet.</p>

The specific attestations for each of the four subsections are shown below.

Attestation Area	Attestation
Attestations required of both Medical QHP and SADP issuers	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 CFR Parts 153, 155, and 156.
Attestations required of Medical QHP issuers only	Applicant agrees to adhere to all applicable requirements in 45 CFR Parts 146, 147, 155, and 156, including those related to the segregation of funds for abortion services.
Attestations required of SADP issuers only	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 CFR Parts 155 and 156.
Optional Attestations	Applicant is submitting a compliance plan that adheres to all applicable laws, regulations, and guidance; that the compliance plan is ready for implementation; and that the applicant agrees to reasonably adhere to the compliance plan provided. The applicant agrees to submit in advance any changes to the compliance plan to the Department of Health and Human Services (HHS) for review. Applicant will upload a copy of the applicant’s compliance plan.

Issuers responding **No** to the optional attestation must provide a justification for why they are not attesting **Yes** to providing a compliance plan. A sample justification form looks like **Figure 1A-1**.



example, issuers may have an Exchange Module as a part of employees' compliance training, or they may develop audit plans to evaluate compliance risks in the Exchange line of business.

A sample partially completed Compliance Plan and Organizational Chart Cover Sheet looks like **Figure 1A-2**.

Figure 1A-2. Sample Compliance Plan and Organizational Chart Review Cover Sheet

<b>QHP Issuer Compliance Plan and Organizational Chart REVIEW COVER SHEET</b>			
<p><i>Issuers will be asked to submit a Compliance Plan and Organizational Chart as part of the application process for certification of qualified health plan(s). The criteria listed below contain minimum requirements for this review. Compliance Plans will be reviewed based on this criteria. Issuers should respond to the evaluation criteria and, where applicable, state the page number where language supporting the response can be found. This initial evaluation and review cover sheet will be used to evaluate the adequacy of the Compliance Plan and Organizational Chart and will assist in the ongoing monitoring of issuer compliance.</i></p> <p><i>Certification of a health plan does not prevent CMS from identifying or addressing weaknesses in the Compliance Plan and/or the Organizational Chart submitted by an issuer as part of its application at a later date.</i></p>			
Evaluation Criteria	Yes	No	Page Number
<b>Compliance Plan and Organizational Chart Submissions</b>			
Applicant included the cover sheet in the QHP Application.	<input checked="" type="radio"/>	<input type="radio"/>	N/A
Applicant uploaded a copy of its Compliance Plan.	<input checked="" type="radio"/>	<input type="radio"/>	N/A
Applicant uploaded a copy of the Organizational Chart.	<input checked="" type="radio"/>	<input type="radio"/>	N/A
<b>Compliance Plan Contents</b>			
<b>A. Written Policies and Procedures</b>			
1. Does the Compliance Plan include a statement that articulates the issuer's commitment to comply with all applicable federal and state rules, regulations, and standards?	<input checked="" type="radio"/>	<input type="radio"/>	13-14
2. Does the Compliance Plan include written standards of conduct for employees?	<input checked="" type="radio"/>	<input type="radio"/>	15
3. Does the Compliance Plan provide guidance for employees, contractors, subcontractors, or other applicable entities on the process for dealing with potential compliance issues?	<input checked="" type="radio"/>	<input type="radio"/>	22

Page 1 QHP Issuer Compliance Plan and Organizational Chart Cover Sheet January 4, 2018

## Section 1B: State Licensure (Optional)

### 1. Introduction

In the State Licensure section, issuers indicate their licensure status and provide documentation that shows they satisfy licensure requirements for the applicable QHP markets, service areas, and products. To verify the licensure information, issuers upload a copy of their state license, certificate of authority (COA), certificate of compliance, or an equivalent form or document for each state in which they seek QHP certification. An issuer may still apply for certification if it has not yet obtained documentation and would then submit evidence of licensure during the QHP Application resubmission window. These instructions apply to QHP and SADP issuers.

## 2. Data Requirements

To complete this section, issuers need one of the following:

1. State license
2. COA
3. Certificate of compliance
4. A form or document equivalent to one of the above.

## 3. Quick Reference

### Key Changes for 2019

- ◆ The Licensure section is optional for the 2019 QHP Application.

### Tips for the Licensure Section

- ◆ Issuers provide licensure documentation for all products and service areas in which they intend to offer a QHP. This applies to all licensed issuers, including any affiliated or other issuers underwriting the dental benefits that the QHP proposes to offer.
- ◆ Issuers submit **one** form of licensure documentation (state license, COA, certificate of compliance, or the equivalent).
- ◆ If the issuer is not yet licensed and therefore unable to provide licensure documentation during the initial application submission, the issuer submits evidence of licensure during the QHP Application resubmission window.
- ◆ Save documents using the following naming convention: [HIOS Issuer ID]\_[Title of Document], for example, "12345\_StateLicense.doc," "12345\_COA.doc," or "12345\_CertificateofCompliance.doc."

## 4. Detailed Section Instructions

Licensure Question	Steps
Does the applicant have either a license, COA, certificate of compliance, or equivalent form or document authorizing it to offer every product type in every service area that it is currently applying for in the identified state?	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the applicant is licensed for every product type and every service area for which it is applying. If <b>Yes</b> is selected, upload supporting documentation.</li> <li>◆ <b>No</b>—if the applicant is <i>not</i> licensed for every product type and every service area for which it is applying. If <b>No</b> is selected, proceed to the next step.</li> </ul>
Does the applicant have either a license, COA, certificate of compliance, or equivalent form or document for some but not all products, or some but not all service areas, for which the applicant is currently applying in this QHP Application?	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the applicant is licensed for some but not all product types or service areas for which it is applying. If <b>Yes</b> is selected, upload supporting documentation.</li> <li>◆ <b>No</b>—if the applicant is <i>not</i> licensed for any of the product types or service areas for which it is applying. If <b>No</b> is selected, enter the estimated date of licensure.</li> </ul>

## Section 1C: Good Standing (Optional)

### 1. Introduction

In the Good Standing section, an issuer demonstrates compliance with all applicable state solvency and regulatory requirements. An issuer must be licensed in the state for which it is applying to satisfy the good standing standard. These instructions apply to QHP and SADP issuers.

## 2. Data Requirements

If an issuer does not comply with the good standing standard, the following information is provided:

1. If applicable, a description of how the issuer will comply with state solvency requirements
2. If applicable, a description of how the issuer will respond to corrective actions.

## 3. Quick Reference

### Key Changes for 2019

- ◆ The Good Standing section is optional for the 2019 QHP Application.

### Tips for the Good Standing Section

- ◆ If the issuer does not comply with the state solvency requirements or the issuer is under corrective action related to financial review, it completes supporting documentation and provides a justification.
- ◆ Save documents using the following naming convention: [HIOS Issuer ID]\_[Title of Document], for example, "12345\_GoodStanding.doc."

## 4. Detailed Section Instructions

Good Standing Questions	Steps
1. Is the applicant seeking QHP certification for this state currently out of compliance with any applicable state solvency requirements for the calendar year in which it is applying to offer QHPs?	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the applicant does <i>not</i> comply with state solvency requirements. If <b>Yes</b> is selected, supporting documentation and a justification are submitted. Upload the supporting documentation in the Good Standing Module and select “Solvency Compliance” as the document type.</li> <li>◆ <b>No</b>—if the applicant <i>complies</i> with state solvency requirements. If <b>No</b> is selected, proceed to the next step.</li> </ul>
2. Is the applicant currently under any corrective action related to financial review?	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the applicant <i>is</i> under corrective action related to financial review. If <b>Yes</b> is selected, supporting documentation and a justification are submitted. Upload the supporting documentation in the Good Standing Module and select “Corrective Action” as the document type.</li> <li>◆ <b>No</b>—if the applicant is <i>not</i> under corrective action related to financial review. If <b>No</b> is selected, proceed to the next section of the application.</li> </ul>

Issuers who do not comply with the good standing standard submit supporting documentation and a justification.

### Good Standing Supporting Document

If the response to question 1 is **Yes** (the issuer does *not* comply with state solvency standards), the issuer uploads a description of how it intends to comply and provides a justification for noncompliance.

- ◆ The description should include the following:
  - List of solvency requirements with which the issuer currently does not comply
  - Detailed explanation of the plan to comply
  - Time frame for complying.

The justification should explain the conditions that caused the issuer to become financially insolvent (such as insufficient premium income or catastrophic medical expenses).

If the response to question 2 is **Yes** (the issuer *is* under corrective action), the issuer uploads a description of how it intends to respond to corrective actions and provides a justification.

- ◆ The description should include the following:
  - List of corrective actions issued
  - Detailed explanation of the plan to respond to corrective actions
  - Time frame for implementing the corrective actions plan.

The justification should explain how a corrective action plan or equivalent document will address the issues identified by the state.

## Section 1D: Accreditation

### 1. Introduction

In the Accreditation section, an issuer enters information to satisfy the accreditation QHP certification requirement. Issuers can provide information for an accredited product in the Commercial, Medicaid, or Exchange markets. These instructions apply only to FFE QHP issuers filing through HIOS.

Issuers in states performing plan management functions and SBE-FP states should comply with the requirements for accreditation data collection specified by their state.

### 2. Data Requirements

To complete this section, an issuer needs the following information:

1. Information about which accrediting entity the issuer is accredited by—the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC) or the Accreditation Association for Ambulatory Health Care (AAAHC)
2. The Quality Improvement Strategy (QIS).

### 3. Quick Reference

#### Key Changes for 2019

- ◆ The accreditation templates (i.e., AAAHC, NCQA, and URAC) are removed.
- ◆ Issuers are no longer required to submit accreditation certificate(s) with their application. Submitting accreditation certificate(s) is now optional.

#### Tips for the Accreditation Section

- ◆ If an issuer is entering its initial year of QHP certification, it must schedule (or plan to schedule) a review with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). An issuer is not required to be accredited in its initial year of QHP certification.
- ◆ Any information provided on accredited products must be for the same legal entity in the same state that submits the QHP Application.
- ◆ If an issuer is entering its fourth consecutive year of QHP participation, it must be accredited in the Exchange market and with one of the following statuses:
  - AAAHC: Accredited
  - NCQA: Excellent, Commendable, Accredited, or Provisional
  - URAC: Full or Conditional.
- ◆ An issuer must provide its accrediting entities with the issuer legal name and HIOS Issuer ID used in its QHP Application to ensure the correct name is used on its accreditation certificate(s).
- ◆ Use the following naming convention for the accreditation certificate: [HIOS Issuer ID]\_[Name of Accrediting entity], for example, “12345\_NCQA.pdf.”

#### 4. Detailed Section Instructions

Accreditation Questions	Steps
Does the applicant currently have any Commercial, Medicaid, or Marketplace health plans in this state, [state of issuer identified], accredited by a HHS recognized accrediting entity?	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the issuer has existing health plan accreditations on any products in the Exchange, Commercial, or Medicaid market from NCQA or URAC. Dual issuers with an accredited medical plan should also select <b>Yes</b>. Proceed to the next step.</li> <li>◆ <b>No</b>—if the issuer is accredited by AAAHC, is offering SADPs, or is not currently accredited by NCQA or URAC.</li> </ul>
Issuers who respond <b>Yes</b> to the above question must then select the accrediting entity.	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>NCQA</b>—if the issuer is accredited by NCQA.</li> <li>◆ <b>URAC</b>—if the issuer is accredited by URAC.</li> <li>◆ <b>NCQA &amp; URAC</b>—if the issuer is accredited by both NCQA and URAC.</li> </ul>

After responding to the above question, issuers will be asked to complete the Terms and Conditions attestation, regardless of whether they are accredited.

Accreditation Attestation	Step
Terms and Conditions	Check the “I agree to the terms and conditions” box.

Issuers may upload copies of their accreditation certificates into HIOS.

Accreditation Certificate	Steps
Scan Certificate	Scan each accreditation certificate (one per accredited market type). If an issuer is accredited by NCQA and does not have a copy of its accreditation certificate, use the NCQA Interactive Survey System (ISS) to get a copy of the survey results. Log into ISS, click on the Results tab, view the survey results, and print the results screen.
Name File	Use the following naming convention for the certificate: [HIOS Issuer ID]_[Name of Accrediting entity], for example, “12345_NCQA.pdf.”
Upload Certificate	Upload the saved file(s) in the Accreditation section of the HIOS Issuer Module. Refer to the Issuer Module User Guide for details on how to complete this.

Figure 1D-1 through Figure 1D-5 show sample accreditation certificates.

Figure 1D-1. Sample NCQA Accreditation Certificate



Figure 1D-2. Sample URAC Accreditation Certificate



Figure 1D-3. Sample AAAHC Accreditation Certificate



If an issuer is unable to locate the NCQA certificate, use the NCQA ISS to obtain a copy of the survey results. Log into ISS, click on the Results tab, view the survey results, and print the results screen. **Figure 1D-4** and **Figure 1D-5** show sample NCQA ISS survey results.

Figure 1D-4. Sample NCQA ISS Survey Results, Page 1

**How to View Results?**

**Step 1:**      *Login to ISS*

**Step 2:**      *Click Results Tab to View*



**2013 Standards and Guidelines for the Accreditation of Health Plans**

Welcome to the Interactive Survey System!

The information in the following sections includes:

- the complete Standards
- information about how your organization will be evaluated against the Standards
- policies and procedures

We designed the system to facilitate understanding of our Standards and the evaluation process. The "Help and Instructions" section above directs users to assistance.

**Policies and Procedures** - This section provides an overview of the survey option you have selected; it describes the goals and principles that guide our approach to evaluation, and provides a high-level summary of areas addressed by the Standards.

The Policies and Procedures describe:

- eligibility criteria, evaluation options; the interactive survey process
- the structure of the Standards and Guidelines and the Survey Tool
- how we report survey results; and obligations of organizations and individuals undergoing a survey.

**Standards and Guidelines** - This section allows you to open or download printable versions of publications.

**Survey Tool** - This section includes the Standards used for evaluation. Standards are organized into categories or functions. Included are:

- the Standards
- the elements that specify how Standards are scored and evaluated
- specific scoring rules for each element
- data sources needed to support scoring
- the scope of review for each element and
- additional explanation and examples.

The Survey Tool allows you to evaluate yourself just as we will evaluate you, but at your own pace. You may score yourself, attach the necessary documentation and make comments. Following your readiness evaluation, if you elect to apply for and undergo a survey you submit the Survey Tool and begin the process. During the survey, your assessment and documentation will be reviewed to determine your performance against the Standards.

**Organization Background** - This section allows you to provide background, historical and other contextual information to us to assist during a survey. This information is not evaluated or scored but is used to help us understand your organization.

**Results** - As you complete the Survey Tool this section provides summarized and detailed results. Results are final only

Figure 1D-5. Sample NCQA ISS Survey Results, Page 2

**Step 3: View Results Page**

**2013 Standards and Guidelines for the Accreditation of Health Plans**

Select an evaluation option for which to view results.

Name:

Evaluation Option: Interim Survey

Standards Year: 2013

Product Line/Product	Overall Score	Status	Valid Dates

\*Reports and numeric results are not final and may not be made public until NCQA's Review Oversight Committee evaluates them. The organization may not represent that it has achieved any endorsement or approval, or that it is in compliance with any standards or is NCQA Accredited based on reports or numeric results from the readiness evaluation without a final decision as described in the Policies and Procedures.

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## Section 1E: Essential Community Providers/Network Adequacy

### 1. Introduction

In the ECP/Network Adequacy section, issuers demonstrate that they meet the requirements of sufficient number and geographic distribution of ECPs, as well as collect provider data in each network associated with a QHP. These instructions apply to QHP and SADP issuers.

### 2. HIOS Interface

The ECP/Network Adequacy section of the HIOS Issuer Module will consist of two questions (note the numbering corresponds to the HIOS screens). Issuers must respond to all attestations in the Issuer Module.

1. Does the applicant meet the General ECP Standard or the Alternate ECP Standard (as defined in the annual Letter to Issuers)?
  - a. In order to meet the General ECP Standard, the applicant has
    - i. contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network;
    - ii. offered contracts in good faith to all available Indian healthcare providers in the plan's service area for the respective QHP certification plan year; and
    - iii. offered contracts in good faith to at least one ECP in each ECP category in each county in the service area for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants).
  - b. In order to meet the Alternate ECP Standard, the applicant has
    - i. contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network; and
    - ii. offered all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the General ECP Standard, or otherwise offered a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area (not applicable to SADP applicants).

**Yes.** (Answer **Yes** if the applicant meets the ECP requirements listed above.)

**No.** (Answer **No** if the applicant does not meet the ECP requirements listed above. Applicants answering **No** are required to submit a supplemental ECP response.)

2. Does the applicant use a provider network (and therefore required to submit an ECP/Network Adequacy Template)?

**Yes.**

**No.**

### 3. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID.
2. Issuer state.
3. Completed Network ID Template.
4. If completing the NA portion of the template, a list of providers in each of the proposed networks, including providers outside the service area (such as in contiguous counties, even if they are across state lines). If a provider is in-network and enrollees can access that service, include the provider name,

National Provider Information (NPI), specialty and facility type, street address of the location providing services, city, state, county, and ZIP code.

*Note:* This section is required only for issuers notified by email that they need to provide this information. All other issuers do not need to populate the Network Adequacy sections of the template.

5. A list of ECPs in each of the proposed networks, including the provider name, NPI, ECP category, street address of the location providing services, city, state, county, ZIP code, number of contracted providers, and associated issuer network IDs.
6. An ECP Write-in Worksheet (as applicable).
7. Supplemental ECP Response—QHP (as applicable).
8. Supplemental ECP Response—SADP (as applicable).
9. Access Plan with Cover Sheet (issuers who are required to submit access plans will be notified by email).

#### 4. Quick Reference

##### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

##### Tips for the ECP/Network Adequacy Section

###### General

- ◆ Issuers must complete the “**Issuer Information**” section on the **User Control** tab before creating and entering the rest of their data into the other tabs.
- ◆ Issuers **should not** change the file names on their ECP/Network Adequacy files after finalizing the template. This file-naming convention allows CMS to easily identify an issuer’s ECP/Network Adequacy Template. Changing the file name could cause the issuer to receive a correction notice.
- ◆ Complete the Network ID Template before completing the ECP/Network Adequacy Template.
- ◆ The PY2019 ECP/Network Adequacy Template includes the ability to delete rows.

###### ECP Updates

- ◆ Issuers will provide hospital bed-count information as part of the ECP portion of their ECP/Network Adequacy Template.
- ◆ Issuers will be evaluated against a 20 percent ECP standard.
- ◆ The Available ECP Write-in List for purposes of the PY2019 QHP Certification Process will be made available within the Draft PY2020 ECP List.

###### Network Adequacy Updates

- ◆ Except for medical issuers in network breadth pilot states who will be notified by email, issuers are **not** required to submit network adequacy data (Individual and Facility/Pharmacy) via the ECP/Network Adequacy Template. **Medical issuers who are notified by email that they are in a network breadth pilot state must submit the network adequacy data.**
- ◆ Network adequacy justifications will not be requested by CMS.
- ◆ If a QHP and SADP issuer is required to submit an Access Plan with Cover Sheet, they will be notified by email. Access plans must be uploaded as Supporting Documents (see the Supporting Documents table at the end of this section for details). As noted, issuers required to submit an Access Plan will be notified by email.

## 5. Detailed Section Instructions

User Control Tab	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Source System	Select the name of the system used to submit the QHP Application: <ul style="list-style-type: none"><li>◆ <b>HIOS</b>—if the user is an FFE issuer.</li><li>◆ <b>SERFF</b>—if the user is an issuer in a state performing plan management functions.</li></ul>
State	Select the state in which the issuer is applying to offer QHPs using the drop-down menu.
Is this an Alternate ECP Standard Issuer?	Choose from the following options: <ul style="list-style-type: none"><li>◆ <b>Yes</b>—if the user is an alternate ECP standard issuer as described under 45 CFR 156.235(b).</li><li>◆ <b>No</b>—if the user is a general ECP standard issuer.</li></ul>

A sample completed **User Control** tab looks like **Figure 1E-1**.



**ECPs:**

Select ECPs Tab	Steps
Filter ECPs	The columns on the <b>Select ECPs</b> tab can be filtered to make selecting ECPs easier. For example, filter the Site State column to show only ECPs available in the issuer's state. SADP issuers may want to filter on Column F, ECP Category, for any provider with "Dental Providers" listed to display only dental providers.
Add ECPs	<p>Double-click anywhere on the row for the ECPs the user wants to add to the ECP tabs. Once selected, the row will be highlighted in blue and "add" will appear in the Add ECP? column. Continue selecting the ECPs until all contracted ECPs from the ECP list are selected.</p> <ul style="list-style-type: none"> <li>◆ To unselect an ECP, double-click on the selected row. The blue highlighting will be removed, and the ECP will not be added to the ECP tabs.</li> <li>◆ To clear <i>all</i> selected ECPs, click the <b>Clear All</b> button at the top of the tab, and all highlighted ECPs will be deselected and will not be added to the ECP tabs.</li> <li>◆ To show only those ECPs that have been selected, click the <b>Show Selected ECPs</b> button at the top of the tab, and all highlighted ECPs will be displayed. To undo this action and show all ECPs, click the <b>Show All ECPs</b> button.</li> </ul>
Insert ECPs	<ul style="list-style-type: none"> <li>◆ Click the <b>Insert Selected ECPs</b> button. The selected ECPs will be added to the <b>Facility ECPs</b> tab (providers with more than one full-time-equivalent [FTE] practitioner and inpatient hospital providers) or the <b>Individual ECPs</b> tab (providers with one or fewer FTE practitioners) of the ECP/Network Adequacy Template. The template will not populate duplicate ECPs into the <b>Facility ECPs</b> or <b>Individual ECPs</b> tabs. The issuer must complete any field within the <b>Facility ECPs</b> tab and <b>Individual ECPs</b> tab that is not populated from the <b>Select ECPs</b> tab before the template is validated.</li> <li>◆ For each ECP facility that was selected and inserted from the <b>Select ECPs</b> tab, a record will be added to the <b>Facility ECPs</b> tab that includes the following: the row number, NPI, facility name, provider name, street address, city, state, ZIP, county, and ECP category.</li> <li>◆ For each individual ECP that was selected and inserted from the <b>Select ECPs</b> tab, a record will be added to the <b>Individual ECPs</b> tab that includes the following: the row number, NPI, name of provider, specialty type, street address, city, state, ZIP, county, and ECP category.</li> </ul>

A sample **Select ECPs** tab looks like **Figure 1E-2**.

Figure 1E-2. Sample ECPs Tab

Add ECP?	Row Number	Site Name	Organization Name	National Provider Identifier	ECP Category (General ECP Standard Issuers Only)	Number of Medical FTEs or Bed Count	Number of Dental FTEs	Site Street Address 1	Site Street Address 2	Site City	Site State	Site Zip Code	
	201800002	Adak Medical Clinic	EASTERI ALEUTIAN TRIBES	1265796094	Community Mental Health Centers, Dent	8		1 2105 Main St	PO Box 2105	Adak	AK	99546-2105	
ADD	201800003	Akhiok Village Clinic	KODIAK AREA NATIVE ASSO	1205883907	Dental Providers, Federally Qualified Hea	1		1 3rd Ave		Akhiok	AK	99615	
	201800004	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1447477815	Indian Health Service, Other ECP Provide	1		0 Main St	PO Box 51089	Akiachak	AK	99551-0089	
	201800005	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1447477815	Indian Health Service, Other ECP Provide	1		0 148 Post Rd	PO Box 216	Akiak	AK	99552	
ADD	201800006	ANESIA KUDRIN MEMORIAL C	Eastern Aleutian Tribes, Inc.	1558423392	Community Mental Health Centers, Dent.	1		1 113 Main St	PO Box 113	Aktutan	AK	99553-0113	
	201800007	Yukon-Kuskokwim Health Corp	YUKON-KUSKOKWIM HEALTH	1447477815	Indian Health Service, Other ECP Provide	1		0 Anderson Street Clinic Drive	PO Box 288	Alakanuk	AK	99554-0288	
	201800008	ALLAKAKET HEALTH CLINIC	Tanana Chiefs Conference (DEH	1821201278	Community Mental Health Centers, Dent.	0.2		0 02 Koyukuk River Junction		Allakaket	AK	99720	
ADD	201800009	SVT Health & Wellness	SELDOVA VILLAGE TRIBE	1338178847	Federally Qualified Health Centers	1		0 34361 Old Sterling Hwy		Anchor Point	AK	99558-9500	
	201800010	Qayana Club House	Southcentral Foundation	1144274986	Other ECP Providers, Tribal Health Progr	0.9		0 225 Eagle St		Anchorage	AK	99501-2626	
ADD	201800011	Pediatric Cardiology of Alaska	Pediatric Cardiology of Alaska	1528203551	Other ECP Providers	2		0 3841 Piper St	Suite T345	Anchorage	AK	99508-4694	
	201800012	Bleeding Disorder Center of Alat	Yukon-Kuskokwim Health Corp	1093956278	Hemophilia Treatment Centers	5		0 3851 Piper St	Suite U120	Anchorage	AK	99502	
ADD	201800013	The Pathway Home	Southcentral Foundation	1639102882	Inpatient Hospitals (other than children's	30		0 4000 San Ernesto Ave		Anchorage	AK	99508-2874	
	201800014	Anchorage Health Center	Planned Parenthood of the Gre	1083700686	Family Planning Providers, Sexually Tran	2		0 4001 Lake Otis Plwy	Suite 101	Anchorage	AK	99508-5200	
	201800015	Dena A Coy Residential	Southcentral Foundation	1194678559	Inpatient Hospitals (other than children's	14		0 4130 San Ernesto Ave		Anchorage	AK	99508-2875	
	201800016	Alaska Native Medical Center	Southcentral Foundation	1437189339	Other ECP Providers, Tribal Health Progr	136.5		0 4315 Diplomacy Dr		Anchorage	AK	99508-5926	
ADD	201800017	Alaska Native Medical Center	Alaska Native Tribal Health Con	1437368891	Dental Providers, Family Planning Provid	1		14 4315 Diplomacy Dr		Anchorage	AK	99508-5926	
	201800018	Alaska Native Medical Center	Alaska Native Tribal Health Con	1437368891	Indian Health Service, Inpatient Hospitals	167		0 4315 Diplomacy Dr		Anchorage	AK	99508-5926	
	201800019	SCF ANMC CLINIC	SOUTHCENTRAL FOUNDATIO	1861533408	Dental Providers	0		1 4315 Diplomacy Dr		Dental Clinic	Anchorage	AK	99508-5926
	201800020	Anchorage Native Primary Care	Southcentral Foundation	1124064894	Community Mental Health Centers, Triba	11		0 4320 Diplomacy Dr		Anchorage	AK	99508-5926	
	201800021	SCF FIREWEED DENTAL CLIN	SOUTHCENTRAL FOUNDATIO	1861533408	Dental Providers	0		1 4341 Tudor Centre Dr		Fireweed Dental	Anchorage	AK	99508-5904
	201800022	Behavioral Health Fireweed	Southcentral Foundation	1932159076	Community Mental Health Centers, Triba	1.7		0 4341 Tudor Centre Dr		Anchorage	AK	99508-5904	
	201800023	Anchorage Neighborhood Health	ANCHORAGE NEIGHBORHOOD	1663475166	Dental Providers, Family Planning Provid	16		3 4951 Business Park Blvd		Anchorage	AK	99508-7174	
	201800024	Clinical Services - Department of Municipality of Anchorage		1104978006	Family Planning Providers, Sexually Tran	3		0 825 L St	Suite No. 102	Anchorage	AK	99501-3337	
	201800025	SEARCH Jessie Norma Jim Het Southeast Alaska Regional Hea	1215983945	Federally Qualified Health Centers, Indiar	2		0 725 Relay Rd			Angoon	AK	99820	
	201800026	ANIAK SUB-REGIONAL CLINIC YUKON-KUSKOKWIM HEALTH	1689857658	Federally Qualified Health Centers	2		0 269 Morgans Rd	PO Box 269		Aniak	AK	99557-0269	
	201800027	YUKON-KUSKOKWIM HEALTH YUKON-KUSKOKWIM HEALTH	1447477815	Indian Health Service, Other ECP Provide	1		0 Charlie Wulf Road #89	PO Box 89		Aniak	AK	99558-0089	
	201800028	ARCTIC VILLAGE HEALTH CLIN COUNCIL OF ATHABASCAN TI	1518753067	Federally Qualified Health Centers, Indiar	1		0 100 Main St			Arctic Village	AK	99722	
	201800029	APIAJ Aika Village Clinic	Aleutian Pribilof Islands Associ	1093939233	Federally Qualified Health Centers, Indiar	1		0 900 A Health Ln		Atka	AK	99547	
	201800030	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1447477815	Indian Health Service, Other ECP Provide	1		0 101 Boardwalk Way	PO Box 6588	Atmauliak	AK	99559-6588	
	201800031	Samuel Simmonds Memorial Hc Arctic Slope Native Association	1306933643	Dental Providers, Outpatient Hospital Clir	22		5 7000 Uula St			Barrow	AK	99723	
	201800032	Samuel Simmonds Memorial Hc Arctic Slope Native Association	1306933643	Inpatient Hospitals (other than children's)	10		0 7000 Uula St			Barrow	AK	99723	
	201800033	BEAVER HEALTH CLINIC	COUNCIL OF ATHABASCAN TI	1205027505	Federally Qualified Health Centers, Indiar	1		0 101 Main St		Beaver	AK	99724	
	201800034	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1821476599	Indian Health Service, Other ECP Provide	2		0 1260 A Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559-0528	
	201800035	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1194945170	Indian Health Service, Other ECP Provide	1		0 5016 Noel Polty Blvd.	PO Box 528	Bethel	AK	99559-0528	
	201800036	BETHEL FAMILY CLINIC	BETHEL FAMILY CLINIC	1124078019	Federally Qualified Health Centers	2.5		0 6311 Main St		Bethel	AK	99559	
	201800037	Yukon-Kuskokwim Delta Region	Yukon-Kuskokwim Health Corp	1083657691	Indian Health Service, Other ECP Provide	167		0 700 Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559-0528	
	201800038	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1326262726	Dental Providers	0		21 829 Chief Eddie Hoffman Hwy	Suite 184	Bethel	AK	99559	
	201800039	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1346466232	Indian Health Service, Other ECP Provide	2		0 829 Chief Eddie Hoffman Hwy	Suite 150	Bethel	AK	99559	
	201800040	FRANK TOBIUK SR HEALTH C DENA NENA HENASH	1821201278	Community Mental Health Centers, Dent.	0.2		0 02 1 Bettles Rd			Bettles	AK	99726	

To complete the information on the **Facility ECPs** tab, follow the steps in the table below.

Facility ECPs Tab	Steps
Facility Type	Select the appropriate facility type for each ECP. Issuers may select multiple facility types for each ECP, as applicable. If none of the facility type selections apply to the ECP, select <b>000 OTHER</b> .
Network IDs	Select the network IDs for each ECP. Issuers may select multiple network IDs for each ECP, as applicable. Dual issuers must create separate network IDs for their medical and dental plans.
Number of Medical FTEs or Bed Count	Enter the number of medical FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Nurse Practitioner (NP). Decimal values may be entered as appropriate to reflect the contracted number of FTEs. For inpatient hospitals in the network, enter the bed count associated with the contracted inpatient services. Note that the maximum allowable number of FTEs or beds is equal to the available FTEs or beds reported by the respective provider at each site location, as reflected in Column G (Number of Medical FTEs or Bed Count) of the <b>Select ECPs</b> tab.
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS). Decimal values may be entered as appropriate. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location, as reflected in Column H (Number of Dental FTEs) of the <b>Select ECPs</b> tab.

A sample completed **Facility ECPs** tab looks like **Figure 1E-3**.

Figure 1E-3. Sample Facility ECPs Tab

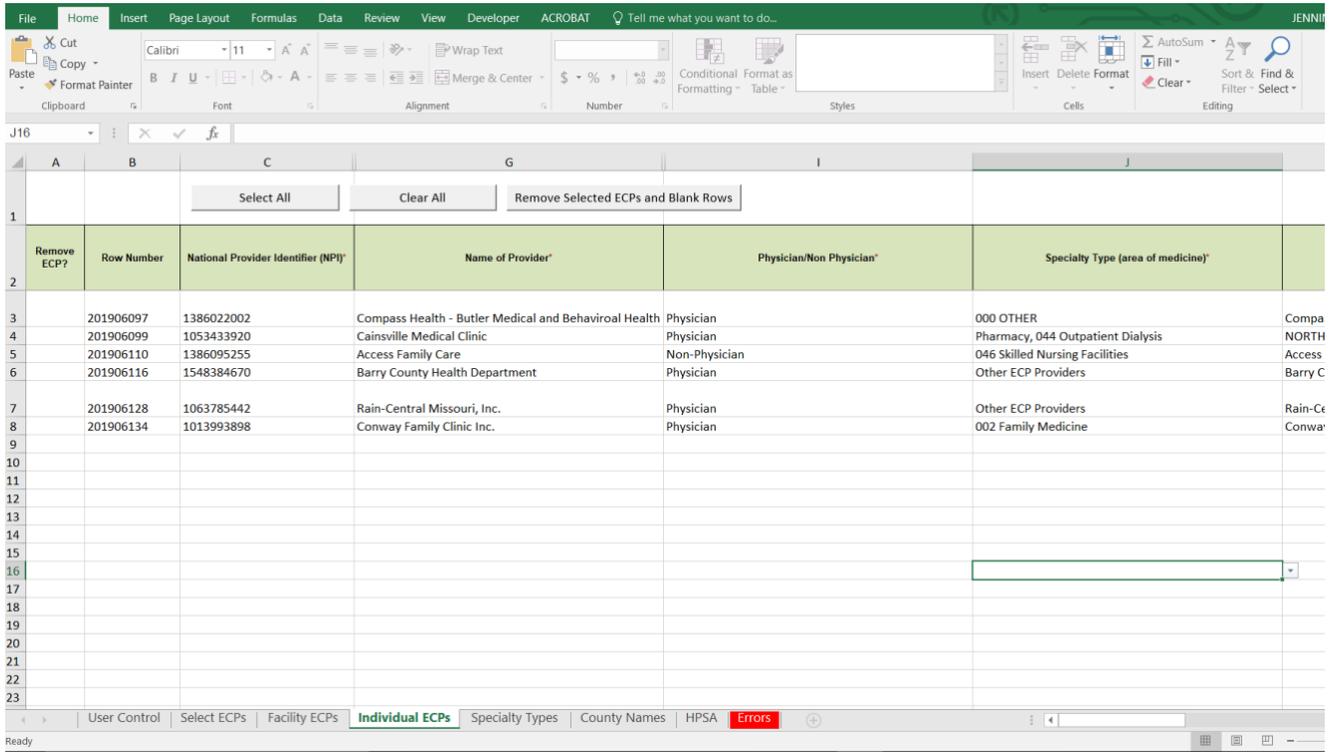
Remove ECP?	Row Number	National Provider Identifier (NPI)	Facility Name	Facility Type	Provider Name	ECP Category (General ECP Standard Issuers Only)
	201906094	1770536740	Bates County Memorial Hospital	Inpatient Hospitals (other than children's hospitals), 003 Internal Medicine, 006 Primary Care - Nurse Practitioner	BATES COUNTY MEMORIAL HOSPITAL	Inpatient Hospitals (other than children's hospitals)
	201906098	1710221130	DOUGLAS COUNTY PUBLIC HEALTH SERVICES GROUP, INC.	Dental Providers	Missouri Ozarks Community Health - CAB	Dental Providers, Federally Qualified Health Centers
	201906100	1205104403	COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI	Federally Qualified Health Centers	CHCMC Monteau Clinic	Dental Providers, Federally Qualified Health Centers
	201906101	1437440856	LAKE REGIONAL HEALTH SYSTEM	Rural Health Clinics	LAKE REGIONAL CLINIC-CAMDENTON	Rural Health Clinics
	201906102	1942750690	Richland Medical Center, Inc.	Federally Qualified Health Centers	Central Ozarks Medical Center	Dental Providers, Family Planning Providers, Federally Qualified Health Centers
	201906104	1033100870	PIGGOTT COMMUNITY HOSPITAL	Rural Health Clinics	CAMPBELL MEDICAL CLINIC	Rural Health Clinics
	201906106	1225337298	Midwest Family Care, LLC	Rural Health Clinics	Midwest Family Care	Rural Health Clinics
	201906107	1356393268	CROSS TRAILS MEDICAL CENTER	Federally Qualified Health Centers	CROSS TRAILS MEDICAL CENTER	Dental Providers, Federally Qualified Health Centers
	201906108	1245609445	The Health Care Coalition of Lafayette County	Federally Qualified Health Centers	Live Well Community Health Center Carrollton	Federally Qualified Health Centers
	201906109	1326496100	SGOH ACQUISITION, INC.	Rural Health Clinics	OCH JASPER COUNTY PEDIATRIC CLINIC	Rural Health Clinics
	201906112	1437251634	Pemiscot Memorial Health Systems	Rural Health Clinics	DOCTOR'S CLINIC	Rural Health Clinics
	201906113	1841463551	Pemiscot Memorial Health Systems	Rural Health Clinics	BOOTHEEL PRIMARY CARE CLINIC CARUTHERSVILLE	Rural Health Clinics
	201906117	1619030681	CoxHealth Network	Rural Health Clinics	Coxville Medical Care Associates	Rural Health Clinics
	201906118	1922332766	Ferguson Medical Group	000 OTHER	Ferguson Medical Group-Charleston Clinic	Other ECP Providers, Rural Health Clinics
	201906119	1437191095	SAINT LUKES HEALTH SYSTEM	Rural Health Clinics	HEDRICK MEDICAL CENTER	Rural Health Clinics
	201906120	1912948308	SAINT LUKES HEALTH SYSTEM	001 General Practice, 003 Internal Medicine, 013 ENT/Otolaryngology, 014 Gastroenterology, 018 Nephrology	Hedrick Medical Center (Hospital)	Inpatient Hospitals (other than children's hospitals)
	201906121	1013297530	NORTHWEST HEALTH SERVICES, INC.	Dental Providers	McCoy & Samples Dental Clinic	Dental Providers
	201906122	1215188313	West Central Missouri Community Action Agency		West Central Missouri Community Action Agency	Family Planning Providers, Other ECP Providers
	201906123	1710075361	Golden Valley Memorial Healthcare		Clinton Christian Church	
	201906126	1689646143	FAMILY HEALTH CENTER OF BOONE COUNTY		Golden Valley Memorial Hospital	Inpatient Hospitals (other than children's hospitals)
	201906127	1275670747	FAMILY HEALTH CENTER OF Boone County		FAMILY HEALTH CENTER OF BOONE COUNTY	Federally Qualified Health Centers
					Family Dental Center	Dental Providers

To complete the information on the **Individual ECPs** tab, follow the steps in the table below.

Individual ECPs Tab	Steps
Physician/ Non-Physician	Indicate the type of provider. Choose from the following: <ul style="list-style-type: none"> <li>◆ <b>Physician</b>—if the provider is a physician practitioner.</li> <li>◆ <b>Non-Physician</b>—if the provider is a non-physician practitioner.</li> </ul>
Specialty Type (area of medicine)	Select the appropriate specialty type for each ECP. Issuers may select multiple specialty types for each ECP, as applicable. If none of the specialty type selections apply to the ECP, select <b>000 OTHER</b> .
Network IDs	Select the network IDs for each ECP. Issuers may select multiple network IDs for each ECP, as applicable. Dual issuers must create separate network IDs for their medical and dental plans.
Number of Medical FTEs or Bed Count	Enter the number of medical FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: MD, DO, PA, and NP. Decimal values may be entered as appropriate to reflect the contracted number of FTEs. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location, as reflected in Column G (Number of Medical FTEs or Bed Count) of the <b>Select ECPs</b> tab.
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: DMD and DDS. Decimal values may be entered as appropriate to reflect the contracted number of FTEs. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location, as reflected in Column H (Number of Dental FTEs) of the <b>Select ECPs</b> tab.

A sample completed **Individual ECPs** tab looks like **Figure 1E-4**.

Figure 1E-4. Sample Individual ECPs Tab



To remove ECPs from the **Facility ECPs** tab or the **Individual ECPs** tab, double-click the record to be deleted in the Remove ECPs column. The provider will be highlighted in blue. Click the **Remove Selected ECPs and Blank Rows** button to remove the ECP from the template.

*Issuers proposing network(s) without ECPs:* If an issuer is proposing network(s) without ECPs, enter the following values in the **Facility ECPs** tab in the ECP/Network Adequacy Template to indicate that there are no ECPs in the network(s) (the issuer must enter this information to proceed with the rest of the application (**Table 1E-1**)).

Table 1E-1. Dummy Data Information

Facility ECPs Tab	Steps
Row Number	Leave blank.
NPI	Enter <b>000000000</b> .
Facility Name	Enter <b>ZZZZZ</b> .
Facility Type	Select <b>000 Other</b> from the drop-down menu.
Provider Name	Enter <b>ZZZZZ</b> .
ECP Category	Select <b>Other ECP Providers</b> .
Street Address	Enter <b>00000</b> .
Street Address 2	Leave blank.
City	Enter <b>ZZZZZ</b> .
State	Select the state in which the service area is located from the drop-down menu.
County	Select a county from the drop-down menu.

Table 1E-1. Dummy Data Information

	Steps
ZIP Code	Select a ZIP code from the <b>HPSA</b> tab that is in the same state in which the service area is located.
Network IDs	Using the drop-down menu, select the network ID(s) associated with the network that does not have an available ECP.
Number of Medical FTEs or Bed Count	Enter <b>0</b> .
Number of Dental FTEs	Enter <b>0</b> .

A sample **Facility ECPs** tab for an issuer proposing a network without ECPs is shown in **Figure 1E-5**.

Figure 1E-5. Sample Facility ECPs Tab

**Note:** Issuers planning to submit write-in ECPs should complete the ECP Write-in Worksheet.

HHS will release the PY2019 Available ECP Write-in List and ECP Write-in Worksheet approximately 2 weeks prior to each QHP certification submission cycle. These documents will be made available at the QHP certification website (<https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>). The Available ECP Write-in List for purposes of the PY2019 QHP Certification Process will be made available within the Draft PY2020 ECP List accessible at the above link. For General ECP Standard issuers, only those providers who are listed on the PY2019 Available ECP Write-in List will count as a qualified ECP write-ins.

Alternate ECP Standard issuers must also use the ECP Write-in Worksheet to submit their employed or contracted ECPs located in health professional shortage areas (HPSAs) or low-income ZIP codes. CMS would not expect these practitioners to submit an ECP petition for their inclusion on the Available ECP Write-in List, as these practitioners are either employees of the issuer or a single contracted medical group and typically are unavailable to contract with other issuers.

To complete the information on the ECP Write-in Worksheet, follow the steps in the table below.

ECP Write-in Worksheet	Steps
HIOS ID	Enter the five-digit HIOS Issuer ID.
Issuer State	Select the state in which the issuer is applying to offer QHPs.
Is this an Alternate ECP Standard Issuer?	Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the user is an Alternate ECP Standard issuer as described in 45 CFR 156.235(b).</li> <li>◆ <b>No</b>—if the user is a General ECP Standard issuer.</li> </ul>
Import Network IDs	Click on the <b>Import Network IDs</b> button to import data from the Network ID Template (please refer to Section 2A for detailed instructions on this template). The network IDs will automatically be imported to the write-in worksheet, and you will receive a message indicating that the network IDs were successfully added.
Approved Write-in Row Number	Enter the row number as it appears on the PY2019 Available ECP Write-in List. For alternate standard issuers reporting ECPs that are not required to submit an ECP provider petition (i.e., providers who are employed by the issuer or a single contracted medical group), the issuer should enter “N/A” in this column.
Provider Name	Enter the provider name as it appears on the PY2019 Available ECP Write-in List.
Site Name	Enter the site name as it appears on the PY2019 Available ECP Write-in List.
Organization Name	Enter the organization name as it appears on the PY2019 Available ECP Write-in List.
NPI	Enter the NPI as it appears on the PY2019 Available ECP Write-in List.
ECP Category	Select the appropriate ECP category for each ECP. Multiple ECP categories for each ECP may be selected, as applicable. If none of the listed menu selections apply to the ECP, select <b>Other ECP Providers</b> .
Number of Medical FTEs or Bed Count	Enter the number of medical FTEs that are included in the identified provider networks for each ECP. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: MD, DO, PA, and NP. Decimal values may be entered as appropriate to reflect the contracted number of FTEs. For inpatient hospitals in the network, enter the bed count associated with the contracted inpatient services.
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: DMD and DDS. Decimal values may be entered as appropriate to reflect the contracted number of FTEs.
Site Street Address 1	Enter the site street address of the contracted provider as it appears on the PY2019 Available ECP Write-in List.
Site Street Address 2	Enter additional street address information as it appears on the PY2019 Available ECP Write-in List, as applicable.
Site City	Enter the city as it appears on the PY2019 Available ECP Write-in List.
Site State	Select the site state from the drop-down list, as it appears on the PY2019 Available ECP Write-in List.
Site ZIP Code	Enter the site ZIP code as it appears on the PY2019 Available ECP Write-in List. For alternate standard issuers, all ECPs must be in an HPSA or low-income ZIP code.
Site County	Select the site county from the drop-down list, as it appears on the PY2019 Available ECP Write-in List.
Network ID(s)	Use the drop-down menu to select the network IDs for the networks to which the ECP belongs.
Validate the worksheet	Once all desired write-in ECPs are added to the worksheet, click the <b>Validate</b> button at the top of the worksheet. If there are errors identified, the worksheet will highlight the cells in red. Correct any errors and click <b>Validate</b> again. When all errors are corrected, a message will appear indicating that no validation errors were found.

ECP Write-in	Steps
Export the worksheet	<p>Click the <b>Export</b> button at the top of the worksheet. A pop-up message will ask you to “Please select the folder where you would like the ECP write-in file to be saved.” Select the appropriate folder and click <b>Select Folder</b> in the pop-up window. A .txt file containing the information from the ECP Write-in Worksheet is now saved at that location.</p> <p>When ready, submit the .txt file via the ECP/Network Adequacy application section within the Issuer Module in HIOS as a Supporting Document under the label “ECP Write-in Worksheet.”</p>

*Network Adequacy:* CMS will only be collecting individual and facility provider data from issuers participating in the network breadth pilot project for PY2019. *Do not* click on the **Create Facility, Pharmacy, Non-MD/DO Tab** button unless you are a medical issuer notified by email to submit these data.

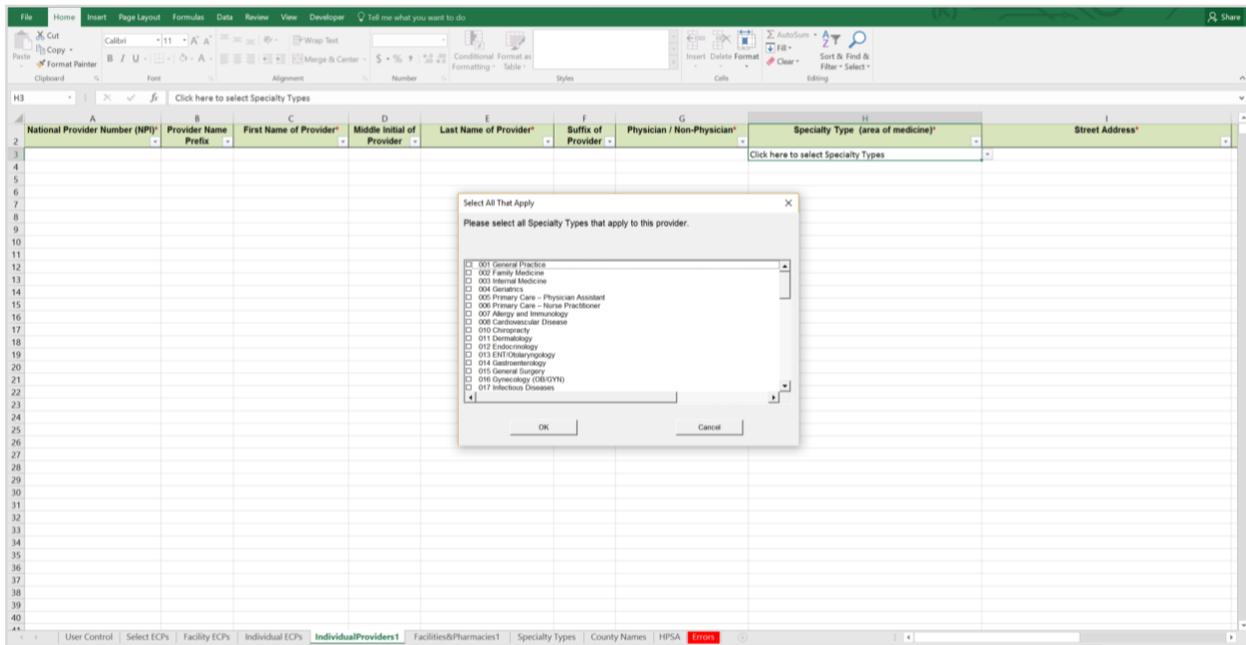
To complete the **Individual Providers** and **Facilities & Pharmacies** tabs, follow the steps in the tables below.

Individual Providers Tab	Steps
National Provider Identifier (required)	Enter the provider’s 10-digit NPI in the NPI column. It is very important for CMS to have the proper NPI number for a provider, so please contact the provider directly to acquire it if the NPI is unknown. If the issuer is unable to obtain the provider’s NPI for PY2019, enter <b>000000000</b> (10 zeros) in the NPI field. Also, please ensure the NPI is active in the National Plan & Provider Enumeration System (NPPES) database.
Provider Name Prefix	Enter the prefix for the provider, such as “Dr.”
First Name of Provider	Enter the first name of the provider.
Middle Initial of Provider	Enter the middle initial of the provider.
Last Name of Provider	Enter the last name of the provider. If a provider has multiple office locations, each with a unique address, add a number to the provider name to distinguish each location, for example, Provider Name-001.
Suffix of Provider	Enter the provider suffix, as applicable, such as “Jr.” or “Sr.”
Physician/Non-Physician	Indicate the type of provider. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Physician</b>—if the provider is a physician practitioner.</li> <li>◆ <b>Non-Physician</b>—if the provider is a non-physician practitioner.</li> </ul>
Specialty Type (area of medicine)	From the drop-down menu, select all specialties offered at the identified provider location. If a provider has multiple specialties at the same address, all specialties should be selected in the same record. <ul style="list-style-type: none"> <li>◆ The template does not allow direct entry into this field; however, issuers may copy and paste data into the template if the specialty type names appear exactly as they appear in the <b>Specialty Types</b> tab data, such as 001 General Practice. If pasted data do not exactly match the specialty type format used in the <b>Individual Providers</b> tab, errors will appear when the data are pasted.</li> <li>◆ If the issuer would like to enter more than one specialty type for a provider, each specialty type must be separated by a comma and a space.</li> <li>◆ If the specialty type is not listed in the <b>Specialty Types</b> tab, please select specialty type <b>000 OTHER</b> from the drop-down menu.</li> </ul>
Street Address	Enter the street address of the provider. If the provider has multiple locations, enter each street address in a separate row. <i>Do not</i> use a P.O. box in the address, as these cannot be geocoded for analysis. All providers with a P.O. box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, if applicable.
City	Enter the city where the provider is located.
State	Enter the state where the provider is located, or select the state using the drop-down menu.

Individual Providers Tab	
County	Enter the county where the provider is located, or select the county using the drop-down menu. A list of accepted county names is available on the <b>County Names</b> tab. Do not include the Federal Information Processing Standards (FIPS) code when entering the county name.
ZIP	Enter the ZIP code where the provider is located. ZIP codes must be entered as either a five-digit or a nine-digit code, such as 00000 or 00000-0000.
Network ID	When entering network IDs, assign networks the same IDs as those assigned in the Network ID Template and Plans & Benefits Template. Dual-product issuers must create separate network IDs for their medical and dental plans. Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, all networks should be selected in the same record.

A sample **Individual Providers** tab looks like **Figure 1E-6**.

Figure 1E-6. Sample Individual Providers Tab



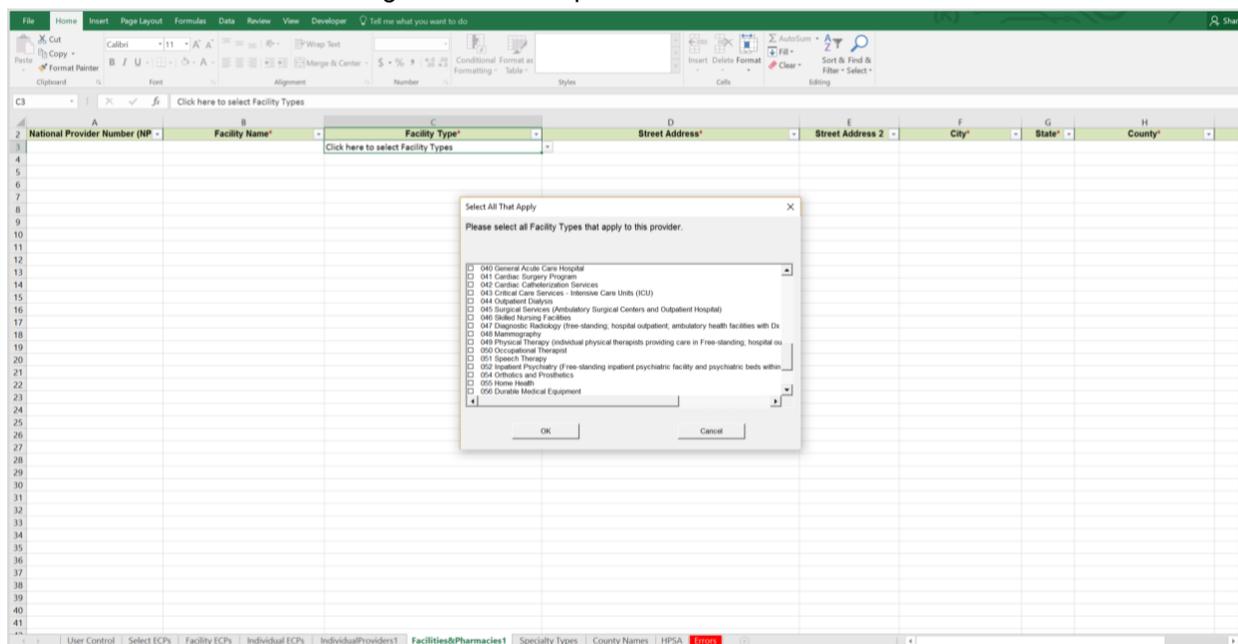
**Individual Provider** tabs can be removed from the template by using the **Delete** function, which is located in Column P of the **User Control** tab. Note that once a tab is deleted, it cannot be recovered, so it is recommended that the template be saved before tabs are deleted.

Facilities & Pharmacies Tab	Steps
National Provider Identifier	Enter the provider's 10-digit NPI. It is very important for CMS to have the proper NPI number for a provider, so please contact the provider directly to acquire it if it is unknown. If the issuer is unable to obtain the provider's NPI for PY2019, enter <b>0000000000</b> (10 zeros) in the NPI field. Also, please ensure that the NPI is active in the NPPES database.
Facility Name	Enter the name of the facility or pharmacy.

Facilities & Pharmacies Tab	
Facility Type	<p>From the drop-down menu, select all facility types that apply to the facility location. If a facility has multiple facility types at the same address, then all facility types should be selected in the same record. The accepted facility types are listed on the <b>Specialty Types</b> tab of the template.</p> <ul style="list-style-type: none"> <li>◆ The template does not allow direct entry into this column; however, issuers may copy and paste data into the template if the facility type names appear exactly as they appear in the <b>Specialty Types</b> tab, such as <b>040 General Acute Care Hospital</b>. If pasted data do not exactly match the facility type format used in the <b>Facilities &amp; Pharmacies</b> tab, errors will appear when the data are pasted.</li> <li>◆ If entering more than one facility type, each facility type must be separated by a comma and a space.</li> <li>◆ If the facility type is not listed in the <b>Specialty Types</b> tab, please select facility type <b>000 OTHER</b> from the drop-down menu.</li> </ul>
Street Address	<p>Enter the street address of the provider. This is the address where the enrollee obtains services, and not the corporate location unless they are the same. If the provider has multiple locations, enter each street address in a separate row. <i>Do not</i> use a P.O. box in the address, as it cannot be geocoded for analysis. All providers with a P.O. box in the address will be excluded from time and distance analysis.</p>
Street Address 2	<p>Enter additional street address information, as applicable.</p>
City	<p>Enter the city where the provider is located.</p>
State	<p>Enter the state where the provider is located, or select the state using the drop-down menu.</p>
County	<p>Enter the county where the provider is located, or select the county using the drop-down menu. A list of accepted county names is available on the <b>County Names</b> tab. Do not include the FIPS code when entering the county name.</p>
ZIP	<p>Enter the ZIP code where the provider is located. ZIP codes must be entered as either a five-digit or a nine-digit code, such as 00000 or 00000-0000.</p>
Network ID	<p>When entering network IDs, assign networks the same IDs as those assigned in the Network ID Template and Plans &amp; Benefits Template. <b>Dual-product issuers must create separate network IDs for their medical and dental plans.</b> Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, all networks should be selected in the same record.</p>

A sample **Facilities & Pharmacies** tab looks like **Figure 1E-7**.

Figure 1E-7. Sample Facilities & Pharmacies Tab



Reference information is provided in the three tabs listed below:

- The **Specialty Types** tab contains the specialty/facility and pharmacy types that can be added into the ECP/Network Adequacy Template.
- The **County Names** tab contains the county names that are used and accepted in the ECP/Network Adequacy Template.
- The **HPSA** tab contains the HPSA and low-income ZIP codes. The issuer can filter by ZIP code and by state.

The **Errors** tab displays any validation errors identified when a completed ECP/Network Adequacy Template is validated.

1. Column A—Tab: indicates the tab that produced the error.
2. Column B—Cell: indicates the cell location for the specific error and a hyperlink that allows the issuer to navigate to the exact cell in the correct tab.
3. Column C—Validation Error Message: describes the error.

Once the ECP/Network Adequacy Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the <b>Validate Data</b> button on the <b>User Control</b> tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Errors	If the template has any errors, they will appear on the <b>Errors</b> tab showing the data element and cell location of each error. Correct any identified errors, and click <b>Validate</b> again. Continue this process until all errors are resolved.
Create Documents	Click the <b>Create Documents</b> button on the <b>User Control</b> tab. This function will create a separate .XML file for each tab in the workbook. All of the separate files will be compressed into one zip file, which will need to be uploaded in the ECP/Network Adequacy section of the Issuer Module in HIOS.

Template Validation	Steps
Save Template	<b>Save</b> the .XML files and template. CMS recommends that the issuer save the validated template on its computer as a standard Excel .XLSM file and the finalized .XML files in the same folder.
Upload Template	Upload the saved files in the ECP/Network Adequacy section of the Issuer Module in HIOS. Refer to the Issuer Module User Guide for details on how to complete this.

Supporting Documents	
General ECP Standard Issuers Supplemental ECP Response Form and Justification	<ul style="list-style-type: none"> <li>◆ An issuer needs to submit an ECP supplemental response form if <i>one of the following applies</i>: <ul style="list-style-type: none"> <li>▪ The issuer does not contract with at least 20 percent of the available ECPs in each applicable service area.</li> <li>▪ The issuer does not offer a contract in good faith to all Indian healthcare providers in each plan's service area for the respective QHP certification plan year, applying the special terms and conditions required by federal law and regulations as referenced in the recommended model QHP Addendum for Indian Health Care Providers developed by HHS, available at <a href="https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy">https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy</a>.</li> <li>▪ The issuer does not offer a contract in good faith to at least one ECP in each available ECP category in each county in the service area for the respective QHP certification plan year.</li> </ul> </li> <li>◆ The issuer should include its HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name (for example, 12345_ecpsupplementalresponse_20180601).</li> </ul>
Alternate ECP Standard Issuers Supplemental ECP Response Form and Justification	<p>An issuer needs to submit an ECP supplemental response form if <i>one of the following applies</i>:</p> <ul style="list-style-type: none"> <li>◆ The issuer does not include in each plan network at least the equivalent of 20 percent of available ECPs in each plan service area, and these providers are located within HPSAs or ZIP codes in which 30 percent or more of the population falls below 200 percent of the federal poverty line (FPL).</li> <li>◆ The issuer does not offer an integrated delivery system that provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area, as outlined in the general ECP standard, or otherwise offer a contract to at least one ECP outside of the issuer's integrated delivery system in each available ECP category in each county in the plan's service area (not applicable to SADP applicants).</li> </ul> <p>The issuer should include its HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name (for example, 12345_ecpsupplementalresponse_20180601).</p>
Cover Sheet and Access Plan	<p>QHPs and SADPs that need to submit access plans will be notified directly by email. These issuers will be required to submit a Cover Sheet and Access Plan that addresses the 11 areas below. The Cover Sheet must include page references to each of the 11 areas in the Access Plan:</p> <ol style="list-style-type: none"> <li>1. The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable.</li> <li>2. The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable.</li> <li>3. The health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the healthcare needs of populations that enroll in network plans.</li> <li>4. The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select (and/or tier) providers.</li> <li>5. The health carrier's efforts to address the needs of covered persons, including children and adults, and those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical</li> </ol>

## Supporting Documents

conditions. This includes the carrier's efforts, when appropriate, to have various types of ECPs in its network.

6. The health carrier's methods for assessing the healthcare needs of covered persons and their satisfaction with services.
7. The health carrier's method of informing covered persons of the plan's covered services and features, including the following:
  - a. The plan's grievance and appeals procedures
  - b. Its process for choosing and changing providers
  - c. Its process for updating its provider directories for each of its network plans
  - d. A statement of healthcare services offered, including those services offered through the preventive care benefit, if applicable
  - e. Its procedures for covering and approving emergency, urgent, and specialty care, if applicable.
8. The health carrier's system for ensuring the coordination and continuity of care:
  - a. For covered persons referred to specialty physicians
  - b. For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.
9. The health carrier's process for enabling covered persons to change primary care professionals, if applicable.
10. The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner.
11. The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals.

*Note:* It is recommended the cover sheet be included in front of the access plan and submitted as one file. In this case, the file name for access plans should be the HIOS Issuer ID followed by "Access Plan" and any additional information deemed appropriate (for example, 12345\_Access\_Planv3). If a cover sheet is submitted as a separate file from the access plan, the file name should be HIOS Issuer ID followed by "Access Plan Cover Sheet" and any additional information deemed appropriate (for example, 12345\_Access\_Plan\_Cover\_Sheetv3).

## Benefits and Service Area Module

Users of the Benefits and Service Area Module are assigned to one or both of the following roles: Benefits Submitter, an individual who submits the data and information necessary to complete the Benefits Module, and Benefits Validator, an individual who is responsible for validating the correctness of the data and information necessary to complete the Benefits Module.

There are three tabs to this module: the Data Submitter page, the Data Validator page, and the Final Submission page (see **Figure 2-1**).

Figure 2-1. Three Tabs to Benefits and Service Area Module



The Data Submitter page allows submitters to work on an existing application or view an already submitted application (see **Figure 2-2**). The Data Validator page allows validators to view a list of all the applications that have been submitted. This section also allows validators to upload supporting documentation and answer supplemental responses through HIOS (see **Figure 2-3**). The Final Submission page allows users to cross-validate data between modules and submit the QHP Application.

Each of these tabs is broken down further with information that issuers need to enter to create a new application or edit an existing application. For the Data Submitter page, all sections listed in the lower part and to the left-hand side of the page need to be completed before moving on to the Data Validator pages.

Figure 2-2. Upload Documentation Page

**Upload Documentation** Update Status

Fields marked with an asterisk (\*) are required.  
Please note that uploading a second version of the template or supporting document(s) will replace the previously uploaded version.

Document Type:	Actions	File Name	Description	Last Update	Status
*Plan & Benefits Template (SHOP)	Upload		<input type="text"/>		
*Plan & Benefits Template (Individual)	Upload		<input type="text"/>		
Dental Plan & Benefits Template (SHOP)	Upload		<input type="text"/>		
Dental Plan & Benefits Template (Individual)	Upload		<input type="text"/>		
*Network ID Template	Upload		<input type="text"/>		
*Service Area Template	Upload		<input type="text"/>		
Prescription Drugs Template	Upload		<input type="text"/>		
Select document type	Upload		<input type="text"/>		

Showing 1 to 8 of 8 entries  
Add Another Document

Figure 2-3. Data Validator Page

Document Type:	File Name	Description	Last Update	Status
*Plan & Benefits Template (SHOP)	87295_NC_2016_PB_Med_SHOP.xls		02/17/2015 3:53:01 PM	Complete
*Plan & Benefits Template (Individual)	87295_NC_2016_PB_Med_Ind.xls		02/17/2015 3:52:52 PM	Complete
Dental Plan & Benefits Template (SHOP)	87295_NC_2016_PB_Dent_SHOP.xls		02/17/2015 3:52:32 PM	Complete
Dental Plan & Benefits Template (Individual)	87295_NC_2016_PB_Dent_Ind.xls		02/17/2015 3:52:38 PM	Complete
*Network ID Template	87295_NC_2016_Network.xls		02/17/2015 3:46:42 PM	Complete
*Service Area Template	87295_NC_2016_ServiceArea.xls		02/17/2015 3:46:53 PM	Complete
Prescription Drugs Template	87295_NC_2016_PrescriptionDrugs.xls		02/17/2015 3:49:51 PM	Complete

Showing 1 to 7 of 7 entries

## Section 2A: Network ID

### 1. Introduction

In the Network ID section, issuers must assign each of their provider networks—groups of providers providing services in an area—to network IDs and provide the network URL that enrollees will use to access information about the issuer’s provider networks. These instructions apply to QHP and SADP issuers.

### 2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. List of provider networks
3. URLs for the provider directory.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

#### Tips for the Network ID Section

- ◆ The URL to the provider directory is the only network identification information made public.
- ◆ Dual-product issuers offering QHPs and SADPs must create two different network IDs for use with the two plan types, regardless of whether the network is intended to serve QHPs and SADPs.
- ◆ Dual-product issuers must use the word “dental” in the network area name for their dental service area to distinguish the QHP network from the dental network.

### 4. Detailed Section Instructions

Perform the following steps to complete the Network ID Template.

Network ID Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Using the drop-down menu, select the state in which the proposed plan will be offered.
Generate Network IDs	Click the <b>Create Network IDs</b> button. This button generates the network IDs that will be used in a later step. When asked how many networks, enter the number of networks, and select <b>OK</b> . The network IDs are automatically generated on the basis of the number of networks specified.
Network Name	Enter a network name. Dual-product issuers must use the word “dental” in the network name for their dental network to distinguish the QHP network from the dental network.
Network ID	Select a network ID using the drop-down menu. The network IDs consist of the state abbreviation plus an “N” and then a sequenced number (such as MDN001 or MDN002). Dual-product issuers offering QHPs and SADPs must create separate network IDs for their QHP and dental networks.
Network URL	Enter the network URL (website). The network URL is the web address on the issuer website that consumers use to view the providers in the issuer’s network associated with the specific identified network.

Repeat these steps for each additional network ID.

A sample completed **Network ID** Template looks like **Figure 2A-1**.

Figure 2A-1. Sample Network ID Template

2019 Network Template v8.1		All fields with an asterisk (*) are required.	
<input type="button" value="Validate"/>		To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.	
<input type="button" value="Finalize"/>		Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.	
		Network IDs will populate in the drop-down box in Network ID column.	
		Use each Network ID only once.	
HIOS Issuer ID*	12345		
Issuer State*	VA		
<input type="button" value="Create Network IDs"/>			
<b>Network Name*</b> Required: Enter the Network Name	<b>Network ID*</b> Required: Select the Network ID	<b>Network URL*</b> Required: Enter the Network URL	
Smith Network	VAN001	https://SmithNetwork1.com	

Once the template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the <b>Validate</b> button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors and click <b>Validate</b> again. Continue this process until all errors are resolved.
Finalize Template	Click the <b>Finalize</b> button in the template. The Finalize function creates the .XML version of the template that issuers need to upload in the network section of the Benefits and Service Area Module.
Save Template	<b>Save</b> the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the network section of the Benefits and Service Area Module in HIOS. Refer to the Benefits and Service Area Module User Guide for details on how to complete this step.

## Section 2B: Service Area

### 1. Introduction

In the Service Area section, issuers identify the service areas associated with their QHPs, SADPs, or both, by state and county. These instructions apply to QHP and SADP issuers, and both types of issuers are required to submit the Service Area Template as part of their QHP Application.

To indicate the geographic coverage of each QHP, SADP, or both, and to demonstrate compliance with the county integrity requirements under 45 CFR 155.1055, issuers must identify proposed service areas in their application. The service area of a QHP or SADP is the geographic area where the plan accepts members, if it limits membership based on where people live.

In almost all situations, HHS will approve only service areas covering full counties. In the rare case in which the issuer proposes a service area covering a partial county, additional justification is required.

### 2. Data Requirements

The Service Area section of the QHP Application comprises three parts:

1. A template for identifying the issuer's service area, and any included counties and ZIP codes as applicable, if the entire state is not covered<sup>1</sup>
2. A detailed partial county supplemental response, if applicable (the recommended form is available at <https://www.qhpcertification.cms.gov/s/Service%20Area>)
3. If applicable, written evidence from the appropriate FFE state regulator indicating that the partial county is approved by the state.

To complete the template for this section, an issuer needs the following information:

1. HIOS Issuer ID
2. Issuer state
3. Names and IDs for proposed service areas to be associated with the issuer's QHPs or SADPs
4. Names of counties that the issuer is applying to cover, if electing not to include an entire state in a service area
5. ZIP codes in any county that the issuer is applying to cover when electing not to include an entire county in a service area.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

#### Tips for the Service Area Section

- ◆ Issuers may not change their service area after their initial submission, unless they submit a data change request to do so, and they may make this change only during the time frame specified by CMS. This includes issuers submitting through SERFF, even if the issuer is responding to an error issued by the state. See the Service Area Data Change Request Process in the Review Periods, Revision Process, and Certification section for more information.
- ◆ Dual-product issuers (issuers offering QHPs and SADPs) must create two different service area IDs for use with the two plan types, regardless of whether the service area is intended to serve both QHPs and dental plans.

<sup>1</sup> The columns these data are entered in appear in the Excel template when **Yes** is selected for Column E.

### Tips for the Service Area Section

- ◆ Dual-product issuers must use the word “dental” in the service area name for their dental service area to distinguish the QHP service area from the dental service area.
- ◆ Excel template file names must be all lowercase and cannot contain spaces. For example, “servicearea\_data” is a valid template file name, but “ServiceArea\_data” and “service area data” are not valid template file names.
- ◆ Name the partial county justification, if applicable, using the following naming convention: [HIOS Issuer ID]\_[State]\_service\_area\_partial\_county, for example, “12345\_AZ\_service\_area\_partial\_county.pdf.”
- ◆ When deciding how to establish service areas, consider existing healthcare delivery markets in the states in which the issuer is applying to offer plans. If people in a rural county generally travel a long distance to see a healthcare provider or dentist and the distance is consistent with practices permitted by the state, it may not be necessary to have a contracted provider in all parts of the rural county. In these cases, issuers may want to consider establishing a service area for the entire state, giving members in the more rural part of the county the option to see providers in other ZIP codes. Alternatively, an issuer may elect to exclude an entire county from its service area if no providers are available in the excluded ZIP codes.
- ◆ A service area can be associated with multiple plans. For example, an issuer has five plans and four service areas. The first plan has a service area (SA001) that covers the entire state. The second and third plans have a service area (SA002) that covers counties A and B. The fourth plan has a service area (SA003) that covers counties C and D. The fifth plan has a service area (SA004) that covers counties A, B, C, and D.
- ◆ A QHP or SADP must always be associated with a single service area ID and with a single network ID, but networks and service areas may be used for multiple QHPs or SADPs. The issuer creates one template for all of its service areas and identifies each service area with a unique service area ID. The issuer also completes the Network ID Template and creates a unique network ID for each network. When the issuer completes the Plans & Benefits Template, it maps each plan to a specific service area ID and network ID as entered in the Service Area and Network ID Templates. Service area IDs and network IDs may both be used for multiple plans and do not have to correspond one to one (for example, an issuer may have a single state-wide network, identified with a network ID, assigned to all of its plans but have two service area IDs, each made up of half the state and each assigned to a different plan).
- ◆ The Exchange does not require an issuer’s service area to cover a complete rating area. However, issuers are also bound by state service area requirements, so carefully review the state guidance on this topic to ensure the proposed service areas comply with state requirements. Multiple rating areas are allowed within a service area as specified by the state. Separate service area IDs are not required even if a service area is made up of multiple rating areas.
- ◆ Issuers in states that perform plan management functions and file through SERFF are strongly encouraged to submit a Microsoft Excel version of their Service Area Template.

## 4. Detailed Section Instructions

The following steps are taken to complete the Service Area Template.

Service Area Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Issuer State	Select the state in which the issuer is intending to offer coverage using the drop-down menu.
Service Area ID	<p>Click the <b>Create Service Area IDs</b> button at the top of the Service Area Template. Service area IDs are generated by the template.</p> <p>Enter the total number of desired service areas for the identified state. Each plan must be associated with a single service area ID, but a service area ID can be associated with multiple plans. The template automatically adds service area IDs to the Service Area ID drop-down menu. For example, if the issuer enters “3” for the total number of service areas, the template automatically generates three service area IDs. If the proposed service area covers the entire state, enter “1” for the number of service areas. The Service Area ID consists of the state abbreviation plus an “S” and then a sequenced number (for example, AZS001 or AZS002).</p> <p>In the first available blank row after the header (Row 13), use the drop-down menu to select a service area ID.</p>

Service Area Template	
Service Area Name	<p>Enter a name for the service area selected.</p> <p><i>Note:</i> It may be helpful to name the service area so that it identifies a plan characteristic, such as health maintenance organization (HMO), or the actual plan name.</p> <p>Dual-product issuers must use the word “dental” in the service area name for their dental service area to distinguish the QHP service area from the dental service area.</p> <p>The Service Area Name will not be displayed to the public on <a href="http://www.HealthCare.gov">www.HealthCare.gov</a>.</p>
State	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the service area includes the entire state. No additional information is required for the identified service area. Continue adding service areas until all service areas have been identified.</li> <li>◆ <b>No</b>—if the service area includes only certain counties in the state. In the next step, county information must be provided for the identified service area. Continue adding service areas and counties as appropriate until all service areas have been identified.</li> </ul> <p><i>Note:</i> The same service area ID <i>cannot</i> be used for both a service area that covers the entire state <i>and</i> a service area that covers only certain counties in the state.</p>
County Name	<p>Use the drop-down menu to select the name of each county included in the identified service area if the issuer indicated above that the identified service area does not cover the entire state.</p> <p>If a service area includes multiple counties, the issuer must add a new row for each new county using the same service area ID and service area name.</p> <p>If the issuer’s service area counties do not appear in the drop-down menu, please contact the Marketplace Service Desk at 855-CMS-1515 or via email at <a href="mailto:CMS_FEPS@cms.hhs.gov">CMS_FEPS@cms.hhs.gov</a>.</p>
Partial County	<p>Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No</b>—if the service area includes the entire county. No additional information is required for the identified county.</li> <li>◆ <b>Yes</b>—if the service area covers only part of the county. If <b>Yes</b> is selected, an informational box appears showing the HHS partial county policy. Select <b>OK</b>. A Service Area ZIP Code(s) column and a Partial County Justification Filename column will appear on the template.</li> </ul>
Service Area ZIP Code	<p>Enter the five-digit ZIP codes included in the partial county if the issuer identified that the county is only partially covered. If entering more than one ZIP code, use a comma to separate each ZIP code.</p>
Partial County Justification Filename	<p>Enter the file name for the partial county justification supplemental response. Use the following naming convention: [HIOS Issuer ID]_[State]_service_area_partial_county, for example, “12345_AZ_service_area_partial_county.pdf.”</p>

A sample completed **Service Area Template** looks like **Figure 2B-1**.

Figure 2B-1. Sample Service Area Template

Service Area ID*	Service Area Name*	State*	County Name	Partial County	Service Area Zip Code(s)	Partial County Justification Filename
AZS004	Service Area Four	Yes				
AZS001	Service Area One	No	Mohave - 04015	No		
AZS001	Service Area One	No	La Paz - 04012	Yes	85325, 85328	12345_AZ_service_area_partial_county
AZS001	Service Area One	No	Yuma - 04027	No		
AZS001	Service Area One	No	Maricopa - 04013	No		
AZS002	Service Area Two	No	Coconino - 04005	No		
AZS003	Service Area Three	No	Apache - 04001	Yes	85920, 85924, 85925	12345_AZ_service_area_partial_county

The following steps are taken if the issuer is requesting to serve a partial county (i.e., the issuer selected **Yes** to one or more counties in Column E of the Service Area Template).

Partial County Justification Supplemental Response	
HHS allows issuers to cover partial county service areas only in extraordinary circumstances. For each requested exception, the issuer must submit a detailed supplemental response substantiating why the entire county will not be served. The issuer must justify that the partial county service area is necessary, non-discriminatory, and in the best interests of potential enrollees and the Exchange program, consistent with 45 CFR 155.1055.	
The specific questions to be answered are on the recommended form found at <a href="https://www.ghcpertification.cms.gov/s/Service%20Area">https://www.ghcpertification.cms.gov/s/Service%20Area</a> . Failure to respond to each of these questions will result in the denial of the partial county request.	
Issuers may request partial county service areas from CMS only with state authorization. Issuers in FFE states that complete the QHP Application in HIOS should provide written evidence that their appropriate state regulator has authorized their partial county service area, such as an email that lists the specific ZIP codes in the partial county requested.	
Issuers in states performing plan management functions that request to serve partial counties must submit a partial county supplemental response but are not required to submit evidence of state approval. Successful transmission of the data will serve as state approval of the partial county request.	
After completing the supplemental response form, do the following:	
<ul style="list-style-type: none"> <li>◆ Combine written evidence that the appropriate FFE state regulator has authorized the partial county service area and the partial county justification supplemental response into one PDF file.</li> <li>◆ Name the PDF file using the following convention: [HIOS Issuer ID]_[State]_service_area_partial_county, for example, "12345_AZ_service_area_partial_county.pdf." Enter this file name in Column G, "Partial County Justification Filename," of the Service Area Template.</li> <li>◆ Upload the combined document in the Plans &amp; Benefits section of the Benefits and Service Area Module in HIOS using the document upload functionality. Select the document type <b>Service Area Justification</b> from the Document Type drop-down menu.</li> </ul>	

Once the Service Area Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the <b>Validate</b> button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click <b>Validate</b> again. Continue this process until all errors are resolved.
Finalize Template	Click the <b>Finalize</b> button in the template. The Finalize function creates the .XML version of the template that issuers need to upload in the Service Area section of the Benefits and Service Area Module in HIOS.
Save Template	<b>Save</b> the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the Service Area section of the Benefits and Service Area Module in HIOS. Refer to the Benefits and Service Area Module User Guide for details on how to complete this step.

## Section 2C: Prescription Drug

### 1. Introduction

In the Prescription Drug section, issuers must create cost sharing for each tier of drug benefits along with specific drugs included in the formulary. They must also select the drugs that are to be offered at each tier level. These instructions apply only to QHP issuers.

### 2. Data Requirements

To complete this section, issuers will need the following:

1. Formulary URLs. Enter the website location for formulary information. URLs must start with “http://” or “https://” to work properly for the consumer.
2. A drug list with RxNorm Concept Unique Identifiers (RxCUIs), along with their formulary tier numbers. An issuer may offer drugs that do not have associated RxCUIs, but they cannot be included on the Prescription Drug Template.<sup>2</sup>

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No major changes for the 2019 QHP Application.

#### Tips for the Prescription Drug Section

- ◆ RxCUIs should have one of the following Term Types (TTYs): semantic branded drug (SBD), semantic clinical drug (SCD), brand name pack (BPCK), or generic pack (GPCK).
- ◆ Set **Tier Level** equal to “NA” (not applicable) if the drug is not part of a given drug list.
- ◆ All formularies associated with the same drug list should have the same **Number of Tiers** and the same **Drug Tier Type** for a given tier. In other words, each drug list may have only one tier structure, as indicated by the number of tiers and drug tier types. The XML generated from the template and submitted to HIOS includes only the **Number of Tiers** and **Drug Tier Type** fields for the first formulary associated with each drug list.

### 4. Detailed Section Instructions

Issuers need to complete the Drug Lists worksheet before they fill out the Formulary Tiers worksheet in the template. An example is shown in **Figure 2C-1**.

<sup>2</sup> Pursuant to 45 CFR 156.122(a)(3), for plan years beginning on or after January 1, 2018, a health plan does not provide EHBs unless it uses a pharmacy and therapeutics committee that meets certain standards.

Figure 2C-1. Drug Lists Worksheet

Drug Lists							
All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.							
Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.							
After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.							
Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.							
Enter all RxCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).							
Drug List ID 1				Drug List ID 2			
RxCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required	
Required: Enter the RxCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
405550	3	No	No		3	No	No
405551	2	No	Yes	NA			
405552	1	No	No		1	No	No
405553	1	No	No		1	No	No
405554	2	No	No		2	No	No
405555	3	No	No		3	No	No
405556	3	No	No		3	No	No
405557	2	No	No	NA			
405558	1	No	No	NA			
405559	1	No	No		1	No	No
405560	2	No	No		2	No	No
405561	3	No	No		3	No	No
405562	3	No	No		3	No	No
405563	2	No	No		2	No	No
405564	1	No	No		1	No	No
405565	1	No	No	NA			
405566	2	No	No		2	No	No
405567	3	No	No		3	No	No
405568	3	No	No		3	No	No

Before entering details for each drug list, enter all RxCUIs included in any of the drug lists. RxCUIs are entered into Column A, beginning in Row 9. Once the issuer has entered all of the unique RxCUIs for its drug lists, it should begin entering the drug-list-specific information in each row.

Drug List	Steps
RxCUI	<ul style="list-style-type: none"> <li>When selecting RxCUIs to include, use the October 2, 2017, full monthly release of RxNorm to find a list of valid RxCUIs. Download the RxNorm release at <a href="https://www.nlm.nih.gov/research/umls/rxnorm/docs/rxnormfiles.html">https://www.nlm.nih.gov/research/umls/rxnorm/docs/rxnormfiles.html</a>. To download the file, the issuer will need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. The issuer can obtain a license and account at no charge by following the instructions at <a href="http://www.nlm.nih.gov/databases/umls.html#license_request">http://www.nlm.nih.gov/databases/umls.html#license_request</a>.</li> <li>CMS posts the EHB Rx Crosswalk and a reformatted RxNorm database along with the state review tools at <a href="https://www.qhpcertification.cms.gov/s/Review%20Tools">https://www.qhpcertification.cms.gov/s/Review%20Tools</a>.</li> <li>RxCUIs should have one of the following TTYs: SBD, SCD, BPCCK, or GPCK.</li> <li>The drug list should include all drugs on the issuer's formulary, even if they do not fall in one of the categories and classes identified in the summary of EHB benchmark information, available at <a href="https://www.qhpcertification.cms.gov/s/Prescription%20Drugs">https://www.qhpcertification.cms.gov/s/Prescription%20Drugs</a>. This includes all drugs deemed by the user as "medical service drugs."</li> </ul>
Tier Level	For each drug, select the RxCUI's cost-sharing tier level from the drop-down menu, or select "NA" if this drug is not part of the given drug list.
Prior Authorization Required	Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following options: <ul style="list-style-type: none"> <li><b>Yes</b>—if prior authorization is required.</li> <li><b>No</b>—if prior authorization is <i>not</i> required.</li> </ul> If Tier Level is "NA," leave this column blank.
Step Therapy Required	Indicate whether the plan requires the enrollee to try at least one other drug before the plan covers the given drug. Choose from the following options: <ul style="list-style-type: none"> <li><b>Yes</b>—if step therapy is required.</li> <li><b>No</b>—if step therapy is <i>not</i> required.</li> </ul> If Tier Level is "NA," leave this column blank.

To add another drug list, click the **Add Drug List** button (Figure 2C-2). For the new drug list, issuers need to complete the Tier Level, Prior Authorization Required, and Step Therapy Required columns as described above. Once an issuer has completed the Tier Level, Prior Authorization Required, and Step Therapy Required columns, it has completed the required information for its drug list.

Figure 2C-2. Add Drug List Button

	A	B	C	D	E	F	G	H
1	<b>Drug Lists</b>	All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.						
2		Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.						
3		After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.						
4		Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.						
5		Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).						
		<b>Drug List ID 1</b>			<b>Drug List ID 2</b>			
7	<b>RXCUI*</b>	<b>Tier Level*</b>	<b>Prior Authorization Required</b>	<b>Step Therapy Required</b>	<b>Tier Level*</b>	<b>Prior Authorization Required</b>	<b>Step Therapy Required</b>	
8	Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3 No	No	No	3 No	No	No	
10	405551	2 No	No	Yes	NA	No	No	
11	405552	1 No	No	No	1 No	No	No	
12	405553	1 No	No	No	1 No	No	No	

If an issuer needs to remove a drug list, click the **Remove Drug List** button (Figure 2C-3). Drug lists are removed in the reverse order in which they were created. In other words, the last drug list created is removed first. If the issuer wants to remove a drug list that is not the last drug list created (for example, if there are four drug lists and the issuer wants to remove the second one), copy and paste the data from the last drug list into the drug list that the issuer wants to delete; then click the **Remove Drug List** button.

Delete any drug lists that are not used. A drug list that is not used links to a Formulary ID that does not link to a Standard Component ID in the Plans & Benefits Template. When removing drug lists, make sure that all remaining Formulary IDs are linked to the correct drug lists.

Figure 2C-3. Remove Drug List Button

	A	B	C	D	E	F	G	H
1	<b>Drug Lists</b>	All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.						
2		Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.						
3		After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.						
4		Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.						
5		Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).						
		<b>Drug List ID 1</b>			<b>Drug List ID 2</b>			
7	<b>RXCUI*</b>	<b>Tier Level*</b>	<b>Prior Authorization Required</b>	<b>Step Therapy Required</b>	<b>Tier Level*</b>	<b>Prior Authorization Required</b>	<b>Step Therapy Required</b>	
8	Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3 No	No	No	3 No	No	No	
10	405551	2 No	No	Yes	NA	No	No	
11	405552	1 No	No	No	1 No	No	No	
12	405553	1 No	No	No	1 No	No	No	

Once the Drug Lists worksheet is completed, go to the Formulary Tiers worksheet.

Formulary Tiers	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Select the state for which the template applies from the drop-down menu.
Generate Formulary IDs	<p>Click the <b>Create Formulary IDs</b> button to create the formulary IDs.</p> <ul style="list-style-type: none"> <li>A pop-up dialog box appears and prompts the issuer to enter the number of formularies.</li> <li>After entering the number of formularies, the message "Formulary IDs have been generated successfully" appears. Click <b>OK</b>. The IDs are automatically generated, consisting of the state abbreviation plus an "F," and then a sequenced number (such as ALF001 and ALF002).</li> <li>Once completed, the formulary IDs appear in a drop-down menu in the Formulary ID column.</li> </ul>

Formulary Tiers	
Formulary ID	<p>Select the formulary ID from the drop-down menu.</p> <ul style="list-style-type: none"> <li>◆ After a formulary ID is selected, the template populates some cells and grays out others that do not apply. When a cell is grayed out, it is locked and cannot be edited. HIOS will not process data entered into the cell before it was grayed out.</li> <li>◆ Select only formulary IDs that will be linked to a standard component ID used in the Plans &amp; Benefits Template.</li> </ul>
Formulary URL	<p>Enter the URL (web address) for the formulary document or website. CMS expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, specific to a given QHP. The URL provided to the Exchange as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating it. If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHPs. CMS makes issuer-provided formulary links available to consumers on <a href="http://HealthCare.gov">HealthCare.gov</a>.</p>
Drug List ID	<p>Select the appropriate drug list ID from the drop-down menu. The menu is auto-populated with the drug list IDs that were created on the Drug Lists worksheet. If the Drug Lists worksheet has not been completed, do so now.</p>
Number of Tiers	<p>Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary should correspond to the number of tiers in the associated drug list. Cost-sharing subgroups cannot be created within a tier. All drugs within the same tier should have the same cost sharing.</p>
Drug Tier ID	<p>The template populates this column according to the selection in Number of Tiers. The other cells are grayed out, indicating they do not apply. The Drug Tier ID column is controlled by the template; do not edit it.</p>
Drug Tier Type	<p>Click the drop-down menu, and select the <b>Click here to select</b> option to open a pop-up dialog box. Choose from the following options, and select a maximum of two drug types, one generic type, and one brand type for each tier. No additional tier type can be selected for Zero Cost Share Preventive Drugs. No additional tier type can be selected for Medical Service Drugs.</p> <ul style="list-style-type: none"> <li>◆ If a tier contains both preferred and non-preferred generic drugs, select only one tier type. Choose the tier type according to the majority of drugs in the tier. For example, if the tier contains 80 percent preferred generic and 20 percent non-preferred generic, then choose the tier type of preferred generic. The same applies for a tier with preferred and non-preferred brand drugs.</li> <li>◆ Multiple tiers may have the same drug tier types, but tiers should have different cost sharing.</li> <li>◆ If the issuer has both preferred and non-preferred specialty drugs, create two tiers and differentiate between the two using cost sharing. One way to represent this design is to designate the first as <b>Preferred Brand, Specialty</b> and the second as <b>Non-Preferred Brand, Specialty</b>.</li> </ul> <p><i>Zero Cost Share Preventive Drugs:</i></p> <ul style="list-style-type: none"> <li>◆ When Zero Cost Share Preventive Drugs is selected, it is the only tier type that can be selected for the tier. It is preferred that the issuer place the Zero Cost Share Preventive Drug tier as Tier 1 if applicable, to represent the lowest-cost tier to the consumer.</li> <li>◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance information will automatically be set to <b>\$0</b> and <b>0 percent</b>, respectively, when this tier type is chosen. The remaining pharmacy benefit types can still be edited. If the remaining pharmacy benefits are offered, then the subsequent cost-sharing fields should be entered as <b>\$0</b> and <b>0 percent</b>.</li> <li>◆ If the issuer has a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, then complete the cost-sharing fields for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Explanation field of the Plans &amp; Benefits Template and in a plan brochure and formulary URL.</li> </ul>

Formulary Tiers	Steps
	<p><i>Medical Service Drugs:</i></p> <ul style="list-style-type: none"> <li>◆ Use this tier type to indicate if a formulary contains medical service drugs. CMS recognizes that there are some state benchmarks that contain medical service drugs in various categories and classes; therefore, a Medical Service Drugs tier can assist in identifying these drugs in the formulary.</li> <li>◆ When Medical Service Drugs is selected, it is the only tier type that can be selected for the tier.</li> <li>◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance will both be automatically set to <b>Not Applicable</b> when this tier type is chosen. The remaining pharmacy benefit types cannot be edited.</li> </ul>
Tier Cost Sharing	<p>This section describes how to document the cost-sharing structure for each drug tier. The only columns that must be populated are 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance. Complete the information for the other three pharmacy types only if they apply to the given drug tier, but the issuer must indicate whether each tier offers these types of pharmacy benefits. The pharmacy benefits are as follows:</p> <ul style="list-style-type: none"> <li>◆ 1 Month In Network Retail Pharmacy (Copayment &amp; Coinsurance)</li> <li>◆ 1 Month Out of Network Retail Pharmacy Benefit Offered?</li> <li>◆ 1 Month Out of Network Retail Pharmacy (Copayment &amp; Coinsurance)</li> <li>◆ 3 Month In Network Mail Order Pharmacy Benefit Offered?</li> <li>◆ 3 Month In Network Mail Order<sup>3</sup> Pharmacy (Copayment &amp; Coinsurance)</li> <li>◆ 3 Month Out of Network Mail Order Pharmacy Benefit Offered?</li> <li>◆ 3 Month Out of Network Mail Order Pharmacy (Copayment &amp; Coinsurance).</li> </ul>
Benefit Offered	<p>Select <b>Yes</b> if the pharmacy benefit is offered for the corresponding tier. Otherwise, select <b>No</b>.</p>
Copayment	<p>Enter the copayment amount for the given pharmacy type. The copayment field allows values to the hundredths decimal. Round any copayments to the hundredths decimal. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, <i>not</i> <b>No Charge</b>, should be used if only a coinsurance is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X</b>—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>\$X Copay after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay with deductible</b>—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a coinsurance. Note that when using <b>Not Applicable</b> for copay, <b>Not Applicable</b> cannot be used for coinsurance (unless the drug tier type is <b>Medical Service Drugs</b>).</li> </ul>

<sup>3</sup> Pursuant to 45 CFR 156.122, for plan years beginning on or after January 1, 2018, a health plan providing EHBs at in-network retail pharmacies, unless the drug meets an exception under 45 CFR 156.122(1)(i) and (ii).

Formulary Tiers	Steps
Coinsurance	<p>Enter the coinsurance amount for the given pharmacy type. The coinsurance field allows values to the hundredths decimal. Round any coinsurance to the hundredths decimal. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, <i>not</i> <b>No Charge</b>, should be used if only a copay is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>X%</b>—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>X% Coinsurance after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a copay. Note that when using <b>Not Applicable</b> for coinsurance, <b>Not Applicable</b> cannot be used for copay (unless the drug tier type is <b>Medical Service Drugs</b>).</li> </ul>

Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most used benefit cost-share design. Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Explanation field of the Plans & Benefits Template and in a plan brochure and Formulary URL.

CMS will review tier placement to ensure that the formulary does not substantially discourage the enrollment of certain beneficiaries. When developing their formulary tier structure, issuers should use standard industry practices. Tier 1 should be considered the lowest cost-sharing tier available, which means a Zero Cost Share Preventive tier should be listed first. Any and all subsequent tiers with the formulary structure will be higher cost-sharing tiers in ascending order. Place the Medical Service Drug tier as the last tier for all formulary designs.

Preventive services under the PPACA must be covered without the consumer having to pay a copayment or coinsurance or meet a deductible. For more information on the coverage of preventive services, see <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/#Prevention> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs18.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html).

CMS recommends that issuers place preventive drugs in a separate Zero Cost Share Preventive tier in the Prescription Drug Template. If an issuer has a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, then complete the cost-sharing fields for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Explanation field of the Plans & Benefits Template and in a plan brochure and Formulary URL.

If an issuer has already used all seven available tiers, include zero cost preventive drugs in the lowest-cost tier and clearly identify in the plan brochures and Formulary URL that these drugs are available at zero cost sharing because all drugs within the same tier should have the same cost sharing.

Alternatively, if an issuer has already used all seven available tiers and one of the tiers is a medical service drug tier, include the zero cost preventive drugs as a tier and remove the medical service drug tier.

If an issuer has a tier cost share of zero and it is not a preventive tier, then the issuer may either select **No Charge** for Copayment and **Not Applicable** for Coinsurance or **Not Applicable** for Copayment and **No Charge** for Coinsurance in the Formulary Tiers worksheet. Note that an issuer cannot use **Not Applicable** for both Copayment and Coinsurance at the same time.

The Prescription Drug Template does not capture minimum or maximum copay or coinsurance. CMS recommends that issuers describe in detail any cost-sharing designs that are not captured in the Prescription Drug Template in the Explanation field of the Plans & Benefits Template and in a plan brochure and Formulary URL.

Once the Prescription Drug Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the <b>Validate</b> button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click <b>Validate</b> again. Continue this process until all errors are resolved.
Finalize Template	Click the <b>Finalize</b> button in the template. The Finalize function creates the .xml file of the template that will need to be uploaded in the Prescription Drug section of the Benefits and Service Area Module in HIOS.
Save Template	<b>Save</b> the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .xlsm file and the finalized .xml file in the same folder.
Upload Template	Upload the saved .xml file in the Prescription Drug section of the Benefits and Service Area Module in HIOS. Refer to the Benefits and Service Area Module User Guide for details on how to complete this.

## Section 2D: Plans & Benefits

### 1. Introduction

In the Plans & Benefits section, issuers will enter data about their plans and list covered benefits with any quantitative limits or exclusions. They will also provide cost sharing and basic plan variation information for each plan that is being submitted, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. These pieces of information will be included through two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet. These instructions apply to QHP and SADP issuers.

### 2. Data Requirements

To complete this section, the issuer will need the following:

1. Completed Network ID (QHP and SADP), Service Area (QHP and SADP), and Formulary Excel Templates (QHP only)
2. Applicable plan URLs
3. Detailed benefit cost sharing for all plans.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ The EHB benchmark, which is populated through the **Refresh EHB** button in the Plans & Benefits Add-In, has been updated to reflect plan year changes.
- ◆ The “Issuer Actuarial Value” field is no longer required for SADPs and is now optional. If provided, it must fall within the previous actuarial value (AV) ranges of high or low.
- ◆ The **Finalize** button in the Plans & Benefits Add-In now ensures that no fields used in the Actuarial Value Calculator (AVC) have been changed since the last time the “Check AV Calc” macro was run.
- ◆ Simple Choice Plans are not being specified in 2019, so there is no Simple Choice Plan Add-In file.
- ◆ Issuers offering SHOP plans through the FF-SHOP must provide a URL linking their plan information in the SBC URL field. This information will be displayed in the **See Plans and Prices** utility on Healthcare.gov.

#### Tips for the Plans & Benefits Section

- ◆ Download the most recent versions of the 2019 Plans & Benefits Template, Plans & Benefits Add-In file, and AVC.
- ◆ Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template for the macros to run properly.
- ◆ All data elements that CMS **anticipates** displaying to individual market consumers on Plan Compare are **identified by a number symbol (#)** next to the field name.
- ◆ All data fields required for SADP issuers are **identified by an asterisk (\*)** next to the field name. Follow the instructions below for details relating to the Benefits Package worksheet. For the Cost Share Variances worksheet, see Sections 4.11, 4.20–4.22, 4.24, 4.26, and 4.27.
- ◆ All data fields used by the AVC are **identified by a caret (^)** next to the field name. See Appendix 1 for additional AVC instructions.
- ◆ The issuer should complete the Network, Service Area, and Prescription Drug Templates (QHPs only) and save them to its computer before filling out the Plans & Benefits Template. This template requires issuers to assign a network, service area, and formulary ID to each plan on the basis of the IDs already created in these three templates.
- ◆ Complete a separate Benefits Package worksheet for each unique benefits package the issuer wishes to offer. To create additional benefits packages, click the **Create New Benefits Package** button on the menu bar under the Plans & Benefits ribbon. The **HIOS Issuer ID, Issuer State, Market Coverage, Dental Only Plan, and Taxpayer Identification Number (TIN)** fields are auto-populated.
- ◆ Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost-sharing reduction plan variation the issuer wishes to offer.

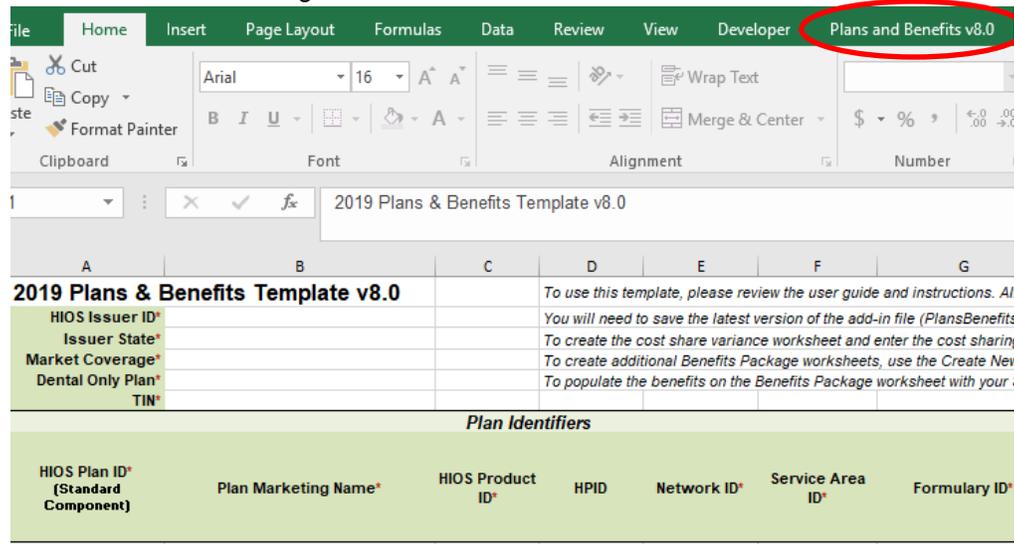
### Tips for the Plans & Benefits Section

- ◆ The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See Appendix 1 for how these values relate to AV.
- ◆ When a cell is grayed out, it is locked and cannot be edited. The Benefits and Service Area Module will not process data entered into the cell before it was grayed out.

## 4. Detailed Section Instructions

When opening the Plans & Benefits Template, if the issuer is asked to enable macros, use the **Options** button on the Security Warning toolbar, and select **Enable this content**. If the macros are not enabled before the data are entered, the template will not recognize those data fields and they will have to be reentered. Once the issuer does this, the **Plans & Benefits** ribbon should appear (**Figure 2D-1**) as tabs on the file's toolbar.

Figure 2D-1. Plans & Benefits Ribbon

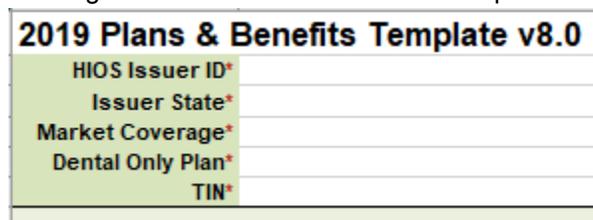


*Note:* Before proceeding, the issuer should confirm that it has downloaded the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the QHP certification website (<https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>).

### 4.1 General Information

The fields in the upper-left portion of the Benefits Package worksheet contain basic information about the issuer and the types of plans to be entered into the template (**Figure 2D-2**). This information must be entered in the first Benefits Package worksheet; it will then auto-populate any additional Benefits Package worksheets generated by the issuer.

Figure 2D-2. Plans & Benefits Template



General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which the issuer is licensed to offer these plans using the drop-down menu.
Market Coverage*	Select the market coverage. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Individual</b>—if the plans are offered on the individual market.</li> <li>◆ <b>SHOP (Small Group)</b>—if the plans are offered on the small-group market.</li> </ul>
Dental Only Plan*	Indicate whether the plans contained in the template are dental-only plans. Choose from the following: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if this is a dental-only package. When <b>Yes</b> is selected, the template grays out areas that do not apply to SADPs and prevents the field from accepting data entry.</li> <li>◆ <b>No</b>—if this is <i>not</i> a dental-only package.</li> </ul>
TIN*	Enter the issuer's nine-digit (xx-xxxxxxx) Tax Identification Number (TIN).

## 4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data on each plan, including its Plan ID and the network, service area, and formulary (QHPs only) it uses (**Figure 2D-3**). Complete this section for each standard plan the issuer plans to offer as part of this benefits package. A “standard plan” is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage or an SADP; a “benefits package” is a group of plans that covers the same set of benefits. Each plan in a benefits package may have different cost-sharing values, which are entered in the corresponding Cost Share Variances worksheet. Enter each standard plan in the Benefits Package worksheet, and the template automatically creates the necessary plan variations in the Cost Share Variances worksheet.

If the issuer runs out of empty rows for new plans, click the **Add Plan** button on the menu bar under the **Plans & Benefits** ribbon. Each benefits package may have up to 50 plans. If there are more than 50 plans associated with the same benefits package, a new benefits package with the identical benefits package structure must be created.

Figure 2D-3. Plan Identifiers Section

2019 Plans & Benefits Template v8.0		<i>To use this template, please review the user guide and instructions. All fields are required.</i>				
HIOS Issuer ID*		<i>You will need to save the latest version of the add-in file (PlansBenefitsAddin.xlsm).</i>				
Issuer State*		<i>To create the cost share variance worksheet and enter the cost sharing amounts, use the Cost Share Variances worksheet.</i>				
Market Coverage*		<i>To create additional Benefits Package worksheets, use the Create New Benefits Package button.</i>				
Dental Only Plan*		<i>To populate the benefits on the Benefits Package worksheet with your State's benefits, use the Benefits Package worksheet.</i>				
TIN*						
Plan Identifiers						
HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPID	Network ID*	Service Area ID*	Formulary ID*

Plan Identifiers	Steps
HIOS Plan ID (Standard Component)**	Enter the 14-character, HIOS-generated Plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name**	Enter the plan marketing name at the standard plan level.
HIOS Product ID*	Enter the 10-character, HIOS-generated Product ID number.
HPID	Enter the 10-digit national Health Plan Identifier (HPID).

Plan Identifiers	Steps
Network ID*	Click the <b>Import Network IDs</b> button on the menu bar under the <b>Plans &amp; Benefits</b> ribbon, and select the completed Network Template Excel file to import a list of values from the Network Template; then select the appropriate one from the drop-down menu. (The Excel version of the Network ID Template must be completed and saved before importing the Network IDs.)
Service Area ID*	Click the <b>Import Service Area IDs</b> button on the menu bar under the <b>Plans &amp; Benefits</b> ribbon, and select the completed Service Area Template Excel file to import a list of values from the Service Area Template; then select the appropriate one from the drop-down menu. (The Excel version of the Service Area Template must be completed and saved before importing the Service Area IDs.)
Formulary ID	Click the <b>Import Formulary IDs</b> button on the menu bar under the <b>Plans &amp; Benefits</b> ribbon, and select the completed Prescription Drug Template Excel file to import a list of values from the Prescription Drug Template; then select the appropriate one from the drop-down menu. (The Excel version of the Prescription Drug Template must be completed and saved before importing the Formulary IDs.)

### 4.3 Plan Attributes

This section includes fields for inputting more specific data for each plan, including its type, its metal level, and other plan-level requirements (**Figure 2D-4**).

Figure 2D-4. Specific Data Fields for Plan Attributes

Plan Attributes					
Notice Required for Pregnancy*	Is a Referral Required for Specialist?*	Specialist(s) Requiring a Referral	Plan Level Exclusions	Limited Cost Sharing Plan Variation - Est Advanced Payment	Does this plan offer Composite Rating?*

Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>New</b>—if this is a new plan that was not offered last year. This includes a plan that was offered last year but is not considered to be the “same plan” as described in 45 CFR 144.103. These plans should use new Plan IDs that were <i>not</i> used for the 2018 plan year.</li> <li>◆ <b>Existing</b>—if this plan was offered last year and the plan is considered to be the “same plan” as described in 45 CFR 144.103. These plans should use <i>the same</i> Plan ID that was used for the 2018 plan year.</li> </ul>
Plan Type**	Select the plan type that best corresponds to plan definitions provided in state law or regulations in the issuer’s state. Plan type selections must be consistent with the issuer’s state form-filing submissions. Choose from the following product network types: <ul style="list-style-type: none"> <li>◆ Indemnity</li> <li>◆ PPO (preferred provider organization)</li> <li>◆ HMO (health maintenance organization)</li> <li>◆ POS (point-of-service)</li> <li>◆ EPO (exclusive provider organization).</li> </ul>

Plan Attributes	Steps
Level of Coverage <sup>^**</sup>	<p>Select the metal level of the plan on the basis of its AV. A de minimis variation of -4/+2 percentage points is allowed for standard metal-level plans. Please note that, pursuant to 45 CFR 156.200(c), QHP issuers must offer at least one QHP in the silver coverage level and one QHP in the gold coverage level in each county they cover through the Exchange, as described in Section 1302(d)(1) of the PPACA. Choose from the following:</p> <ul style="list-style-type: none"> <li>◆ <b>Bronze</b>—AV of 60 percent.</li> <li>◆ <b>Expanded Bronze</b>—AV of 56–65 percent. A plan may use this option if it either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2).</li> <li>◆ <b>Silver</b>—AV of 70 percent.</li> <li>◆ <b>Gold</b>—AV of 80 percent.</li> <li>◆ <b>Platinum</b>—AV of 90 percent.</li> <li>◆ <b>Catastrophic</b>—offered to certain qualified individuals and families; it does not meet a specific AV but must comply with several requirements, including the MOOP and deductible limits.</li> </ul> <p>Level of coverage for SADPs are optional. If provided, it must fall within the previous actuarial value (AV) ranges of high or low, as described in 45 CFR 156.140:</p> <ul style="list-style-type: none"> <li>◆ <b>Low</b>—AV of 70 percent.</li> <li>◆ <b>High</b>—AV of 85 percent.</li> </ul>
Design Type*	This field is not applicable for PY2019. All plans should select <b>Not Applicable</b> for this field.
Unique Plan Design	<p>Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available for HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix 1. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the unique plan design features cause the use of the AVC to yield an AV result that materially differs from that of the other approved methods described in 45 CFR 156.135(b). This indicates that the plan is not compatible with the AVC. If <b>Yes</b> is selected for this reason, upload the Unique Plan Design Supporting Documentation and Justification (see Supporting Document section). The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.</li> <li>◆ <b>No</b>—if the plan design is <i>not</i> unique.</li> </ul>
QHP/Non-QHP*	<p>Indicate whether the plan will be offered only outside the Exchange or whether the plan will be offered through and outside the Exchange. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>On the Exchange</b>—under the guaranteed availability requirements in 45 CFR 147.104, a plan offered through the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan outside the Exchange. Issuers who offer a plan through the Exchange should select the “Both” option below unless an exception to guaranteed availability applies.</li> <li>◆ <b>Off the Exchange</b>—if the plan will be offered only outside the Exchange. This includes non-QHPs as well as plans that are substantially the same as a QHP offered through the Exchange for purposes of the risk corridor program (see 45 CFR 153.500 for more details).</li> <li>◆ <b>Both</b>—if the plan will be offered both through and outside the Exchange. A plan that is offered both through and outside the Exchange must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of whether it is offered through or outside of the Exchange. Selecting this option creates two separate plan variations in the Cost Share Variances worksheet when the worksheet is created: one on-Exchange plan and one off-Exchange plan.</li> </ul>

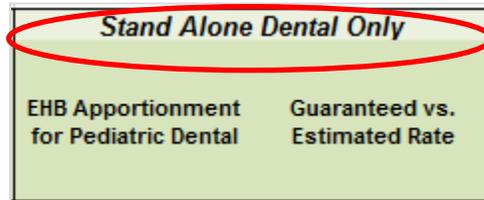
Plan Attributes	Steps
Notice Required for Pregnancy	Indicate whether the plan has to be notified (by a member or a doctor) before pregnancy benefits are covered. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if a notice is required.</li> <li>◆ <b>No</b>—if a notice is <i>not</i> required.</li> </ul>
Is a Referral Required for a Specialist?#	Indicate whether a referral is required to see a specialist. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if a referral is required to see a specialist.</li> <li>◆ <b>No</b>—if a referral is <i>not</i> required to see a specialist.</li> </ul>
Specialist(s) Requiring a Referral#	(Required if <b>Yes</b> is entered for “Is a Referral Required for a Specialist?”) Enter the types of specialists that require a referral.
Plan Level Exclusions*	Enter any plan exclusions.
Limited Cost Sharing Plan Variation—Est Advance Payment	This data element is not necessary this year because, as specified in the annual 2015 HHS Notice of Benefit and Payment Parameters, beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost-sharing plan variations. Therefore, leave this field blank.
Does this plan offer Composite Rating?	This field is not applicable for PY2019. All plans should select <b>No</b> for this field.
Child-Only Offering*	Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (offered only to individuals who, as of the beginning of the plan year, have not attained the age of 21 for QHP and 19 for SADP); one option must be selected consistent with the requirements at 45 CFR 156.200. This does not apply if the plan’s level of coverage is catastrophic. Please note that FF-SHOP does not accommodate child-only plans for both medical and SADPs. Enrollment in FF-SHOP must include an employee enrollment. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Allows Adult and Child-Only</b>—if the plan allows adult and child-only enrollment and is offered at a child-only rate.</li> <li>◆ <b>Allows Adult-Only</b>—if the plan does <i>not</i> allow child-only enrollment. This does not mean that only adults can enroll but that these plans require an adult as the primary subscriber. This plan needs a corresponding child-only plan (unless the plan’s coverage level is catastrophic). Because child-only plans are required if “Allows Adult-Only” is selected, as a work-around for FF-SHOP plans, issuers should designate these plans as “Allows Adult and Child-Only” and note in the Plan Level Exclusions field that the plan excludes child-only enrollment. This does not apply to SADPs because they must have the option of being offered to child-only subscribers. Do not select this option unless the SADP is offered in FF-SHOP.</li> <li>◆ <b>Allows Child-Only</b>—if the plan is a child-only plan that allows only child subscribers. Do not select this option for SADP plans offered in FF-SHOP.</li> </ul>
Child-Only Plan ID	(Required if “Allows Adult-Only” is entered for Child-Only Offering for plans that are not catastrophic.) Enter the corresponding 14-character Plan ID if this plan does <i>not</i> allow child-only enrollment. The entered Plan ID must correspond to a plan in which Child-Only Offering is equal to “Allows Adult and Child-Only” or “Allows Child-Only.” The corresponding plan must have the same Level of Coverage as the plan for which the issuer is entering data.

Plan Attributes	Steps
Tobacco Wellness Program Offered	<p>Indicate whether, as required to rate for tobacco use in the small-group market, the plan offers a wellness program designed to prevent or reduce tobacco use that meets the standards of Section 2705 of the Public Health Service (PHS) Act. (This is unrelated to whether the plan provides benefits for recommended preventive services, including tobacco-use counseling and interventions, under Section 2713 of the PHS Act.) Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act.</li> <li>◆ <b>No</b>—if the plan does <i>not</i> offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter <b>No</b> if either of the following applies: <ul style="list-style-type: none"> <li>▪ The plan is offered in the individual market.</li> <li>▪ The plan is offered in the small-group market and does not rate for tobacco use.</li> </ul> </li> </ul>
Disease Management Programs Offered <sup>#</sup>	<p>Indicate whether the plan offers disease management programs. Choose one or more of the following options:</p> <ul style="list-style-type: none"> <li>◆ Asthma</li> <li>◆ Heart Disease</li> <li>◆ Depression</li> <li>◆ Diabetes</li> <li>◆ High Blood Pressure &amp; High Cholesterol</li> <li>◆ Low Back Pain</li> <li>◆ Pain Management</li> <li>◆ Pregnancy</li> <li>◆ Weight Loss Programs.</li> </ul>
EHB Percent of Total Premium	<p>Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). This is required for all plans on the individual and SHOP markets except for catastrophic plans. This value will be used to calculate advanced premium tax credits and is required to match the value entered in the Unified Rate Review Template (URRT), except for catastrophic plans. For detailed instructions for completing this field, refer to the URRT instructions.</p> <p>Please note that if abortion services are included in the benefits package of the EHB benchmark plan, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below:</p> <ul style="list-style-type: none"> <li>◆ If the plan is a QHP offered in the FFE or SBE, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Because subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.</li> <li>◆ If the plan is not a QHP offered in the FFE or SBE, but rather is only offered in the outside market, the percentage of the premium associated with abortion services should be included in the EHB percentage.</li> </ul> <p>If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state-mandated benefits portion or the other benefits portion regardless of whether the plan is sold through or outside of the Exchange.</p>

#### 4.4 Stand-Alone Dental Only

The fields in this section apply to SADPs only (**Figure 2D-5**).

Figure 2D-5. SADPs-Only Fields



Stand-Alone Dental Only	Steps
EHB Apportionment for Pediatric Dental*	Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age-banded, use the EHB percent that applies to the pediatric rates. If the rates are family-tiered, use the EHB percent of the individual rate assuming a child enrollment. This percentage is used to determine the amount of the advance payment of the premium tax credit required under 45 CFR 155.340(e)(2). Issuers must also submit the "Stand-Alone Dental Plans—Description of EHB Allocation" form as a supporting document.
Guaranteed vs. Estimated Rate*	This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. CMS calculates the rates a consumer sees using the Rates Table Template and the Business Rules Template. By indicating the rate is a "Guaranteed Rate," the issuer commits to charging the premium shown to the consumer on the website, which has been calculated by taking into account consumers' geographic location, age, and other permissible rating factors provided for in the Rates Table Template and Business Rules Template. Estimated rates require enrollees to contact the issuer to determine a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported. Please note that FF-SHOP that SADPs offered on the Exchange do not accommodate estimated rates, and they must have guaranteed rates in order to be offered on the Exchange. Select whether this plan offers guaranteed or estimated rates: <ul style="list-style-type: none"> <li>◆ <b>Guaranteed Rate</b>—if the plan offers a guaranteed rate.</li> <li>◆ <b>Estimated Rate</b>—if the plan offers an estimated rate.</li> </ul>

#### 4.5 Plan Dates

This section contains fields for the effective date and expiration date for each plan. The FFE and FF-SHOP rating engine uses the effective dates in the Rates Table Template, not the Plans & Benefits Template (**Figure 2D-6**).

Figure 2D-6. Plan Dates



Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2019 plan year—even for existing plans offered on-Exchange in 2018. Enter the effective date of the plan using the mm/dd/yyyy format. This must be January 1, 2019, for all plans that will be offered through the FFE and FF-SHOP.

Plan Dates	Steps
Plan Expiration Date*	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (it must be December 31, 2019, for the individual market). In the context of FF-SHOP, the plan is effective for a 12-month plan year. The plan expiration date is 12 months after the original employer coverage effective date.

#### 4.6 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations. Issuers should only select **Yes** for these data elements if the plan offers the entire package of benefits for the geographic unit. Issuers should not select **Yes** if the plan covers only emergency services for the geographic unit (**Figure 2D-7**).

Figure 2D-7. Geographic Coverage Fields



Geographic Coverage	Steps
Out of Country Coverage*	Indicate whether care obtained outside the country is covered under the plan. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the plan covers care obtained out of the country.</li> <li>◆ <b>No</b>—if the plan does <i>not</i> cover care obtained out of the country.</li> </ul>
Out of Country Coverage Description*	(Required if "Yes" is selected for Out of Country Coverage.) Enter a short description of the care obtained outside the country that the plan covers.
Out of Service Area Coverage*	Indicate whether care obtained outside the service area is covered under the plan. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the plan covers care obtained outside the plan service area.</li> <li>◆ <b>No</b>—if the plan does <i>not</i> cover care obtained outside the plan service area.</li> </ul>
Out of Service Area Coverage Description*	(Required if "Yes" is entered for Out of Service Area Coverage.) Enter a short description of the care obtained outside the service area that is covered under the plan.
National Network**	Indicate whether a national network is available. Choose from the following: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if a national network is available.</li> <li>◆ <b>No</b>—if a national network is <i>not</i> available.</li> </ul>

#### 4.7 URLs

This section contains a field pertaining to URL information on plans (**Figure 2D-8**).

Figure 2D-8. URL Fields



URLs	Steps
URL for Enrollment Payment*	Enter the website location for enrollment payment information. Only submit a URL if it is a working payment site capable of collecting a consumer's first-month premium and it complies with the latest payment redirect business service description. URLs must start with "http://" or "https://" to work properly for the consumer. This is optional for SADPs.

#### 4.8 Benefit Information

After completing the sections of the template discussed above, issuers will complete the Benefit Information section of the template to indicate the scope of benefits covered in their plans (**Figure 2D-9**).

Figure 2D-9. Benefit Information Section

<i>Benefit Information</i>				
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity
Primary Care Visit to Treat an Injury or Illness				
Specialist Visit				
Other Practitioner Office Visit (Nurse, Physician Assistant)				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				
Outpatient Surgery Physician/Surgical Services				
Hospice Services				
Routine Dental Services (Adult)				
Infertility Treatment				
Long-Term/Custodial Nursing Home Care				
Private-Duty Nursing				

Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. If this benefits package has multi-state plans using an alternate benchmark, click **Yes** to the pop-up. Otherwise, click **No**. The Plans & Benefits Add-In file has been updated to accurately reflect the current EHB benchmark data. Scroll down the worksheet to the Benefit Information section. The following fields may auto-populate, depending on the state, market type, and EHB benchmark:

- EHB
- Is this Benefit Covered?
- Quantitative Limit on Service
- Limit Quantity
- Limit Unit
- Exclusions
- Benefit Explanation.

To add a benefit not listed on the template, click the **Add Benefit** button on the menu bar under the **Plans & Benefits** ribbon.

- Look through the drop-down menu to see whether the benefit already exists as an option, and select it if it does. If the benefit is not on this menu, click the Custom button and type in the benefit name. The benefit name may not be identical to any other benefit's name.
- A row for this benefit then appears below the last row in the Benefit Information section.
- If a benefit is mistakenly added, it cannot be deleted, but an issuer may do one of the following:
  - Select **Not Covered** under the "Is this Benefit Covered?" column (described below).

- Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. This deletes the added benefit, but the issuer also loses any other data entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections.
- If the benefit added is not found in the state’s benchmark, and the issuer is not substituting for an EHB found in the state’s benchmark, select **Not EHB** as the EHB Variance Reason.
- If the benefit added is not found in the state’s benchmark, but the issuer is substituting for an EHB found in the state’s benchmark, select **Additional EHB Benefit** as the EHB Variance Reason.
- If the benefit added is a state-required benefit enacted after December 2011, select **Not EHB** as the EHB Variance Reason.
- For more information on how to select the correct EHB Variance Reason, see Section 5.6.
- A benefits package should not have multiple benefits with identical names. In the event of multiple cost-sharing schemas for a given benefit based on multiple limits, choose the cost-sharing type that applies to the limits in Limit Quantity and Limit Unit for each of the network types.

#### 4.9 General Information

This section contains fields that give more information on each benefit in the benefits package, such as whether it is covered, whether it has any limits, and any applicable exclusions or benefit explanations (**Figure 2D-10**).

Figure 2D-10. General Information Fields

Benefit Information		General Information						
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
Primary Care Visit to Treat an Injury or Illness								
Specialist Visit								
Other Practitioner Office Visit (Nurse, Physician Assistant)								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services								

General Information	Steps
EHB*	This field is auto-populated for all benefits listed in the template that are covered by the state EHB benchmark plan for the market coverage. Issuers cannot edit this field. <i>Note:</i> Issuers should carefully review the benefits covered by their applicable EHB benchmark plan as identified on CMS’s “Information on Essential Health Benefits (EHB) Benchmark Plans” web page at <a href="https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html">https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html</a> . On the basis of their review of the applicable EHB benchmark plan documents, issuers may need to update the Benefits Package worksheet with any changes required to accurately reflect their coverage of EHB benchmark benefits. See the EHB Variance Reason field instructions below for more information on updating the Benefit Package worksheet.
Is this Benefit Covered?*	This field is auto-populated with <b>Covered</b> for benefits identified in the template as EHB. If the “Is this Benefit Covered?” data element is changed to <b>Not Covered</b> , the issuer must substitute another benefit in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see the EHB Variance Reason data field and Supporting Document section). If a benefit is marked as <b>Not Covered</b> , it does not appear on the Cost Share Variances worksheet and the remaining fields for this benefit may be left blank. Choose from the following options: ♦ <b>Covered</b> —if this benefit is covered by the plan. A benefit is considered covered if the issuer covers the cost of the benefit listed in a policy either through first-dollar coverage or in combination with a cost-sharing mechanism (e.g., copays, coinsurance, or deductibles).

General Information	Steps
	<ul style="list-style-type: none"> <li>◆ <b>Not Covered</b>—if this benefit is <i>not</i> covered by the plan. A benefit is considered not covered if the subscriber is required to pay the full cost of the services with no effect on deductible and MOOP limits.</li> </ul>
Quantitative Limit on Service?*	<p>(Required if <b>Covered</b> is entered for Is this Benefit Covered?) This field is auto-populated for benefits identified in the template as EHBs. If this data element is changed, an EHB variance reason must be provided and associated supporting documents. For any benefits not identified as EHBs, choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if this benefit has quantitative limits.</li> <li>◆ <b>No</b>—if this benefit does <i>not</i> have quantitative limits.</li> </ul> <p><i>Note:</i> Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2018, issuers may not impose combined limits on habilitative and rehabilitative services and devices. Therefore, when completing the Benefit Information and General Information sections of the Plans &amp; Benefits Template Benefit Package worksheet, issuers must provide a separate limit for those benefits.</p>
Limit Quantity**	<p>(Required if <b>Yes</b> is entered for Quantitative Limit on Service?) This field is auto-populated for benefits in the template identified as EHBs. If the issuer changes this data element, it must provide an EHB Variance Reason. For any benefits not identified as EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., a limit of two specialist visits per year, enter <b>2</b> here).</p>
Limit Unit**	<p>(Required if <b>Yes</b> is entered for Quantitative Limit on Service?) This field is auto-populated for benefits in the template identified as EHBs. If data are changed for this element, select the EHB Variance Reason of <b>Substantially Equal</b>. For any benefits not identified as EHBs, using the drop-down menus, enter the units being restricted per interval to show the quantitative limits that are placed on this benefit (e.g., if the plans have a limit of two specialist visits per year, enter <b>Visits per year</b> here). Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ Hours per week</li> <li>◆ Hours per month</li> <li>◆ Hours per year</li> <li>◆ Days per week</li> <li>◆ Days per month</li> <li>◆ Days per year</li> <li>◆ Months per year</li> <li>◆ Visits per week</li> <li>◆ Visits per month</li> <li>◆ Visits per year</li> <li>◆ Lifetime visits</li> <li>◆ Treatments per week</li> <li>◆ Treatments per month</li> <li>◆ Lifetime treatments</li> <li>◆ Lifetime admissions</li> <li>◆ Procedures per week</li> <li>◆ Procedures per month</li> <li>◆ Procedures per year</li> <li>◆ Lifetime procedures</li> <li>◆ Dollar per year</li> <li>◆ Dollar per visit</li> <li>◆ Days per admission</li> <li>◆ Procedures per episode.</li> </ul> <p>If a benefit has limit units that do not align with the list above, the limit does not auto-populate in the Limit Unit field but does auto-populate in the Benefit Explanation field (e.g., a limit of one hearing aid per ear every 48 months for subscribers up to age 18).</p>

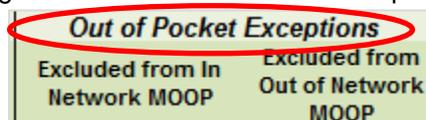
General Information	Steps
	<p>If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB benchmarks on the Center for Consumer Information &amp; Insurance Oversight (CCIIO) website (<a href="http://www.cciio.cms.gov/resources/data/ehb.html">http://www.cciio.cms.gov/resources/data/ehb.html</a>). The message “Quantitative limit units apply, see EHB benchmark” appears in the Benefit Explanation field (e.g., Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services).</p> <p>If a benefit has multiple limit units, they do not auto-populate. Put the limit quantity and limit unit that should be displayed on the Plan Compare function of the FFE website in these columns, and put all other quantitative limits in the Benefit Explanation field (e.g., Outpatient Rehabilitative Services—90 days per year in the Limit Quantity and Limit Unit columns; two treatments per year in the benefit explanation).</p> <p>The message “Quantitative limit units apply, see EHB benchmark” may appear in the Benefit Explanation field for a benefit that does not have quantitative limits in the “Benefits and Limits” section of the EHB benchmark on the CCIIO website (<a href="http://www.cciio.cms.gov/resources/data/ehb.html">http://www.cciio.cms.gov/resources/data/ehb.html</a>). This message appears because certain benefits, identified in the Other Benefits section of the EHB benchmark Benefit Template, may have quantitative limits, which may not apply to all services in the higher-level benefit category.</p>
Exclusions*#	<p>Enter any benefit-level exclusions.</p> <ul style="list-style-type: none"> <li>◆ If particular services or diagnoses are subject to exclusions (covered under some circumstances but not others), list those specific exclusions.</li> <li>◆ If <i>no</i> services or diagnoses are excluded, leave this field blank.</li> </ul>
Benefit Explanation*#	<p>Enter any benefit explanations.</p> <ul style="list-style-type: none"> <li>◆ Examples of benefit explanations include additional quantitative limits, links to additional plan documents, child-specific MOOP or deductible limits, detailed descriptions of services provided, and alternate cost-sharing structures if they depend on provider type or place of service.</li> </ul>
EHB Variance Reason*	<p>(Required if the issuer changed the Is this Benefit Covered?, Limit Units, or Limit Quantity fields or if the benchmark has an unallowable limit or exclusion under the PPACA.) Select from the following EHB Variance Reasons if this benefit differs from the state’s benchmark:</p> <ul style="list-style-type: none"> <li>◆ <b>Not EHB</b>—if this benefit is <i>not</i> an EHB. <ul style="list-style-type: none"> <li>▪ If the issuer has added a new benefit and it is not found in the state’s benchmark, the EHB field will be blank and the issuer should set the EHB Variance Reason to <b>Not EHB</b>. This benefit is <i>not</i> considered an EHB.</li> <li>▪ If a benefit auto-populated as <b>Yes</b> in the EHB column, but the issuer has received guidance from CMS or the state indicating that it should not be considered an EHB, set the EHB Variance Reason to <b>Not EHB</b>. This benefit is <i>not</i> considered an EHB.</li> </ul> </li> <li>◆ <b>Substituted</b>—if a benefit is included in the state’s benchmark, the EHB field auto-populates as <b>Yes</b>. If substituting a different benefit for an EHB, set the EHB Variance Reason field to <b>Substituted</b> and the Is this Benefit Covered? field to <b>Not Covered</b>. The benefit that takes its place must be designated as <b>Additional EHB Benefit</b>.</li> <li>◆ <b>Substantially Equal</b>—if the Limit Quantity for a benefit differs from the limit quantity in the EHB benchmark, but is still substantially equal to the EHB benchmark, select <b>Substantially Equal</b> as the Variance Reason. Also, if the Limit Unit for a benefit differs from the limit unit in the EHB benchmark, but is still substantially equal to the EHB benchmark, select <b>Substantially Equal</b> as the Variance Reason. For example, if the benchmark lists a limit of 40 hours per month, and the plan defines a day as 8 hours and lists a limit of 5 days per month, the issuer should use that variance reason.</li> </ul>

General Information	Steps
	<ul style="list-style-type: none"> <li>◆ <b>Using Alternate Benchmark</b>—multi-state plans use an alternate benchmark. Issuers should select this EHB variance reason for any benefit that has <b>Yes</b> for EHB but is not an EHB in the alternate benchmark.</li> <li>◆ <b>Other Law/Regulation</b>—if a benefit is required by a state or federal law or regulation that was enacted on or before December 31, 2011, and the benefit is not represented in the state’s EHB benchmark plan. (State-required benefits that were enacted after December 31, 2011, are <i>not</i> EHBs, and for those the issuer should use <b>Not EHB</b> as the variance reason instead.) For example, a benefit may not appear as an EHB because the benchmark plan is a small-group plan and coverage is only state-required in the individual market. When an issuer is filling out the template for an individual market plan, coverage of the benefit must be changed from blank to <b>Covered</b> using the EHB variance reason “Other Law/Regulation.”</li> <li>◆ <b>Additional EHB Benefit</b>—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list by state. For example, non-preferred brand drug benefits may appear as not being covered in the auto-populated table when they actually are. In this case, change the benefit to <b>Covered</b>, and choose <b>Additional EHB Benefit</b> as the EHB variance reason. This benefit is considered an EHB, and cost-sharing values for the plan variations should be entered accordingly.</li> <li>◆ <b>Dental Only Plan Available</b>—if a dental benefit auto-populates as <b>Covered</b>, but the issuer is not covering a benefit because it is a dental EHB covered by a separate dental-only plan, set the EHB Variance Reason to <b>Dental Only Plan Available</b>. For example, an issuer may offer SADPs to cover pediatric dental benefits, so they will not need to cover pediatric dental as part of the medical plans. The issuer would select <b>Not Covered</b> and select <b>Dental Only Plan Available</b> as the EHB variance reason for benefits, such as Dental Check-Up for Children, Basic Dental Care—Child, Orthodontia—Child, and Major Dental Care—Child if the benefits are designated as a <b>Covered</b> EHB. (This option is not applicable to SADPs.)</li> </ul> <p><i>Note:</i> Because EHB benchmark plan benefits are based on plans that were sold previously, some of the benchmark plan designs may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Therefore, issuers should carefully review the information available on the CMS “Information on Essential Health Benefits (EHB) Benchmark Plans” web page (<a href="https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html">https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html</a>).</p> <p>If more than one EHB variance reason applies, select the option related to EHB designation instead of the one related to limits. For example, if an issuer adds a new benefit that is an EHB and also changes its limits, the EHB variance reason that should be selected is “Additional EHB Benefit” instead of “Substantially Equal.” It is important that the issuer enter the correct EHB Variance Reason because it has implications for nondiscrimination and EHB reviews as well as cost-sharing requirements for EHBs and non-EHBs related to cost-sharing reduction plan variations.</p>

#### 4.10 Out-of-Pocket Exceptions

This section is for indicating whether each benefit is excluded from the MOOP. All plans in a benefits package must have the same MOOP structure and exclude the same benefits from the MOOP. To create plans with a different MOOP structure, issuers must create a new benefits package and then a new Cost Share Variances worksheet (**Figure 2D-11**).

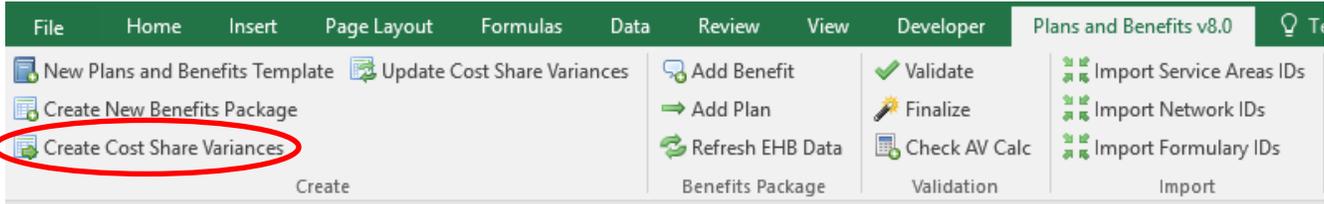
Figure 2D-11. Out of Pocket Exceptions



Out-of-Pocket Exceptions	Steps
Excluded from In-Network MOOP*	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if this benefit is excluded from the in-network MOOP.</li> <li>◆ <b>No</b>—if this benefit is <i>not</i> excluded from the in-network MOOP.</li> </ul>
Excluded from Out-of-Network MOOP*	Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if this benefit is excluded from the out-of-network MOOP.</li> <li>◆ <b>No</b>—if this benefit is <i>not</i> excluded from the out-of-network MOOP.</li> </ul>
<ul style="list-style-type: none"> <li>◆ If the plans only have a combined (no separate in-network) MOOP, set Excluded from In Network MOOP equal to Excluded from Out of Network MOOP.</li> <li>◆ If Is this Benefit Covered? for a benefit is <b>Not Covered</b>, or blank, leave Excluded from In Network MOOP and Excluded from Out of Network MOOP blank.</li> <li>◆ If the plans do not have an out-of-network MOOP, set Excluded from Out of Network MOOP equal to <b>Yes</b>.</li> </ul>	

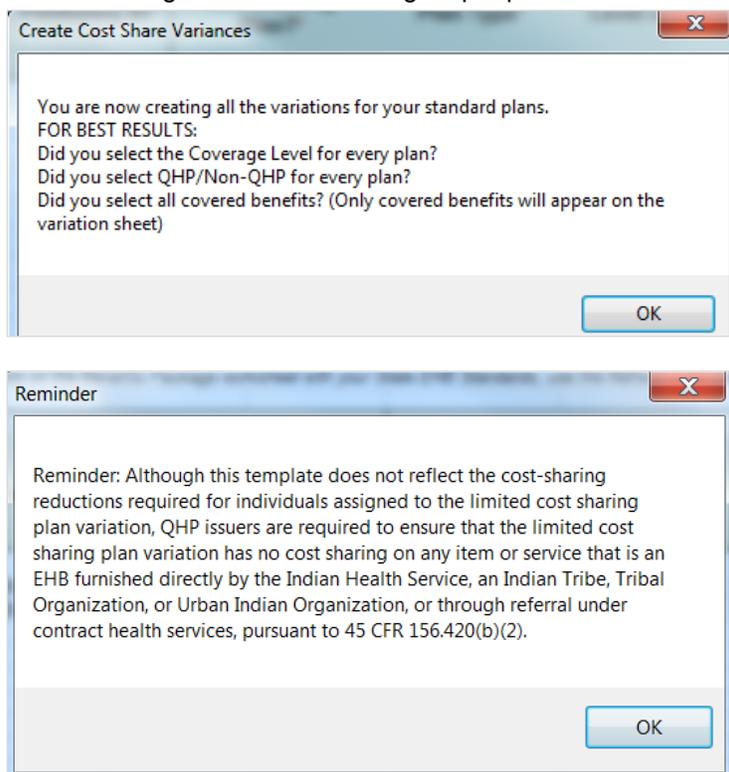
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon (**Figure 2D-12**). The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

Figure 2D-12. Create Cost Share Variances Button



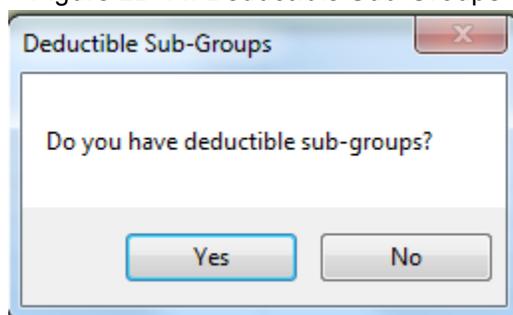
Click **OK** after reading the warnings (**Figure 2D-13**), and make any necessary changes.

Figure 2D-13. Warning Pop-Up Boxes



The following questions pop up regarding deductible sub-groups (**Figure 2D-14**). Deductible sub-groups should be used to identify benefits or groupings of benefits that have their own deductibles. These deductible sub-groups are not separate deductibles outside any maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to have any deductible sub-groups.

Figure 2D-14. Deductible Sub-Groups

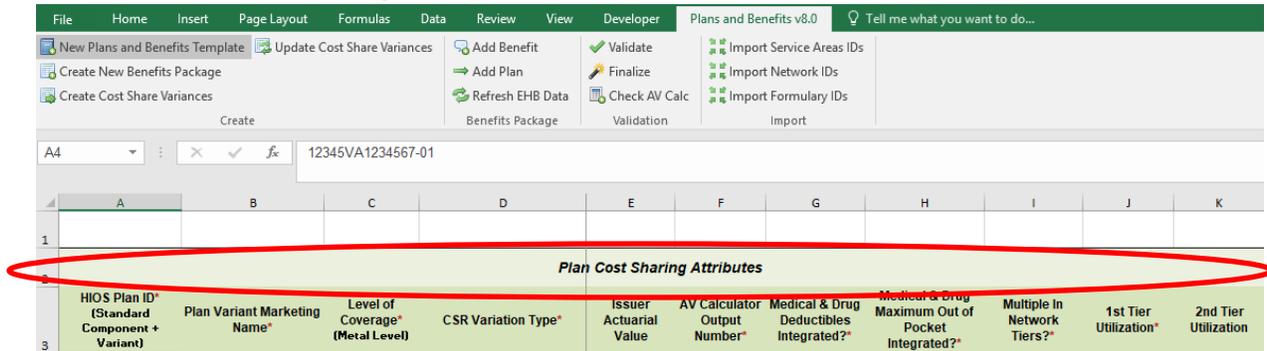


1. Do you have any deductible sub-groups?
  - a. **Yes**—if the plan contains deductible sub-groups.
  - b. **No**—if the plan does *not* contain deductible sub-groups.
2. How many deductible sub-groups do you have? Enter the correct number, and click **OK**.
3. What is the name of this deductible sub-group? Enter the name of each sub-group, and click **OK** after each. You must use a different name for each sub-group.

A new worksheet, Cost Share Variances, is created for each Benefits Package worksheet (**Figure 2D-15**). Corresponding worksheets are labeled with the same number. For example, enter information on Cost Share

Variations 2 for plans created on Benefits Package 2. The worksheet contains several auto-populated cells; verify that the information in each is accurate.

Figure 2D-15. Cost Share Variances Worksheet



For details on updating the Cost Share Variances worksheet after it has been created and incorporating changes made to the Benefits Package worksheet, see Section 5.4.

#### 4.11 Plan Cost-Sharing Attributes

This section has fields with basic information on each plan and cost-sharing reduction plan variation, such as its Plan ID, marketing name, and metal level. It also asks questions about the medical and drug integration for deductibles and MOOP to determine the appropriate columns to fill out later in the template.

*Note:* The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans and plan variations submitted by the issuer. However, cost-sharing reductions do not apply to SADPs.

Plan Cost-Sharing Attributes	Steps
HIOS Plan ID*	<p>The HIOS-generated number auto-populates for each cost-sharing plan variation.</p> <ul style="list-style-type: none"> <li>◆ Standard plans to be offered on the Exchange have a Plan ID variant suffix of “-01,” and standard plans to be offered outside the Exchange have a Plan ID variant suffix of “-00.”</li> <li>◆ For the individual market, each standard plan (except for catastrophic) has two cost-sharing reduction plan variations for American Indians and Alaska Natives: one with zero cost sharing and one with limited cost sharing. These are indicated with a Plan ID variant suffix of “-02” and “-03,” respectively. <ul style="list-style-type: none"> <li>▪ In the zero cost-sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs.</li> <li>▪ In the limited cost-sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian healthcare provider or from another provider if they have a referral from an Indian healthcare provider.</li> </ul> </li> <li>◆ Also in the individual market, each silver plan has three additional cost-sharing reduction plan variations created: a 73 percent AV plan, an 87 percent AV plan, and a 94 percent AV plan. These are indicated with a Plan ID variant suffix of “-04,” “-05,” and “-06,” respectively. <ul style="list-style-type: none"> <li>▪ These silver plan variations offer a discount that lowers the amount consumers have to pay out of pocket for deductibles, coinsurance, and copayments, and there is also a lower MOOP. Consumers qualify for these plans if their income is below a certain level.</li> </ul> </li> </ul>

Plan Cost-Sharing Attributes	Steps
Plan Variant Marketing Name**	The name of the plan auto-populates for all standard plans and plan variations with the standard plan's plan marketing name. The field can be edited on this worksheet for each of the plan variations. The marketing name entered for each plan variation on this worksheet will be the one that displays to consumers. The field has a limit of 255 characters.
Level of Coverage^*	The coverage level for the plan auto-populates for standard plans.
CSR Variation Type^	The plan variation type auto-populates. This defines the plan variation as a standard on-Exchange plan, a standard off-Exchange plan, or one of the CSR plan variations explained in this section.
Issuer Actuarial Value*	(Required if <b>Yes</b> is entered for Unique Plan Design.) Enter the issuer-calculated AV. (This is optional for SADPs for PY2019. If provided, it must fall within the previous AV ranges.) This applies to health plans that indicate they are a unique plan for AV purposes. SADP issuers must submit the "Stand-Alone Dental Plan Actuarial Value" supporting documentation noting the value of the AV level of the pediatric dental benefit EHB and certifying that their actuarial value was developed by a certified member of the American Academy of Actuaries using generally accepted principles and methods.
AV Calculator Output Number	Clicking the <b>Check AV Calc</b> button on the <b>Plans &amp; Benefits</b> ribbon and selecting the correct file populates this field with the AV for all plans on this worksheet with a non-unique plan design. All cost-sharing information and benefits package information must be filled in before clicking this button. (For more information, see Appendix 1.) This field is optional for SADPs but is required for medical QHPs.
Medical & Drug Deductibles Integrated?^	Indicate whether the medical and drug deductible is integrated. An integrated deductible means that both medical and drug charges contribute to a total plan-level deductible. A separate deductible means medical and drug charges contribute to separate plan-level deductibles. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the medical and drug deductible is integrated. If <b>Yes</b> is entered, issuers should not enter information in Medical Deductible or Drug Benefits Deductible.</li> <li>◆ <b>No</b>—if the medical and drug deductible is <i>not</i> integrated. If <b>No</b> is entered, issuers should not enter information in Combined Medical &amp; Drug Deductible.</li> </ul>
Medical & Drug Maximum Out of Pocket Integrated?^	Indicate whether the medical and drug MOOP is integrated. An integrated MOOP means that both medical and drug charges contribute to a total plan-level MOOP. A separate MOOP means medical and drug charges contribute to separate plan-level MOOP values. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the medical and drug MOOP is integrated. If <b>Yes</b> is entered, issuers should not enter information in Maximum Out of Pocket for EHB Benefits or Maximum Out of Pocket for Drug Benefits.</li> <li>◆ <b>No</b>—if the medical and drug deductible MOOP is <i>not</i> integrated. If <b>No</b> is entered, issuers should not enter information in Maximum Out of Pocket for EHB and Drug Benefits (Total).</li> </ul>
Multiple In Network Tiers?^*	Indicate whether there are multiple in-network provider tiers, meaning that the plan applies to different levels of in-network cost sharing depending on the tier of the provider or facility. The value must be the same for all variations of a plan. Choose from the following options: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if there are multiple in-network provider tiers. Enter Tier 1 information into the In Network and In Network (Tier 1) sections and Tier 2 information into the In Network (Tier 2) sections.</li> <li>◆ <b>No</b>—if there are <i>not</i> multiple in-network provider tiers. Issuers will not be able to enter information into the In Network (Tier 2) sections, which will be grayed out and locked for editing.</li> </ul>

Plan Cost-Sharing Attributes	Steps
1st Tier Utilization <sup>^*</sup>	If the answer to “Multiple In Network Tiers?” is <b>Yes</b> , enter the 1st Tier Utilization as a percentage here. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. If the answer to “Multiple In Network Tiers?” is <b>No</b> , the field auto-populates to “100%.” (All plan variations must have the same 1st tier utilization as the standard plan.)
2nd Tier Utilization <sup>^*</sup>	If the answer to “Multiple In Network Tiers?” is <b>Yes</b> , enter the 2nd Tier Utilization as a percentage here. This cell will be grayed out and locked for editing if the answer to “Multiple In-Network Tiers?” is <b>No</b> . (All plan variations must have the same 2nd tier utilization as the standard plan.)

#### 4.12 Summary of Benefits and Coverage Scenario

This section contains fields for basic information on three Summary of Benefits and Coverage (SBC) scenarios. This section is not applicable to SADPs. Additional information containing SBC scenario coverage examples and further resources for completing the scenarios can be found in the Summary of Benefits and Coverage and Uniform Glossary section of the CCIO website at <http://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index.html>. Any other concerns or technical assistance inquiries about these fields can be directed to [abc@cms.hhs.gov](mailto:abc@cms.hhs.gov). Fill out the following data fields for all three coverage examples (Having a Baby, Having Diabetes, and Treatment of a Simple Fracture).

Plan Cost Sharing Attributes	Steps
Deductible <sup>#</sup>	Enter the numerical value for the deductible.
Copayment <sup>#</sup>	Enter the numerical value for the copayment.
Coinsurance <sup>#</sup>	Enter the numerical value for the coinsurance.
Limit <sup>#</sup>	Enter the numerical value for the benefit limits or exclusion amount.

#### 4.13 Maximum Out-of-Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Not all of the sections should be filled out, depending on whether the medical and drug MOOP and deductibles are integrated, as indicated through the entries in the “Medical & Drug Deductibles Out of Pocket Integrated?” and “Medical & Drug Maximum Out of Pocket Integrated?” fields. SADP issuers should skip to Sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (For guidance filling out the MOOP and Deductible sections of the template, and ensuring that all requirements are met, see Section 5.1.)

The Family fields for In Network, In Network (Tier 2), and Out of Network MOOP and deductibles will have additional options. When selecting these fields, a pop-up will appear allowing the issuer to enter a per-group amount and a per-person amount. The per-group amount is the total MOOP or deductible limit when accruing costs for all members in a family (i.e., any coverage other than self-only). The per-person amount is the MOOP or deductible limit that applies separately to each person in a family. The Per Person and Per Group fields will be displayed to consumers on Plan Compare when they are shopping for coverage with more than one person in the enrollment group. The following requirements apply to this new field:

- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan (\$7,900) and for the specific cost-sharing reduction plan variations. See Section 5.5 for more details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.
- There must be a per-person amount and per-group amount entered for MOOP; the issuer may not enter **Not Applicable** for all these cells in all Family fields. The only exception is if a given plan is available to consumers only as self-only coverage.

#### 4.14 Maximum Out-of-Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in **Figure 2D-16**.

Figure 2D-16. MOOP Fields

Maximum Out of Pocket for Medical EHB Benefits							
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	Family	Individual	Family	Individual	Family	Individual	Family

This section is used for inputting MOOP values for medical EHB benefits and is required only if the medical and drug MOOPs are *not* integrated (**No** is entered for Medical & Drug Maximum Out of Pocket Integrated?). If the MOOPs are integrated (**Yes** is entered for Medical & Drug Maximum Out of Pocket Integrated?), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family MOOP for EHB benefits in the following areas of the template.

MOOP Medical EHB Benefits	Steps
In Network—Individual <sup>^#</sup>	If the MOOPs are <i>not</i> integrated, enter the dollar amount for Medical In Network Individual Maximum Out of Pocket for EHB Benefits.
In Network—Family <sup>^#</sup>	If the MOOPs are <i>not</i> integrated, enter the per-person and per-group dollar amount for Medical In Network Family Maximum Out of Pocket for EHB Benefits.
In Network (Tier 2)—Individual <sup>^</sup>	If the MOOPs are <i>not</i> integrated and the plan has multiple in-network tiers, enter the dollar amount for Medical In Network (Tier 2) Individual Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If the MOOPs are <i>not</i> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for Medical In Network (Tier 2) Family Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If the MOOPs are <i>not</i> integrated, enter the dollar amount for Medical Out of Network Individual Maximum Out of Pocket for EHB Benefits.
Out of Network—Family	If the MOOPs are <i>not</i> integrated, enter the per-person and per-group dollar amount for Medical Out of Network Family Maximum Out of Pocket for EHB Benefits.
Combined In/Out Network—Individual <sup>^#</sup>	If the MOOPs are <i>not</i> integrated, enter the dollar amount for Medical Combined In/Out of Network Individual Maximum Out of Pocket for EHB Benefits.
Combined In/Out Network—Family <sup>#</sup>	If the MOOPs are <i>not</i> integrated, enter the per-person and per-group dollar amount for Medical Combined In/Out of Network Family Maximum Out of Pocket for EHB Benefits.

#### 4.15 Maximum Out-of-Pocket for Drug EHB Benefits

This section is used for inputting MOOP values for drug EHB benefits and is required only if the medical and drug MOOPs are *not* integrated (**No** is entered for Medical & Drug Maximum Out of Pocket Integrated?). If the MOOPs are integrated (**Yes** is entered for Medical & Drug Maximum Out of Pocket Integrated?), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family MOOP for drug EHB benefits in the following areas of the template.

MOOP Drug EHB Benefits	Steps
In Network—Individual <sup>^#</sup>	If the MOOPs are <i>not</i> integrated, enter the dollar amount for In Network Individual Maximum Out of Pocket for Drug EHB Benefits.
In Network—Family <sup>#</sup>	If the MOOPs are <i>not</i> integrated, enter the per-person and per-group dollar amount for In Network Family Maximum Out of Pocket for Drug EHB Benefits.

MOOP Drug EHB Benefits	Steps
In Network (Tier 2)—Individual <sup>^</sup>	If the MOOPs are <i>not</i> integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the In Network—Individual field.)
In Network (Tier 2)—Family	If the MOOPs are <i>not</i> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the In Network—Family field.)
Out of Network—Individual	If the MOOPs are <i>not</i> integrated, enter the dollar amount for Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.
Out of Network—Family	If the MOOPs are <i>not</i> integrated, enter the per-person and per-group dollar amount for Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.
Combined In/Out Network—Individual <sup>^#</sup>	If the MOOPs are <i>not</i> integrated, enter the Combined In/Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.
Combined In/Out Network—Family <sup>#</sup>	If the MOOPs are <i>not</i> integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.

#### 4.16 Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)

This section is used for inputting MOOP values for medical and drug EHB benefits, and it is required only if the medical and drug MOOPs are integrated (**Yes** is entered for Medical & Drug Maximum Out of Pocket Integrated?). If the MOOPs are *not* integrated (**No** is entered for Medical & Drug Maximum Out of Pocket Integrated?), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family MOOP for medical and drug EHB benefits in the following areas on the template.

MOOP Medical & Drug EHB Benefits	Steps
In Network—Individual <sup>^#</sup>	If the MOOPs are integrated, enter the dollar amount for the Total In Network Individual Maximum Out of Pocket.
In Network—Family <sup>#</sup>	If the MOOPs are integrated, enter the per-person and per-group dollar amount for the Total In Network Family Maximum Out of Pocket.
In Network (Tier 2)—Individual <sup>^</sup>	If the MOOPs are integrated and the plan has multiple in-network tiers, enter the dollar amount for the Total In Network (Tier 2) Individual Maximum Out of Pocket. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If the MOOPs are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for the Total In Network (Tier 2) Family Maximum Out of Pocket. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If the MOOPs are integrated, enter the dollar amount for the Total Out of Network Individual Maximum Out of Pocket.
Out of Network—Family	If the MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Out of Network Family Maximum Out of Pocket.
Combined In/Out Network—Individual <sup>^#</sup>	If the MOOPs are integrated, enter the dollar amount for the Total Combined In/Out of Network Individual Maximum Out of Pocket.

MOOP Medical & Drug EHB Benefits	Steps
Combined In/Out Network—Family <sup>#</sup>	If the MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Combined In/Out of Network Family Maximum Out of Pocket.

#### 4.17 Medical EHB Deductible

This section is used for inputting deductible values for medical EHB benefits and is required only if the medical and drug deductibles are *not* integrated (**No** is entered for Medical & Drug Deductibles Integrated?). If the deductibles are integrated (**Yes** is entered for Medical & Drug Deductibles Integrated?), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family deductible for EHB benefits in the following areas on the template.

Medical EHB Deductible	Steps
In Network—Individual <sup>^#</sup>	If the deductibles are <i>not</i> integrated, enter the dollar amount for In Network Individual Medical EHB Deductible.
In Network—Family <sup>#</sup>	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for In Network Family Medical EHB Deductible.
In Network—Default Coinsurance <sup>^</sup>	If the deductibles are <i>not</i> integrated, enter the numerical value for the in-network coinsurance. <i>Note:</i> If the deductibles are <i>not</i> integrated, this is a required field for the AV calculation for those plans using the AVC.
In Network (Tier 2)—Individual <sup>^</sup>	If the deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Medical EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If the deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Medical EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Default Coinsurance <sup>^</sup>	If the deductibles are <i>not</i> integrated, enter the numerical value for the in-network coinsurance. If there are <i>not</i> multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If the deductibles are <i>not</i> integrated, enter the dollar amount for Out of Network Individual Medical Deductible.
Out of Network—Family	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Out of Network Family Medical EHB Deductible.
Combined In/Out Network—Individual <sup>^#</sup>	If the deductibles are <i>not</i> integrated, enter the dollar amount for Combined In/Out of Network Individual Medical EHB Deductible.
Combined In/Out Network—Family <sup>#</sup>	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Medical EHB Deductible.

#### 4.18 Drug EHB Deductible

This section is used for inputting deductible values for drug EHB benefits and is required only if the medical and drug deductibles are *not* integrated (**No** is entered for Medical & Drug Deductibles Integrated?). If the deductibles are integrated (**Yes** is entered for Medical & Drug Deductibles Integrated?), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family deductible for drug EHB benefits in the following areas on the template.

Drug EHB Deductible	Steps
In Network—Individual <sup>^#</sup>	If the deductibles are <i>not</i> integrated, enter the dollar amount for In Network Individual Drug EHB Deductible.

Drug EHB Deductible	Steps
In Network—Family <sup>#</sup>	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for In Network Family Drug EHB Deductible.
In Network—Default Coinsurance <sup>^</sup>	If the deductibles are not integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual <sup>^</sup>	If the deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the In Network—Individual field.)
In Network (Tier 2)—Family	If the deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the In Network—Family field.)
In Network (Tier 2)—Default Coinsurance <sup>^</sup>	If the deductibles are <i>not</i> integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the In Network—Default Coinsurance field.)
Out of Network—Individual	If the deductibles are <i>not</i> integrated, enter the dollar amount for Out of Network Individual Drug EHB Deductible.
Out of Network—Family	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Out of Network Family Drug EHB Deductible.
Combined In/Out Network—Individual <sup>^#</sup>	If the deductibles are <i>not</i> integrated, enter the dollar amount for Combined In/Out of Network Individual Drug EHB Deductible.
Combined In/Out Network—Family <sup>#</sup>	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Drug EHB Deductible.

#### 4.19 Combined Medical and Drug EHB Deductible

This section is used for inputting deductible values for medical and drug EHB benefits and is required only if the medical and drug deductibles are integrated (**Yes** is entered for Medical & Drug Deductibles Integrated?). If the deductibles are *not* integrated (**No** is entered for Medical & Drug Deductibles Integrated?), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family deductible for medical and drug EHB benefits in the following areas on the template.

Medical & Drug EHB Deductible	Steps
In Network—Individual <sup>^#</sup>	If the deductibles are integrated, enter the dollar amount for In Network Individual Combined Medical and Drug EHB Deductible.
In Network—Family <sup>#</sup>	If the deductibles are integrated, enter the per-person and per-group dollar amount for In Network Family Combined Medical and Drug EHB Deductible.
In Network—Default Coinsurance <sup>^</sup>	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. (If deductibles are integrated, this field is required for the AV calculation for plans using the AVC.)
In Network (Tier 2)—Individual <sup>^</sup>	If the deductibles are integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.

Medical & Drug EHB Deductible	Steps
In Network (Tier 2)—Family	If the deductibles are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Combined Medical and Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Default Coinsurance <sup>^</sup>	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If the deductibles are integrated, enter the dollar amount for Out of Network Individual Combined Medical and Drug EHB Deductible.
Out of Network—Family	If the deductibles are integrated, enter the per-person and per-group dollar amount for Out of Network Family Combined Medical and Drug EHB Deductible.
Combined In/Out Network—Individual <sup>^#</sup>	If the deductibles are integrated, enter the dollar amount for Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible.
Combined In/Out Network—Family <sup>#</sup>	If the deductibles are integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Combined Medical and Drug EHB Deductible.

#### 4.20 Maximum Out-of-Pocket for Dental EHB Benefits

This section is used for inputting MOOP values for dental EHBs. When entering the MOOP values, ensure that the following limits are met: The MOOP values must be equal to or below the required limits of \$350 for one covered child (considered the “individual” limit) and \$700 for two or more covered children (considered the “family” limit). To include multiple children in child-only plans, use the “family” fields. (For SADPs, an individual is considered one child and a family is considered two or more children.) Using the drop-down menus, enter the appropriate values for the Individual and Family MOOP for EHB dental benefits in the following areas of the template.

MOOP Dental EHB Benefits	Steps
In Network—Individual <sup>*^#</sup>	Enter the dollar amount for Dental In Network Individual MOOP for EHB Benefits.
In Network—Family <sup>**</sup>	Enter the per-person and per-group dollar amount for Dental In Network Family MOOP for EHB Benefits.
In Network (Tier 2)—Individual <sup>*^</sup>	Enter the dollar amount for Dental In Network (Tier 2) Individual Dental for EHB Benefits.
In Network (Tier 2)—Family <sup>*</sup>	Enter the per-person and per-group dollar amount for Dental In Network (Tier 2) Family MOOP for EHB Benefits.
Out of Network—Individual <sup>*</sup>	Enter the dollar amount for Dental Out of Network Individual MOOP for EHB Benefits.
Out of Network—Family <sup>*</sup>	Enter the per-person and per-group dollar amount for Dental Out of Network Family MOOP for EHB Benefits.
Combined In/Out Network—Individual <sup>*^#</sup>	Enter the dollar amount for Dental Combined In/Out of Network Individual MOOP for EHB Benefits.
Combined In/Out Network—Family <sup>**</sup>	Enter the per-person and per-group dollar amount for Dental Combined In/Out of Network Family MOOP for EHB Benefits.

#### 4.21 Dental EHB Deductible

This section is used for inputting deductible values for dental EHB benefits. The deductible value may not be higher than the MOOP value. Using the drop-down menus, enter the appropriate values for the Individual and Family deductible for EHB benefits in the following areas on the template.

Dental EHB Deductible	Steps
In Network—Individual <sup>*^#</sup>	Enter the dollar amount for Dental In Network Individual Deductible.

Dental EHB Deductible	Steps
In Network—Family**	Enter the per-person and per-group dollar amount for Dental In Network Family Deductible.
In Network—Default Coinsurance*^	Enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual*^	Enter the dollar amount for Dental In Network (Tier 2) Individual Dental Deductible.
In Network (Tier 2)—Family*	Enter the per-person and per-group dollar amount for Dental In Network (Tier 2) Family Deductible.
Out of Network—Individual*	Enter the dollar amount for Dental Out of Network Individual Deductible.
Out of Network—Family*	Enter the per-person and per-group dollar amount for Dental Out of Network Family Deductible.
Combined In/Out Network—Individual*^#	Enter the dollar amount for Dental Combined In/Out of Network Individual Deductible.
Combined In/Out Network—Family**	Enter the per-person and per-group dollar amount for Dental Combined In/Out of Network Family Deductible.

#### 4.22 Other Deductible

Issuers should complete this section if they have deductible sub-groups; they can add an unlimited number of deductible sub-groups and name them. Enter the appropriate values for the Individual and Family data elements in the following areas on the template. (These values are *not* separate deductibles outside any maximums allowed, and they still contribute to the MOOP and deductible limits.)

Other Deductible	Steps
In Network—Individual*^#	If deductibles are <i>not</i> integrated, enter the dollar amount for In Network Individual Other Deductible.
In Network—Family**	If deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for In Network Family Other Deductible.
In Network Tier 2—Individual*^	If deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Other Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network Tier 2—Family*	If deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Other Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual*	If deductibles are <i>not</i> integrated, enter the dollar amount for Out of Network Individual Other Deductible.
Out of Network—Family*	If deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Out of Network Family Other Deductible.
Combined In/Out Network—Individual*	If deductibles are <i>not</i> integrated, enter the dollar amount for Combined In/Out of Network Individual Other Deductible.
Combined In/Out Network—Family*	If deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Other Deductible.

#### 4.23 Health Savings Account (HSA)/Health Reimbursement Account (HRA) Detail

HSA/HRA Detail	Steps
HSA-Eligible <sup>A#</sup>	Indicate whether the plan meets all requirements to be an HSA-eligible plan. Choose from the following: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the plan meets all HSA requirements.</li> <li>◆ <b>No</b>—if the plan does <i>not</i> meet all HSA requirements.</li> </ul>
HSA/HRA Employer Contribution <sup>A</sup>	(Required for small group only; must be left blank for individual market.) Indicate whether the employer contributes to an HSA/HRA. Choose from the following: <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if the plan has an HSA/HRA employer contribution.</li> <li>◆ <b>No</b>—if the plan does <i>not</i> have an HSA/HRA employer contribution.</li> </ul>
HSA/HRA Employer Contribution Amount <sup>A</sup>	(Required if <b>Yes</b> is entered for HSA/HRA Employer Contribution; must be left blank for individual market.) Enter a numerical value representing the employer contribution amount to HSA/HRA. The template does not permit an individual market plan to enter an HSA/HRA contribution amount. As discussed at 78 <i>Federal Register</i> (FR) 12850, Col. 3 (February 25, 2013), because the issuer uses the AVC to determine a plan's AV, the HSA employer contribution or the amount newly made available by the employer under an integrated HRA that may be used only for cost sharing may be considered part of the AV calculation when the contribution is available and known to the issuer at the time the plan is purchased.

#### 4.24 URLs

This section contains fields for URLs for applicable websites. URLs must start with “http://” or “https://” to work properly for the consumer. To give consumers access to all relevant plan information needed to compare and select plans, CMS asks that issuers ensure that their URLs link directly to up-to-date and accurate information that is readily obtainable on their websites. Issuers should ensure that prospective enrollees can view the relevant information without logging on to a website, clicking through several web pages, or creating user accounts, memberships, or registrations.

Issuer URLs should link directly to each SBC and each plan brochure, respectively, for the standard plan or plan variation in question. This will provide consumers with the best and most accurate shopping experience when searching for available plans through the FFE. Linking directly to the SBCs and plan brochures will guarantee that consumers will see the document that directly applies to the health plan that they are considering for purchase. Issuers offering SHOP plans through FF-SHOP must provide a URL linking to their SHOP plan information in the SBC URL field. This information will be displayed in the see Plans and Prices utility on Healthcare.gov.

As part of the ongoing compliance monitoring, CMS may compare the benefits coverage and cost-sharing information inputted in the Plans & Benefits Template with the information issuers provide to consumers on the plan's SBC and plan brochure. Please take care to review the information submitted on this template, as well as what coverage is represented on the plan's SBC and the plan brochure, to ensure that all of this information is aligned with the actual terms of coverage before submission.

URLs	Steps
URL for Summary of Benefits & Coverage <sup>#</sup>	Enter the URL that takes the consumer directly to the SBC content for the specific standard plan or plan variation. As defined in 45 CFR 155.205(b)(1)(ii), plans will <i>not</i> be displayed to consumers if this field is not completed.
Plan Brochure <sup>#</sup>	<ul style="list-style-type: none"> <li>◆ Enter the URL that goes directly to the plan brochure for the specific standard plan or plan variation. These documents should clearly communicate any cost sharing and other information not displayed by Plan Compare that consumers need to understand when shopping for insurance coverage. For example, if the plan has different cost sharing for benefits depending on service location, further details on these cost-sharing differences should be communicated through the plan brochure.</li> </ul>

URLs	Steps
	<ul style="list-style-type: none"> <li>◆ CMS expects that issuers submit SBC and plan brochure URLs by the final deadline for submission of QHP data so that the FFE can meet its responsibility to provide consumers access to the appropriate SBCs through its website (see 45 CFR 155.205). CMS expects these links to be active and directly route the user to the appropriate document by the time the issuer has signed its QHP agreements. Issuers are strongly encouraged to submit these links and make them active earlier so that they can fully test their data through Plan Preview.</li> </ul>

#### 4.25 AV Calculator Additional Benefit Design

This section contains optional fields, which may be filled out for use as inputs in the AVC.

URLs	Steps
Maximum Coinsurance for Specialty Drugs <sup>^</sup>	Indicate whether the per-script coinsurance amount for specialty drugs is capped at a set amount. Enter the maximum coinsurance payments allowed for specialty prescription drugs. If no maximum coinsurance exists, leave the field blank.
Maximum Number of Days for Charging an Inpatient Copay? <sup>^</sup>	Indicate whether there is a limit on the number of days that a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day. Enter the maximum number of days allowed (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost-Sharing After a Set Number of Visits? <sup>^</sup>	Indicate whether primary care cost-sharing begins after a certain number of fully covered visits. Enter the maximum number of fully covered visits (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <sup>^</sup>	Indicate whether primary care visits are subject to the deductible and/or coinsurance after a certain number of primary care visits with copay have occurred. Enter the maximum number of copay visits (1–10) that can occur before visits become subject to the deductible and/or coinsurance. If this option does not apply, leave the field blank.

#### 4.26 Covered Benefits

This section contains fields for copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

Fill in information for each of the benefits as follows:

1. If the issuer has plans that do not have out-of-network benefits for a given covered benefit, enter “Not Applicable” for the out-of-network copay fields and “100%” for the out-of-network coinsurance fields.
2. There is a drop-down option of **Not Applicable** for all cost-sharing fields. This value should be used:
  - a. If the issuer charges only a copay or a coinsurance for a benefit, enter “Not Applicable” for the other. For example, if an issuer wishes to charge a \$20 copay for a benefit, enter “\$20” for the copay and “Not Applicable” for the coinsurance. Please note that “No Charge” was used for this scenario in past years, but “Not Applicable” is the correct option in the 2019 template.
  - b. If the issuer has multiple in-network tiers, for any benefit category that does not have tiers, enter “Not Applicable” for the In Network (Tier 2) copay and coinsurance. For example, if the issuer has only multiple in-network tiers for its inpatient hospital covered benefits, it would enter Tier 2 cost sharing as described below. For other covered benefits without multiple in-network tiers, issuers should enter “Not Applicable” for the In Network (Tier 2) copay and coinsurance.
3. For further instructions on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see Section 5.8.
4. For further instructions on how to fill out the copayment and coinsurance fields corresponding to the AVC, please see Appendix 1.

5. There are many cost-sharing requirements for the cost-sharing reduction silver plan variations and the zero and limited cost-sharing plan variations (see Section 5.5).
6. If cost sharing varies on the basis of place of service or provider type, ensure that no benefit already specifically applies to the place of service or provider type. If there is not one available, fill out the copay and/or coinsurance most typical for most enrollees (such as the highest used); in the Benefit Explanation field, add appropriate and brief detail to communicate the cost sharing in the scenarios other than the most common one already entered into the worksheet. An issuer's plan brochure (which the consumer can access via the submitted URL) also should clearly communicate any cost-sharing information that may vary on the basis of place of service or provider type.

Figure 2D-17 shows an example of how the fields for each benefit are laid out.

Figure 2D-17. Benefit Information Fields

BV	BW	BX	BY	BZ	CA
<b>Primary Care Visit to Treat an Injury or Illness</b>					
<b>Copay</b>			<b>Coinsurance</b>		
<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>	<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>
0	\$0	\$0	\$0	0%	0%

Covered Benefits	Steps
Copay—In Network (Tier 1)*^#	<p>If an in-network copayment is charged, enter the dollar amount here. If no copayment is charged, enter <b>Not Applicable</b>. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a coinsurance is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X</b>—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>\$X Copay after deductible</b>—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay with deductible</b>—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a coinsurance. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul>
Copay—In Network (Tier 2)*^#	<p>If the plan has multiple in-network tiers and an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter “Not Applicable.” For any benefit category that does not have tiers, enter “Not Applicable” for this field, as well as the Coinsurance—In Network (Tier 2) field. This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a coinsurance is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).</li> </ul>

Covered Benefits	Steps
	<ul style="list-style-type: none"> <li>◆ <b>\$X</b>—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>\$X Copay after deductible</b>—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay with deductible</b>—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a coinsurance, or there are not multiple tiers for this benefit. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul>
Copay—Out of Network*#	<p>If an out-of-network copayment is charged, enter the amount here. If no copayment is charged, enter <b>Not Applicable</b>. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a coinsurance is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X</b>—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>\$X Copay after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay with deductible</b>—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a coinsurance. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul>
Copay—In Network (Tier 1), Copay—In Network (Tier 2), Copay—Out of Network	<p>The following options are the only available options for the benefits Inpatient Hospital Services (e.g., Hospital Stay) and Skilled Nursing Facility. Define the copayment as charged per day or per stay. When entering values for plan variations, ensure that all variations follow the same “per day” or “per stay” cost-sharing structure. If no copayment is charged, enter <b>Not Applicable</b>.</p> <p>The benefits Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services include these options as well as those described in the “Copay—In Network (Tier 1)” section above. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a coinsurance is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay per Day</b>—the consumer pays a copayment per day (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>\$X Copay per Stay</b>—the consumer pays a copayment per stay (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>\$X Copay per Day after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible).</li> </ul>

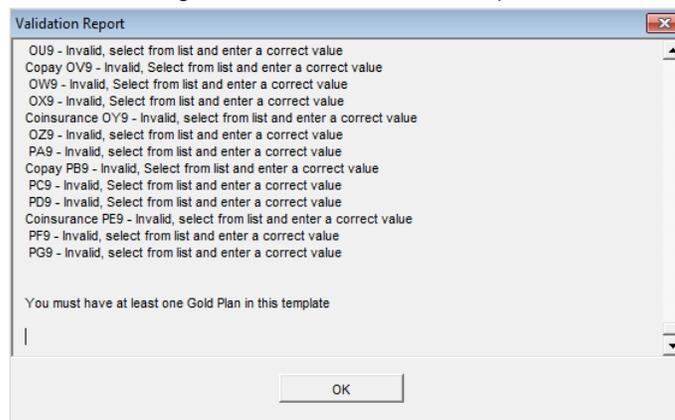
Covered Benefits	Steps
	<ul style="list-style-type: none"> <li>◆ <b>\$X Copay per Stay after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay per Day with deductible</b>—the consumer first pays the copay per day, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>\$X Copay per Stay with deductible</b>—the consumer first pays the copay for the stay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a coinsurance. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul> <p>For Inpatient Hospital Services (e.g., Hospital Stay) and Skilled Nursing Facility covered benefits, <i>do not</i> copy and paste cost-sharing values entered for other benefits (e.g., \$25 copay). The entered values should have the “per day” or “per stay” qualifiers. Copying and pasting any other cost-sharing values could negatively affect the AV calculation and the display of this benefit on Plan Compare.</p>
Coinsurance—In Network (Tier 1)*^#	<p>If an in-network coinsurance is charged, enter the percentage the consumer will pay here. If no coinsurance is charged, enter <b>Not Applicable</b>, unless the plan has a Tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a copay is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>X% Coinsurance after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>X%</b>—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer only pays a copay. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul>
Coinsurance—In Network (Tier 2)*^#	<p>If the plan has multiple in-network tiers and an in-network coinsurance is charged, enter the percentage the consumer will pay here. If no coinsurance is charged, enter <b>Not Applicable</b>, unless the plan has a Tier 2 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” For any benefit category that does not have tiers, enter <b>Not Applicable</b> for this field, as well as for the Copay—In Network (Tier 2) field. This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a copay is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>X% Coinsurance after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).</li> </ul>

Covered Benefits	Steps
	<ul style="list-style-type: none"> <li>◆ <b>X%</b>—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul>
Coinsurance—Out of Network**	<p>If an out-of-network coinsurance is charged, enter the percentage the consumer pays here. If no coinsurance is charged, enter <b>Not Applicable</b>, unless the plan has an out-of-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” If this benefit is not covered out of network, enter “100%.” Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No Charge</b>—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that <b>Not Applicable</b>, not <b>No Charge</b>, should be used if only a copay is charged.</li> <li>◆ <b>No Charge after deductible</b>—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>X% Coinsurance after deductible</b>—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).</li> <li>◆ <b>X%</b>—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible).</li> <li>◆ <b>Not Applicable</b>—the consumer pays only a copay. If both copay and coinsurance are <b>Not Applicable</b>, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.</li> </ul>

#### 4.27 Completed Plans & Benefits Template

Once the entire template, including all Benefits Package and Cost Share Variances worksheets, has been completed, click the **Validate** button on the menu bar under the **Plans & Benefits** ribbon. If there are validation errors, a Validation Report (**Figure 2D-18**) will appear showing the data element and cell location of each error. The issuer must correct these errors for its Plans & Benefits Template to be accepted.

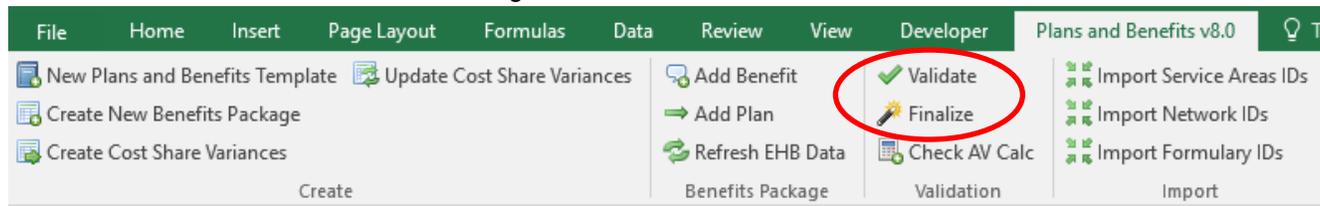
Figure 2D-18. Validation Report



Once the validation is successful, click the **Finalize** button on the menu bar under the **Plans & Benefits** ribbon (**Figure 2D-19**) to save the template as an XML file. Upload the saved file in the Benefits and Service Area

Module. Before closing the template, save an XLSM version of the Excel file onto the computer for future reference.

Figure 2D-19. Finalize Button



## 5. Key Requirements and Application Guidance

This section contains guidance and examples for filling out specific sections of the Plans & Benefits Template and describes specific plan requirements. Issuers should read this section to ensure plan compliance.

### 5.1 MOOP and Deductible Guidance

Several requirements must be met for MOOP and deductible values. Complete the MOOP and deductible sections of the template as follows:

1. Annual Limitation on Cost Sharing.<sup>4</sup> When entering the MOOP values, ensure that the limits listed below are met for the in-network EHB MOOP. (See the 2019 HHS Notice of Benefit and Payment Parameters for more details on the annual limit values.)
  - a. If the plan has separate medical and drug MOOP limits, these values are added together before being compared with the annual limitation on cost sharing.
  - b. The standard plan's in-network EHB MOOP values must be less than or equal to \$7,900 for an individual (self-only) or \$15,800 for a family (other than self-only).
  - c. For the 73 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to \$6,300 for an individual (self-only) or \$12,600 for a family (other than self-only).
  - d. For the 87 percent and 94 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to \$2,600 for an individual (self-only) or \$5,200 for a family (other than self-only).
  - e. For the zero cost-sharing plan variations, the in- and out-of-network MOOP and deductible values for EHB must be \$0. These fields auto-populate and should not be changed for EHB.
  - f. For the limited cost-sharing plan variations, the MOOP and deductible values must be the same as the associated standard plan's EHB MOOP value. These fields auto-populate whenever a value is entered for a standard plan and should not be changed.
2. Family MOOP Requirements. When entering the MOOP values, ensure that the limits listed below are taken into consideration. (See the 2019 HHS Notice of Benefit and Payment Parameters for more details on the annual limit on cost sharing.)
  - a. Plans that allow multi-member enrollment (family plans) must have a numeric value for either in-network or combined in- and out-of-network MOOP for both per group and per person. These plans are subject to the annual limitation on cost sharing for other than self-only coverage (\$15,800) discussed above, as well as the annual limitation on cost sharing for self-only coverage.
  - b. For these plans, the per-person amount for family coverage needs to be less than or equal to the annual limitation on cost sharing for self-only coverage for the standard plan (\$7,900) and for the

<sup>4</sup> See the rule on the HHS Notice of Benefit and Payment Parameters for 2019 (81 FR 94058; December 22, 2016). Issuers must comply with policies that are incorporated into the final rule on the HHS Notice of Benefit and Payment Parameters for 2019.

specific cost-sharing reduction plan variations as detailed in the annual limitation on cost sharing discussion immediately above.<sup>5</sup>

- c. If a plan is available for self-only coverage only (an individual plan), all family MOOP values may be entered as **Not Applicable**. However, this self-only coverage must be reflected on the Business Rules Template when indicating the relationship types allowed. (See the Business Rules Template instructions for more details on offering self-only coverage and eligible dependent relationships.)
3. Definition of **Not Applicable** and **\$0** for Deductible and MOOP.
    - a. Do not enter **Not Applicable** if there is a zero dollar deductible or MOOP; **\$0** is the appropriate data entry. For example, if a plan has a separate medical and drug deductible, and if there is no drug deductible, issuers must enter **\$0** as opposed to **Not Applicable**.
    - b. **Not Applicable** should be used in the In Network MOOP or deductible field only to imply that in-network service costs accumulate toward the entered Combined In/Out of Network MOOP or deductible.
    - c. If the Individual In Network and Individual Combined In/Out of Network deductible fields are equal to **Not Applicable**, the template returns an error when calculating the plan's AV using the AVC.
  4. To include multiple children in child-only plans, use the "family" MOOP and deductible fields to capture the data.
  5. The following explains how the values for various MOOP and deductible fields are related. Complete the fields as follows:
    - a. Some plans may have only combined in-network and out-of-network deductibles or MOOPs, rather than separate in-network and out-of-network deductibles or MOOPs. Other plans may have a mixture of in-network, out-of-network, and combined in-network and out-of-network deductibles or MOOPs. When defining deductibles and MOOPs, issuers must adhere to the guidelines.
    - b. If the plan does *not* have multiple in-network tiers, the following applies:
      - i. If the In Network field is equal to a dollar value (\$X), the Combined In/Out of Network field can be either a dollar value or **Not Applicable**.
      - ii. If the In Network field is **Not Applicable**, the Combined In/Out of Network field must be equal to a dollar value.
      - iii. The Out of Network field has no restrictions: it can be either a dollar value or **Not Applicable**.
    - c. If the plan has multiple in-network tiers, the following applies:
      - i. If the In Network and In Network (Tier 2) fields are equal to dollar values, the Combined In/Out of Network field can be either a dollar value or **Not Applicable**.
      - ii. If the In Network field is **Not Applicable**, the In Network (Tier 2) field must be **Not Applicable** and the Combined In/Out of Network field must be equal to a dollar value.
      - iii. If the In Network (Tier 2) field is **Not Applicable**, the In Network field must be **Not Applicable** and the Combined In/Out of Network field must be equal to a dollar value.
      - iv. The Out of Network field has no restrictions: it can be either a dollar value or **Not Applicable**.

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<sup>5</sup> Ibid.

## 5.2 Catastrophic Plan Instructions

Consistent with Section 1302(e) of the PPACA and regulations codified in 45 CFR 156.155, catastrophic plans have the following characteristics:

1. They can be offered only in the individual market.
2. They are permitted, but not required, to cover multiple-person enrollment (families) when all members meet eligibility requirements for this type of plan.
3. They do not have multiple in-network tiers for EHBs.
4. They have integrated medical and drug deductibles.
5. They have integrated medical and drug MOOPs.
6. They have an in-network deductible and in-network MOOP equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the PPACA and in the HHS Notice of Benefit and Payment Parameters for 2019. For PY2019, this limit is \$7,900 for individuals (self-only) and \$15,800 for families (other than self-only).
7. They have an out-of-network deductible and out-of-network MOOP greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
8. If they have an in-network deductible and in-network MOOP, and a combined in/out-of-network deductible and combined in- and out-of-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
9. If they have a combined in- and out-of-network deductible and in- and out-of-network MOOP but no specific in-network deductible or in-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be equal to the annual limitation on cost sharing.
10. They have in-network cost sharing equal to no charge after the deductible for all EHBs, excluding primary care and preventive health services. (See Section 5.10 for direction on completing the copay and coinsurance fields to have this cost-sharing value displayed to the consumer.)
11. All benefits except primary care visits and coverage of preventive health services—in accordance with Section 2713 of the PHS Act—are subject to the in-network deductible. Issuers must provide benefits for at least three primary care visits and coverage of preventive health services (in accordance with Section 2713 of the PHS Act) prior to the consumer reaching the deductible.
12. Coverage of preventive health services (in accordance with Section 2713 of the PHS Act) is not subject to the in-network deductible and does not impose any other cost-sharing requirement.

## 5.3 Actuarial Value Details

For all AVs, whether calculated by the AVC or input by the issuer, the following requirements must be met:

1. A de minimis variation of -4/+2 percentage points is used for standard plans.
  - a. The AV for a bronze plan must be between 56 percent and 62 percent.
  - b. The AV for an expanded bronze plan must be between 56 percent and 65 percent.
  - c. The AV for a silver plan must be between 66 percent and 72 percent.
  - d. The AV for a gold plan must be between 76 percent and 82 percent.
  - e. The AV for a platinum plan must be between 86 percent and 92 percent.

2. A de minimis variation of  $\pm 1$  percentage point is used for silver plan variations.
  - a. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent.
  - b. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.
  - c. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.
3. The AV of a standard silver plan and the AV of the associated 73 percent silver plan variation must differ by at least 2 percentage points.
4. The AV of the zero cost-sharing plan variations must be 100 percent.
5. The AV of the limited cost-sharing plan variations must be equal to the associated standard plan's AV.

(For more information on how the cost-sharing information from the Plans & Benefits Template translates to inputs for the stand-alone AVC, see Appendix 1.)

## 5.4 Editing the Template

Keep the following in mind when making changes to the template:

1. If a benefit is mistakenly added as an additional benefit, it cannot be manually deleted, but issuers may do one of the following:
  - a. Select **Not Covered** under the "Is this Benefit Covered?" column. When the Cost Share Variance worksheet is generated, this benefit will not appear on that worksheet.
  - b. Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but the issuer also loses any other data it has entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.
  - c. Additional steps need to be taken if the issuer has already created the Cost Share Variances worksheet. See below.
2. If an issuer changes whether a benefit is **Covered** on the Benefits Package worksheet after the Cost Share Variances worksheet is created, the benefits will *not* update the Cost Share Variances worksheet even if the issuer selects the **Update Cost Share Variances** button. Instead the issuer must delete the entire Cost Share Variances worksheet and then click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon and generate a new worksheet. The updated worksheet then reflects the changes made to the Benefits Package worksheet.
3. Do the following to add a new plan or delete a plan after the Cost Share Variances worksheet has already been created:
  - a. After adding a new plan to the Benefits Package worksheet, click the **Update Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon. This adds the new plan to the Cost Share Variances worksheet.
  - b. To delete a plan on the Benefits Package worksheet, delete all data for that plan's row. If any plans are below that row, cut these rows and paste them into the empty row (see below). This is an important step because if the **Update Cost Share Variances** button is clicked when there is an empty row between plans, all plans below this blank row and their corresponding data are deleted from the Cost Share Variances worksheet.
  - c. Example: To delete Plan 2 (**Figure 2D-20**), delete all data from the plan's row, cut and paste Plan 3 from Row 11 to Row 10, and then cut and paste Plan 4 from Row 12 to Row 11. Once those steps are completed, click the **Update Cost Share Variances** button; Plan 2 is removed from the Cost Share Variances worksheet, while Plans 3 and 4 remain.

Figure 2D-20. Deleting a Plan

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10	12345MI2222222	Plan 2
11	12345MI3333333	Plan 3
12	12345MI4444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10		
11	12345MI3333333	Plan 3
12	12345MI4444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10	12345MI3333333	Plan 3
11	12345MI4444444	Plan 4
12		

- d. If the issuer changes any benefits package data on a specific plan that already exists, the only changes that will be reflected on the Cost Share Variances worksheet when the issuer clicks the **Update Cost Share Variances** button are the following: Plan Marketing Names will be updated, plans added to the Benefits Package worksheet will be added to the Cost Share Variance worksheet, and plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet. If there is a need to update the information for an existing plan, the issuer must first delete that plan on the Benefits Package worksheet, as explained above, and then click the **Update Cost Share Variances** button. All previously entered information for this plan on the Cost Share Variances worksheet will be deleted. Reenter the plan and associated data on the Benefits Package worksheet, and click the **Update Cost Share Variances** button.

## 5.5 Requirements for Cost-Sharing Reduction Plan Variations

There are three types of cost-sharing reduction plan variations: silver plan variations, zero cost-sharing plan variations, and limited cost-sharing plan variations.

The zero cost-sharing and limited cost-sharing plan variations are for American Indians and Alaska Natives. In the zero cost-sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs. In the limited cost-sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian healthcare provider or from another provider if they have a referral from an Indian healthcare provider.

Silver plan variations offer a discount that lowers the MOOP as well as the amount consumers pay out of pocket for deductibles, coinsurance, and copayments. Consumers qualify to enroll in these plans if their income is below a certain level.

Each variation type has several requirements.

1. The requirements for zero cost-sharing plan variations are as follows:
  - a. The template automatically generates a zero cost-sharing plan variation for all metal-level plans (except catastrophic) on the individual market.
  - b. The AV of the plan variation must be 100 percent.
  - c. All In Network MOOP values must be **\$0**. Out of Network and Combined In/Out Network MOOP values should be **\$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.
  - d. All In Network deductible values must be **\$0**. Out of Network and Combined In/Out Network deductible values should be **\$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.
  - e. All EHBs must have cost-sharing values of **\$0**, **0%**, or **“no charge”** for both in- and out-of-network services.<sup>6</sup> However, if the associated standard plan does not cover out-of-network services, the

<sup>6</sup> Under 45 CFR 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to EHB, including deductibles, coinsurance, copayments, or similar charges, but it excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

zero cost-sharing plan variation is not required to cover out-of-network services either. (See Section 5.6 for details on indicating whether a benefit is an EHB.)

- f. For benefits that are not EHBs, the cost-sharing must follow successive cost-sharing with the associated limited cost-sharing plan variation. If the associated standard plan is a silver plan, the cost-sharing also must follow successive cost-sharing with the associated 94 percent AV silver plan variation. (See Section 5.7 for further explanation and examples of successive cost-sharing.)
  - g. Tier utilization must be the same as the associated standard plan.
2. The requirements for limited cost-sharing plan variations are as follows:
- a. The template automatically generates a limited cost-sharing plan variation for all metal-level plans (except catastrophic) on the individual market.
  - b. The AV of the limited cost-sharing plan variation must be greater than or equal to the associated standard plan's AV.
  - c. All MOOP values for EHBs must be the same as the associated standard plan's MOOP values for EHBs.
  - d. All deductible values must be the same as the associated standard plan's values.
  - e. All EHBs must have the same cost-sharing values as the associated standard plan's values (see Section 5.6).
  - f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see Section 5.7).
  - g. Tier utilization must be the same as the associated standard plan.
3. The requirements for silver plan variations are as follows:
- a. Each silver plan offered on the individual market must have 73 percent AV, 87 percent AV, and 94 percent AV silver plan variations.
  - b. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent, and it must also be at least 2 percentage points greater than the associated standard plan's AV.
  - c. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.
  - d. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.
  - e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to \$6,300 for an individual (self-only) or \$12,600 for a family (other than self-only).
  - f. For the 87 percent and 94 percent AV silver plan variations, the MOOP must be less than or equal to \$2,600 for an individual (self-only) or \$5,200 for a family (other than self-only).
  - g. All MOOP values must follow successive cost sharing for all plan variations (see Section 5.7).
  - h. All deductible values must follow successive cost sharing for all plan variations.
  - i. The copay and coinsurance for all benefits must follow successive cost sharing for all plan variations.
  - j. Tier utilization must be the same as the associated standard plan.

## 5.6 EHB Variance Reason and EHB Designation

As explained in Section 5.5, benefits in the plan variations have specific requirements, depending on whether a benefit is considered an EHB. A benefit's EHB designation is based on the two fields, EHB and EHB Variance Reason, for the benefit on the Benefits Package worksheet as outlined in Section 4.10. **Table 2D-1** explains when a benefit is considered an EHB on the basis of different inputs.

Table 2D-1. EHB Designation

EHB Field Value	EHB Variance Reason Field Value	Evaluated as an EHB?
Yes	Anything other than <b>Not EHB</b>	Yes
Blank	<b>Additional EHB Benefit</b> or <b>Other Law/Regulation</b>	Yes
Yes	<b>Not EHB</b>	No
Blank	Anything other than <b>Additional EHB Benefit</b> or <b>Other Law/Regulation</b>	No

## 5.7 Successive Cost Sharing Guidance

As explained in Section 5.5, successive cost sharing is required to be reviewed for multiple plan variations and data fields. The purpose of successive cost sharing is to ensure that a specific element in a given plan variation always has an equal or more generous cost-sharing value for the consumer compared with a standard plan or plan variation. (See the HHS Notice of Benefits and Payment Parameters for details on the cost-sharing regulatory requirements for cost-sharing reduction plan variations.)

The following explains which plan variations should be compared depending on the requirement:

1. A standard silver plan and its associated silver plan variations must follow successive cost sharing for the MOOP, deductible, copay, and coinsurance fields. This includes EHBs and non-EHBs. All of the following must be true:
  - a. The cost sharing value of the 73 percent AV silver plan variation must be less than or equal to that of the associated standard plan.
  - b. The value of the 87 percent AV silver plan variation must be less than or equal to that of the 73 percent AV silver plan variation.
  - c. The value of the 94 percent AV silver plan variation must be less than or equal to that of the 87 percent AV silver plan variation.
2. A zero cost-sharing plan variation must follow successive cost-sharing with the associated limited cost-sharing plan variation for the copay and coinsurance fields for non-EHBs. This means that the value of the zero cost-sharing plan variation must be less than or equal to that of the limited cost-sharing plan variation.
3. A zero cost-sharing plan variation for a standard silver plan must follow successive cost sharing with the associated 94 percent AV silver plan variation for the copay and coinsurance fields for non-EHBs. This means the value of the zero cost-sharing plan variation must be less than or equal to that of the 94 percent AV silver plan variation.
4. A limited cost-sharing plan variation must follow successive cost sharing with the associated standard plan for the copay and coinsurance fields for non-EHBs. This means the value of the limited cost-sharing plan variation must be less than or equal to that of the standard plan. The MOOP, deductible, and EHB cost-sharing fields should be equal to that of the associated standard plan.

Again, the fields that may be used for successive cost sharing include MOOP, deductible, copay, and coinsurance. Because successive cost sharing requires that the plan *always* be equal or preferable to the consumer, changes to the cost-sharing structures are not allowed when the consumer in the higher AV plan variation may be worse off and pay increased cost sharing. The following two examples illustrate noncompliant changes to the cost-sharing structure in the template:

1. A plan variation with a benefit that has 20 percent coinsurance may result in higher cost sharing for the consumer than a plan variation with a lower AV that has a \$20 copay for the benefit. The better value depends on the total cost of the service.

2. A plan variation with a copay of \$5 after deductible may result in higher cost sharing for the consumer than a plan variation with a lower AV that has a \$20 copay for a given benefit. The better value depends on whether the deductible has already been reached.

**Table 2D-2** through **Table 2D-8** show the compliant and noncompliant data entry options for the different cost-sharing fields discussed, as well as numerous examples.

Table 2D-2. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Options for MOOP or Deductible Values

First Plan (Lower AV) MOOP/Deductible Value	Compliant Second Plan (Higher AV) MOOP/Deductible Values	Noncompliant Second Plan (Higher AV) MOOP/Deductible Values
\$X	◆ \$Y (when $Y \leq X$ )	◆ Not Applicable ◆ \$Y (when $Y > X$ )
Not Applicable	◆ Not Applicable	◆ \$Y

Table 2D-3. Examples of Compliant (Green) and Noncompliant (Red) Successive Cost-Sharing MOOP/Deductible Values

Example	MOOP/Deductible	Compliance
Lower AV Plan	\$2,200	Compliant
Higher AV Plan	\$2,000	
Lower AV Plan	\$2,200	Not Compliant
Higher AV Plan	\$2,500	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	\$2,500	

Table 2D-4. Compliant and Noncompliant Successive Cost-Sharing Options for Coinsurance Values

First Plan (Lower AV) Coinsurance Value	Compliant Second Plan (Higher AV) Coinsurance Values	Noncompliant Second Plan (Higher AV) Coinsurance Values
No Charge	◆ No Charge ◆ 0% Coinsurance ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (all values)
No Charge After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ 0% Coinsurance ◆ 0% Coinsurance After Deductible ◆ Not Applicable	◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (when greater than 0)
X% Coinsurance	◆ No Charge ◆ Y% Coinsurance (when $Y\% \leq X\%$ ) ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% > X\%$ ) ◆ Y% Coinsurance After Deductible (all values)
X% Coinsurance After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% \leq X\%$ ) ◆ Y% Coinsurance After Deductible (when $Y\% \leq X\%$ ) ◆ Not Applicable	◆ Y% Coinsurance (when $Y\% > X\%$ ) ◆ Y% Coinsurance After Deductible (when $Y\% > X\%$ )

Table 2D-4. Compliant and Noncompliant Successive Cost-Sharing Options for Coinsurance Values

First Plan (Lower AV) Coinsurance Value	Compliant Second Plan (Higher AV) Coinsurance Values	Noncompliant Second Plan (Higher AV) Coinsurance Values
Not Applicable	<ul style="list-style-type: none"> <li>◆ Not Applicable</li> <li>◆ No Charge</li> </ul>	<ul style="list-style-type: none"> <li>◆ No Charge After Deductible</li> <li>◆ Y% Coinsurance (all values)</li> <li>◆ Y% Coinsurance After Deductible (all values)</li> </ul>

Table 2D-5. Examples of Compliant and Noncompliant Successive Cost-Sharing Coinsurance Values

Plan	Coinsurance	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	0%	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	25%	Compliant
Higher AV Plan	20%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	25% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	30%	

Table 2D-6. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Option for Copay Values

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
No Charge	<ul style="list-style-type: none"> <li>◆ No Charge</li> <li>◆ \$0 Copay</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (when greater than 0)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
No Charge After Deductible	<ul style="list-style-type: none"> <li>◆ No Charge</li> <li>◆ No Charge After Deductible</li> <li>◆ \$0 Copay</li> <li>◆ \$0 Copay After Deductible</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay (when greater than 0)</li> <li>◆ \$Y Copay After Deductible (when greater than 0)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
\$X Copay	<ul style="list-style-type: none"> <li>◆ No Charge</li> <li>◆ \$Y Copay (when <math>Y \leq X</math>)</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
\$X Copay After Deductible	<ul style="list-style-type: none"> <li>◆ No Charge</li> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (when <math>Y \leq X</math>)</li> <li>◆ \$Y Copay After Deductible (when <math>Y \leq X</math>)</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay After Deductible (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
\$X Copay With Deductible	<ul style="list-style-type: none"> <li>◆ No Charge</li> <li>◆ \$0 Copay</li> <li>◆ \$Y Copay With Deductible (when <math>Y \leq X</math>)</li> <li>◆ No Charge After Deductible</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay (when greater than 0)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (when <math>Y &gt; X</math>)</li> </ul>
Not Applicable	<ul style="list-style-type: none"> <li>◆ Not Applicable</li> <li>◆ No Charge</li> </ul>	<ul style="list-style-type: none"> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>

Table 2D-7. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Options for Inpatient Specific Copay Values

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
\$X Copay Per Day	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Day (when <math>Y \leq X</math>)</li> <li>◆ \$Y Copay Per Stay (when <math>Y \leq X</math>)</li> <li>◆ No Charge</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Day (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Stay (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Day With Deductible (all values)</li> <li>◆ \$Y Copay Per Day After Deductible (all values)</li> <li>◆ \$Y Copay Per Stay With Deductible (all values)</li> <li>◆ \$Y Copay Per Stay After Deductible (all values)</li> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>

Table 2D-7. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Options for Inpatient Specific Copay Values

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
\$X Copay Per Stay	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay (when <math>Y \leq X</math>)</li> <li>◆ \$0 Copay Per Day</li> <li>◆ No Charge</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Day (when greater than 0)</li> <li>◆ \$Y Copay Per Day After Deductible (all values)</li> <li>◆ \$Y Copay Per Stay With Deductible (all values)</li> <li>◆ \$Y Copay Per Stay After Deductible (all values)</li> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
\$X Copay Per Day With Deductible	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Day With Deductible (when <math>Y &lt; X</math>)</li> <li>◆ \$Y Copay Per Stay With Deductible (when <math>Y &lt; X</math>)</li> <li>◆ No Charge</li> <li>◆ No Charge After Deductible</li> <li>◆ \$0 Copay Per Day</li> <li>◆ \$0 Copay Per Stay</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Day With Deductible (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Day (when greater than 0)</li> <li>◆ \$Y Copay Per Day After Deductible (all values)</li> <li>◆ \$Y Copay Per Stay With Deductible (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Stay After Deductible (all values)</li> <li>◆ \$Y Copay Per Stay (when greater than 0)</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
\$X Copay Per Stay With Deductible	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay With Deductible (when <math>Y &lt; X</math>)</li> <li>◆ \$Y Copay Per Day With Deductible (when <math>Y &lt; X</math>)</li> <li>◆ No Charge</li> <li>◆ No Charge After Deductible</li> <li>◆ \$0 Copay Per Stay</li> <li>◆ \$0 Copay Per Day</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay With Deductible (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Stay (when greater than 0)</li> <li>◆ \$Y Copay Per Stay After Deductible (all values)</li> <li>◆ \$Y Copay Per Day With Deductible (all values)</li> <li>◆ \$Y Copay Per Day After Deductible (all values)</li> <li>◆ \$Y Copay Per Day (when greater than 0)</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
\$X Copay Per Day After Deductible	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Day After Deductible (<math>Y &lt; X</math>)</li> <li>◆ \$Y Copay Per Stay After Deductible (<math>Y &lt; X</math>)</li> <li>◆ \$Y Copay Per Day (<math>Y &lt; X</math>)</li> <li>◆ \$Y Copay Per Stay (<math>Y &lt; X</math>)</li> <li>◆ No Charge</li> <li>◆ No Charge After Deductible</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Day With Deductible (all values)</li> <li>◆ \$Y Copay Per Day After Deductible (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Day (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Stay With Deductible (all values)</li> <li>◆ \$Y Copay Per Stay After Deductible (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay Per Stay (when <math>Y &gt; X</math>)</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>

Table 2D-7. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Options for Inpatient Specific Copay Values

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
\$X Copay Per Stay After Deductible	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay After Deductible (\$Y &lt; \$X)</li> <li>◆ \$Y Copay Per Stay (\$Y &lt; \$X)</li> <li>◆ \$0 Copay Per Day After Deductible</li> <li>◆ \$0 Copay Per Day</li> <li>◆ No Charge</li> <li>◆ No Charge After Deductible</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay With Deductible (all values)</li> <li>◆ \$Y Copay Per Stay After Deductible (when \$Y &gt; \$X)</li> <li>◆ \$Y Copay Per Stay (when \$Y &gt; \$X)</li> <li>◆ \$Y Copay Per Day With Deductible (all values)</li> <li>◆ \$Y Copay Per Day After Deductible (when greater than 0)</li> <li>◆ \$Y Copay Per Day (when greater than 0)</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
No Charge After Deductible	<ul style="list-style-type: none"> <li>◆ No Charge After Deductible</li> <li>◆ No Charge</li> <li>◆ \$0 Per Day</li> <li>◆ \$0 Per Stay</li> <li>◆ \$0 Copay Per Day After Deductible</li> <li>◆ \$0 Copay Per Stay After Deductible</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay With Deductible (all values)</li> <li>◆ \$Y Copay Per Stay After Deductible (when greater than 0)</li> <li>◆ \$Y Copay Per Stay (when greater than 0)</li> <li>◆ \$Y Copay Per Day With Deductible (all values)</li> <li>◆ \$Y Copay Per Day After Deductible (when greater than 0)</li> <li>◆ \$Y Copay Per Day (when greater than 0)</li> <li>◆ Not Applicable</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>
No Charge	<ul style="list-style-type: none"> <li>◆ No Charge</li> <li>◆ \$0 Per Day</li> <li>◆ \$0 Per Stay</li> <li>◆ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>◆ \$Y Copay Per Stay With Deductible (all values)</li> <li>◆ \$Y Copay Per Stay After Deductible (all values)</li> <li>◆ \$Y Copay Per Stay (when greater than 0)</li> <li>◆ \$Y Copay Per Day With Deductible (all values)</li> <li>◆ \$Y Copay Per Day After Deductible (all values)</li> <li>◆ \$Y Copay Per Day (when greater than 0)</li> <li>◆ No Charge After Deductible</li> <li>◆ \$Y Copay (all values)</li> <li>◆ \$Y Copay After Deductible (all values)</li> <li>◆ \$Y Copay With Deductible (all values)</li> </ul>

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	\$0	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	\$40	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	\$45 Copay With Deductible	

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	\$45 Copay After Deductible	
Lower AV Plan	\$40	Compliant
Higher AV Plan	\$40	
Lower AV Plan	\$40	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	\$40	Not Compliant
Higher AV Plan	\$40 Copay After Deductible	
Lower AV Plan	\$40	Not Compliant
Higher AV Plan	\$45	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$40	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$35 Copay After Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$35 Copay With Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$45	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$40	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$35 Copay After Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$35 Copay With Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$45	
Lower AV Plan	\$40 Copay per Day	Compliant
Higher AV Plan	\$30 Copay per Day	
Lower AV Plan	\$40 Copay per Stay	Compliant
Higher AV Plan	\$40 Copay per Stay	
Lower AV Plan	\$40 Copay per Day	Not Compliant
Higher AV Plan	\$35 Copay per Stay	
Lower AV Plan	\$40 Copay per Day After Deductible	Compliant
Higher AV Plan	\$30 Copay per Day	
Lower AV Plan	\$40 Copay per Stay After Deductible	Compliant
Higher AV Plan	\$40 Copay per Stay	

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	\$40 Copay per Day After Deductible	Not Compliant
Higher AV Plan	\$35 Copay per Stay With Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	\$35 Copay per Stay With Deductible	

### 5.8 Suggested Coordination of Drug Data between Templates

This section describes some options on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template.

To support the AV calculations using the AVC, the Plans & Benefits Template contains four drug benefit categories that represent a typical four-tier drug design available in the market today: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. CMS understands that plans may have drug benefits that do not fit neatly into the Plans & Benefits Template. The following are some options for how issuers could translate their cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template:

1. Enter the cost-sharing data for the tier in the Prescription Drug Template with the highest generic drug utilization into the Generic Drugs benefit category in the Plans & Benefits Template.
2. Enter the cost-sharing data for the two tiers in the Prescription Drug Template with the most brand drug utilization into the Preferred Brand Drugs and Non-Preferred Brand Drugs benefit categories in the Plans & Benefits Template. Enter the tier with the higher cost sharing into the Non-Preferred Brand Drugs category. If the formulary contains only one brand tier, enter the same cost sharing for the Preferred Brand Drugs and Non-Preferred Brand Drugs benefit categories.
3. Enter the cost-sharing data for the tier in the Prescription Drug Template with the most specialty drug utilization into the Specialty Drugs benefit category in the Plans & Benefits Template.

Cost-sharing data should reflect the following:

1. The Copay—In Network (Tier 1) and Coinsurance—In Network (Tier 1) fields in the Plans & Benefits Template should generally correspond to the 1 Month In Network Retail Pharmacy Copayment and Coinsurance fields from the Prescription Drug Template.
2. The Copay—Out of Network and Coinsurance—Out of Network fields in the Plans & Benefits Template should correspond to the 1 Month Out of Network Retail Pharmacy Copayment and Coinsurance fields from the Prescription Drug Template.

The Copay—In Network (Tier 2) and Coinsurance—In Network (Tier 2) fields in the Plans & Benefits Template do not have corresponding fields in the Prescription Drug Template. While the concept of “tiers” is used as a framework to group drugs in the Prescription Drug Template, in the Plans & Benefits Template, “tiers” refer to provider and pharmacy networks. If the issuer has multiple in-network tiers for medical benefits, it may use the tiered cost-sharing field for drugs to represent preferred and non-preferred pharmacies on the Plans & Benefits Template. Following this approach, the issuer could enter the cost-sharing data in the following manner:

1. Preferred pharmacy cost sharing corresponds to In Network (Tier 1).
2. Non-preferred pharmacy cost sharing corresponds to In Network (Tier 2).
3. If the issuer does not have multiple in-network tiers for its medical benefits, representing non-preferred pharmacy cost sharing under the Tier 2 fields on the Plans & Benefits Template is not necessary.

If the plan has multiple in-network tiers for certain medical benefit categories, but not for drug benefits, set all drug benefit Tier 2 copay and coinsurance fields equal to **Not Applicable**.

The Maximum Coinsurance for Specialty Drugs field is defined only once in the Plans & Benefits Template for each plan; it cannot change among plan variations, and it must be the same for In Network (Tier 1), In Network (Tier 2), and Out of Network.

CSR plan variations must offer the same drug list as the applicable standard plan. The cost-sharing structure of the formulary for each plan variation must meet the requirements related to CSRs (45 CFR 156.420). However, issuers are not required to submit a separate formulary in the Prescription Drug Template for their plan variations.

Regardless of the method being used to translate the plan’s cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template, the inputs into the Plans & Benefits Template for the drug tiers should be reflective of the cost sharing used in the AV calculation.

### 5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

Throughout this section, all data fields that CMS anticipates displaying to consumers on Plan Compare for individual market coverage are identified by a number symbol (#) next to the field name. **Table 2D-9** and **Table 2D-10** list the Plans & Benefits Template data elements that CMS anticipates displaying on Plan Compare. This should not be viewed as the final list of data elements for display to consumers, and CMS may change this list after these instructions are published. It is provided here as a reference for issuers before they submit QHP Applications.

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare Label Name	Template Value	Template Source
Deductibles and Maximum Out of Pocket Rules	<ul style="list-style-type: none"> <li>◆ If Medical and Drug amounts are integrated, the combined amount displays.</li> <li>◆ If Medical and Drug amounts are not integrated, only the Medical amount displays on the Plan Summary page. (The Drug amount displays in the prescription drug details section.)</li> <li>◆ If there is only one person in the enrollment group, the Individual Per Person amount displays.</li> <li>◆ If there is more than one person in the enrollment group, the Family Per Group amount displays. The dollar amount will display followed by “Per Group.”</li> <li>◆ If there is more than one person in the enrollment group and the plan design does not have a per group deductible, then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by “Per Person.”</li> </ul>	Plans & Benefits Template
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template
	Combined Medical & Drug EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare Label Name	Template Value	Template Source
Maximum Out of Pocket	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
Metal Level	Level of Coverage	Plans & Benefits Template
Provider Directory	Network URL	Network ID
Summary of Benefits and Coverage	URL for Summary of Benefits & Coverage	Plans & Benefits Template
Insurance Company + Plan Marketing Name + Plan Type <i>Issuer Legal Name (as recorded in HIOS) will display if Issuer Marketplace Marketing Name is null</i>	Issuer Marketplace Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template
Adult Dental Included Adult Dental Not-Included	Routine Dental Services (Adult) Basic Dental Care (Adult) Major Dental Care—Adult <i>Note: All three must be available to show Adult Dental Included</i>	Plans & Benefits Template
Pediatric Dental Included Pediatric Dental Not-Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child <i>Note: All three must be available to show Pediatric Dental Included</i>	Plans & Benefits Template
National Provider Network Offered/National Network	National Network	Plans & Benefits Template
Health Care Costs	Derived from “Level of Coverage”	Plans & Benefits Template
Reduced Costs	Indicates whether the plan is a CSR variant	Based on Consumer Eligibility information

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare Label Name	Template Value	Template Source
Plan Brochure	Plan Brochure URL	Plans & Benefits Template
<b>Benefit Data Rules</b> These data display for each covered benefit below when the “Is This Benefit Covered?” value is <b>Yes</b>	Tier 1 In-Network Copay Tier 1 In-Network Coinsurance Tier 2 In-Network Copay Tier 2 In-Network Coinsurance Out of Network Copay Out of Network Coinsurance Limit Quantity Limit Unit "Limits and Exclusions Apply" hyperlink displays when Explanation or Exclusions is not null	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare Label Name	Template Value	Template Source
<b>Medical Care Coverage</b>		
Visit to a Primary Care Provider	Primary Care Visit to Treat an Injury or Illness	Plans & Benefits Template
Visit to a Specialist	Specialist Visit	Plans & Benefits Template
X-Rays and Diagnostic Imaging	X-Rays and Diagnostic Imaging	Plans & Benefits Template
Laboratory and Outpatient Professional Services	Laboratory Outpatient and Professional Services	Plans & Benefits Template
Hearing Aids	Hearing Aids	Plans & Benefits Template
Routine Eye Exam for Adults	Routine Eye Exam for Adults	Plans & Benefits Template
Routine Eye Exam for Children	Routine Eye Exam for Children	Plans & Benefits Template
Eyeglasses for Children	Eyeglasses for Children	Plans & Benefits Template
Health Savings Account Eligible Plan	HSA-Eligible	Plans & Benefits Template
<b>Prescription Drug Coverage</b>		
Generic Drugs	Generic Drugs	Plans & Benefits Template
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template
Specialty Drugs	Specialty Drugs	Plans & Benefits Template
List of Covered Drugs	Formulary URL	Prescription Drug Template
3 Month In-Network Mail Order Pharmacy Benefit Offered?	3 Month In-Network Mail Order Pharmacy Benefit Offered?	Prescription Drug Template
Prescription Drug Deductible	Drug EHB Deductible: In-Network—Individual Drug EHB Deductible: In-Network—Family (When the “Medical & Drug Deductibles Integrated?” value is <b>Yes</b> , “Included with Medical” displays)	Plans & Benefits Template
Prescription Drug Out of Pocket Maximum	Drug EHB Maximum Out-of-Pocket: In-Network—Individual Drug EHB Maximum Out-of-Pocket: In-Network—Family (When the “Medical & Drug MOOP Integrated?” value is <b>Yes</b> , “Included with Medical” displays)	Plans & Benefits Template
<b>How to Access Doctors and Hospitals</b>		
Provider Directory	Network URL	Network ID Template
National Provider Network	National Network	Plans & Benefits Template
Referral Required to See a Specialist	Referral Required to See a Specialist	Plans & Benefits Template
<b>Hospital-Based Services</b>		
Emergency Room Services	Emergency Room Services	Plans & Benefits Template
Inpatient Physician and Surgical Services	Inpatient Physician and Surgical Services	Plans & Benefits Template
Inpatient Hospital Services (e.g., Hospital Stay)	Inpatient Hospital Services (e.g., Hospital Stay)	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare Label Name	Template Value	Template Source
Outpatient Physician and Surgical Services	Outpatient Surgery Physician/Surgical Services	Plans & Benefits Template
Outpatient Hospital Services	Outpatient Facility Fee	Plans & Benefits Template
<b>Coverage Examples</b>		
Total Cost of Having a Baby	SBC Scenario—Having a Baby. Sum of the following data elements: ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit	Plans & Benefits Template
Total Cost of Managing Diabetes	SBC Scenario—Managing Diabetes. Sum of the following data elements: ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit	Plans & Benefits Template
Total Cost of Treating a Simple Fracture	SBC Scenario—Treatment of a Simple Fracture. Sum of the following data elements: ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit	Plans & Benefits Template
<b>Adult Dental Coverage</b>		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template
Orthodontia	Orthodontia—Adult	Plans & Benefits Template
Find Dentists	Network URL	Network ID
<b>Pediatric Dental Coverage</b>		
Check-Up	Dental Check-Up for Children	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Child	Plans & Benefits Template
Major Dental Care	Major Dental Care—Child	Plans & Benefits Template
Orthodontia	Orthodontia—Child	Plans & Benefits Template
<b>Medical Management Programs</b>		
Asthma	Disease Management Programs Offered	Plans & Benefits Template
Heart Disease	Disease Management Programs Offered	Plans & Benefits Template
Depression	Disease Management Programs Offered	Plans & Benefits Template
Diabetes	Disease Management Programs Offered	Plans & Benefits Template
High Blood Pressure & Cholesterol	Disease Management Programs Offered	Plans & Benefits Template
Low Back Pain	Disease Management Programs Offered	Plans & Benefits Template
Pain Management	Disease Management Programs Offered	Plans & Benefits Template
Pregnancy	Disease Management Programs Offered	Plans & Benefits Template
Weight Loss Program	Disease Management Programs Offered	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare Label Name	Template Value	Template Source
<b>Other Benefits</b>		
Acupuncture	Acupuncture	Plans & Benefits Template
Chiropractic Care	Chiropractic Care	Plans & Benefits Template
Infertility Treatment	Infertility Treatment	Plans & Benefits Template
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health Outpatient Services	Plans & Benefits Template
Mental/Behavioral Health Inpatient Services	Mental/Behavioral Health Inpatient Services	Plans & Benefits Template
Habilitative Services	Habilitative Services	Plans & Benefits Template
Bariatric Surgery	Bariatric Surgery	Plans & Benefits Template
Outpatient Rehabilitative Services	Outpatient Rehabilitation Services	Plans & Benefits Template
Skilled Nursing Facility	Skilled Nursing Facility	Plans & Benefits Template
Private-Duty Nursing	Private-Duty Nursing	Plans & Benefits Template

### 5.10 Plan Compare Cost-Sharing Display Rules

Below is a summary of the anticipated deductible, MOOP, copay, and coinsurance cost-sharing display logic for Plan Compare for individual market coverage effective starting January 1, 2019. It covers the majority of situations but is not exhaustive. This should not be viewed as the final display logic for Plan Compare, and CMS may make changes after these instructions are published. It is provided here as a reference for issuers before submitting QHP Applications.

#### 5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug amounts are integrated, then the total amount for the medical and drug data element will display on the Plan Summary page. “Included with Medical” will display on the plan details page under the drug amounts.
- If medical and drug amounts are not integrated, only the medical amount displays on the Plan Summary page. The drug amount displays in the prescription drug details section on the Plan Details page.
- If there is only one person in the enrollment group, the individual MOOP and deductible amount displays on the Plan Summary and Plan Details pages.
- On the Plan Summary page, if more than one person is in the enrollment group, the Family Per Group MOOP amount displays. The dollar amount will display followed by “Per Group.”
- On the Plan Summary page, if there is more than one person in the enrollment group, and if the issuer entered either \$0 or a positive dollar amount for the Family Per Group data field, the Family Per Group deductible amount displays. The dollar amount will display followed by “Per Group.” If there is more than one person in the enrollment group and the plan design does not have a per-group deductible (i.e., the Family Per Group Deductible is **Not Applicable**), then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by “Per Person.”
- On the Plan Details page, the Family Per Group and the Family Per Person deductible and MOOP amounts will appear.
- The out-of-network deductible and MOOP are not displayed on Plan Compare.

### 5.10.2 Covered Benefit Plan Compare Display Logic

- Generally speaking, the Plan Compare display logic considers the entered values for copay and coinsurance. For example, if the issuer enters “Not Applicable” for copay and “20%” for coinsurance for a specialist visit, “20%” will display on Plan Compare.
- When copay is “Not Applicable” and rounded coinsurance is greater than zero and less than 100 percent, the coinsurance value is displayed.
- When copay is greater than zero and coinsurance is “Not Applicable,” the entered copay value is displayed.
- If coinsurance is equal to “100%,” a benefit is displayed as “Not Covered.”
- “No Charge After Deductible” is displayed if one of the following occurs:
  - “No Charge After Deductible” is entered for copay and coinsurance.
  - The issuer entered “Not Applicable” for copay and “No Charge After Deductible” for coinsurance, or vice versa.
- “No Charge” is displayed when the combination of entered copay and coinsurance values include “0,” “No Charge,” or “Not Applicable.” Similarly, if any of the aforementioned values include copay or coinsurance qualifiers of “After Deductible,” then “No Charge After Deductible” is displayed.
- When copay and coinsurance are each greater than zero, both are displayed.

### 5.11 Troubleshooting the Plans & Benefits Add-In File

When opening the Plans & Benefits Add-In file before the template, Excel sometimes loads an older version of the Add-In file not compatible with the template. This causes run-time errors when entering data into the template or clicking buttons on the **Plans & Benefits** ribbon.

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for best results.
2. *Never* rename the Add-In file to a different name.
3. Ensure that only one copy of the Add-In file is on the computer; delete all extra copies. When downloading a new one, always “Replace” the old version.

If the issuer still experiences run-time errors, Excel may have loaded a previous version of the Add-In file. Take the following steps:

1. Open a blank sheet in Excel (no template or file). The Excel ribbon should not have a **Plans & Benefits** ribbon.
  - a. If the **Plans & Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-Ins > Go > uncheck Plansbenefitsaddin > OK (**Figure 2D-21** through **Figure 2D-23**). In Excel 2007, the label names may differ slightly.

Figure 2D-21. Excel Options Window

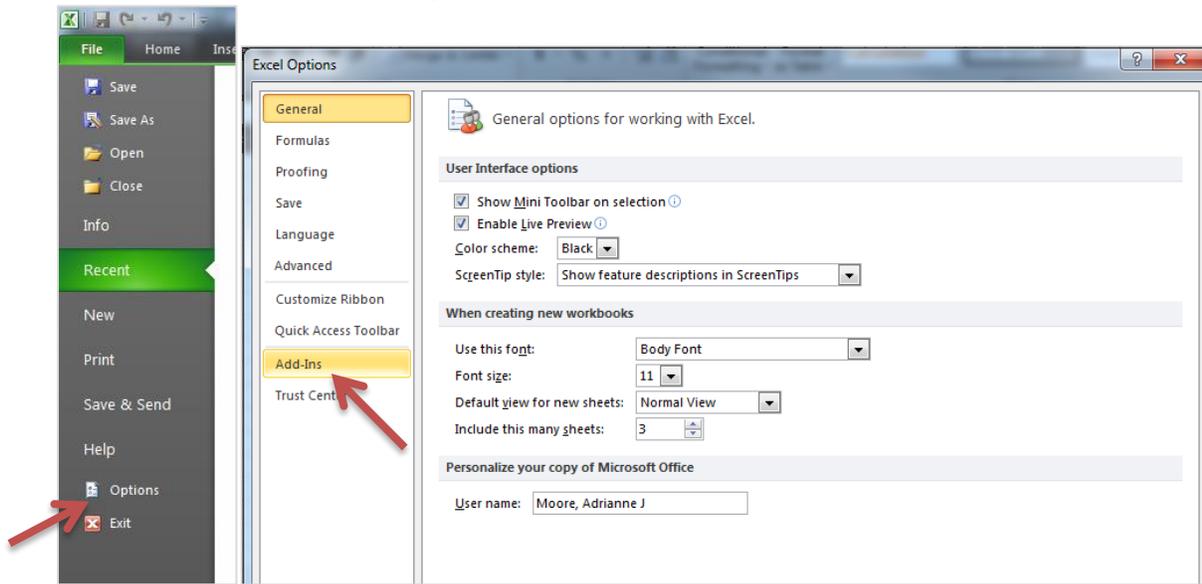


Figure 2D-22. Add-Ins Tab in Excel Options Window

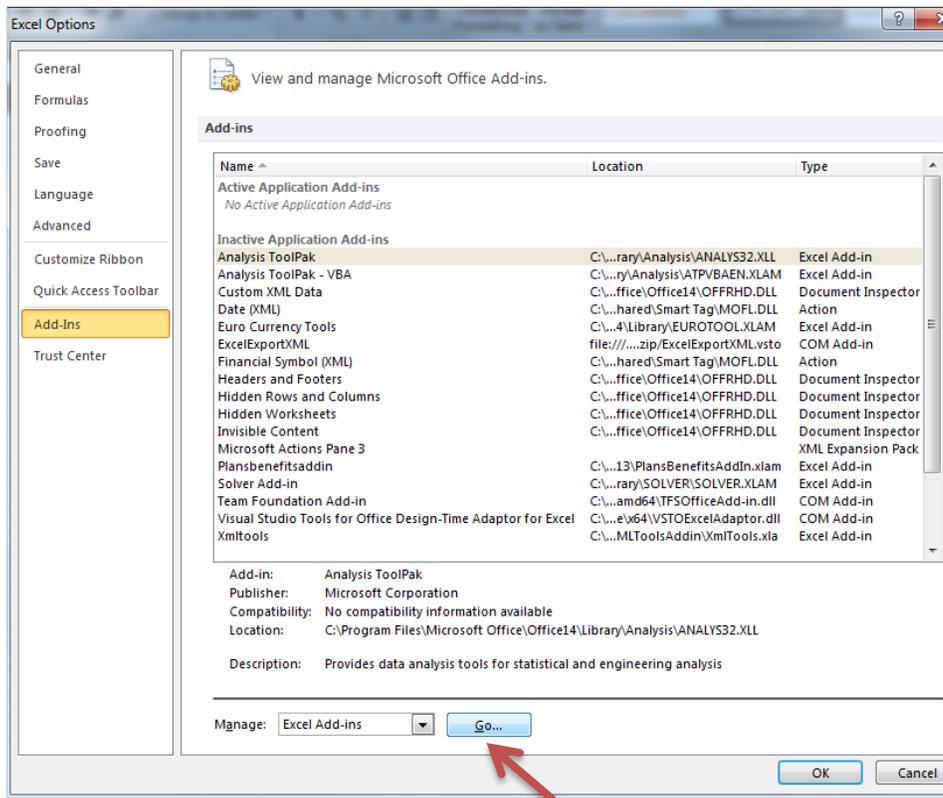
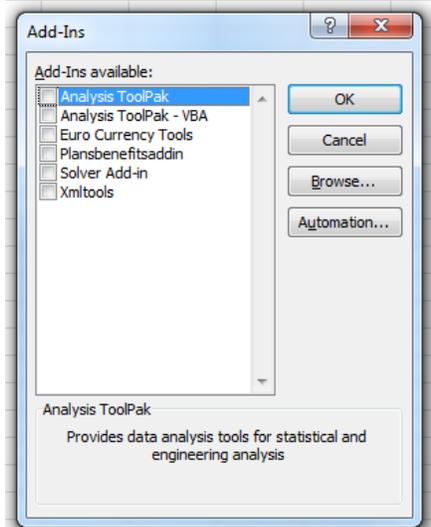


Figure 2D-23. Add-Ins Window



2. Verify that the **Plans & Benefits** ribbon is gone.
3. Open a Plans & Benefits Template.
4. The template should open the Add-In automatically after **Enable Macros** is clicked. This means the template successfully loaded the Add-In.

## Rating Module

Users of the Rating Module are assigned to one or both of the following roles: the Issuer Submitter (an individual who submits the data necessary to complete the Rating Module) and the Issuer Validator (an individual who validates the data necessary to complete the Rating Module).

This module is divided into various sections, and the tabs to navigate through the sections of the module are listed on the top of the page. There are three tabs to this module: the Data Submitter page, the Data Validator page, and the Final Submission page (**Figure 3-1**).

Figure 3-1. Three Module Tabs



The Data Submitter page allows submitters to work on an existing application or view an application that the issuer already submitted (**Figure 3-2**). The Data Validator page allows validators to view a list of all submitted applications. This section also allows validators to upload supporting documents and answer supplemental responses through HIOS (**Figure 3-3**). The Final Submission page allows the submitter to cross-validate data between modules and submit the QHP Application (**Figure 3-4**).

Each of these tabs is broken down further with information that needs to be entered to create a new application or edit an existing application. For the Data Submitter page, all sections listed in the lower part and to the left-hand side of the page need to be completed before moving on to the Data Validator pages.

Figure 3-2. Upload/Download Data Submitter Page

**Upload/Download Rates & Business Rules**

**Download Templates**

- BusinessRules.xls
- Rates.xls

**Upload File(s)**  
Fields marked with an asterisk (\*) are required.

**i** Please note that uploading a second version of the template will replace the previously uploaded version.

**Document Type:** Select document type  
**Upload File(s):** Browse... No file selected. Upload

**Uploaded File History** Update Status

Document Type	File Name	Submission Date	Status
Business Rules	87296_NC_2016_BusinessRules.xls	02/17/2015 2:40:22 PM	Complete
Rates	87296_NC_2016_Med_Rates.xls	02/17/2015 2:48:33 PM	Pending

Figure 3-3. Data Validator Snapshot

[Data Submitter](#) | [Data Validator](#) | [Final Submission](#)

### Validate The Rates & Business Rules Submission

Please review and validate the completed submissions.  
Fields marked with an asterisk (\*) are required.

**Uploaded File(s)**

Document Type:	File Name	Upload Date
Business Rules	87296_NC_2016_BusinessRules.xls	02/17/2015 2:48:22 PM
Rates	87296_NC_2016_Med_Rates.xls	02/17/2015 2:48:40 PM

\*Do you validate that the information submitted for this section is correct?

Yes     No

Figure 3-4. Final Submission Snapshot

[Data Submitter](#) | [Data Validator](#) | [Final Submission](#)

 **Issuer ID 87296 has been Cross Validated.**

To qualify for QHP Certification, Cross Validation must be passed. To cross validate template data within a submission, click the Cross Validate or Submit Button. A submission must pass cross validation prior to the submission window closing in order to be a certified QHP.

Please Note: The Rate Review module submission(s) are required in order to successfully complete cross-validation.

Module	Submission Date	Status
Issuer Module	02/17/2015 3:32:53 PM	Validation Completed
Benefits and Service Area Module	02/17/2015 4:09:42 PM	Validation Completed
Rating Module	02/17/2015 3:05:11 PM	Validation Completed

## Section 3A: Rates Table

### 1. Introduction

In the Rates Table section, issuers must define the premium rate that the issuer charges for each type of subscriber that a plan covers. These instructions apply to QHP and SADP issuers.

### 2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Federal Taxpayer Identification Number (TIN)
3. Plan IDs.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

#### Tips for the Rates Section

- ◆ SADPs should be entered on a separate Rates Table Template from QHPs.
- ◆ Issuers are encouraged to use separate sheets for individual plans and SHOP plans.
- ◆ For individual market plans, the rate effective date must be January 1, 2019.
- ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1st, April 1st, July 1st, or October 1st). Each worksheet in the Rates Table Template is bound to a separate effective date range. An issuer submitting SHOP trended quarterly rates should submit a separate worksheet for each date range that a set of rates will be in effect.

### 4. Detailed Section Instructions

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Federal TIN	Enter the nine-digit (xx-xxxxxxx) TIN.
Rate Effective Date	Enter the rate effective date as mm/dd/yyyy. For individual market plans, the rate effective date must be January 1, 2019. <ul style="list-style-type: none"><li>◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1st, April 1st, July 1st, and October 1st). Each worksheet in the Rates Table Template is bound to a separate effective date range. An issuer submitting SHOP trended quarterly rates should submit a separate worksheet for each date range that a set of rates will be in effect.</li><li>◆ An issuer submitting a SHOP quarterly rate change should submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable quarterly rate change submission window. An issuer may submit rate changes that would apply for the next quarter and/or any subsequent quarter in the remaining plan year. An issuer should not change or delete rates for any current or previous quarter during the submission window. For example, during the submission for updated second-quarter SHOP rates, the first-quarter rates should match the original submission. For SHOP medical plans, the changes must be consistent with the revised index rates that are submitted in the corresponding Unified Rate Review Template.</li></ul>

Rates Table Template	Steps
Rate Expiration Date	Enter the rate expiration date as mm/dd/yyyy. <ul style="list-style-type: none"> <li>◆ For individual market plans, the rate expiration date must be December 31, 2019.</li> <li>◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (March 31st, June 30th, September 30th, or December 31st).</li> </ul>
Rating Method	Select whether the plans on the worksheet use age-based rates or family-tier rates. <i>Note:</i> Only issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers or issuers entering rates for individual market SADPs are eligible to select “Family-Tier Rates.” A list of states that use family-tier rating is available here: <a href="http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html#family">http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html#family</a> .
Add Sheets	Use the <b>Add Sheet</b> button to add additional worksheets for the following: <ul style="list-style-type: none"> <li>◆ If the issuer has SHOP plans with different rates effective and expiration dates. All plans on a single worksheet <i>must</i> have the same effective and expiration dates.</li> <li>◆ To separate individual market plans and SHOP plans.</li> <li>◆ If the issuer offers individual market SADPs that use individual and family-tier rating. Note that FF-SHOP SADPs can only use individual rating.</li> <li>◆ To separate by rating area.</li> </ul>
Plan ID	Enter the 14-character alphanumeric HIOS-generated Plan ID (xxxxxAxxxxxx) that identifies the plan associated with the rates in that row.
Rating Area	Select the rating area from the list. The rating area is the geographic area where the rates in the row are valid. Rating areas are defined by each state. A list of rating areas for each state is available here: <a href="http://cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html">http://cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html</a> .
Tobacco	If using age-based rates, select from the following options in the drop-down menu to indicate whether rates vary on the basis of tobacco use: <ul style="list-style-type: none"> <li>◆ <b>Tobacco User/Non-Tobacco User</b>—if rates are different for tobacco and non-tobacco users. If this option is selected, rates must be entered for non-tobacco and tobacco users. Market rules require tobacco rates to be no more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.<sup>7</sup>  <i>Note:</i> Small-group market medical plans (including SHOP QHPs) with tobacco rating <i>must</i> offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act and indicate the wellness program on their Plans &amp; Benefits Template. If the plan does not offer such a wellness program, the plan cannot rate for tobacco use.  <i>Note:</i> For FF-SHOP, if an enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used.</li> <li>◆ <b>No Preference</b>—if the rate applies to tobacco and non-tobacco users. No separate rates should be submitted for tobacco and non-tobacco users.</li> </ul>
Age	If using age-banded rates, the template will automatically generate a row for each age band 0–14 through 64 and over. <ul style="list-style-type: none"> <li>◆ If the issuer elects to rate by tobacco use, then tobacco rates for the child age bands of 0–14, 15, 16, and 17 will be auto-populated with the non-tobacco rates of the corresponding child age bands if the non-tobacco rates are first entered in the template. The issuer has the option to edit the auto-populated non-tobacco rates.</li> </ul>

<sup>7</sup> 42 U.S.C. 300gg—Fair Health Insurance Premiums.

Rates Table Template	Steps
	<ul style="list-style-type: none"> <li>◆ For dental plans only: Individual market SADPs that meet the definition of excepted benefits are not subject to the market rating rules. These plans may adjust for rating age bands that are not present in this template. In the Plan Attributes section of the Plans &amp; Benefits Template, individual market SADP issuers have the option to elect whether they are voluntarily complying with the rating rules in this template (“Guaranteed”), or if the issuer reserves the right to make further premium adjustments (“Estimated”). The plan display will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate.</li> <li>◆ If the issuer is in a state that does not permit rating for age or tobacco use and establishes uniform family tiers (and corresponding multipliers), or is entering rates for an individual market SADP using “Family-Tier Rates” as the rating method, skip to Family Tier.</li> </ul>
Individual Rate	<ul style="list-style-type: none"> <li>◆ Enter the individual rate that applies to that row. Market rules require individual rates to vary on the basis of age by not more than 3 times the 21 age rate. In addition, QHPs may not have a 0–20 age rate higher than the 21 age rate and must follow the federal age-rating curve, or state age-rating curve for issuers in states with state age-rating curves within the 1:3 market rule. A list of states using state-specific age curve variations is available here: <a href="http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-5-14-2013.pdf">http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-5-14-2013.pdf</a>.</li> </ul> <p><i>Note:</i> QHPs and SADPs must enter a value above \$0.00 for all age bands under the Individual Rate column unless the QHP or SADP has a value of “Allows Child-Only” under the Child-only Offering column of the Plans &amp; Benefits Template. QHP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19, and 20 age bands and are allowed to enter a value of \$0.00 for adult age bands 21 through 64 and over. SADP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, and 18 age bands and are allowed to enter a value of \$0.00 for adult age bands 19 through 64 and over.</p> <ul style="list-style-type: none"> <li>◆ QHPs and SADPs that rate by tobacco use should enter a positive non-zero value under the Individual Tobacco Rate column for age bands 18 through 64 and over. QHPs and SADPs are allowed to enter a value of \$0.00 as the tobacco rate for child age bands 0–14, 15, 16, and 17. QHP child-only offerings are allowed to enter a value of \$0.00 as the tobacco rate for adult age bands 21 through 64 and over. SADP child-only offerings are allowed to enter a value of \$0.00 as the tobacco rate for adult age bands 19 through 64 and over.</li> </ul>
Family Tier	<p>Issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, or individual market SADP issuers that selected “Family-Tier Rates” in the rating method field, will enter the individual rate in the individual rate field. Selecting “Family-Tier Rates” will also generate the following family tier columns:</p> <ul style="list-style-type: none"> <li>◆ <b>Individual Rate</b> (required): Enter the rate of an individual non-tobacco or no preference enrollee on a plan.</li> <li>◆ <b>Couple</b> (required): Enter the rate for a couple. A couple is defined as a primary subscriber and his or her spouse. A couple may also be a domestic partnership or same-sex partnership if allowed by the issuer in the Business Rules Template.</li> <li>◆ <b>Primary Subscriber and One Dependent</b> (required): Enter the rate for a primary subscriber with one dependent.</li> <li>◆ <b>Primary Subscriber and Two Dependents</b> (required): Enter the rate for a primary subscriber with two dependents.</li> <li>◆ <b>Primary Subscriber and Three or More Dependents</b> (required): Enter the rate for a primary subscriber with three or more dependents.</li> <li>◆ <b>Couple and One Dependent</b> (required): Enter the rate for a couple with one dependent.</li> </ul>

Rates Table Template	Steps
	<ul style="list-style-type: none"> <li>◆ <b>Couple and Two Dependents</b> (required): Enter the rate for a couple with two dependents.</li> <li>◆ <b>Couple and Three or More Dependents</b> (required): Enter the rate for a couple with three or more dependents.</li> </ul> <p>In the family tier option defined above, a dependent is defined as any dependent relationship allowed by the issuer that falls under the maximum age of a dependent as defined in the Business Rules Template. If any member of the enrollment group is determined to be ineligible, no rate will be returned for that plan.</p>

Figure 3A-1 shows an example of a completed Rates Table Template when “Age-Based Rates” is selected.

Figure 3A-1. Rates Table Template (Age-Based Rates)

2019 Rates Table Template v8.1		All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F. If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns. If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band. If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use. To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.		
Validate				
Finalize				
HIOS Issuer ID*	12345			
Federal TIN*	12-3456789			
Rate Effective Date*	1/1/2019			
Rate Expiration Date*	12/31/2019			
Rating Method*	Age-Based Rates			
Add Sheet				
Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an individual Non-Tobacco or No Preference enrollee on a plan
12345AB1234567	Rating Area 1	No Preference	0-14	10.00
12345AB1234567	Rating Area 1	No Preference	15	11.00
12345AB1234567	Rating Area 1	No Preference	16	12.00
12345AB1234567	Rating Area 1	No Preference	17	13.00

Figure 3A-2 shows an example of a completed Rates Table Template when “Family-Tier Rates” is selected.

Figure 3A-2. Rates Table Template (Family-Tier Rates)

2019 Rates Table Template v8.1		All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F. If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns. If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band. If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use. To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.				
Validate						
Finalize						
HIOS Issuer ID*	12345					
Federal TIN*	12-3456789					
Rate Effective Date*	1/1/2019					
Rate Expiration Date*	12/31/2019					
Rating Method*	Family-Tier Rates					
Add Sheet						
Plan ID*	Rating Area ID*	Individual Rate*	Couple*	Primary Subscriber and One Dependent*	Primary Subscriber and Two Dependents*	Family Tier Primary Subscriber and Three or More Dependents*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Enter the rate of an individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Required: Enter the rate of a family based on a single parent with one dependent	Required: Enter the rate of a family based on a single parent with two dependents	Required: Enter the rate of a family based on a single parent with three or more dependents
12345AB1234567	Rating Area 1	10.00	20.00	15.00	25.00	30.00

Once the Rates Table Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the <b>Validate</b> button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click <b>Validate</b> again. Continue this process until all errors are resolved.
Finalize Template	Click the <b>Finalize</b> button in the template. The Finalize function creates the .xml file of the template that will need to be uploaded in the Rates section of the Rating Module in HIOS.
Save Template	<b>Save</b> the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .xml file in the same folder.
Upload Template	Upload the saved file in the Rates section of the Rating Module in HIOS. Refer to the Rating Module User Guide for details on how to complete this.

## Section 3B: Business Rules

### 1. Introduction

In the Business Rules section, issuers must answer a series of questions that are used to calculate rates and determine if an enrollment group is eligible for coverage under a plan. These instructions apply to QHP and SADP issuers.

### 2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Federal Taxpayer Identification Number (TIN)
3. Plan IDs.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

#### Tips for the Business Rules Section

- ◆ Rules associated with individual and SHOP plans should be entered into one Business Rules Template.
- ◆ The first row of rules (Row 10) is the base set of issuer business rules, which must have blank values for the product ID and plan ID and must have data entered for all subsequent columns. This row applies to all products and plans associated with the HIOS Issuer ID, including individual, SHOP, QHP, and SADP products and plans. Products or plans with rules that differ from the base set of issuer business rules are defined at the product or plan level on the subsequent rows.

### 4. Detailed Section Instructions

*Note for SERFF Submitters:* The HIOS system allows only one set of issuer-level business rules (Row 10). If an issuer submits two templates (for example, one in the Individual Market SERFF binder and one in the SHOP SERFF binder), each with different issuer-level business rules (Row 10), the last template transferred by the state from SERFF into HIOS will apply to all plans, individual market and SHOP, unless the product or plan is listed separately. The issuer-level rules (Row 10) submitted on the first template uploaded will be overwritten by the issuer-level rules (Row 10) submitted on the second template uploaded and so on.

To avoid problems connected with issuer-level rule overwrites, all Business Rules Template issuer-level business rules (Row 10) should be the same. Products and plans that do not adhere to the business rules described at the issuer level (Row 10) should be further described in the rows below Row 10, as described in the instructions below.

Business Rules Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Federal TIN	Enter the nine-digit (xx-xxxxxxx) TIN.
Product ID	For products with rules that differ from those entered in Row 10, enter the 10-character (xxxxxAxxx) HIOS-generated Product ID number that identifies the product that will be associated with the rules defined in that row. <ul style="list-style-type: none"><li>◆ If a Product ID is entered, then the rules defined in that row will be applied to all plans associated with that Product ID. All other plans and products will use the rules associated with either the HIOS Issuer ID in Row 10 or a different Product ID rule.</li></ul>

Business Rules Template	Steps
	<ul style="list-style-type: none"> <li>◆ If no Product ID is entered, the rules associated with the HIOS Issuer ID in Row 10 will be used for all products.</li> </ul>
Plan ID	<p>Enter the 14-character alphanumeric HIOS-generated plan ID (xxxxxAAxxxxxx) that identifies the plan that will be associated with the rates in that row.</p> <ul style="list-style-type: none"> <li>◆ If a Plan ID is entered, then the rules defined in that row will be applied to that Plan ID only. All other plans and products will use the rules associated with the HIOS Issuer ID rule, Product ID rule, or a different Plan ID rule.</li> <li>◆ If no Plan ID is entered, then the rules for the Product ID associated with that plan ID will be used for all plans. If no Product ID rules were entered, the rules associated with the HIOS Issuer ID in Row 10 will be used for all products and plans.</li> </ul>
How are rates for contracts covering two or more enrollees calculated?	<p>Select one of the following two options from the drop-down menu:</p> <ul style="list-style-type: none"> <li>◆ <b>There are rates specifically for couples and families (not just addition of individual rates):</b> <ul style="list-style-type: none"> <li>▪ Use this selection if a QHP issuer in a state that does not permit rating for age or tobacco use, or if an individual market SADP issuer in any state. Health insurance issuers in states that require community rating must determine premiums for family coverage by using uniform family tiers and the corresponding multipliers established by the state.</li> <li>▪ <i>Note for SHOP issuers:</i> Please do not make this selection for FF-SHOP or SHOP states performing plan management functions products or plans. To display any FF-SHOP or SHOP states performing plan management functions for on-Exchange plans, select the next option. This applies to QHPs and SADPs.</li> </ul> </li> <li>◆ <b>A different rate (specifically for parties of two or more) for each enrollee is added together:</b> <ul style="list-style-type: none"> <li>▪ Use this selection if a QHP issuer (except those in pure community-rated states with uniform family tiers and corresponding multipliers) or a SHOP issuer. Premium rates are calculated by adding the per-member rates and providing the sum. Individual market SADP issuers may also use an individual rating if allowed by the state.</li> </ul> </li> </ul>
What are the maximum number of underage (under 21) dependents used to quote a two-parent family?	<p>Select the maximum number of underage (under 21) dependents from the drop-down menu.</p>
What are the maximum number of underage (under 21) dependents used to quote a single parent family?	<p>Select the maximum number of children (under age 21) from the drop-down menu.</p>
Is there a maximum age for a dependent?	<p>Set the maximum age for a child for purposes of eligibility. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—if selected, a pop-up will appear allowing the issuer to enter the maximum age with a default value of 21 or higher. QHP issuers must enter a minimum value of 25. SADP issuers must enter a minimum value of 21. Please note that the age entered is inclusive <i>through</i> that age. For example, a value of 25 is through age 25, up to age 26.</li> <li>◆ <b>Not Applicable</b>—if selected, then there is no maximum age and the dependent is allowed to enroll regardless of age as long as he or she meets the other eligibility rules.</li> <li>◆ Market rules require QHP issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26.<sup>8</sup></li> <li>◆ Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 21.</li> </ul>

<sup>8</sup> 45 CFR 147.120.

Business Rules Template	Steps
	<i>Note:</i> The maximum age for a dependent applies only to the dependent relationships of Child, Adopted Child, Brother or Sister, Foster Child, and Stepson or Stepdaughter.
What are the maximum number of children used to quote a children-only contract?	Select the maximum number of children allowed to be rated on a child-only plan.
Are domestic partners treated the same as secondary subscribers?	<p>Selection determines whether a domestic partner is allowed to be covered as a secondary subscriber. Please note that domestic partners are not differentiated by sex and can be same-sex or opposite-sex:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—select if the plan covers domestic partners. If the plan covers domestic partners, the domestic partner will be treated as a secondary subscriber and the household will be considered a “two-parent family” (referred to in “What are the maximum number of underage dependents used to quote a two-parent family?”).</li> <li>◆ <b>No</b>—select if the plan does <i>not</i> cover domestic partners.</li> </ul>
Are same-sex partners treated the same as secondary subscribers?	<p>Selection determines whether a same-sex partner is covered as a secondary subscriber. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—select if the plan covers domestic or life partners. If the plan covers domestic or life partners, then the primary subscriber/same-sex partner will be treated as a secondary subscriber and the household will be considered a “two-parent family” (referred to in “What are the maximum number of underage dependents used to quote a two-parent family?”) for rating and eligibility purposes.</li> <li>◆ <b>No</b>—select if the plan does <i>not</i> cover domestic or life partners.</li> </ul>
How is age determined for rating and eligibility purposes?	<p>Select how age is defined to determine if a consumer is eligible for a plan rate. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>Age on effective date</b>—return the rate based on the consumer’s age on the effective date.</li> <li>◆ <b>Age on January 1st of the effective date year</b>—return the rate based on the consumer’s age on January 1st of the effective date.</li> <li>◆ <b>Age on insurance date (age on birthday nearest the effective date)</b>—return the rate based on the consumer’s age closest to the effective date of the plan.</li> <li>◆ <b>Age on January 1st or July 1st</b>—return the rate based on the following: <ul style="list-style-type: none"> <li>◆ If the date of enrollment is before July 1st, then use the age as of January 1st.</li> <li>◆ If the date of enrollment is after July 1st, then use the age as of July 1st.</li> </ul> </li> <li>◆ Market rules require QHP plans to select the first option, “Age on Effective Date,” whereas dental plans may choose from any of the four options above.<sup>9</sup> Please note, to be offered on-Exchange, FF-SHOP SADPs should select only “Age on Effective Date.” No matter the entry, all FF-SHOP QHPs and SADPs, will be displayed according to “Age on Effective Date.”</li> </ul>

<sup>9</sup> 45 CFR 147.102(a)(I)(iii).

Business Rules Template	Steps
<p>How is tobacco status returned for subscribers and dependents?</p>	<p>Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following options:</p> <ul style="list-style-type: none"> <li>◆ <b>No tobacco use for at least [x] months</b>—if selected, a pop-up will appear asking for the number of months used to determine tobacco use. Market rules require QHP issuers to enter a tobacco look-back period of no more than six months. Dental issuers are not subject to the look-back period.<sup>10</sup> Please note that FF-SHOP plans will not recognize look-back periods other than six months. Rates will be tobacco or non-tobacco depending only on whether an enrollee indicates that he or she was an active tobacco user within the last six months (tobacco rate) or not an active tobacco user within the last months (non-tobacco rate). In addition, if the enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used.</li> <li>◆ <b>Not Applicable</b>—if selected, then there are no separate tobacco and non-tobacco use rates.</li> <li>◆ If rates are calculated by adding up individual rates, then the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and the non-tobacco rate for individuals who qualify for the non-tobacco rate.</li> <li>◆ For states that (1) do not permit rating for age or tobacco use and (2) establish uniform family tiers and corresponding multipliers, there are no separate tobacco rates for each family tier.</li> </ul>
<p>What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?</p>	<ul style="list-style-type: none"> <li>◆ Select from the pop-up list which relationships are allowed to be included when returning rates and if the dependent must live in the same household to be eligible to return a rate. All selected relationships will be accepted regardless of the sex of either the primary or dependent. Please note that FF-SHOP does not differentiate between dependents who live with the primary subscriber and those who do not.</li> <li>◆ Note that for FF-SHOP, only Spouse, Adopted Child, Foster Child, Ward, Stepson or Stepdaughter, Self, Child, Life Partner, and Other Relationship are accommodated.</li> <li>◆ For each relationship, select <b>Yes</b> or <b>No</b> if the dependent is required to live in the same household: <ul style="list-style-type: none"> <li>▪ <b>Yes</b>—the dependent must live in the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed.</li> <li>▪ <b>No</b>—the dependent may live in or outside the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. Please note that FF-SHOP does not differentiate between dependents who reside with the primary subscriber and those who do not.</li> <li>▪ Market rules require QHP issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26, regardless of support, residency, or dependency factors.</li> <li>▪ QHP products and plans that cover children must select a value of <b>No</b> for whether the child dependent is required to live in the same household. This requirement applies for all child dependent relationships, including Child, Adopted Child, Foster Child, and Stepson or Stepdaughter.</li> </ul> </li> <li>◆ Select the relationship “Life Partner” to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Please note that relationships are not differentiated by sex. If an individually rated plan covers spouses and life partners, same-sex and opposite-sex spouses and life partners are covered.</li> </ul>

<sup>10</sup> 45 CFR 147.102(a)(1)(iv).

A sample completed Business Rules Template is shown in **Figure 3B-1**.

Figure 3B-1. Sample Business Rules Template

**2019 Business Rules Template v8.1**

*All fields with an asterisk (\*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Enter the Issuer Rule on the first row (no Product ID or Plan ID).  
For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.  
For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule*

Validate							
Finalize							
HIOS Issuer ID*		12345					
TIN*	12-3456789						
Product ID	Plan ID (Standard Component)	How are rates for contracts covering two or more enrollees calculated?	What are the maximum number of under age (under 21) dependents used to quote a two parent family?	What are the maximum number of under age (under 21) dependents used to quote a single parent family?	Is there a maximum age for a dependent?	What are the maximum number of children used to quote a children-only contract?	
		There are rates specifically for couples and for families (not just addition of individual rates)	2	1	Not Applicable	1	

Once the Business Rules Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the <b>Validate</b> button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click <b>Validate</b> again. Continue this process until all errors are resolved.
Finalize Template	Click the <b>Finalize</b> button in the template. The Finalize function creates the .xml file of the template that will need to be uploaded in the Business Rules section of the Rating Module in the QHP Application System.
Save Template	<b>Save</b> the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .xml file in the same folder.
Upload Template	Upload the saved file in the Business Rules section of the Rating Module in the QHP Application System. Refer to the Rating Module User Guide for details on how to complete this.

## Appendices

The appendices contain information that indirectly affects the QHP Application.

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## Appendix 1: Actuarial Value Calculator

### 1. Introduction

To satisfy the AV requirements of 45 CFR 156.140 and 156.420, QHP issuers must use the AV Calculator (AVC) developed and made available by HHS for the given benefit year unless the plan design is not compatible with the AVC (a unique plan design) (45 CFR 156.135). To assist with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP Application, HHS recalculates this value to validate that an issuer's plan designs meet AV requirements.<sup>11</sup>

### 2. Purpose

The purpose of this section is to describe how the cost-sharing information from the Plans & Benefits Template is translated into the inputs for the stand-alone AVC. This information is applicable to QHP issuers.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

#### Tips for using the AVC

- ◆ Download the revised final 2019 stand-alone AVC, which is available at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.
- ◆ If a user is having difficulty matching AVs from the Plans & Benefits Template to the stand-alone AVC, follow the instructions in Section 5.2 (Differences between Stand-Alone AV Calculator and Plans & Benefits Template) on Troubleshooting.
- ◆ The AVC has an “Additional Notes” field that outputs error messages that can be seen only in the stand-alone AVC. These notes are intended to help AVC users understand the AVC’s assumptions and provide some information on the AV calculation being run in the AVC. When an AV calculation is not returned because of an input error, please check the “Additional Notes” field for an explanation of the error.<sup>12</sup>
- ◆ If any changes are made to the Plans & Benefits Template after running the **Check AV Calc** procedure, rerun the procedure so that the AVs in the **AV Calculator Output Number** field are updated to reflect the changes.
- ◆ When unique plan design features cause the AVC to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AVC. In that case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).

### 4. About the AVC

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan CSR variations, and all limited cost-sharing plan variations. The AVC cannot be used with catastrophic or SADP. The **Check AV Calc** procedure skips catastrophic plans entered in the Plans & Benefits Template and stops running when used with a SADP Plans & Benefits Template. If the Cost Share Variances worksheet contains unique plan designs and non-unique plan designs, the **Check AV Calc** procedure attempts to calculate an AV for the unique as well as the non-unique plan designs. If the stand-alone AVC returns an error for a unique plan design, resulting in a blank AV Calculator Output Number, the issuer does not need to address the error to validate the template, so long as the issuer's AV falls within the relevant de minimis range. While not required, CMS recommends that issuers run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that the issuers' submissions include the AV Calculator Output Number for plans that do not generate an error in the stand-alone AVC.

<sup>11</sup> For additional information on the AVC, see the AVC Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

<sup>12</sup> Examples of these notes include how the special cost-sharing provisions are being engaged in the calculations.

## 5. Detailed Section Instructions

**Table A1-1** describes the steps involved when using the **Check AV Calc** procedure in the Plans & Benefits Template.

Table A1-1. Plans & Benefits Check AV Calc Steps

Check AV Calc	Steps	
The <b>Check AV Calc</b> procedure on the <b>Plans &amp; Benefits</b> ribbon allows the user to calculate AVs for all applicable plans.	Step 1	Select the relevant Cost Share Variances worksheet, and fill out all the cost-sharing information necessary to run the AVC.
	Step 2	Click the <b>Check AV Calc</b> button. The <b>Check AV Calc</b> procedure will prompt the user to select the file location of the stand-alone AVC. The AVC file selected should also not have any saved output worksheets in it; otherwise, the AVC will return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all of the messages to finish the <b>Check AV Calc</b> procedure.
	Step 3	<ul style="list-style-type: none"> <li>◆ A prompt will appear asking if the issuer would like to save the screenshots.</li> <li>◆ Select <b>Yes</b> if the screenshots will be saved. Using the prompt, select the file name and location to save the output and create a copy of the AVC with worksheets that contain AV screenshots for each plan and plan variation.</li> <li>◆ Select <b>No</b> if the screenshots will not be saved, and the <b>Check AV Calc</b> procedure will complete without creating any new files.</li> </ul>
	Step 4	A validation message box will appear with the Status/Error Messages from the AVC for each plan or plan variation. The AV Calculator Output Number (Column F in the Cost Share Variances worksheet) is updated with the AV from the AVC. If an error prevented an AV from being calculated, the AV Calculator Output Number is left blank.
	Step 5	If any changes are made to the Plans & Benefits Template after running the <b>Check AV Calc</b> procedure, the user must rerun the procedure so that the AVs in the AV Calculator Output Number field are updated to reflect the changes.
	Step 6	After the AVC is completed, a procedure auto-populates the AV for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template. The AVC file selected also should not have any saved output worksheets in it; otherwise, the AVC will return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all of the messages to finish the <b>Check AV Calc</b> procedure.
For Unique Plan Designs: Upload Screenshot into HIOS <sup>13</sup>	Step 6— (Optional)	<ul style="list-style-type: none"> <li>◆ Copy the screenshots into a Word document (HIOS does not allow Excel files as supporting documents).</li> <li>◆ Upload a screenshot of the stand-alone AVC with the Plan Name, Plan ID, and HIOS Issuer ID fields filled in as a supporting document, and include the HIOS Plan ID (Standard Component) and date in the file name.</li> </ul>

### 5.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 156.135(b), the issuer application should include the Unique Plan Design Supporting Documentation and Justification. The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.<sup>14</sup>

<sup>13</sup> Issuers can use the stand-alone AVC to test plan designs, but they do not need to submit a completed stand-alone AVC or other supplemental documentation, such as a screenshot, except in scenarios described later (see Section 5.1). Instead, they submit a completed Plans & Benefits Template that includes the AVs populated by the Check AV Calc procedure.

<sup>14</sup> Template for this certification is available at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>

For plan designs that are calculated in accordance with 156.135(a) and do not need to use an alternative method under 156.135(b), issuers should first try to use the integrated version of the AVC for those plans before reverting to the use of the unique plan design option.

For plans compatible with the AVC, issuers must always use an actuarially justifiable process when inputting their plan designs into the AVC.<sup>15</sup> If the AV obtained from the template is not identical to the AV obtained from the stand-alone AVC, do the following:

1. Ensure the template has been filled out correctly per the instructions in this Appendix.
2. Follow the steps below in 5.2 on troubleshooting the AVC.
3. After following the troubleshooting steps, determine whether the user can replicate the results of the stand-alone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.
  - a. If the user cannot replicate the stand-alone AVC results because of the design of the Plans & Benefits Template, but the AVs obtained from the stand-alone AVC and through the Plans & Benefits Template *both* fall within the relevant de minimis range for the plan's metal level or CSR variation, the user does not need to designate the plan as a unique plan design. Instead, the user shall set the Unique Plan Design field equal to "No", leave the Issuer Actuarial Value field blank, and run the integrated AVC.
  - b. If the AV obtained via the Plans & Benefits Template does not fall within the relevant de minimis range but the AV obtained via the stand-alone AVC does, designate that particular plan as a unique plan design by setting the Unique Plan Design field equal to "Yes." For this plan, complete the Issuer Actuarial Value field with the value from the stand-alone AVC. The AV from the stand-alone AVC must fall within the relevant de minimis range. Also, upload a screenshot of the stand-alone AVC with the Plan Name, Plan ID, and HIOS Issuer ID fields filled in as a supporting document and include the Plan ID (Standard Component) and date in the file name. In this situation, designating the plan as a unique plan design does not require submission of an actuarial certification, and the plan is not considered unique for review purposes.

*Note:* There are certain cases in which issuers may not be able to match AVs between the Plans & Benefits Template and the AVC. The following are two examples in which the cost-sharing input in the Plans & Benefits Template may differ from the cost-sharing input in the AVC:

1. One or more benefits applies a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AVC.<sup>16</sup>
2. One or more benefits that can be split into component parts have a coinsurance equal to the default coinsurance, but the issuer does not wish to split the benefits into their component parts during the coinsurance phase. The X-rays and Diagnostic Imaging category can be split into Primary Care and Specialist Office Visit components. The following benefits can be split into Outpatient Facility and Outpatient Professional components: Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, Imaging (CT/PET Scans, MRIs), Speech Therapy, Occupational and Physical Therapy, Laboratory Outpatient, and Professional Services.

## 5.2 Differences between Stand-Alone AV Calculator and Plans & Benefits Template

The screenshot feature, as mentioned at the start of this section allows for a quick comparison between plan designs created using the Plans & Benefits Template and those manually entered into the stand-alone AVC. When using the **Check AV Calc** procedure in the Plans & Benefits Template, the user can select "Yes" after a prompt appears asking if the user wants to save the AVC screenshots. The user then selects the location where he or she wants the screenshots to be saved. Once the **Check AV Calc** procedure has finished, the user can

<sup>15</sup> For additional guidance, see the May 16, 2014, CMS Frequently Asked Questions on actuarial value, available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf>.

<sup>16</sup> For more information, please refer to the AVC User Guide located in the first tab of the AVC here: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

open the folder and use the automatically generated screenshots to compare with those manually created in the stand-alone AVC. This side-by-side comparison can be very helpful in determining if the cost-sharing structure has been entered and applied as intended.

**Table A1-2** describes the steps an issuer should take in order to compare the AV generated by the **Check AV Calc** procedure and the AV generated by the stand-alone AVC.

Table A1-2. Comparing Plans & Benefits and Stand-Alone AVC Screenshots

Create and Compare Screenshots	
Step 1	Calculate the plan's AV in the stand-alone AVC and save the screenshot.
Step 2	Calculate the plan's AV in the Plans & Benefits Template and save the screenshot.
Step 3	Compare the two screenshots created in Steps 1 and 2 line by line to identify the difference. The difference is what is causing the AV impact.

For example, if a plan is supposed to have a \$30 copay for Primary Care Visits, the cost sharing would be entered into the stand-alone AVC as shown in **Figure A1-1**. However, if the user entered the benefit cost sharing in the Plans & Benefits Template as shown in **Figure A1-2**, the AV from the stand-alone AVC and the AV returned from the **Check AV Calc** button in the Plans & Benefits Template would be significantly different. To resolve the discrepancy between the two AVs, the issuer could open the screenshot file created by the **Check AV Calc** macro and the stand-alone AVC. Upon comparing the stand-alone AVC screenshot (**Figure A1-1**) and the screenshot generated by the **Check AV Calc** macro in the Plans & Benefits Template (**Figure A1-3**), the issuer would see that the Subject to Deductible? checkbox is checked in the Plans & Benefits Template screenshot, indicating that the copay is being applied with the deductible only in the Plans & Benefits Template. The issuer could resolve this by referring to **Table A1-4**, which shows how to correctly enter cost sharing to ensure that it maps from the Primary Care Visit to Treat an Injury or Illness field as intended.

Figure A1-1. Stand-Alone AVC Screenshot

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00

Figure A1-2. Example Plans & Benefits Template Cost Sharing

Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$30.00		Not Applicable	No Charge after deductible		100.00%

Figure A1-3. Screenshot Created by Check AV Calc

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00

## 6. Field Mapping

This section describes how the **Check AV Calc** procedure maps data from the Plans & Benefits Template into the AVC. The user does not need to perform these mappings, which take place automatically. If any of the required data fields in the Plans & Benefits Template are blank or contain invalid values, the procedure returns an error. The layout of the following instructions is intended to align with the order that the fields appear in the Plans & Benefits Template.

### 6.1 Metal Tier

The Level of Coverage selected for the plan in the Plans & Benefits Template is mapped to the Desired Metal Tier in the AVC.

*Expanded Bronze Plans:* The AVC includes an option for users to indicate that the user is running an expanded bronze plan as finalized in the 2018 HHS Notice of Benefit and Payment Parameters.<sup>17</sup> The expanded bronze plan option in the AVC allows the user to calculate the AV for bronze plans that meet certain requirements and, therefore, the user would be allowed to use an expanded bronze plan de minimis range. The option may be used only if the bronze plan either covers and pays for at least one major service, other than preventive services, before the deductible, or it meets the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2) as established in 45 CFR 156.140(c). The AVC does not check the plan for compliance with the requirements to use the expanded bronze plan de minimis range. It is the responsibility of the issuer to ensure that its bronze plan meets the requirements under this policy in 45 CFR 156.140(c) if the issuer uses the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation is -4 percentage points and +5 percentage points. Please see the AVC Methodology and 2018 Notice of Benefit and Payment Parameters final rule for more information. For expanded bronze and silver plan CSR variations, the Indicate if Plan Meets CSR or Expanded Bronze AV Standard? checkbox in the AVC is checked. To ensure that the correct continuance table is used for these plans, the Desired Metal Tier depends on the AV level of the variation. The Desired Metal Tier for silver plan variances is set equal to “Silver” for the 73 percent variation, “Gold” for the 87 percent variation, and “Platinum” for the 94 percent variation. The Desired Metal Tier must be set to “Bronze” for expanded bronze plans.

*De Minimis Range:* In April 2017, CMS released a final rule, *Patient Protection and Affordable Care Act; Market Stabilization*,<sup>18</sup> that amends 45 CFR 156.140(c), which establishes the de minimis variation range for the AV level of coverage. Specifically, for plan years beginning on or after January 1, 2018, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is -4 percentage points and +2 percentage points. An exception exists for bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is -4 percentage points and +5 percentage points.

### 6.2 Health Savings/Reimbursement Account Options

If HSA/HRA Employer Contribution is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the HSA/HRA Employer Contribution? checkbox in the AVC is checked. The dollar amount entered for the HSA/HRA Employer Contribution Amount in the Plans & Benefits Template is mapped to the Annual Contribution Amount in the AVC.

**Figure A1-4** shows the HSA/HRA input fields in the Plans & Benefits Template, and **Figure A1-5** shows the corresponding input fields in the AVC.

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<sup>17</sup> The 2018 Notice of Benefit and Payment Parameters is available at: <https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>.

<sup>18</sup> The Market Stabilization final rule is available at: <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>.

Figure A1-4. HSA/HRA Input Fields in Plans & Benefits Template

HSA/HRA Detail		
HSA Eligible *	HSA/HRA Employer Contribution	HSA/HRA Employer Contribution Amount
Yes	Yes	\$500.00

Figure A1-5. HSA/HRA Input Fields in AVC

HSA/HRA Options	
HSA/HRA Employer Contribution?	<input checked="" type="checkbox"/>
Annual Contribution Amount:	\$500.00

### 6.3 Tiered Network Options

The AVC can accommodate plans using a multi-tiered, in-network plan design with up to two tiers of in-network services. The user may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, MOOPs, and service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting AV is a blend of the AVs for the two tiers.<sup>19</sup>

If Multiple In Network Tiers? is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the Tiered Network Plan? checkbox in the AVC is checked. The 1st Tier Utilization and 2nd Tier Utilization fields in the Plans & Benefits Template are mapped to the 1st Tier Utilization and 2nd Tier Utilization fields in the AVC. The Plans & Benefits Template requires that all silver plan CSR and limited cost-sharing plan variations have the same 1st Tier Utilization and 2nd Tier Utilization as the standard plan.

The Tiered Network Plan? checkbox in the AVC is not related to the Plan Type selection in the Plans & Benefits Template. Non-point-of-service plans can have multiple in-network tiers in the Plans & Benefits Template, resulting in the Tiered Network Option checkbox being checked in the AVC.

**Figure A1-6** shows the multi-tier input fields in the Plans & Benefits Template, and **Figure A1-7** shows the corresponding input fields in the AVC.

Figure A1-6. Multiple In-Network Tier Options in Plans & Benefits Template

Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
Yes	80%	20%

Figure A1-7. Multi-Tier Options in AVC

Tiered Network Option	
Tiered Network Plan?	<input checked="" type="checkbox"/>
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the “Not Applicable” option, issuers can explicitly indicate which benefits have tiered cost sharing in a plan with multiple in-network tiers. If a benefit has a Copay—In Network (Tier 2) and a Coinsurance—In Network

<sup>19</sup> For more information on this option, please refer to the AVC Methodology and User Guide located in the first tab of the AVC here: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

(Tier 2) equal to “Not Applicable,” the **Check AV Calc** procedure assumes the benefit does not have tiered cost sharing and uses the Copay—In Network (Tier 1) and Coinsurance—In Network (Tier 1) values when mapping to Tier 2 in the AVC. This exception to the Tier 2 mapping applies to all fields other than MOOPs, default coinsurance, and deductibles, but for simplicity it will not be noted in the individual sections that follow.

## 6.4 MOOP and Deductible Values

The AV calculator uses the individual MOOP and deductible limits to calculate the AV of the plan. Therefore, individual MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC. The individual MOOPs and deductibles mapped to the AVC are *not* the family per-person MOOPs and deductibles.

Because some plans may have only combined in- and out-of-network MOOPs or deductibles, rather than separate in-network and out-of-network MOOPs or deductibles, the following logic determines which MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC.

The following applies if the plan does *not* have multiple in-network tiers:

1. If the In Network field is equal to a dollar value (**\$X**), the In Network field is used for the AVC.
2. If the In Network field is equal to **Not Applicable** and the Combined In/Out of Network field is equal to a dollar value, the Combined In/Out of Network field is used for the AVC.
3. If the In Network and Combined In/Out of Network fields are equal to **Not Applicable**, the Plans & Benefits Template returns an error when attempting to calculate an AV.

The following applies if the plan has multiple in-network tiers:

1. If the In Network and In Network (Tier 2) fields are equal to dollar values, the In Network and In Network (Tier 2) fields are used for the AVC.
2. If the In Network and In Network (Tier 2) fields are equal to **Not Applicable**, and the Combined In/Out of Network field is equal to a dollar value, the Combined In/Out of Network field is used for the AVC. In that case, the Combined In/Out of Network MOOP or deductible is mapped to the Tier 1 and Tier 2 MOOPs or deductibles, respectively, in the AVC.
3. The Plans & Benefits Template returns an error when attempting to calculate an AV in the following scenarios:
  - a. The In Network field is equal to a dollar value, and the In Network (Tier 2) field is equal to **Not Applicable**.
  - b. The In Network field is equal to **Not Applicable**, and the In Network (Tier 2) field is equal to a dollar value.
  - c. The In Network, In Network (Tier 2), and Combined In/Out of Network fields are equal to **Not Applicable**.

### 6.4.1 Maximum Out-of-Pocket

If Medical & Drug Maximum Out-of-Pocket Integrated? is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the Use Separate OOP Maximum for Medical and Drug Spending? checkbox in the AVC is unchecked. The following applies to integrated MOOPs:

1. The Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—In Network—Individual **or** Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 OOP Maximum in the AVC, depending on the logic above.
2. If the plan has multiple in-network tiers, the Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—In Network (Tier 2)—Individual **or** Maximum Out-of-Pocket for Medical and Drug EHB Benefits

(Total)—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 OOP Maximum in the AVC.

**Figure A1-8** shows the integrated medical and drug MOOP fields in the Plans & Benefits Template, and **Figure A1-9** shows a corresponding example in the AVC.

Figure A1-8. MOOP for Medical and Drug EHB Benefits (Total) Fields in Plans & Benefits Template

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$4,000	\$4000 per person   \$8000 per group			\$10,000	\$10000 per person   \$20000 per group

Figure A1-9. Integrated Deductible, Coinsurance, and MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$1,500.00
Coinsurance (% , Insurer's Cost Share)			70.00%
MOOP (\$)			\$4,000.00
MOOP if Separate (\$)			

If Medical & Drug Maximum Out-of-Pocket Integrated? is equal to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the Use Separate OOP Maximum for Medical and Drug Spending? checkbox in the AVC is checked. The following applies to separate MOOPs:

1. The Maximum Out-of-Pocket for Medical EHB Benefits—In Network—Individual *or* Maximum Out-of-Pocket for Medical EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Medical MOOP in the AVC.
2. The Maximum Out-of-Pocket for Drug EHB Benefits—In Network—Individual *or* Maximum Out-of-Pocket for Drug EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Drug MOOP in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
  - a. The Maximum Out-of-Pocket for Medical EHB Benefits—In Network (Tier 2)—Individual *or* Maximum Out-of-Pocket for Medical EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Medical MOOP in the AVC.
  - b. The Maximum Out-of-Pocket for Drug EHB Benefits—In Network (Tier 2)—Individual *or* Maximum Out-of-Pocket for Drug EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Drug MOOP in the AVC.

**Figure A1-10** shows the separate medical and drug MOOP fields in the Plans & Benefits Template, and **Figure A1-11** shows a corresponding example in the AVC.

Figure A1-10. MOOP for Medical EHB Benefits and MOOP for Drug EHB Benefits Fields in Plans & Benefits Template

Maximum Out of Pocket for Medical EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$3,000	\$3000 per person   \$6000 per group			\$8,000	\$8000 per person   \$16000 per group

Maximum Out of Pocket for Drug EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$1,000	\$1000 per person   \$2000 per group			\$5,000	\$5000 per person   \$10000 per group

Figure A1-11. Separate Deductible and MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	80.00%	
MOOP (\$)			
MOOP if Separate (\$)	\$3,000.00	\$1,000.00	

The AVC will return an error to the Plans & Benefits Template when the sum of the medical and drug MOOPs exceeds \$8,000. Because the AVC can be available before the finalization of the annual limit on cost sharing for a given plan year, there is an estimated annual limit on cost sharing in the AVC to ensure that the final AVC does not contain an annual limit on cost sharing that is lower than the finalized one. For the 2019 AV Calculator, the MOOP limit and related functions have been set at \$8,000 to account for an estimated 2019 annual limitation on cost sharing. The proposed 2019 annual limitation on cost sharing was specified in the proposed HHS Notice of Benefit and Payment Parameters for 2019 and is \$7,900 for self-only coverage and \$15,800 for other than self-only coverage for 2019. Issuers that are required to meet AV standards must comply with the limit established in the regulation and may not use the projected estimates stated in the 2019 AV Calculator when finalizing plan designs.

The AVC does not allow a plan to have separate MOOPs if it has an integrated medical and drug deductible. If Medical & Drug Maximum Out-of-Pocket Integrated? is equal to **No** and Medical & Drug Deductibles Integrated? is equal to **Yes** in the Plans & Benefits Template, the Plans & Benefits Template returns an error when attempting to calculate the AV.

## 6.4.2 Deductibles

If the user has a deductible greater than \$0, one service must be subject to the deductible or the AVC will return an error.

If the Medical & Drug Deductibles Integrated? field is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the Use Integrated Medical and Drug Deductible? checkbox in the AVC is checked.<sup>20</sup> The following applies to integrated deductibles:

1. The Combined Medical & Drug Essential Health Benefit (EHB) Deductible—In Network—Individual *or* Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Combined Deductible in the AVC.
2. If the plan has multiple in-network tiers, the Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Individual *or* Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Combined Deductible in the **AVC**.

**Figure A1-12** shows the integrated deductible fields in the Plans & Benefits Template, and **Figure A1-9** (shown earlier) displays a corresponding example in the AVC.

Figure A1-12. Combined Medical and Drug EHB Deductible Fields in Plans & Benefits Template

Combined Medical and Drug EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	
\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	

If the value in the Medical & Drug Deductibles Integrated? field is equal to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the Use Integrated Medical and Drug Deductible? checkbox in the AVC is unchecked. The following applies to separate medical and drug deductibles:

1. The Medical EHB Deductible—In Network—Individual *or* Medical EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Medical Deductible in the AVC.
2. The Drug EHB Deductible—In Network—Individual *or* Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Drug Deductible in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
  - a. The Medical EHB Deductible—In Network (Tier 2)—Individual *or* Medical EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Medical Deductible in the AVC.
  - b. The Drug EHB Deductible—In Network (Tier 2)—Individual *or* Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Drug Deductible in the AVC.

<sup>20</sup> For information on the combined versus separate deductible in the AVC, please refer to the AVC User Guide located on the first tab of the AVC at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

**Figure A1-13** and **Figure A1-14** show the separate medical and drug deductible fields, respectively, in the Plans & Benefits Template, and **Figure A1-15** shows a corresponding example of separate medical and drug deductibles in the AVC.

Figure A1-13. Medical EHB Deductible Fields in Plans & Benefits Template

Medical EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person   \$3000 per group	20%	\$2,000	\$2000 per person   \$4000 per group	30%	\$3,000	\$3000 per person   \$6000 per group	
\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	
\$1,500	\$1500 per person   \$3000 per group	20%	\$2,000	\$2000 per person   \$4000 per group	30%	\$3,000	\$3000 per person   \$6000 per group	

Figure A1-14. Drug EHB Deductible Fields in Plans & Benefits Template

Drug EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	
\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	

Figure A1-15. Separate Medical and Drug Deductibles and Integrated MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$1,500.00	
Coinurance (% , Insurer's Cost Share)	80.00%	70.00%	
MOOP (\$)	\$4,000.00		
MOOP if Separate (\$)			

## 6.5 Default Coinsurance

While the coinsurance values in the Plans & Benefits Template represent the percentage of costs the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AVC must be set equal to 1-X percent, where X percent is the coinsurance value entered in the Plans & Benefits Template. For example, if enrollees pay 10 percent of specialist visit costs, the coinsurance in the Plans & Benefits Template would be equal to 10 percent. The coinsurance in the AVC would be equal to 90 percent to represent the 90 percent of costs incurred by the issuer. **Table A1-3** shows the mapping between the Plans & Benefits Template and the AVC and provides examples of coinsurance values in both.

Table A1-3. Coinsurance Mapping between the Plans & Benefits Template and the AVC

Plans & Benefits (Enrollee's Cost Share)	AVC (Issuer's Cost Share)
X%	(1 - X)%
10%	90%
40%	60%

If the plan has an integrated medical and drug deductible, it also must have an integrated default coinsurance in the AVC. If Medical & Drug Deductibles Integrated? is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the Combined Medical & Drug EHB Deductible—In Network—Default Coinsurance value in the Plans & Benefits Template is mapped to the default Tier 1 Combined Coinsurance in the AVC (found in the Tier 1 Plan Benefit Design table).

2. If the plan has multiple in-network tiers, one minus the Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance value in the Plans & Benefits Template is mapped to the default Tier 2 Combined Coinsurance in the AVC (found in the Tier 2 Plan Benefit Design table).

**Figure A1-12** (displayed earlier) shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and **Figure A1-9** (displayed earlier) shows an example in the AVC.

If the plan has separate medical and drug deductibles, it also must have separate default coinsurance values in the AVC. If Medical & Drug Deductibles Integrated? is equal to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the Medical EHB Deductible—In Network—Default Coinsurance value in the Plans & Benefits Template is mapped to the default Tier 1 Medical Coinsurance in the AVC (found in the Tier 1 Plan Benefit Design table).
2. One minus the Drug EHB Deductible—In Network—Default Coinsurance value in the Plans & Benefits Template is mapped to the default Tier 1 Drug Coinsurance in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
  - a. One minus the Medical EHB Deductible—In Network (Tier 2)—Default Coinsurance value in the Plans & Benefits Template is mapped to the default Tier 2 Medical Coinsurance in the AVC (found in the Tier 2 Plan Benefit Design table).
  - b. One minus the Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance value in the Plans & Benefits Template is mapped to the default Tier 2 Drug Coinsurance in the AVC.

## 6.6 Subject to Deductible?

The copay and coinsurance qualifiers in the Plans & Benefits Template determine whether the Subject to Deductible? checkbox in the AVC is checked (see **Figure A1-16** and **Figure A1-17**). For each benefit, if either the Copay—In Network (Tier 1) or the Coinsurance—In Network (Tier 1) field in the Plans & Benefits Template contains the text “with deductible” or “after deductible,” the Tier 1 Subject to Deductible? checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers (the plan has multiple tiers and both Copay—In Network (Tier 2) and Coinsurance—In Network (Tier 2) are not equal to **Not Applicable**), the same logic applies to Tier 2.

Figure A1-16. Fields in Plans & Benefits Template Mapping to Subject to Deductible? Fields in AVC

Primary Care Visit to Treat an Injury or Illness						Specialist Visit					
Copay			Coinsurance			Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$20.00	\$25.00	\$40.00	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	10.00% Coinsurance after deductible	20.00% Coinsurance after deductible	40.00% Coinsurance after deductible

Figure A1-17. Benefit Categories in AVC

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

**Table A1-4** shows all possible mappings of copay and coinsurance values from the Plans & Benefits Template to the AVC—including the Subject to Deductible? logic—for all benefits other than Mental/Behavioral Health and Substance Use Disorder benefits. For mental health and substance abuse benefits, see **Table A1-6**. Section 6.11.4 describes the copay and coinsurance mappings in more detail.

Table A1-4. Benefit Category Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coin-surance	Copay	Copay applies only after deductible?
\$X Copay after deductible \$X Copay per Day after deductible, \$X Copay per Stay after deductible, or No Charge after deductible	X% or X% Coinsurance after deductible	Checked	Checked	(1-X)%	Blank	Unchecked
No Charge or Not Applicable	X% Coinsurance after deductible					
\$X, \$X Copay per Day, or \$X Copay per Stay	X% Coinsurance after deductible	Checked	Checked	(1-X)%	\$X	Unchecked
\$X Copay with deductible, \$X Copay per Day with deductible, or \$X Copay per Stay with deductible	X% or X% Coinsurance after deductible					

Table A1-4. Benefit Category Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coin-surance	Copay	Copay applies only after deductible?
No Charge or Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge or Not Applicable					
No Charge after deductible	No Charge after deductible					
\$X Copay after deductible, \$X Copay per Day after deductible, or \$X Copay per Stay after deductible	No Charge, Not Applicable, or No Charge after deductible	Checked	Unchecked	Blank	\$X	Checked
\$X, \$X Copay per Day, or \$X Copay per Stay	No Charge after deductible	Checked	Unchecked	Blank	\$X	Unchecked
\$X Copay with deductible, \$X Copay per Day with deductible, or \$X Copay per Stay with deductible	No Charge, Not Applicable, or No Charge after deductible					
No Charge, or Not Applicable	X%	Unchecked	Checked	(1-X)%	Blank	Unchecked
\$X, \$X Copay per Day, or \$X Copay per Stay	X%	Unchecked	Checked	(1-X)%	\$X	Unchecked
No Charge or Not Applicable	No Charge or Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X, \$X Copay per Day, or \$X Copay per Stay	No Charge or Not Applicable	Unchecked	Unchecked	Blank	\$X	Unchecked

### 6.7 Subject to Coinsurance?

For each benefit, if Coinsurance—In Network (Tier 1) is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the Tier 1 Subject to Coinsurance? checkbox for the corresponding benefit in the AVC is checked. For a plan with multiple in-network tiers, if Coinsurance—In Network (Tier 2) is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the Tier 2 Subject to Coinsurance? checkbox for the corresponding benefit in the AVC is checked.

### 6.8 Different Coinsurance Values

A coinsurance value for a benefit category is mapped to the AVC only if the coinsurance for the given benefit differs from the relevant default coinsurance. For each benefit, if the Tier 1 Subject to Coinsurance? checkbox in the AVC is checked as described above, one minus X percent, where X percent is the coinsurance value from the Coinsurance—In Network (Tier 1) field in the Plans & Benefits Template, is mapped to the Tier 1 Coinsurance, if different field for the corresponding benefit in the AVC. For a benefit with multiple in-network tiers, if the Tier 2 Subject to Coinsurance? checkbox in the AVC is checked, one minus X percent, where X percent is the coinsurance value from the Coinsurance—In Network (Tier 2) field, is mapped to the Tier 2 Coinsurance, if different field for the corresponding benefit in the AVC.

The AVC functionality does not support plan designs in which the benefit has a coinsurance without being subject to the deductible or a copay element. Please refer to the AVC User Guide for more information on the operation of copay and coinsurance cost sharing in the deductible and coinsurance ranges.<sup>21</sup>

The AVC treats “No Charge” (or “Not Applicable”) and “0%” coinsurance differently when a benefit’s copay is greater than “\$0.” If the benefit has coinsurance equal to “No Charge” (or “Not Applicable”) and a copay greater than “\$0,” the relevant Subject to Coinsurance? checkbox in the AVC is unchecked, and the AVC assumes that the enrollee pays a copay until reaching the MOOP. If the benefit has a coinsurance equal to “0%” and a copay greater than “\$0,” the relevant Subject to Coinsurance? checkbox in the AVC is checked and “100%” is entered into the relevant Coinsurance, if different field in the AVC. In the latter case, the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing.

## 6.9 Copay Values

For each benefit, if Copay—In Network (Tier 1) in the Plans & Benefits Template is equal to “\$X,” “\$X Copay with deductible,” “\$X Copay per day,” “\$X Copay per stay,” “\$X Copay per stay with deductible,” or “\$X Copay per day with deductible,” the Tier 1 Copay, if separate field in the AVC is set equal to X. If Copay—In Network (Tier 1) is equal to “\$X Copay after deductible,” “\$X Copay per stay after deductible,” or “\$X Copay per day after deductible” and the corresponding Coinsurance—In Network (Tier 1) field is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable,” the Tier 1 Copay, if separate field in the AVC is set equal to X. If Copay—In Network (Tier 1) is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable,” the Tier 1 Copay, if separate field in the AVC is left blank.

When both coinsurance and copay values are present for a given benefit, the AVC can consider a copay in the deductible range and a coinsurance rate in the coinsurance range; however, the stand-alone AVC does not support applying both a copay and a coinsurance in the coinsurance range. If a benefit’s copay is only after deductible and before the MOOP, and the benefit also has a coinsurance, the AVC considers only the coinsurance value in the coinsurance range. Therefore, if Copay—In Network (Tier 1) is equal to “\$X Copay after deductible,” “\$X Copay per stay after deductible,” or “\$X Copay per day after deductible” and Coinsurance—In Network (Tier 1) is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the Tier 1 Copay, if separate field in the AVC is left blank. For benefits with multiple in-network tiers, the logic described above for Tier 1 also applies to Tier 2.

As discussed in the AVC Methodology and User Guide, five service types (Mental/Behavioral Health and Substance Use Disorder Outpatient Services; Imaging; Speech Therapy; Occupational Therapy and Physical Therapy; and Laboratory Outpatient and Professional Services) include services also classified as Outpatient-Facility and Outpatient-Professional. If special cost-sharing provisions are indicated for Outpatient-Facility and/or Outpatient-Professional claims and no special cost sharing is indicated for the service type, services including both an Outpatient-Facility and Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The AV Calculator also allows the user to indicate the cost sharing for Primary Care and/or Specialist Office Visits and X-rays. The stand-alone AV Calculator will indicate if the special cost sharing was engaged in the AV calculation in the Additional Notes field. For additional information on the operations of these features, review the AVC Methodology and User Guide.

## 6.10 Copay Applies Only After Deductible

For each benefit, if the Copay—In Network (Tier 1) is equal to “\$X after deductible,” “\$X Copay per stay after deductible,” or “\$X Copay per day after deductible” and the Coinsurance—In Network (Tier 1) is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable” in the Plans & Benefits Template, the Tier 1 Copay applies only after the deductible? checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers, the same logic applies to Tier 2. While the stand-alone AVC returns an error if the

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<sup>21</sup> The AVC User Guide can be found on the first tab of the AVC located at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>. The appendix at the end of the User Guide contains charts that provide detail and examples regarding the application of cost sharing within the deductible and coinsurance range.

Copay applies only after the deductible? checkbox is checked and the benefit is also subject to a coinsurance, a copay after the deductible is never mapped from the Plans & Benefits Template if the benefit also has a coinsurance.

## 6.11 Benefit Categories<sup>22</sup>

**Table A1-5** shows the alignment of benefit categories in the Plans & Benefits Template and the AVC, and **Figure A1-17** (shown earlier) displays the benefit categories, along with their cost-sharing fields, in the AVC.

If a benefit included in the AVC is substituted in the Plans & Benefits Template, the benefit is considered not covered for purposes of mapping to the AVC. When a benefit is not covered, the Coinsurance, if different field for the benefit in the AVC is set to “0%,” and the Subject to Coinsurance? and Subject to Deductible? checkboxes are checked.

No inputs into the AVC are specific to the pediatric dental or vision benefits. Pediatric dental and vision are generally low-cost benefits that do not have a material impact on AV. Additional information on how pediatric dental and vision benefits are taken into account in the AVC is available in the AVC methodology.

Table A1-5. Benefit Category Alignment between Plans & Benefits Template and AVC

Plans & Benefits Template Category Name	AVC Category Name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., Hospital Stay)	All Inpatient Hospital Services (inc. MHSU)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (exc. Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Occupational and Physical Therapy
Preventive Care/Screening/Immunization <sup>23</sup>	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Specialty Drugs	Specialty Drugs (high-cost)

<sup>22</sup> The 2019 AVC uses new claims data from 2015 projected forward to 2019. For information about the considerations of the new claims data, please refer to the AVC Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

<sup>23</sup> Section 2713 of the Public Health Service Act, codified in 45 CFR 147.130, requires issuers to offer certain preventive care services without cost sharing, so the stand-alone AVC automatically takes into account no cost sharing for these services in the AV calculation and does not allow users to enter cost sharing for the Preventive Care/Screening/Immunization benefit category. Thus, regardless of the cost sharing in the Preventive Care/Screening/Immunization benefit category in the Plans & Benefits Template, no mapping occurs between the Plans & Benefits Template and the stand-alone AVC for this benefit category.

### 6.11.1 Inpatient Hospital Services

If the Inpatient Hospital Services Copay—In Network (Tier 1) in the Plans & Benefits Template is equal to “\$X Copay per Day,” “\$X Copay per day with deductible,” or “\$X Copay per day after deductible,” the Apply Inpatient Copay per Day? checkbox in the AVC is checked. If the Inpatient Hospital Services copay is charged per day for Tier 1, the AVC automatically assumes that the Inpatient Hospital Services copay is also charged per day for Tier 2, if applicable.

If Maximum Number of Days for Charging an Inpatient Copay? is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the Set a Maximum Number of Days for Charging an In Patient (IP) Copay? checkbox in the AVC is checked, and the Maximum Number of Days for Charging an Inpatient Copay? field in the Plans & Benefits Template is mapped to # Days (1–10) in the AVC. If the Maximum Number of Days for Charging an Inpatient Copay? field is blank in the Plans & Benefits Template, the Set a Maximum Number of Days for Charging an IP Copay? checkbox in the AVC is unchecked and # Days (1–10) in the AVC is left blank.

The Maximum Number of Days for Charging an Inpatient Copay? field is set at the plan variation level, allowing the values to differ between variations. However, the Set a Maximum Number of Days for Charging an IP Copay? checkbox and the # Days (1–10) field cannot vary between Tier 1 and Tier 2. **Figure A1-18** shows the Maximum Number of Days for Charging an Inpatient Copay? field in the Plans & Benefits Template, and **Figure A1-19** shows the corresponding checkbox and field in the AVC.

When filling out the stand-alone AVC, issuers intending to use the Maximum Number of Days for Charging an Inpatient Copay feature need to ensure that the Apply Inpatient Copay per Day? checkbox in the AVC (**Figure A1-20**) is checked. Otherwise the AVC will return an error when trying to calculate the AV. On the Plans & Benefits Template side, the user needs to follow the instruction in the first paragraph and select a cost sharing option that includes “per day” in order to ensure the “Apply Inpatient Copay per Day?” checkbox is checked in the AV Calculator mapping.

Figure A1-18. AVC Additional Benefit Design Fields in Plans & Benefits Template

AV Calculator Additional Benefit Design			
Maximum Coinsurance for Specialty Drugs	Maximum Number of Days for Charging an Inpatient Copay?	Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?
\$200	5	3	

Figure A1-19. Maximum Number of Days for IP Copay Checkbox and Field in AVC

Set a Maximum Number of Days for Charging an IP Copay?

# Days (1-10): 5

Figure A1-20. Apply IP Copay Checkbox in AVC

**User Inputs for Plan Parameters**

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Use Separate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR or Expanded Bronze AV Standard?

Desired Metal Tier: Silver

### 6.11.2 Skilled Nursing Facility

If the Skilled Nursing Facility Copay—In Network (Tier 1) in the Plans & Benefits Template is equal to “\$X Copay per Day,” “\$X Copay per day with deductible,” or “\$X Copay per day after deductible,” the Apply Skilled Nursing Facility Copay per Day? checkbox in the AVC is checked. If the Skilled Nursing Facility copay is charged

per day for Tier 1, the AVC automatically assumes that the Skilled Nursing Facility copay is also charged per day for Tier 2, if applicable.

Users intending to charge a Skilled Nursing Facility Copay per day should ensure that they have selected the Apply Skilled Nursing Facility Copay per Day? checkbox while filling out the stand-alone AVC to ensure accuracy of AV calculations.

### 6.11.3 Primary Care

If Begin Primary Care Cost-Sharing After a Set Number of Visits? is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the Begin Primary Care Cost-Sharing After a Set Number of Visits? checkbox in the AVC is checked, and the Begin Primary Care Cost-Sharing After a Set Number of Visits? field in the Plans & Benefits Template is mapped to # Visits (1–10) in the AVC. If the Begin Primary Care Cost-Sharing After a Set Number of Visits? field is blank in the Plans & Benefits Template, then the Begin Primary Care Cost-Sharing After a Set Number of Visits? checkbox in the AVC is unchecked and # Visits (1–10) in the AVC is left blank. As discussed in the AV Calculator User Guide, the use of this option does not imply a benefit design for primary care visits after the initial fully covered visits have occurred. The user must still indicate whether or not primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost-sharing (such as deductible and coinsurance) in the Plans & Benefits Template under the “Primary Care Visit to Treat an Injury or Illness.”

If Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? checkbox in the AVC is checked and the Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? field in the Plans & Benefits Template is mapped to # Copays (1–10) in the AVC. If the Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? field is blank in the Plans & Benefits Template, the Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? checkbox in the AVC is unchecked and # Copays (1–10) in the AVC is left blank. Per the AV Calculator User Guide, the use of this option does not imply a benefit design for primary care visits after the initial copays have occurred. The user must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under the “Primary Care Visit to Treat an Injury or Illness.”

The Begin Primary Care Cost-Sharing After a Set Number of Visits? and Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? fields (**Figure A1-21**) are set at the plan variation level, allowing the values to differ between variations. However, these primary care fields and checkboxes (**Figure A1-21**) cannot vary between Tier 1 and Tier 2. In addition to inputting any copay amount, these options must be used in conjunction with the Subject to Deductible? option for primary care services. Unchecking Subject to Deductible? with this option will result in an error message.

Figure A1-21. Primary Care Options in AVC

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input checked="" type="checkbox"/>
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
52	# Copays (1-10):	

### 6.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services copay and coinsurance inputs are weighted averages of the Mental/Behavioral Health Outpatient Services and the Substance Abuse Disorder Outpatient Services cost-sharing fields in the Plans & Benefits Template. However, the **Check AV Calc** procedure uses only the copay and coinsurance values for the Mental/Behavioral Health Outpatient Services benefit in the Plans & Benefits Template when mapping to the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Subject to Deductible?, Subject to Coinsurance?, and Copay applies only after the deductible? checkboxes in the AVC. The copay and coinsurance values for the Substance

Abuse Disorder Outpatient Services benefit in the Plans & Benefits Template do not affect the mapping to these AVC checkboxes.

If either the Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1) or Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1) fields in the Plans & Benefits Template contain the text “with deductible” or “after deductible,” the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Tier 1 Subject to Deductible? checkbox in the AVC is checked.

If the Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1) is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the Tier 1 Subject to Coinsurance? checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked. Then,  $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)})]$  is mapped to the Tier 1 Coinsurance, if different field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC.

In the following two scenarios,  $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)})]$  is mapped to the Tier 1 Copay, if separate field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC:

1. When the Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1) is equal to “\$X” or “\$X with deductible” in the Plans & Benefits Template.
2. When the Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1) is equal to “\$X after deductible” and the Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1) is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable” in the Plans & Benefits Template.

If the Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1) is equal to “\$X after deductible” and the Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1) is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable” in the Plans & Benefits Template, the Tier 1 Copay applies only after the deductible? checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked.

The logic described above (and captured generically in **Table A1-6**) also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services unless both the Tier 2 copay and Tier 2 coinsurance are equal to “Not Applicable.” If Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 2) and Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 2) are both equal to “Not Applicable,” the **Check AV Calc** procedure will use the Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1) and Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1) values when mapping to the Tier 2 checkboxes and fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC. If Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 2) and Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 2) are both equal to “Not Applicable,” the **Check AV Calc** procedure will use the Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1) and Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1) values for Substance Abuse Disorder Outpatient Services when mapping to the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Tier 2 fields in the AVC.

**Table A1-6** shows the detailed mappings described in this section.

Table A1-6. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template— Mental/Behavioral Health Outpatient Services		AVC—Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay Applies Only after Deductible?
\$X Copay after deductible or No Charge after deductible	X% or X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
No Charge or Not Applicable	X% Coinsurance after deductible					
\$X	X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	X% or X% Coinsurance after deductible					
No Charge or Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge, Not Applicable, or No Charge after deductible					
\$X Copay after deductible	No Charge, Not Applicable, or No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Checked
\$X	No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	No Charge, Not Applicable, or No Charge after deductible					
No Charge, or Not Applicable	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
\$X	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
No Charge, or Not Applicable	No Charge or Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X	No Charge or Not Applicable	Unchecked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked

### 6.11.5 Drugs

The Plans & Benefits Template and the AVC require cost sharing for four types of drugs: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs.

The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AVC returns an error. If a drug benefit has only a copay, enter “No Charge,” “No Charge after the deductible,” or “Not Applicable” rather than “0%” or “0% Coinsurance after

deductible” in the Coinsurance—In Network (Tier 1) or Coinsurance—In Network (Tier 2) fields in the Plans & Benefits Template to avoid an error from the AVC. Likewise, if a drug benefit has only a coinsurance, enter “No Charge,” “No Charge after the deductible,” or “Not Applicable” rather than “\$0” or “\$0 Copay after deductible” in the Copay—In Network (Tier 1) or Copay—In Network (Tier 2) fields in the Plans & Benefits Template.

#### 6.11.5.1 Specialty Drugs

If the Maximum Coinsurance for Specialty Drugs field includes a positive number in the Cost Share Variances worksheet of the Plans & Benefits Template, the Set a Maximum on Specialty Rx Coinsurance Payments? checkbox in the AVC is checked, and the Maximum Coinsurance for Specialty Drugs field in the Plans & Benefits Template is mapped to the Specialty Rx Coinsurance Maximum field in the AVC. If the Maximum Coinsurance for Specialty Drugs field is blank in the Plans & Benefits Template, the Set a Maximum on Specialty Rx Coinsurance Payments? checkbox in the AVC is unchecked, and the Specialty Rx Coinsurance Maximum field in the AVC is left blank.

The Maximum Coinsurance for Specialty Drugs field (**Figure A1-22**) is set at the plan variation level, allowing the values to differ between variations. However, the specialty drugs maximum coinsurance checkbox and amount field (**Figure A1-22**) cannot vary between Tier 1 and Tier 2.

Figure A1-22. Specialty Drugs Maximum Payment Fields in AVC

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$200

## 7. Zero Cost-Sharing and Limited Cost-Sharing Plan Variations

Zero cost-sharing plan variations, which are required to have zero cost sharing for all EHB categories, are automatically assigned an AV of 100 percent because they cover 100 percent of the average enrollee’s costs. Limited cost-sharing plan variations, which are required to have the same cost sharing and MOOPs as the standard plan for all EHB categories, must have the same AV as the standard plan. Although limited cost-sharing plan variations must provide zero cost sharing to certain individuals for EHB items or services furnished directly by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral under contract health services (45 CFR 156.420[b][2]), these CSRs are not represented in the Plans & Benefits Template and are not included in the AV calculation.

## Appendix 2: Plan ID Crosswalk

### 1. Introduction

The Plan ID Crosswalk Template crosswalks PY2018 QHP standard component ID and service area combinations (e.g., Plan ID and county combinations) to a PY2019 QHP Plan ID. These data will facilitate 834 enrollment transactions from CMS to the issuer for those enrollees in the individual market who have not actively selected a different QHP during open enrollment. These instructions apply to QHP and SADP issuers that offered individual market QHPs on the exchange during PY2018.

### 2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Issuer state
3. Market coverage
4. Completed Plans & Benefits Template
5. Completed Service Area Template.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ Issuers should crosswalk any discontinued PY2018 plan to an available plan in a different product, if one exists. If an issuer does not provide a crosswalk for a discontinued plan, but still offers products in that same service areas, CMS, in accordance with the hierarchy established in 45 CFR 155.355(j)(2), will crosswalk the discontinued plan to another product offered by the same issuer under the same HIOS ID.

#### Tips for the Plan ID Crosswalk

- ◆ First-time QHP issuers are not expected to submit a Plan ID Crosswalk Template.
- ◆ For PY2019, CMS has deferred the FF-SHOP's ability to auto-renew employees. Therefore, issuers should not attempt to submit a Plan ID Crosswalk Template for FF-SHOP plans.
- ◆ Issuers need to submit the Plan ID Crosswalk Template through the Plan Management Community.
- ◆ You must import only one Plans & Benefits Template and one Service Area Template. You must make separate submissions for multi-state plans and SADPs.

### 4. State Authorization of the Plan ID Crosswalk Template

Issuers are expected to submit evidence from the state, such as an email confirmation, that the issuer is authorized to submit its Plan ID Crosswalk Template. CMS will require this evidence to be submitted by issuers no later than June 29, 2018. Any subsequent submission of an issuer's Plan ID Crosswalk Template after June 29, 2018 should include an updated state authorization form. Issuers should provide evidence of state authorization through the Plan Management Community.

States have the opportunity to review the Plan ID Crosswalk Template for overall approval and compliance with the Patient Protection and Affordable Care Act market reforms such as uniform modification of coverage standards. States have the flexibility to determine the exact method by which they will review the Plan ID Crosswalk Template. For example, a state may perform a detailed review to confirm that the submitted Plan ID Crosswalk Template is consistent with state and federal requirements and reflects what the state expects to see in relation to their form filing reviews.

CMS will not send Plan ID Crosswalk Templates to states. Issuers may be asked by their state regulators to provide this template in addition to their submission to CMS [e.g., include the template as part of the National Association of Insurance Commissioners (NAIC) SERFF binder].

Issuers in direct enforcement states (Missouri, Oklahoma, Texas, and Wyoming) should submit the authorization form to their state department of insurance and to CMS’s Compliance and Enforcement Division ([formfiling@cms.hhs.gov](mailto:formfiling@cms.hhs.gov)) to obtain the necessary authorization for submission.

## 5. Detailed Section Instructions

The following steps outline how to complete the Plan ID Crosswalk Template.

To complete the information on the 2018 Plan Crosswalk tab, follow the steps in the table below.

2018 Plan Crosswalk Tab	Steps
Import 2018 Plans & Benefits and Service Area Template	<p>Click the <b>Import 2018 Plans &amp; Benefits and Service Area Template</b> button. This action imports the completed templates.</p> <p>The template will prompt you to select your completed <b>2018 Plans &amp; Benefits Template</b> and <b>2018 Service Area Template</b>. The Plans &amp; Benefits and Service Area Templates must be selected at the same time; therefore both templates should be saved in the same folder prior to importing. To select both files, click on one template, and then press and hold the <b>Ctrl</b> button while clicking on the other template. Then click <b>Open</b>. You must select exactly one Plans &amp; Benefits Template and one Service Area Template.</p> <p>The Plan ID Crosswalk Template will populate a list of PY2018 Plan IDs and their associated service areas on the <b>2018 Plan and Service Area Data</b> tab. Review this tab to ensure the data was accurately imported. After the PY2018 plan and service area data has been imported, the <b>2018 Plan Crosswalk</b> tab will be populated with all applicable issuer information as well as a row for each PY2018 Plan ID.</p>
HIOS Issuer ID	Ensure the template has accurately populated the five-digit HIOS Issuer ID.
Issuer State	Ensure the template has accurately populated the state in which the issuer is offering coverage.
Market Coverage	<p>Ensure the template has accurately populated the market coverage from the drop-down menu.</p> <p>The FF-SHOP Exchange will not allow auto-renewals for PY2019. Therefore, this field will be hard coded to <i>Individual</i>.</p>
Dental Only	<p>Ensure the template accurately indicates whether this Plan ID Crosswalk Template is for dental only plans. Choose from the following:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—this template is for SADPs only.</li> <li>◆ <b>No</b>—this template is for QHPs.</li> </ul>
Multi-State Plan	<p>Choose from the drop-down to indicate whether this Plan ID Crosswalk template is for the U.S. Office of Personnel Management (OPM) multi-state plans or not. Choose from the following:</p> <ul style="list-style-type: none"> <li>◆ <b>Yes</b>—this template is for the issuer’s multi-state plans.</li> <li>◆ <b>No</b>—this template is for the issuer’s non-multi-state plans.</li> </ul>
Crosswalk Level	<p>Select from the drop-down menu the level at which you would like to crosswalk each PY2018 plan. Choose from the following:</p> <ul style="list-style-type: none"> <li>◆ <b>Crosswalking to the Same Plan ID:</b> Select this option if you are crosswalking your PY2018 plan to the same Plan ID for PY2019, and you have no service area changes.</li> <li>◆ <b>Crosswalking at the Plan ID Level:</b> Select this option if you have no service area changes but are using a different PY2019 Plan ID to reflect the same plan.</li> <li>◆ <b>Crosswalking at the Plan ID and county coverage level:</b> Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2018 plan to two or more PY2019 Plan IDs.</li> </ul> <p><i>Note:</i> If your PY2018 plan covered the entire state, you will need to crosswalk the plan for every county in the state.</p>

2018 Plan Crosswalk Tab	Steps
	<ul style="list-style-type: none"> <li>◆ <b>Crosswalking at the ZIP level for one or more counties:</b> Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2018 plan to two or more PY2019 Plan IDs for the same county. Selecting this option will require you to select the counties from the PY2018 plan’s service area that will be crosswalked at the ZIP-code level. The remaining PY2018 service area will be crosswalked at the county level. <i>Note:</i> CMS discourages issuers from crosswalking at the ZIP level unless absolutely necessary.</li> <li>◆ <b>Discontinue with no crosswalk:</b> Select this option if you are discontinuing a PY2018 plan with no re-enrollment option for its enrollees.</li> <li>◆ <b>Plan withdrawn prior to certification:</b> Select this option if the PY2018 plan was withdrawn from the Exchange prior to certification and has no enrollment. Issuers should also select this option if the PY2018 Plan ID listed on the template was not approved by the state or FFE to be offered on the Exchange in PY2018.</li> </ul>
Counties Crosswalked at ZIP Level	Select from the pop-up menu which counties in your PY2018 plan’s service area will be crosswalked at the ZIP-code level.

To complete the information on the 2019 Plan Crosswalk tab, follow the steps in the table below.

2019 Plan Crosswalk Tab	Steps
Create “2019 Crosswalk Tab”	<p>Click the <b>Create “2019 Crosswalk Tab”</b> button. This action creates one 2019 Plan Crosswalk tab.</p> <p>The first four columns, 2018 HIOS Plan ID, County Name, Service Area Zip Codes, and Crosswalk Level, will be auto-populated based on your entries in the <b>2018 Plan Crosswalk</b> tab. If you decided to crosswalk at the Plan ID-County level for one or more plans, a row will appear for each county that plan covered in PY2018. If the user decided to crosswalk at the ZIP level for specific counties covered by a PY2018 plan, a row for each Plan ID-County-ZIP code combination will appear.</p> <p>Only click the <b>Create “2019 Crosswalk Tab”</b> button when you are sure the <b>2018 Plan Crosswalk</b> tab is complete. If you want to make changes on this tab after the <b>2019 Plan Crosswalk</b> tab is created, you will need to click the <b>Create “2019 Crosswalk Tab”</b> button again and start over on the <b>2019 Plan Crosswalk</b> tab. Clicking the <b>Create “2019 Crosswalk Tab”</b> button will clear all data you have already entered on the <b>2019 Plan Crosswalk</b> tab, so copy and paste this information into a separate workbook if you want to save your previous work.</p>
Crosswalk Reason	<p>Choose from the drop-down menu the reason for the crosswalk. The list of options will depend upon the crosswalk level selected. <b>Table A2-1</b> lists the possible crosswalk reason entries for each crosswalk level:</p> <ul style="list-style-type: none"> <li>◆ <b>Renewing exact same product/plan combination (Same PY2018 Plan ID):</b> Select this option if you are crosswalking this Plan ID/service area to the exact same HIOS Plan ID. Under this option, the template will auto-populate the PY2019 Plan ID field with your PY2018 Plan ID. Issuers are expected to comply with the “same plan” standards as defined in 45 CFR § 144.103. Issuers should use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2019 plan year.</li> <li>◆ <b>Renewing exact same product/plan combination (Different 2018 Plan ID):</b> Select this option if you are crosswalking this Plan ID/service area to the same product/plan combination but with a different PY2019 Plan ID. Issuers are expected to comply with the “same plan” standards as defined in 45 CFR § 144.103. As stated above, in most cases, issuers should use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming PY2019. <ul style="list-style-type: none"> <li>▪ In the limited cases where an issuer is continuing the same plan but has a need to crosswalk to a different HIOS Plan ID, the issuer should seek guidance and</li> </ul> </li> </ul>

2019 Plan Crosswalk Tab	Steps
	<p>approval from their state regulatory authority prior to submitting their Plan ID Crosswalk template to CMS. In the case of MSP options, an issuer should contact OPM for guidance and prior approval.</p> <ul style="list-style-type: none"> <li>◆ <b>Renewing product: renewal in a different plan within product:</b> Select this option if you are renewing this product, but crosswalking this Plan ID/service area to a different plan within the product offered through the FFE. If you select this option, you must use the same Product ID embedded in the plan's 2018 Plan ID.</li> <li>◆ <b>Continuing product: no plan available in the particular service area under that product; enrollment in a different product:</b> Select this option if you are continuing this product in PY2019 but will no longer offer any plans in part of the service area covered by the product in PY2018 and are crosswalking to a plan within a different product offered through the FFE. Select this reason for that portion of the service area that you no longer offer any plans under that product. If you select this option, you must crosswalk to a PY2019 Plan ID with a different Product ID from the PY2018 Plan ID.</li> <li>◆ <b>Continuing product: no plan available in the particular service area under that product; no enrollment option:</b> Select this option if you are continuing a PY2018 product, but there is no plan under this product available to crosswalk to for this plan/service area combination. Issuers should not enroll pertinent plans into a plan offered outside the Exchange. Selecting this option will disable the 2019 HIOS Plan ID field.</li> <li>◆ <b>Continuing product: no silver plan available in the particular service area under that product; enrollment in a silver plan under a different product:</b> Select this option if there is no available silver plan within the enrollee's product in a particular service area and the enrollee is being enrolled in a silver plan within another product.</li> <li>◆ <b>Discontinuing product: enrollment into a different product:</b> Select this option if this PY2018 product is discontinued for PY2019 and enrollees in this plan and associated service area will be re-enrolled in a plan under a different product offered through the FFE. Under this option, the entered PY2019 Plan ID must have a different Product ID and you may not enter the discontinued PY2018 Product ID for any other row under the PY2019 Plan ID. Issuers should crosswalk any discontinued PY2018 plan to an available plan in a different product, if one exists. If an issuer does not provide a crosswalk for a discontinued plan, but still offers products in that same service areas, CMS, in accordance with the hierarchy established in 45 CFR 155.355(j)(2), will crosswalk the discontinued plan to another product offered by the same issuer under the same HIOS ID.</li> <li>◆ <b>Discontinuing product: no enrollment option:</b> Select this option if a PY2018 product is discontinued for PY2019 and there is no enrollment option through the FFE for PY2018 enrollees in this Plan ID/service area combination. Issuers should not enroll pertinent plans into a plan offered outside the Exchange. Selecting this option will disable the PY2019 Plan ID field. Under this option, you may not enter the discontinued PY2018 Product ID for any other row under the PY2019 Plan ID. Issuers should crosswalk any discontinued PY2018 plan to an available plan in a different product, if one exists. If an issuer does not provide a crosswalk for a discontinued plan, but still offers products in that same service area, CMS, in accordance with the hierarchy established in 45 CFR 155.355(j)(2), will crosswalk the discontinued plan to another product offered by the same issuer under the same HIOS ID.</li> </ul>
2019 HIOS Plan ID	<p>Enter the PY2019 Plan ID you would like to crosswalk your enrollees to for the row's PY2018 Plan ID/service area. This field will be auto-populated when "Renewing exact same product/plan combination (Same 2018 Plan ID)" is chosen under the Crosswalk Reason. This field will be disabled when "Discontinuing product; no enrollment option," "Continuing product; no plan available in the particular service area under than product; no enrollment option," is chosen under the Crosswalk Reason.</p> <p><i>Note:</i> Issuers should only input PY2019 Plan IDs for plans that will be offered through the Exchange and are listed in the 2019 QHP Application. CMS will not accept any PY2019 Plan IDs for plans only sold outside the Exchange.</p>

2019 Plan Crosswalk Tab	Steps
Is this PY2018 Plan a Catastrophic or Child-Only Plan?	This field will default to <b>No</b> . Please select <b>Yes</b> for any catastrophic or child-only plan being crosswalked.
PY2019 Plan ID for Enrollees Aging off Catastrophic or Child-Only Plan	If selecting “ <b>Yes</b> ” in the previous data element, this field will allow you to enter a PY2019 Plan ID. Enrollees who no longer meet the criteria for continued eligibility in these plans will be crosswalked to the PY2019 Plan ID entered in this field.
Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s)	<p>CMS has included the following optional data fields to be completed if requested by an issuer’s state regulator:</p> <ul style="list-style-type: none"> <li>◆ PY2018 Plan ID—Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s).</li> <li>◆ PY2019 Plan ID—Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s).</li> <li>◆ PY2019/8 Plan ID (catastrophic or child-only)—Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s).</li> </ul>

A sample completed Plan ID Crosswalk Template looks like **Figure 2A-1**.

Figure A2-1. Sample Plan ID Crosswalk Template

Service Area Zip Code(s)	Crosswalk Level	Reason for Crosswalk	CROSSWALK PLAN 2018 HIOS PlanID (Standard Component)	Is this Plan a Catastrophic or Child-Only Plan?	2019 Plan ID for Enrollees Aging off Catastrophic or Child-Only Plan.
Required if crosswalking at the zip level	Based on Option Selected on "2018 Plan Crosswalk" Worksheet	Required	Required	Required	Required if Yes Under this Plan a Catastrophic Child-Only Plan.
	Crosswalking to same Plan ID	Renewing exact same product/plan combination (Same 2018 Plan ID)	12345VA0010001	No	
	Crosswalking at the plan ID level			No	
	Crosswalking at the plan ID level			No	

**Table A2-1** lists the crosswalk reason and PY2019 Plan ID entry options for each crosswalk level.

Table A2-1. Crosswalk Level, Reason for Crosswalk, and PY2019 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2019 HIOS Plan ID
Crosswalking to same Plan ID	Renewing exact same product/plan combination. (Same PY2018 Plan ID). <i>(auto-populated)</i>	Template populates field with PY2018 Plan ID. <i>(auto-populated)</i>
Crosswalking at the Plan ID Level	Renewing exact same product/plan combination. (Different PY2019 Plan ID).	Different Plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same Product ID as PY2018 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different Product ID from PY2018 Plan ID.
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2019 Plan ID.
	Discontinuing product; enrollment into a different product.	Plan ID with different Product ID from PY2018 Plan ID.
Crosswalking at the Plan ID and county coverage level	Renewing exact same product/plan combination. (Same PY2018 Plan ID).	Template populates field with PY2018 Plan ID. <i>(auto-populated)</i>
	Renewing exact same product/plan combination. (Different PY2019 Plan ID).	Different Plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same Product ID as PY2018 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different Product ID from PY2018 Plan ID.
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2019 Plan ID.
	Continuing product; no plan available in the particular service area under than product; no enrollment option.	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
	Discontinuing product; enrollment into a different product.	Plan ID with different Product ID from PY2018 Plan ID.
	Discontinuing product; no enrollment option.	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
Crosswalking at the zip level for one or more counties	Renewing exact same product/plan combination. (Same PY2018 Plan ID).	Template populates field with PY2018 Plan ID. <i>(auto-populated)</i>
	Renewing exact same product/plan combination. (Different PY2019 Plan ID).	Different Plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same Product ID as PY2018 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different Product ID from PY2018 Plan ID.
	Continuing product; no plan available in the particular service area under than product; no enrollment option.	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different Product ID from PY2019 Plan ID.
	Discontinuing product; no enrollment option.	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>

Crosswalk Level	Crosswalk Reason	2019 HIOS Plan ID
	Discontinuing product; enrollment into a different product.	Plan ID with different Product ID from PY2018 Plan ID.
Discontinue with no crosswalk	Discontinuing product; no enrollment option.	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
	Continuing product; no plan available in the particular service area under than product; no enrollment option.	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
Plan Withdrawn Prior to Certification	Plan Withdrawn Prior to Certification. No enrollment option. <i>(auto-populated)</i>	PY2019 HIOS Plan ID field is disabled. <i>(auto-populated)</i>

Once the Plan ID Crosswalk Template is completed, issuers must validate, finalize, and email the file(s).

Template Validation	Steps
Validate Template	Click the <b>Validate</b> button on the 2018 Plan Crosswalk tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click <b>Validate</b> again. Continue this process until all errors are resolved.
Finalize Template	Click the <b>Finalize</b> button on the 2018 Plan Crosswalk tab. The Finalize function creates the .xml file of the template.
Save Template	<b>Save</b> the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .xml file in the same folder.
Upload Template	Email the finalized template to the Plan Management Community with the subject title "2018 Plan ID Crosswalk." <i>Note:</i> If the .xml file name is modified after finalization, CMS cannot process the template.

## Appendix 3: Transparency in Coverage Template

### 1. Introduction

This document provides instructions for QHP issuers submitting transparency in coverage data (transparency data) for PY2019.

Issuers seeking certification of a QHP must make accurate and timely disclosures of transparency reporting<sup>24</sup> information to the appropriate Exchange, Secretary of HHS, state insurance commissioner, as well as make it available to the public.<sup>25</sup> These instructions apply to issuers participating as a QHP in the Federally-facilitated Marketplaces (FFMs) in PY2019, including issuers in FFMs where states are performing plan management functions. This includes SADPs. There are no requirements for SBE issuers at this time.

### 2. Data Requirements

To complete this section, issuers will need the following:

- Information on whether the QHP was on the Exchange in 2017
- HIOS Issuer ID
- Issuer legal name
- Points of contact
- Claims policy and URL
- Number of claims
- Number of appeals.

### 3. Quick Reference

#### Key Changes for 2019

- ◆ No changes for the 2019 QHP Application.

#### Tips for the Transparency Template

- ◆ Issuers that seek to offer QHPs for plan year 2019 but did not offer QHPs in 2017 must still submit a Transparency in Coverage Template for 2017 data.
- ◆ The data elements that are required will be **identified by a caret (^)** next to the field name. If a field is not required, enter "N/A."
- ◆ Complete the template for each unique HIOS Issuer ID.
- ◆ Test the URL(s) to ensure proper function prior to submission.

### 4. Transparency in Coverage Template

Perform the following steps to complete the Transparency in Coverage Template (**Figure A3-1**).

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<sup>24</sup> Section 2715A of the PHS Act extends the transparency reporting provisions under section 1311(e)(3) to non-grandfathered groups and issuers offering group or individual coverage, except for a plan not offered through an Exchange.

<sup>25</sup> The implementation of the transparency reporting requirements under 1311(e)(3) for QHP issuers as described in this document does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under 2715A of the PHS Act, incorporated into section 715(a)(1) of the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

Figure A3-1. Transparency in Coverage Template

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting	
Plan Year 2019	
Please complete the fields below, following the instructions in the Transparency in Coverage QHP Issuer Instruction Guide.	
<b>General Information</b>	
Was this plan on the Exchange in 2017?	
Issuer Name	
Issuer D/B/A, if Applicable	
Issuer HIOS ID	
Issuer Point of Contact Name	
Issuer Point of Contact E-mail Address	
Issuer Point of Contact Phone Number	
Issuer Backup Point of Contact	
Issuer Backup Point of Contact E-mail Address	
Issuer Backup Point of Contact Phone Number	
<b>2019 Data: Reporting of all fields is required for 2019</b>	
Claims Payment Policies & Other Information URL	
Number of Claims Received in Calendar Year 2016 for Services Rendered in 2017	
Number of Claims Denied in Calendar Year 2017	
Number of Internal Appeals Filed in Calendar Year 2017	
Number of Internal Appeals Overturned from Calendar Year 2017 Appeals	
Number of External Appeals Filed in Calendar Year 2017	
Number of External Appeals Overturned from Calendar Year 2017 Appeals	
<b>Notes: (Please enter any comments/notes here.)</b>	

General Information	Steps
Was this plan on the Exchange in 2017?^	Enter Yes or No, indicating whether or not this plan was on the Exchange in 2017. If Yes, then the issuer must fill out claims and appeals data.
Issuer Name^	Enter the issuer's legal name.
Issuer D/B/A, if Applicable^	
Issuer HIOS ID^	Enter the five-digit HIOS Issuer ID. If the issuer has more than one HIOS ID, it should submit a separate template for each HIOS ID.
Issuer Point of Contact Name^	Enter the first and last name of the issuer's primary point of contact for transparency data.
Issuer Point of Contact Email Address^	Enter the email address for the issuer's point of contact.
Issuer Point of Contact Phone Number^	Enter the phone number for the issuer's point of contact.
Issuer Back-up Point of Contact^	Enter the first and last name of the issuer's back-up point of contact.
Issuer Back-up Point of Contact Email Address^	Enter the email address for the issuer's back-up point of contact.
Issuer Back-up Point of Contact Phone Number^	Enter the phone number for the issuer's back-up point of contact.

2019 Data	Steps
Claims Payment Policies & Other Information URL <sup>^</sup>	<p>Enter the active and easily accessible URL. A URL is easily accessible when:</p> <ul style="list-style-type: none"> <li>◆ It can be viewed on the plan’s public website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and</li> <li>◆ If an issuer offers more than one plan, when an individual can easily discern what information applies to which plan.</li> </ul> <p>The URL is the web address on the issuer website that consumers use to view the providers claims information. All URLs should be live, with one URL for a landing page or single page with a link providing the information indicated below.</p>
Out-of-network liability and balance billing	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Balance billing occurs when an out-of-network provider bills an enrollee for charges—other than copayments, coinsurance, or any amounts that may remain on a deductible.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ Information regarding whether an enrollee may have financial liability for out-of-network services.</li> <li>◆ Any exceptions to out-of-network liability, such as for emergency services.</li> <li>◆ Information regarding whether an enrollee may be balance-billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing.</li> </ul>
Enrollee claim submission	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ General information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.</li> <li>◆ A time limit to submit a claim, if applicable.</li> <li>◆ Links to any applicable forms.</li> <li>◆ The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number.</li> </ul>
Grace periods and claims pending	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of what a grace period is.</li> <li>◆ An explanation of what claims pending is.</li> <li>◆ An explanation that it will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.</li> </ul>

2019 Data	Steps	
	Retroactive denials	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.</li> <li>◆ Ways to prevent retroactive denials when possible, for example paying premiums on time.</li> </ul>
	Recoupment of overpayments	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ Instructions to enrollees on obtaining a refund of premium overpayment.</li> </ul>
	Medical necessity and prior authorization timeframes and enrollee responsibilities	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.</li> <li>◆ Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation that some services may require prior authorization and/or be subject to review for medical necessity.</li> <li>◆ Any ramifications should the enrollee not follow proper prior authorization procedures.</li> <li>◆ A time frame for the prior authorization requests.</li> </ul>
	Drug exception timeframes and enrollee responsibilities (not required for SADPs)	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.</li> <li>◆ The time frame for a decision based on a standard review or expedited review due to exigent circumstances.</li> <li>◆ How to complete the application.</li> </ul>
	Explanation of benefits (EOB)	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ An EOB is a statement an issuer sends the enrollee to explain what medical treatments and/or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of what an EOB is.</li> <li>◆ Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).</li> <li>◆ How a consumer should read and understand the EOB.</li> </ul>

2019 Data	Steps	
	Coordination of benefits	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of what coordination of benefits is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).</li> </ul>
Number of Claims Received in Calendar Year 2017	Enter the number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network healthcare provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Claims should be counted by date of service.	
Number of Claims Denied in Calendar Year 2017	<p>Enter the number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network healthcare provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied.</p> <ul style="list-style-type: none"> <li>◆ A claim means any individual line of service within a bill for services (medical and pharmacy, including pharmacy point of sale).</li> <li>◆ Include claims for all QHPs in FFEs and SBE-FPs that fall under the reporting HIOS ID. If the issuer has more than one HIOS ID, it should submit a separate spreadsheet for each HIOS ID.</li> <li>◆ Do not include claims that were pended for additional information and subsequently paid.</li> <li>◆ Do not include out-of-network claims.</li> <li>◆ Include <i>all</i> denials in the total number of claims denied in calendar year 2016. This includes, but is not limited to: <ul style="list-style-type: none"> <li>▪ Pediatric vision and dental denials;</li> <li>▪ Partial denials;</li> <li>▪ Denials due to ineligibility;</li> <li>▪ Denials due to incorrect submission;</li> <li>▪ Denials for incorrect billing; and</li> <li>▪ Duplicate claims.</li> </ul> </li> </ul>	
Number of Internal Appeals Filed in Calendar Year 2017	Enter the number of requests by the insured for internal reviews of grievances involving adverse determinations. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of an admission, availability of care, continued stay, or healthcare service for a covered person.	
Number of Internal Appeals Overturned from Calendar Year 2017	Enter the number of final determinations adverse to the consumer that are overturned upon request for internal review, in whole or in part. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of an admission, availability of care, continued stay, or healthcare service for a covered person.	
Number of External Appeals Filed in Calendar Year 2017	Enter the number of requests by the insured for appeals on final adverse determinations to an external review organization.	
Number of External Appeals Overturned from Calendar Year 2017	Enter the number of final adverse determinations overturned upon request for external review, in whole or in part.	

Issuers are required to use the deadlines shown below for the transparency data submission.

Activity	Dates
Initial QHP transparency submission window	07/31/2018–08/30/2018
CMS reviews initial QHP data submissions as of 09/01/2017	08/31/2018–09/05/2018
CMS sends first correction/non-submission notice	09/06/2018–09/10/2018
Deadline for submission of revised QHP data	09/24/2018
CMS reviews revised QHP data as of 09/24/2018	09/24/2018–10/01/2018

Once the template is completed, issuers must save the template as an Excel file and submit their template to [Transparency@cms.hhs.gov](mailto:Transparency@cms.hhs.gov) by the required deadline above. Issuers will receive an automated response indicating that the template has been received. Issuers who need to resubmit or correct any errors must follow the steps above for resubmission to correct any identified error(s).

If issuers have questions about the transparency data submission process, contact the CMS Marketplace Service Desk at 855-CMS-1515 or via email at [CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov).